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

ORIENTAL YOUTH ECO CARE -PROSPECTUS

1. **ELIGIBILITY**: Any Person aged between 18 years and 45 years residing in India can take this Insurance.

2. SALIENT FEATURES:

i. Minimum Sum Insured INR. 3.0 lac and Maximum Sum Insured INR. 100.0 lacs.
ii. Coverage is being offered in different modalities
- Individual basis
- Floater basis
- Floater with Floater basis.

iii. Pre and Post Hospitalization- Medical expenses incurred 45 days prior to Hospitalization and up to 90 days post Hospitalization.
iv. Cumulative Bonus -Sum insured (excluding CB) shall be increased by 10% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 100% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.
v. Pre Existing Disease waiting period 12 months.
vi. Telemedicine/Online Consultation Covered
vii. Additional Sum Insured for defined CRITICAL ILLNESS

3. OTHER FEATURES :

i. The Policy term is one year.
ii. The Coverage under this Policy are available on Individual/Floater Basis under two plans, viz Basic & Premium.
iii. Road Ambulance service charges Covered
iv. AYUSH Treatment Covered
v. Mental Illness Cover Available
vi. Modern Treatment Covered
vii. Air Ambulance Cover Available.
viii. Organ Donor Expenses- When Insured Person Is The Recipient
ix. Organ Donor Benefit- When Insured Person Is The Donor –Actual expenses up to 10% of Sum Insured, to take care of medical and other incidental expenses.
x. Cost Of Health Checkup Covered
xi. Daily Hospital Cash Allowance
xii. Medical Second Opinion Covered
xiii. Maternity Expenses Covered
xiv. Assisted Reproduction Treatment (Art) is covered
xv. Policy is lifelong renewable.
xvi. On-line Discount – 10% (subject to maximum INR 2,000).
xvii. TPA Discount – 5.5% if TPA services are not opted for.
xviii. Family discount – 10% Applicable if more than one members are covered under a single policy.

4. DEFINITIONS

STANDARD DEFINITIONS

4.1 ACCIDENT is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

4.2 AMBULANCE SERVICES means ambulance service charges reasonably and necessarily incurred in shifting the Insured Person from residence to Hospital for admission in emergency ward / ICU or from one Hospital / Nursing Home to another Hospital / Nursing Home, by registered ambulance only. The ambulance service charges are payable only if the Hospitalization expenses are admissible under the Policy.

4.3 ANY ONE ILLNESS Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

4.4 CASHLESS FACILITY Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of 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 pre- authorization is approved.

4.5 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.

4.6 CONDITION PRECEDENT means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

4.7 CO-PAYMENT means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

4.8 CUMULATIVE BONUS: Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

4.9 DAY CARE CENTRE means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:-

A. has qualified nursing staff under its employment;
B. has qualified medical practitioner/s in charge;
C. has fully equipped operation theatre of its own where surgical procedures are carried out;
D. Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

4.10 DAY CARE TREATMENT means medical treatment, and/or surgical procedure which is:
A. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs. Because Of technological advancement, and
B. Which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition. (Insurers may, in addition, restrict coverage to a specified list.

4.11 DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

4.12 DOMICILIARY HOSPITALISATION means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at

home under any of the following circumstances:

A. the condition of the patient is such that he/she is not in a condition to be moved to a hospital, or
B. The patient takes treatment at home on account of non-availability of room in a hospital.

4.13 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.

4.14 DEDUCTIBLE

Deductible means 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.

4.15 EMERGENCY CARE means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

4.16 FAMILY consists of the Insured and/ or anyone or more of the family members as mentioned below:

A. Legally wedded spouse.
B. up to four Dependent Children (i.e. natural or legally adopted) between the ages 1day up to 18 years. However male child can be covered up to the age of 25 years if he is a bonafide regular student and financially dependent. Female child can be covered until she gets married. Divorced and widowed daughter / daughters are also eligible for coverage under the Policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.
C. There is no upper age limit for dependent children who are physically or mentally challenged.

4.17 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.

4.18 HOSPITAL A hospital 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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:

A. has qualified nursing staff under its employment round the clock;
B. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
C. has qualified medical practitioner(s) in charge round the clock;
D. has a fully equipped operation theatre of its own where surgical procedures are carried out;
E. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

*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:

- The Andhra Pradesh Private Medical care Establishments (Registration and Regulations) Act, 2002
- The Bombay Nursing Homes Registration Act, 1949
- The Delhi Nursing Home Registration Act, 1953
- The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (RagistrikaranTathaAnugyapan) Adhiniyam, 1973.

