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

Oriental Super Health Top-Up!- Prospectus

1.1 PRODUCT Oriental Super Health Top Up Policy is a high threshold indemnity health insurance product, covering the members of a family under a single sum insured on floater basis or each member on individual sum insured basis. Claim under the Policy is payable provided the cumulative medical expenses for the insured (individual basis) or the family (floater basis) in a policy period exceeds the threshold. The Policy covers expenses in respect of inpatient treatment reasonably and customarily incurred for treatment of a disease or an injury contracted/sustained during the policy period. The Policy also covers pre hospitalization and post hospitalization expenses, 180 day care procedures/surgeries, organ donor's medical expenses, hospital cash, ambulance charges, HIV/ AIDS treatment, and maternity.

1.2. BASIS OF PAYMENT: The Company shall indemnify the insured, subject to aggregate of all admissible expenses incurred exceeding the Deductible but not exceeding the Sum Insured, under this policy and Dates of admission in the hospital falling within the policy period.

2 A. INSURED EXPENSES

ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE RECIPIENT: The policy covers in-patient hospitalization expenses in respect of the person donating the organ to the insured person, provided that the donation conforms to the Transplantation of Human Organs Act 1994 (or as amended from time to time) and/or any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs.
Further provided that the organ donated is for the use of the Insured Person who has been medically advised to undergo organ transplant and the claim of the Insured Person is admissible under the hospitalization section of the policy.
The policy does not cover:
a) Costs directly or indirectly associated with the acquisition of the organ and/or cost of organ.
b) Costs towards donor screening
c) Pre & post hospitalization medical expenses of the donor.

ORGAN DONOR BENEFIT- WHEN INSURED PERSON IS THE DONOR: A lump sum payment of 10% of Sum Insured, to take care of medical and other incidental expenses is payable to the Insured Person donating an organ, provided that the donation conforms to the Transplantation of Human Organs Act 1994(as amended from time to time) and any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. This benefit is available only to the Insured person provided that this policy has been in force for a continuous period of minimum 24 months in respect of such an insured person. This lump sum payment will be made even if the Deductible has not been exceeded, and will be in addition to any amount payable under this head in any other Policy / or any other source. However, payment made under this section shall be within the Sum Insured limit of the Policy.

MATERNITY EXPENSES: The policy provides automatic maternity cover up to 10% of the Sum Insured. The Company shall pay the Medical Expenses incurred as an inpatient for a delivery (including caesarean section) or lawful medical termination of pregnancy during the policy period limited to two deliveries or terminations or either, during the lifetime of the Insured Person. Cover under this section is not available to those insured who already have two living children. This benefit is available only to the Insured or his spouse provided that this

policy has been in force for a continuous period of minimum 12 months in respect of both the Insured and his/her spouse. However, miscarriage due to accident or abdominal operation for extra uterine pregnancy (ectopic pregnancy) which is proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner, if left untreated, is not part of maternity coverage and hence no waiting period would apply in such cases.

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

In case the 90 days period for the New Born Baby is spread over two policy periods, the aggregate liability of the Company, for all claims in respect of the New Born Baby, shall be limited to 5% of the Sum Insured of the policy under which the claim had triggered. Claim under this section is independent of the claim status in respect of Maternity expenses, i.e admissibility or otherwise of claim under 2A3 will not affect the claim in respect of New Born Baby

Special conditions applicable to Maternity Expenses and New Born Baby Cover

- These benefits are admissible only if the expenses are incurred in a Hospital as an in-patient.
- Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve Weeks from the date of conception are not covered.
- Pre-natal and post-natal expenses are not covered unless admitted in Hospital and treatment is taken there.
- Pre Hospitalization and Post Hospitalization benefits are not available under these two clauses.
- Subject to the terms & conditions, the policy covers New Born Baby beyond 90 days only on payment of requisite premium.

TELEMEDICINE: Expenses incurred by insured on telemedicine/Teleconsultation with a registered medical practitioner for Diagnosis & treatment of a disease/illness covered under the Policy. Such reasonable incurred expenses will be reimbursable wherever consultation with a registered medical practitioner is allowed in the terms and conditions of policy contract and shall be subject to Limits/Sublimit prescribed in Policy Schedule. Telemedicine offered shall be in compliance with the Telemedicine Practice Guidelines dated 25th of March 2020 by MCI and as amended from time to time."