- The Manipur Homes and Clinics Registration Act, 1992
- The Nagaland Health Care Establishments Act, 1997
- The Orissa Clinical Establishments (Control and Regulations) Act, 1990
- The Punjab State Nursing Home Registration Act, 1991
- The West Bengal Clinical Establishment Act, 1950

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

A. Central or State Government AYUSH Hospital; or
B. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/ Central Council for Homeopathy; or
C. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least five in- patient beds;
ii. Having qualified AYUSH Medical Practitioner 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.

4.20 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:

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

4.21 HOSPITALISATION means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

4.23 ILLNESS means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

A. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

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

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests.
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

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

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

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

4.27 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.

4.28 ICU (INTENSIVE CARE UNIT) 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.

4.29 MATERNITY EXPENSES means

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.

4.30 MEDICAL ADVICE Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

4.31 MEDICAL EXPENSES 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.

4.32 MEDICAL PRACTITIONER 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 its scope and jurisdiction of license.

4.33 MEDICALLY NECESSARY TREATMENT means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

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

4.34 MIGRATION means, the right accorded to health insurance policyholders (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.

4.35 NEW BORN BABY means baby born during the Policy Period and is aged upto90 days.

4.36 NETWORK PROVIDER means hospitals, or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

4.37 NON-NETWORK PROVIDER means any hospital, day care centre or other provider that is not part of the network.

4.38 NOTIFICATION OF CLAIM means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

4.39 OPD 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.

4.40 PRE-HOSPITALISATION MEDICAL EXPENSES means medical expenses incurred during the period up to 45 days prior to the date of admission in the Hospital, provided that:
A. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
B. the In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

4.41 POST-HOSPITALISATION MEDICAL EXPENSES means medical expenses incurred for a period up to 90 days from the date of discharge from the Hospital, provided that:

A. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

B. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

4.42 PRE-EXISTING DISEASE (PED) means any condition, ailment, injury or disease:

A. That is/are diagnosed by a physician within 12 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 12 months prior to the effective date of the policy or its reinstatement,

4.43 POLICY PERIOD means the period of coverage as mentioned in the schedule.

4.44 PORTABILITY means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for preexisting conditions and time bound exclusions, from one insurer to another insurer.

4.45 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

4.46 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.

4.47 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.

4.48 ROOM RENT means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expense.

4.49 SURGERY/ 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 day care centre by a medical practitioner.

4.50 THIRD PARTY ADMINISTRATOR (TPA) means any person who is licensed under the IRDAI (Third Party Administrators – Health Service) Regulations, 2016 & its amendments by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

4.51 UNPROVEN/EXPERIMENTAL TREATMENT means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

SPECIFIC DEFINITIONS

4.52 MENTAL ILLNESS means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

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

4.54 MENTAL HEALTH PROFESSIONAL

A. a psychiatrist or

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

C. a professional having a post-graduate degree (Ayurveda) in Mano VigyanAvum Manas Roga or a post- graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post- graduate degree (Siddha) in SirappuMaruthuvam;

4.55 DAILY HOSPITAL CASH ALLOWANCE

When an Insured Person is hospitalized and a claim is admitted under the Policy, then the Insured Person shall be eligible for a Daily Cash Allowance for every continuous and completed period of 24 hours of Hospitalization, subject to a maximum of 7 days per hospitalization and 14 days per policy period, provided, there is a valid claim for hospitalization under this policy and 3 day deductible will be applicable.

4.56 FLOATER COVER: A single Sum Insured will be provided for all family members which covers your entire family (as per definition clause 4.16) under a single plan. i.e. anyone can utilize as much amount up to Sum Insured limits.

4.57 FLOATER WITH FLOATER COVER: Policy holder can opt for coverage on floater basis for different group of members of family within same policy for different Sum Insured limits. For e.g. a policyholder can purchase floater cover for 10 lakhs for self and spouse and floater cover of 5 lakhs for children within same policy.

- Minimum four persons to be covered under floater with floater cover with minimum two persons in each floater.
- All the members falling within the family definition at 4.16 are eligible to take this coverage.

• Cross combination of parents/Children not allowed and higher Sum Insured shall always be opted for parents.
• Both the floaters under this coverage shall be of same plan either Basic/Premium only.

5. COVERAGE UNDER THE POLICY

SUM INSURED
Minimum Sum Insured INR. 3.0 lac and Maximum Sum Insured INR. 100.0 lacs.
(SI Bands - 3,5,7,10,15,20,25,30,35,40,45,50,75,100 lacs).
Sum Insured is available as per the option of the Proposer, on Individual/Floater/Floater with Floater Basis.

BASIC PLAN

Hospitalization Cover

COVERAGE The benefits under this Policy are available on Individual/Floater/Floater with Floater Basis under two plans, viz BASIC PLAN & PREMIUM PLAN as opted in the proposal form. The Policy covers reasonable and customary charges in respect of Hospitalization and / or Domiciliary Hospitalization for medically necessary treatment only for Illnesses / diseases contracted / suffered or Injury sustained by the Insured Person(s) during the Policy Period, up to the limit of Sum Insured or mentioned sublimit, as detailed below:

5.1 Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.

Sum Insured Slabs	**Limit per day**
Up to 5 lakhs	Single Room up to 1% of Sum Insured, maximum up to Rs 5,000/- per day
7- 10 lakhs	Single Room, maximum up to Rs. 10,000/- per day.
Above 10 lakhs	Actuals Expenses.

5.2 Intensive Care Unit (ICU) Expenses as provided by the Hospital /Nursing Home.

Sum Insured Slabs	**Limit per day**
Up to 5 lakhs	maximum up to Rs.10,000/- per day
7- 10 lakhs	maximum up to Rs. 20,000/- per day
Above 10 lakhs	Actual expenses.

5.3 Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees as per the limits of Sum Insured. (subject to A & B below).

5.4 Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines &Drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs and similar expenses as per the limits of Sum Insured. (subject to A & B below).

Note:-

A) Number of days of stay under 5.1 & 5.2 above should not exceed total number of days of admission in the Hospital. All related expenses (including 5.3 & 5.4 above) shall also be payable as per the entitled room category based on the Room Rent limit as mentioned above. This will not apply on pharmaceuticals, consumables, diagnostics, medical devises and body implants.
B) Any expenses in excess of reasonable and customary charges under definitions clause 4.46 or, in excess of the negotiated prices (in case of network hospitals) shall not be payable.
C) Relaxation to 24 hours minimum duration for Hospitalization is allowed in Day care procedures / surgeries (Appendix I of policy) where such treatment is taken by an Insured Person in a Hospital / day care centre (but not the Out-patient department of a Hospital).

5.5 Pre and Post Hospitalization- Medical expenses incurred 45 days prior to Hospitalization and up to 90 days post Hospitalization.

5.6 Road Ambulance Expenses

Subject to an admissible hospitalization claim, Emergency Road Ambulance expenses incurred is payable as per below table-

Sum Insured Slabs	**Limits**
Up to 10 lakhs	Up to 5,000/- per occurrence maximum up to 10,000/- per policy period.
15-25 lakhs	Up to 10,000/- per occurrence maximum up to 20,000/- per policy period.
Above 25 lakhs	Up to 25,000/- per occurrence maximum up to 50,000/- per policy period.

5.7 Air Ambulance Cover

Expenses incurred towards transportation by an Air Ambulance for treatment of a disease / illness / injury in case of an emergency that requires admission to a Hospital. The necessity of an ambulance must be certified by the treating Medical Practitioner. Policy does not provide cover for the return transportation of Insured Person's to his home by air ambulance. Limits are as below-:

Sum Insured Slabs	**Limits**
Up to 10 lakhs	Maximum up to 10% of Sum Insured
15-25 lakhs	Maximum up to 25% of Sum Insured
Above 25 lakhs	Actual expenses Incurred.

I. The policy covers Air Ambulance cost as per limits above Subject to an admissible hospitalization claim.
II. This cover is available only for life threatening medical emergency condition/s which requires immediate and rapid ambulance transportation to the hospital / medical centre that ground transportation cannot provide.
III. Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency.
IV. It is prescribed by the Medical Practitioner and is medically necessary.
V. The insured person is in India.
VI. The cover will be available in case of the following ailments:-
    - Cardio – Vascular diseases

- Central nervous system diseases
- Accidental Trauma Cases

VII. This cover can be availed only once during the entire policy lifetime.
VIII. Such Air ambulance should have been duly licensed to operate.