The limit of amount payable for telemedicine is: i). Maximum Rs. 2,000/- per insured &/or per family, for a policy period for sum insured up to Rs. 20.0 lakhs and ii). Maximum Rs. 5,000/- per insured &/or per family, for a policy period for sum insured up to Rs. 30.0 lakhs.
Note: The expenses towards Telemedicine will be payable, only if, they form part of Pre and Post Hospitalization and/or Hospitalization claims.

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

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

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

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

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

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

Name of the Procedure	**Sub limits for sum insured slab from Rs.3.0 lac to Rs. 10.0 lacs**	**Sub limits for sum insured slab from Rs.15.0 lac to Rs. 30.0 lacs**
A. Uterine Artery Embolization and HIFU	Per policy period: Up to INR 50,000.	
B. Balloon Sinuplasty	Per policy period: Up to INR 40,000.	
C. Deep Brain stimulation	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
D. Oral chemotherapy	Per policy period 25% of SI, subject to maximum INR 50,000.	Per policy period: Up to INR 1,50,000.
E. Immunotherapy- Monoclonal Antibody to be given as injection	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
F. Intra vitreal injections	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
G. Robotic surgeries	Per policy period 10% of SI, subject to maximum INR 1,00,000.*	Per policy period 10% of SI, subject to maximum INR 2,00,000.*
	***(The sub limit is on the cost incurred due to modern treatment methods of robotics and associated expenses and this amount is over and above the limit for conventional surgery for that ailment).**	
H. Stereotactic radio surgeries	Per policy period 10% of SI, subject to maximum INR 1,00,000.	Per policy period 10% of SI, subject to maximum INR 2,00,000.
I. Bronchial Thermoplasty	Per policy period 10% of SI, subject to maximum INR 1,00,000.	Per policy period 10% of SI, subject to maximum INR 2,00,000.
J. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
K. IONM - (Intra Operative Neuro Monitoring)	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.

2B. POLICY TRIGGER: This policy would trigger when the aggregate of actual admissible expenses incurred in respect of any one or more claims (either for an Individual in case of an Individual plan, or for one or more than one insured person, in case of a Family Floater plan) in a policy period, exceeds the Deductible under the Policy. If there are other sources (other than Insurance policies) from where the Insured Person can receive an amount which is greater than the Deductible, the Insured Person has the option either to exhaust other options first and subsequently claim under this Policy; or to first claim under this Policy. If the Insured Person chooses to first claim under this Policy, and if subsequently he receives reimbursement from other sources for any amount which has also been paid under this Policy, the Insured Person shall refund to the Company such excess payment. In no

case shall the liability of the Company exceed the Sum Insured for one or all claims in aggregate during the policy period.

3. DEFINITIONS:

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

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

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

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

Cashless Facility: means a facility extended by the insurer or TPA on behalf of the Insurer to the insured, where the payments for the costs of the treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent of pre- authorization is approved.

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

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

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

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

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

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

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

Day Care Treatment: means medical treatment, and/or surgical procedure which is:
Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and which would have otherwise required a hospitalization of more than 24 hours. Treatments normally taken on an out-patient basis is not included in the scope of this definition.

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

- Legally wedded spouse.
- Parents / Parents-in-law (either of them)
- Dependent Children- natural or legally adopted, between the ages of 91days to 18 years.

Grace Period: means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

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

- has qualified nursing staff under its employment round the clock;
- 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;
- has qualified Medical Practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- 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:

- Central or State Government AYUSH Hospital; or
- Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/ Central Council for Homeopathy; or
- 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:

1. Having at least five in- patient beds;
2. Having qualified AYUSH Medical Practioner in charge round the clock;
3. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
4. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

AYUSH Day Care Centre: means and includes Community Health Centre (CHC), Primary health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable

and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practioner (s) on day care basis without inpatient services and must comply with all the following criterion:

- Having qualified registered AYUSH Medical Practitioner (s) in charge.
- Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

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

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

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation or to be specially trained to cope with it
4. it continues indefinitely
5. it comes back or is likely to come back.

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

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

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

ICU Charges: means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

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

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

Maternity Expenses: shall include (a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections) incurred during hospitalization (b) expenses towards lawful medical termination of pregnancy during the policy period.