5.8 AYUSH TREATMENT

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 25% of Sum Insured as specified in the policy schedule in any AYUSH Hospital.

5.9 HIV/ AIDS COVER

The Company shall indemnify the Hospital or the Insured the Medical Expenses incurred (including Pre and Post Hospitalization Expenses) for treatment as an Inpatient /Day Care related to the 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

5.10 MENTAL ILLNESS COVER

The Company shall indemnify the Hospital or the Insured the Medical Expenses incurred (including Pre and Post Hospitalization Expenses) for treatment as an inpatient/daycare under certain conditions with following limits as below:-

1. Illness covered under definition of mental illness mentioned under clause4.52.
2. Hospitalization in Mental Health Establishment as defined under clause4.53.
3. Hospitalization as advised by Mental Health Professional as defined under clause4.54.
4. Mental Conditions associated with the abuse of alcohol and drugs are excluded.
5. Mental Retardation and associated complications arising therein are excluded.
6. 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.

Sum Insured Slabs	**Limit per policy period**
Up to 10 lakhs	up to 50% of Sum Insured
Above 10 lakhs	As per the limits of Sum Insured

5.11 MODERN TREATMENT

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital/day care centre, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy - Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries

I. Bronchial Thermoplasty
J. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

Following limits will be applied-

Sum Insured Slabs	**Limit per policy period**
Up to 10 lakhs	up to 25% of Sum Insured
Above 10 lakhs	As per the limits of Sum Insured

5.12 DOMICILIARY HOSPITALIZATION

A. Expenses for Domiciliary Hospitalization i.e. treatment at home , if medical treatment is continuously required for more than three (3) days, in which case the cost of medical treatment for the eligible period shall be payable up to 10% of Sum Insured subject to maximum up to Rs 50000/- per Individual/family per policy period subject to:
(i) The condition of the patient is such that he/she is not in a condition to be moved to a Hospital,
Or
(ii) The patient takes treatment at home on account of non-availability of room in a Hospital.
.
B. Treatment for Dog bite (or bite of any other rabid animal like monkey, cat etc.)- Maximum Rs.5, 000/- actually incurred on immunization injections in any one Policy Period. (Exclusion Clause 6.24 shall not apply)

This benefit shall, however, not cover expenses in any of the following cases:

A. if the treatment lasts for a period of three days or less
B. 3 day deductible will be applicable
C. incurred on treatment of any of the following diseases:

- Asthma
- Bronchitis
- Chronic Nephritis and Nephritic Syndrome
- Diarrhea and all types of Dysenteries including Gastro-enteritis
- Diabetes Mellitus and Insipidus
- Epilepsy
- Hypertension
- Influenza, Cough and Cold
- Pyrexia of unknown origin for less than 10days
- Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis
- Arthritis, Gout and Rheumatism.

Note: Liability of the Company under Domiciliary Hospitalization Benefit is restricted as stated above.

5.13 TELEMEDICINE/ONLINE CONSULTATION

Expenses incurred by insured on telemedicine/Tele-consultation/Online 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 as per below table:

Sum Insured Slabs	Limit
Up to 10 lakhs	Max 2 consultations per policy period, max Rs. 1000 per consultation
Above 10 lakhs	Max 3 consultations per policy period, max Rs. 1500 per consultation

5.14 ADDITIONAL Sum Insured FOR CRITICAL ILLNESSES (List as per APPENDIX II of policy)

Extra benefit on account of consumption of Sum Insured due to defined 11 critical illness shall be available for insured whose Sum Insured is 10 lacs or above only after waiting period of 2 years. The provision of extra Sum Insured (up to specified limit) available only for critical illness maximum up to 10% of Sum Insured, only once in the policy period. This will be a separate cover and availing this benefit will not affect base Sum Insured. This benefit will not apply to the accrued enhanced Sum Insured due to Cumulative Bonus.

Illustration: Insured has the continuous coverage under the policy for more than 2 year and has a base SI of INR 20 lakhs. Then the Additional Sum Insured for Critical Illness of 10% i.e. INR 2 lakhs (10% of Base SI i.e. INR 20 lakhs) is applicable. If a person claimed INR 18 lakhs for critical illness in first incidence and again Rs. 4 lakhs for other critical illness in second incidence. Then the policy will pay INR 18 lakhs from his opted SI in first incidence but later to pay the claim in second incidence, out of INR 4 lakhs, 2 lakhs will be paid from the basic Sum Insured and additional 2 lakhs will be paid from additional critical illness Sum Insured.

5.15 CUMULATIVE BONUS

Sum insured (excluding CB) shall be increased by 10% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 100% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.

5.16 ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE RECIPIENT

The Policy covers in-patient Hospitalization Medical expenses in respect of the organ donor provided that the donation conforms to the Transplantation of Human Organs Act 1994(amended) and/or any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. Further provided that:

i. the organ donated is for the use of the Insured Person who has been medically advised to undergo organ transplant

ii. The claim of the Insured Person is admissible under the Hospitalization section of the Policy. The Policy does not cover:

- Cost directly or indirectly associated with the acquisition of the organ and / or cost of organ.
- cost towards donor screening
- Any Pre and Post Hospitalization medical expenses of the donor.
- Any other medical treatment or complication consequent to organ harvesting, in respect of the donor.

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

5.17 ORGAN DONOR BENEFIT- WHEN INSURED PERSON IS THE DONOR Actual Expenses upto 10% of Sum Insured, to take care of medical and other incidental expenses is payable to the Insured Person donating an organ provided that the donation conforms to the Transplantation of Human Organs

Act 1994 (amended) and any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. This benefit is subject to the Policy having been continuously in force for at least 12 (twelve) months in respect of that Insured Person. This benefit will not apply to the accrued enhanced Sum Insured due to Cumulative Bonus.

5.18 CATARACT TREATMENT

The Company shall indemnify medical expenses incurred for treatment of Cataract, The specified limits also includes pre-post hospitalization if any as per below table-

Sum Insured Slabs	**Limits**
Up to 10 lakhs	up to Rs 50,000/- per eye including IOL.
Above 10 lakhs	up to Rs 1,00,000/- per eye including IOL.

5.19 COST OF HEALTH CHECKUP

The Insured shall be entitled for reimbursement of cost of Health checkup undertaken once at the expiry of a block of every THREE continuous underwriting years provided there are no claims reported during the block. This benefit is available to the insured person after three claim free years, till the expiry of the fourth year of the policy. If the benefit is not claimed in the fourth year of the policy, then in future at the time of the insured claiming this benefit, last three claim free years preceding the year in which the benefit is claimed, shall be taken into consideration. This clause shall apply separately to each insured person i.e for any insured person, if there is no claim reported for the preceding three years, he would be eligible for this benefit even when there is a claim reported for other person(s) covered under the policy. This benefit will not apply to the accrued enhanced Sum Insured due to Cumulative Bonus. This provision is applicable only in respect of continuous insurance without break under Oriental's Youth Eco Care policy

For Individual-:

Sum Insured(without Cumulative Bonus)	**Benefit**
Upto 10 lakhs	Upto Rs 1,500
15-25 lakh	Upto Rs 2,000
Above 25 lakh	Upto Rs 3,000

For Family-:

Sum Insured(without Cumulative Bonus)	**Benefit**
Upto 10 lakhs	Upto Rs 3,000
15-25 lakh	Upto Rs 4,000
Above 25 lakh	Upto Rs 6,000

PREMIUM PLAN (In addition to coverage under BASIC PLAN)

5.20 DAILY HOSPITAL CASH ALLOWANCE

When an Insured Person is hospitalized and a claim is admitted under the Policy, then the Insured Person shall be eligible for a Daily Cash Allowance for every continuous and completed period of 24 hours of Hospitalization, subject to a maximum of 7 days per hospitalization and 14 days per policy period,

provided, there is a valid claim for hospitalization under this policy and 3 day deductible will be applicable.

Following limits will be applicable:

Sum Insured Slabs	**Limit (INR)**
Up to 5 lakhs	500 per day
Above 5 lakhs	1000 per day

5.21 MEDICAL SECOND OPINION

Policy provides for a Medical Second Opinion whether before starting the treatment or during the course of treatment, post the diagnosis of a specified Critical Illness or has been advised for a surgery during the policy year .The Policy covers Medical Expert's fees to the extent given below. Claim under this clause would be admissible subject to the Hospitalization claim being admissible.