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

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

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

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

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

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

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

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

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

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

Pre-Hospitalization Expenses Medical Expenses: means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Post-Hospitalization Medical Expenses: means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital, provided that Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

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

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

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

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

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

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

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

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

Surgery or Surgical Procedure: means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or a day care centre by a Medical Practitioner.

Third Party Administrator (TPA): means any person who is registered under the IRDAI (Third Party Administrators – Health Service) Regulations, 2016, notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those regulations.

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

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

4. EXCLUSIONS:

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

Pre-existing Diseases - code –ExcI 01

- Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with the insurer or its reinstatement.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- 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.
- Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer or its reinstatement.

Specified disease / procedure waiting period- code- ExcI 02

- 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.
- in case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- 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.
- The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- 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.

The expenses on treatment of following ailments / diseases / surgeries, if contracted and / or manifested after inception of first Policy (subject to continuity being maintained), are not payable during the waiting period specified below.

	Ailment / Disease / Surgery	**Waiting Period**
i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	12 months
ii	Polycystic ovarian diseases.	12 months
iii	Surgery of hernia.	24 months
iv	Surgery of hydrocele.	24 months
v	Non infective Arthritis.	24 months
vi	UnDescendent Testes.	24 months
vii	Cataract.	24 months
viii	Surgery of benign prostatic hypertrophy.	24 months
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse	24 months
x	Fissure / Fistula in anus.	24 months
xi	Piles.	24 months
xii	Sinusitis and related disorders.	24 months
xiii	Surgery of gallbladder and bile duct excluding malignancy.	24 months
xiv	Surgery of genito urinary system excluding malignancy.	24 months

xv	Pilonidal Sinus.	24 months
xvi	Gout and Rheumatism.	24 months
xvii	Hypertension.	90 Days*
xviii	Diabetes.	90 Days*
	*Subject to application of clause 40 of policy conditions.	
xix	Calculus diseases.	24 months
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	24 months
xxi	Surgery of varicose veins and varicose ulcers.	24 months
xxii	Congenital internal diseases.	24 months
xxiii	Joint Replacement due to Degenerative condition.	48 months
xxiv	Age related osteoarthritis and Osteoporosis.	48 months

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

30 day waiting period- code – ExcI 03

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

Investigation & Evaluation – Code – ExcI 04 Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded. b). Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

Rest Cure, rehabilitation and respite care – Code –ExcI 05
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

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

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

- Surgery to be conducted is upon the advice of the Doctor.
- The surgery /Procedure conducted should be supported by clinical protocols.
- The member has to be 18 years of age or older and
- Body Mass Index (BMI):

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

Change of Gender Treatments: Code – ExcI 07
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite.

Cosmetic or Plastic Surgery- Code- ExcI 08
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for Reconstruction following an accident, burns(s) or Cancer or as part of medically necessary treatment to remove direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical practioner.

Hazardous or Adventure sports- Code- ExcI 09
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

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

Excluded Providers- Code – ExcI 011
Expenses incurred towards treatment in any hospital or by any Medical Practioner or any other provider specifically excluded by the Insurer and disclosed in its website /notified to the policy holders are not admissible. However, in case of life threatening situations or following an accident, expenses upto the stage of stabilization are payable but not complete claim.

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

Code- ExcI013 Treatments received in health hydro's, 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- ExcI014 Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practioner as part of hospitalization claim or day care procedure.-

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

Unproven Treatments- Code – excI 016
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

Sterility and Infertility- Code- ExcI 017
Expenses related to sterility and infertility. This includes:

- Any type of contraception, sterilization.
- Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, and ICSI.
- Gestation Surrogacy.
- Reversal of sterilization.

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

restraints and detainment of all kinds.

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

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

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

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

-Costs of spectacles, contact lenses, hearing aids etc.

-Congenital external diseases or defects or anomalis.

-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.

-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.

-Stem cell implantation and/or Surgery other than Hematopoietic stem cells for bone marrow transplant for hematological conditions, which to be covered.

-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).

-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.

-Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

-Any stay in the Hospital for any domestic reason or where no active regular treatment is given by the Specialist.

- Any kind of Service charges, Surcharges, Admission fees / Registration charges etc levied by the Hospital.