Major Illnesses covered:

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

Sum Insured Slabs	**Limits**
Up to 10 lakhs	Maximum up to Rs 5,000/- per policy period
15-25 lakhs	Maximum up to Rs 10,000/- per policy period
Above 25 lakhs	Maximum up to Rs 25,000/- per policy period

5.22 MATERNITY EXPENSES

The Company shall pay the Medical Expenses incurred as an In-patient for a delivery (including caesarean section) or lawful medical termination of pregnancy during the Policy Period limited to two deliveries or terminations or either during the lifetime of the Insured Person provided that:

i. Policy has been continuously in force for a period of minimum 24 months in respect of both the Insured and his/her spouse.
ii. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.
iii. These benefits are admissible only if the expenses are incurred in Hospital/Nursing Homes as in- patients in India.
iv. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.

v. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.
vi. Pre Hospitalization and Post Hospitalization benefits are not available under these two clauses
vii. If this benefit is opted by the insured, then exclusion under 6.18 will be deleted.
viii. Company's maximum liability per delivery or termination shall be limited as below table.

The maximum liability under maternity expenses shall be as below:-

Sum Insured Slabs	**Limit per event(Maternity expenses)**
Up to 10 lakhs	Maximum up to Rs 50,000/-
15 -25 lakhs	Maximum up to Rs 75,000/-
Above 25 lakhs	Maximum up to Rs 1,00,000/-

5.23 ASSISTED REPRODUCTION TREATMENT (ART)

Assisted Reproduction Treatment is defined as set of techniques and medical treatments that allow couples to start a family when it cannot be achieved naturally due to infertility problems. It should be proven by the specialized doctor that it is not possible to conceive through natural process due to established sub-fertility/ infertility problems of the couple. For the scope of this policy, ART will be covering any treatment or procedure that involves the in-vitro handling of human oocytes and sperm or embryos for the purpose of establishing a pregnancy. The Company will reimburse expenses incurred on Assisted Reproduction Treatment, where indicated as mentioned above, for sub-fertility/ infertility subject to:

i. A waiting period of 36 months from the date of first inception of this policy with the Company for the insured persons (both spouses). The benefit is only payable if the treatment has been initiated after the specified waiting period.
ii. The maximum liability of the Company for such treatment shall be limited to Rs. 2, 00,000/-. This benefit (2 Lakhs) will be a part of the basic SI, not in addition to it.
iii. For the purpose of claiming under this benefit, in-patient treatment is not mandatory.
iv. If this benefit is opted by the insured, then exclusion under 6.17 will be deleted.

Note: To be eligible for this benefit both partners should stay insured continuously without break under this policy.This cover is limited for one child once in lifetime only. If the couple has one living child this benefit will not be available. This benefit of Rs. 2, 00,000/- will only be given once in a lifetime.

6. 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:

STANDARD EXCLUSIONS

6.1 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 12 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 12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

6.2 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 during the waiting period specified below.

	Ailment / Disease / Surgery	**Waiting Period**
I	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	1 year
Ii	Polycystic ovarian diseases.	1 year
Iii	Surgery of hernia.	2 years
Iv	Surgery of hydrocele.	2 years
V	Non infective Arthritis.	2 years
Vi	Undescendent Testes.	2 Years
Vii	Cataract.	2 Years
Viii	Surgery of benign prostatic hypertrophy.	2 Years
Ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus	2 Years
X	Fissure / Fistula in anus.	2 Years
Xi	Piles.	2 Years
Xii	Sinusitis and related disorders.	2 Years
Xiii	Surgery of gallbladder and bile duct excluding malignancy.	2 Years
Xiv	Surgery ofgenito-urinary system excluding malignancy.	2 Years
Xv	Pilonidal Sinus.	2 Years
Xvi	Gout and Rheumatism.	2 Years
Xvii	Hypertension.	90 days*
Xviii	Diabetes.	90 days*
Xix	Calculus diseases.	2 Years

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

***If the above diseases are pre-existing at the time of inception, , then the longer of the two waiting periods shall apply.**

6.3 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.

Note: If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh Policy and clauses 6.1., 6.2, 6.3 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 6.1, 6.2 and 6.3 shall apply afresh on the enhanced portion of the Sum Insured.

6.4 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.

6.5 Rest Cure, rehabilitation and respite care – Code -ExcI05

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.

6.6 Obesity/Weight Control : Code- EscI06 Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor.

b. The surgery /Procedure conducted should be supported by clinical protocols.

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI):

- greater than or equal to 40 or
- 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.

6.7 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.

6.8 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.

6.9 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.

6.10 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.

6.11 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 up to the stage of stabilization are payable but not complete claim.

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

6.13 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- ExcI13**

6.14 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**

6.15 Refractive Error- Code- ExcI15 Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

6.16 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.

6.17 Sterility and Infertility- Code- ExcI17 Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization.

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI. This exclusion does not apply to Plan-B to the limits mentioned therein.

iii. Gestation Surrogacy

iv. Reversal of sterilization.

6.18 Maternity- Code- ExcI18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean sections incurred during hospitalization) except ectopic pregnancy.

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of

pregnancy during the policy period.

NOTE: - The exclusion 6.17 & 6.18 does not apply for PREMIUM PLAN.

SPECIFIC EXCLUSIONS:-

6.19 Hormone Replacement Therapy Expenses for hormone replacement therapy, unless part of Medically Necessary Treatment, except for Puberty and Menopause related Disorders

6.20 General Debility, Congenital External Anomaly General debility, congenital external anomaly.

6.21 Self Inflicted Injury Treatment for intentional self-inflicted injury, attempted suicide.

6.22 Stem Cell Surgery Stem Cell Surgery (except Hematopoietic stem cells for bone marrow transplant for hematological conditions).

6.23 Circumcision unless necessary for treatment of a disease (if not excluded otherwise) or necessitated due to an accident.

6.24 Vaccination or Inoculation. Vaccination or inoculation unless forming part of treatment and requires Hospitalization. (Does not apply to clause 5.12 (B)).

6.25 Massages, Steam Bath, Alternative Treatment (Other than Ayurveda and Homeopathy) Massages, steam bath, expenses for alternative or AYUSH treatments (other than Ayurveda and Homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.

6.26 Dental treatment Dental treatment, unless necessitated due to an Injury.

6.27 Out Patient Department (OPD) Any expenses incurred on OPD (Excludes ART under PREMIUM Plan)

6.28 Stay in Hospital which is not Medically Necessary. Stay in hospital which is not medically necessary.

6.29 Spectacles, Contact Lens, Hearing Aid, Cochlear Implants Spectacles, contact lens, hearing aid, cochlear implants.

6.30 Non Prescription Drug Drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses (as listed in respective Appendix-III of policy).

6.31 Treatment not related to Disease for which Claim is Made Treatment which the insured person was on before Hospitalization for the Illness/Injury, different from the one for which claim for Hospitalization has been made.

6.32 Equipment's External/durable medical/non-medical equipment's/instruments of any kind used for diagnosis/ treatment including CPAP, CAPD, infusion pump, ambulatory devices such as walker, crutches, belts, collars, caps, splints, slings, braces, stockings, diabetic foot-wear, glucometer, thermometer and similar related items (as listed in respective Appendix-III of policy) and any medical equipment which could be used at home subsequently.

6.33 Items of personal comfort Items of personal comfort and convenience (as listed in respective Appendix-III of policy) including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.

6.34 Service charge/ registration fee Any kind of service charges including surcharges, admission fees, registration charges and similar charges (as listed in respective Appendix-III of policy) levied by the hospital.

6.35 Home visit charges Home visit charges during Pre and Post Hospitalization of doctor, attendant and nurse.

6.36 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.

6.37 Radioactivity 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.

6.38 Treatment taken outside the geographical limits of India.

6.39 Permanently Excluded Diseases In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on the insured's consent), policyholder is not entitled to get the coverage for specified ICD coded as listed below:

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, polycythaemiavera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy

4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS 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 (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta- (super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37

13	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
14	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

7. TERMS & CLAUSES

STANDARD GENERAL TERMS & CLAUSES

7.1 DISCLOSURE OF INFORMATION: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder. (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

7.2 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.

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 of claim.

  ("Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

7.3 COMPLETE DISCHARGE: Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

7.4 FRAUD: If any claim made by the insured person, is in any respect fraudulent, or if any false

statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited. Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

i. the suggestion as a fact of that which is not true and which the Insured Person does not believe to be true;
ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
iii. any other act fitted to deceive; and
iv. any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis- statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

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

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. 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 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation non- disclosure.