- Doctor’s home visit charges, Attendant / Nursing charges during pre and post Hospitalisation period

- Pre and Post Hospitalization expenses unrelated with disease / Injury for which Hospitalization claim has been admitted under the Policy

- Any expenses incurred on OPD treatment

- Treatment taken outside the geographical limits of India.

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

permanently excluded from the policy coverage:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C Malignant neoplasms of digestive organs, • C30-C39 Malignant ne of respiratory and intrathoracic organs• C40-C41 Malignant neopl bone and articular cartilage• C43-C44 Melanoma and other malign neoplasms of skin • C45-C49 Malignant neoplasms of mesothelia tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malig neoplasms of female genital organs • C60-C63 Malignant neoplas male genital organs • C64-C68 Malignant neoplasms of urinary tra C72 Malignant neoplasms of eye, brain and other parts of central n system • C73-C75 Malignant neoplasms of thyroid and other endo glands • C76-C80 Malignant neoplasms of ill-defined, other secon unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B Secondary neuroendocrine tumours • C81-C96 Malignant ne of lymphoid, hematopoietic and related tissue• D00-D09 In situ n • D10-D36 Benign neoplasms, except benign neuroendocrine tumo D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera myelodysplastic syndromes • D3A-D3A Benign neuroendocrine D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Conger disease and valvu disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart dis Q20 Congenital malformations of cardiac chambers and connectio Congenital malformations of cardiac septa • Q22 Congenital malfo of pulmonary and tricuspid valves • Q23 Congenital malformation aortic and mitral valves • Q24 Other congenital malformations of Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformatio peripheral vascular system• Q28 Other congenital malformations circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Ch rheumatic heart diseases Nonrheumatic mitral valve disorders mitr (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When unspecified cause but with mention of: • diseases of aortic valve (I mitral stenosis or obstruction (I05.0) when specified as congenital Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insu • Mitral (valve): incompetence / regurgitation - • NOS or of specif except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular dise

6	Inflammatory Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's diseas intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51. ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liv withfibrosis cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.- liver disease; Oesophageal varices in diseases classifiedelsewhere K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital cond pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney diseas	N17-N19) Renal failure; I12.0 - Hypertensive renal disease w failure; I12.9 Hypertensive renal disease without renal failure Hypertensive heart and renal disease with renal failure; I13.2 - Hyp heart and renal disease with both (congestive) heart failure and ren N99.0 - Post procedural renal failure; O08.4 - Renal failure abortion and ectopic and molar pregnancy; O90.4 - Postpartum a failure; P96.0 - Congenital renal failure. Congenital malformatio urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B withd (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with d (coinfection) without hepatic coma; B16.2 - Acute hepatitis B with agent with hepatic coma; B16.9 –Acute hepatitis B without delta- without hepaticcoma; B17.0 –Acute (super)infection of hepatitis B carrier; B18.0 -Chronic viral hepati delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified;F0 G30.9Dementia in Alzheimer's unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20 disease resulting in other bacterial infections; B20.2 - HIV disease in cytomegaloviral disease; B20.3 - HIV disease resulting in o infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HI resulting in other mycoses; B20.6 - HIV disease resulting in Pne carinii pneumonia; B20.7 - HIV disease resulting in multiple i B20.8 - HIV disease resulting in other infectious and parasitic B20.9 - HIV disease resulting in unspecified infectious or parasiti B23.0 - Acute HIV infection syndrome; B24 - Unspecifie immunodeficiency virus [HIV] disease

14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hea unilateral with unrestricted hearing on the contralateral side; Conductive hearing loss, unspecified; H90.3 - Sensorineural hea bilateral; H90.4 - Sensorineural hearing loss, unilateral with un hearing on the contralateral side; H90.6 - Mixed conduc sensorineural hearing loss, bilateral; H90.7 - Mixed conduc sensorineural hearing loss, unilateral with unrestricted hearin contralateral side; H90.8 - Mixed conductive and sensorineural hea unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, un
15.	Papulosquamous disor skin	L40 - L45 Papulosquamous disorder of the skin including psoria Planus
16.	Avascular (osteonecrosis)	M 87 to M 87.9

6) CONDITIONS:

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

2. **DUE OBSERVANCE AND FULFILMENT** of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorized official of the Company.

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

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

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

6. **PLANS**: Policy has Two Plans - **Individual and Family Floater** with following Sums Insured and corresponding Deductibles.

Option is also available to remove the Room rent limits by paying an additional premium:

Sl.No.	**Deductible (INR)**	**Sum Insured (INR)**
1	300000	300000
2	300000	500000

3	500000	500000
4	500000	700000
5	600000	600000
6	600000	800000
7	800000	800000
8	800000	1000000
9	1000000	1000000
10	1000000	1500000
11	1500000	1000000
12	1500000	1500000
13	1800000	1000000
14	1800000	1200000
15	2000000	1000000
16	2000000	2000000
17	2000000	3000000

7. PAYMENT OF PREMIUM: The premium under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the company. Advance premium payment shall be condition precedent to the contract.

8. PREMIUM LOADINGS / DISCOUNTS

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

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

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

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

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

of insured persons who had entered the policy at the age of 65years or earlier.

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

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

9A. PROPORTIONATE CLAUSE - If the Insured Person is admitted in the hospital in a room where the room category or the Room Rent incurred is higher than the eligibility as specified in the Policy Schedule/ Certificate of Insurance, then the Policyholder/ Insured Person shall bear a rate able proportion of the total & specified Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to the Room Rent actually incurred. However, this will not be applicable in respect of Medicines/Pharmacy/ Drugs, Consumables, Medical Devices/ implants and Cost of Diagnostics.

9B. ASSOCIATED MEDICAL EXPENSES:

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

1. Chemotherapy/Radiotherapy charges
2. Nebulisation
3. Hemodialysis
4. PICC line insertion
5. Catheterisation charges Tracheostomy etc.
6. IV charges
7. Blood transfusion charges
8. Dialysis
9. Surgery Charges
10. OT charges including OT gas, equipment charges

9C.PRE-INSURANCE MEDICAL CHECK-UP: In following cases, pre-insurance Medical Checkup

Is required:-

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

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

1	GENERAL PHYSICAL EXAMINATION
2	CBC WITH ESR
3	LIPID PROFILE
4	HbA1c
5	S.CREATININE
6	URINE-ROUTINE & MOLECULAR
7	ECG
8	TSH

9	X-RAY CHEST
10	USG
11	EYE EXAMINATION-FUNDUS & GLAUCO

- In case of adverse medical history, the Company may ask for additional tests depending on the medical condition.
- Medical reports up to 30 days prior to the date of proposal, are only valid.
- In case of fresh proposals where an insured person has undergone pre-insurance Medical Checkup, 50% cost of Medical Check-up shall be reimbursed if the proposal has been accepted by the Company. Where there has been a break in the Policy Period and continuity benefits are not restored (i.e the Policy is treated as fresh and not as renewal), and the insured person has had to undergo such Medical Checkup, in such cases also 50% cost of Medical Check-up shall be reimbursed.

10. FREE LOOK PERIOD:

The free look period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy. The insured shall be allowed free look period of fifteen days from the date of receipt of the policy document to review the terms and conditions of the policy and to return the same if not acceptable.

11. COMMUNICATION: Every notice or communication to be given or made under this policy shall be delivered in writing at the address of the policy issuing office / TPA as shown in the Schedule. Updated list of the TPAs is also available on Company's website www.orientalinsurance.org.in.

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

- Newly wed spouse within 90days of marriage or at the time of renewal of the policy.
- New Born / adopted Child from 91st day of birth / legal adoption or at the time of renewal of the Policy

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

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

- The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give notice for renewal
- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years
- Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
- At the end of the policy period, the policy shall terminate and can be renewed within the Grace period of 30 day to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

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

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

may increase the Deductible at renewal

16. GRACE PERIOD: In the event of delay in renewal of the policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period.

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

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

- Should any information be available with the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorization of cashless facility may be withdrawn. However this shall be done by the Company / TPA before the patient is discharged from the Hospital and notice to this effect shall be given to the treating Hospital and the insured.
- Liability under the policy in respect of all expenses incurred in a Network Provider shall be subject to the pre-agreed rates between the Company/TPA and the Network Provider. This is irrespective of the claim being under cashless or re-imbursement
- List of network Hospitals is available on our official website-www.orientalinsurance.org.in and will also be provided to the insured by the concerned TPA.

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

20. 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

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

- Original receipt, pathological and other test reports from a pathologist / radiologist including film etc. supported by a note from attending medical practitioner / surgeon demanding such tests.
- Original attending Consultants / Anesthetists / Specialist certificates regarding diagnosis and bills / receipts etc.

(a) Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
(b) MLC/FIR/Post Mortem Report,(if applicable)
(c) Document in respect of Organ donation by the insured person: a certificate from the concerned hospital that the organ donation is in accordance with the extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. However, no proof of expenses incurred is required.
(d) Original Bills with supporting documents to the TPA for reimbursement of expenses incurred during pre and post hospitalization.
(e) Any other information required by Company / TPA.

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

22. MULTIPLE POLICIES:

- In case of multiple policies taken by an insured person during from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- The insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies even if the sum inured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of the policy.
- If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, the insured shall have the right to choose insurers from whom he wants to claim the balance amount.
- Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

23. CLAIM SETTLEMENT (provision for Penal Interest):

- The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- However, where the circumstance of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above bank rate from the date of receipt of last necessary document to the date of payment ofclaim.

24. PAYMENT OF CLAIM: All medical treatments (including diagnostic tests) for the purpose of this insurance will have to be taken in India only (or in SAARC countries) and all claims shall be payable in Indian currency only. For the purpose of claim settlement in respect of treatment taken in SAARC countries, currency conversion rate on the date of admission to Hospital would apply. Claim for any of the Insured Person will be payable in the name of the insured and discharge voucher signed by him/her will be considered valid. However, in the unfortunate event of demise of the insured, the claim shall be payable to the Nominee as declared by the insured in the Proposal form.

25. 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 at least 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 insurance 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

26. 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, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health 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

27. GRIEVANCE REDRESSAL:
In case of any grievance the insured person may contact the company through

Website: www.orientalinsurance.org.in
Toll free: 1800118485 Or 011- 33208485
E-mail: csd@orientalinsurance.co.in
Insured person may also approach the grievance cell at any of the company's branches with the d details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:
Customer Service Department 4th
Floor, Agarwal House Asaf Ali
Road,
New Delhi-110002.
For updated details of grievance officer, kindly refer the link
https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7-5cac-c613-ffc05d578a3e

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

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

28.ARBITRATION CLAUSE: If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties; or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in

accordance with the provisions of the Arbitration and Conciliation Act, 1996 as amended from time to time. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

29. DISCLAIMER OF CLAIM: If the Company disclaims liability and communicates in writing to the Insured in respect of the claim and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a Court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

30. 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.

31. 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
Up to 1 Month	1/4th of the annual rate
Up to 3 Months	1/2 of the annual rate
Up to 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.

32. 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.

33. 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.

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

35. 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.

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

37. Premium:

Premium(Individual Basis without GST)							
Age Group	Deductible	Sum Insured			Final Premium		
0-35	300000	300000	500000		1814	2495	0
	500000	500000	700000		1553	1826	0
	600000	600000	800000		1426	1683	0
	800000	800000	1000000		1415	1688	0
	1000000	1000000	1500000		1437	2093	0
	1500000	1000000	1500000		1352	2007	0
	1800000	1000000	1200000		1332	1594	0
	2000000	1000000	2000000	3000000	1320	2556	3725
36-45	300000	300000	500000		2628	3520	0
	500000	500000	700000		1975	2285	0
	600000	600000	800000		1741	2033	0
	800000	800000	1000000		1601	1896	0
	1000000	1000000	1500000		1591	2317	0
	1500000	1000000	1500000		1478	2203	0
	1800000	1000000	1200000		1466	1756	0
	2000000	1000000	2000000	3000000	1461	2841	4158
46-60	300000	300000	500000		3724	4739	0
	500000	500000	700000		2530	2946	0
	600000	600000	800000		2356	2696	0
	800000	800000	1000000		2275	2980	0
	1000000	1000000	1500000		2131	3042	0
	1500000	1000000	1500000		1994	2905	0
	1800000	1000000	1200000		2006	2372	0
	2000000	1000000	2000000	3000000	2019	3756	5416
61 and above	300000	300000	500000		6775	8449	0
	500000	500000	700000		4210	5270	0
	600000	600000	800000		4210	5106	0
	800000	800000	1000000		4734	6194	0
	1000000	1000000	1500000		4734	6194	0
	1500000	1000000	1500000		3540	4734	0
	1800000	1000000	1200000		3090	3540	0
	2000000	1000000	2000000	3000000	2851	4997	7075

Premium(Premium with GST)

Age Group	Deductible	Sum Insured			Final Premium		
0-35	300000	300000	500000		2141	2944	0
	500000	500000	700000		1833	2155	0
	600000	600000	800000		1683	1986	0
	800000	800000	1000000		1670	1992	0
	1000000	1000000	1500000		1696	2470	0
	1500000	1000000	1500000		1595	2368	0
	1800000	1000000	1200000		1572	1881	0
	2000000	1000000	2000000	3000000	1558	3016	4396
36-45	300000	300000	500000		3101	4154	0
	500000	500000	700000		2331	2696	0
	600000	600000	800000		2054	2399	0
	800000	800000	1000000		1889	2237	0
	1000000	1000000	1500000		1877	2734	0
	1500000	1000000	1500000		1744	2600	0
	1800000	1000000	1200000		1730	2072	0
	2000000	1000000	2000000	3000000	1724	3352	4906
46-60	300000	300000	500000		4394	5592	0
	500000	500000	700000		2985	3476	0
	600000	600000	800000		2780	3181	0
	800000	800000	1000000		2685	3516	0
	1000000	1000000	1500000		2515	3590	0
	1500000	1000000	1500000		2353	3428	0
	1800000	1000000	1200000		2367	2799	0
	2000000	1000000	2000000	3000000	2382	4432	6391
61 and above	300000	300000	500000		7995	9970	0
	500000	500000	700000		4968	6219	0
	600000	600000	800000		4968	6025	0
	800000	800000	1000000		5586	7309	0
	1000000	1000000	1500000		5586	7309	0
	1500000	1000000	1500000		4177	5586	0
	1800000	1000000	1200000		3646	4177	0
	2000000	1000000	2000000	3000000	3364	5896	8349

Taxes as applicable shall be extra.
*****means the age completed as on the date of the policy inception/renewal. So, for a person aged 45 years 364 days, completed age would be 45 years and premium would be charged on the age of 45years, not that of 46years.

FAMILY FLOATER PLAN:
The above table of rates as applicable in case of Individual Plan shall apply. Only the basis of charging premium in case of a family floater Plan would be as stated below:

Insured Member's age	**Premium to be charged**
Member with highest age	100% of the premium as applicable to that age &

	Deductible/Sum Insured combination.
Member with second highest age	50% of the premium as applicable to that age & Deductible/Sum Insured combination.
All other members with lower ages	40% of the premium as applicable to that age & Deductible/Sum Insured combination.

IMP: The Policy gets triggered only when the aggregate of all the claims, or any single claim,in any Policy period exceed(s) the Deductible opted under the Policy.**iii. Loadings / Discounts applicable in relevant cases**:

a. Loadings:

i For new entrants above the age of 65yearsand upto 70 years –10%. This loading of 10% on premium will apply on every subsequent renewal as well.

ii For Removal of Room rent limits – loading depending upon the Deductible chosen, as given below shall apply:

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

b. Discounts:

i. Family Discount (If two or more family members are covered in an Individual Plan) - 10% to each member

ii. Loyalty Discount -10%. Available only in respect of the insured member who has Company's retail Health insurance policy / Bancassurance Health policy

iii. Staff Discount (serving and retired)-33%.This discount will be allowed to the family members as well.

iv. Portal Discount – 10%, subject to maximum of Rs.2000. This discount is available if the Policy is taken On-line using our Portal and where no intermediary is involved and is not available on renewals.

NOTE:

i. All loadings and discounts shall be applied successively in the same order as they appear above and not on cumulative basis.

ii. First the loadings, given above and as applicable shall apply

iii. Then subsequently, on the loaded premium (if applicable), the discounts shall be applied.

38. **DISCLAIMER: The** prospectus contains salient features of the Policy. For details reference is to be made to the Policy. In case of any difference between the prospectus and the Policy, the terms and conditions of the Policy shall prevail. The prospectus and proposal form are part of the Policy. Hence please read the prospectus carefully and sign the same. The proposal form is to be completed in all respects for each insured person. Both the prospectus and the proposal form are to be submitted to the office or to the agent. Place Signature Date Name Insurance is the subject matter of solicitation. No loading shall apply on renewals based on individual claims experience.