7.6 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

7.7 FREE LOOK PERIOD: The free look period shall be applicable on new health insurance Policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look period of 15 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

- A refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Persons and the stamp duty charges or
- where the risk has already commenced and the option of return of the Policy is exercised by

the Insured person, a deduction towards the proportionate risk premium for period on cover or

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

7.8 RENEWAL OF POLICY: The policy shall ordinarily be renewable lifelong 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 any notice for renewal.
- Renewal shall not be denied on the ground that the insured 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 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- No loading shall apply on renewals based on individual experience.

7.9 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

7.10 WITHDRAWAL OF POLICY

- In the likelihood of this product being withdrawn in future, the Company will intimate the Insured person about the same 90 days prior to expiry of the policy.
- Insured person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. As per IRDAI guidelines, provided the policy has been maintained without a break.

7.11 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.

7.12 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.

7.13 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, Oriental House, A-25/27, 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

7.14 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- I of policy & revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html.

7.15 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. In 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.

SPECIFIC TERMS & CLAUSES:-

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

7.17 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.

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

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

7.20 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 the note from attending Medical Practitioner / Surgeon demanding such tests.
- Original attending Consultants / Anesthetists/ Specialist certificates regarding diagnosis and bills / receipts etc.
- Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
- MLC/FIR/Post Mortem Report,(if applicable)
- Disability certificate, Death certificate (if applicable)
- Documents in respect of organ donation claim, shall be in accordance with the extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs
- Details of previous policies, if the details are already not with TPA.
- Any other information required by TPA /Company.

a. All documents must be duly attested by the Insured Person/Claimant.
b. In case of Post Hospitalization treatment (limited to 90 days) all supporting claim papers / documents as listed above should also be submitted within 15 days from completion of such treatment 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.
c. Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.
d. On receipt of the last document /clarification, the Company/TPA shall within a period of 30 days offer a settlement of the claim to the insured. If the Company/TPA, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the Policy, it shall do so within a period of 30 days from the receipt of the last document/ clarification.

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

- Claim in respect of Cashless Access Services will be through the Company / TPA provided admission is in a network Hospital/ Nursing Home and is subject to pre admission authorization. The Company / TPA shall, upon getting the related medical details / relevant information from the Insured Person / Network Hospital / Nursing Home, verify that the person is eligible to claim under the Policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as an in-patient. The Company / TPA reserves the right to deny pre-authorization in case the Hospital / Insured Person is unable to provide the relevant information/medical details as required by the Company/ TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of liability. The Insured Person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the Company / TPA within 15 days of the discharge from Hospital / Nursing Home for

consideration of Company /TPA.

- 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 given to the treating Hospital / insured.
- List of network Hospitals is available on our official website- www.orientalinsurance.org.inand will also be provided by the concerned TPA on demand.

7.22 MEDICALRECORDS:

- The Insured Person hereby agrees to and authorizes the disclosure, to the Company/ TPA or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from which the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company / TPA in connection with any claim made under this Policy or the Company's liability there under.
- The Company / TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (i) above and will only use it in connection with any claim made under this Policy or the Company's liability there under.
- Any Medical Practitioner authorized by the Company / TPA shall be allowed to examine the Insured Person in case of any alleged Injury or disease requiring Hospitalization when and so often as the same may reasonably be required on behalf of the Company/ TPA.

7.23 PAYMENT OF CLAIM: All medical treatment for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency only. The Company shall settle the claim within 30 days from the date of the receipt of last necessary documents in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016.Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured. However, where the circumstances 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 the claim within 45 days from the date of receipt of last necessary document. In case of any delay in the payment, the Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is settled.

7.24 MULTIPLE POLICIES

- In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any 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.
- 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 insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

7.25 REPUDIATION:

- The Company, shall repudiate the claim if not payable under the Policy. The Company/ TPA shall mention the reasons for repudiation in writing to the Insured Person. The Insured Person shall have the right to appeal / approach the Customer Service department of the Company at its Policy issuing office, concerned Regional Office or of the Head Office, situated at A- 25/27, Asaf Ali Road, NewDelhi-110002.
    - If the insured is not satisfied with the reply of the Customer Service department under clause 7.13, he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims uptoRs.30lacs.

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

7.27 ARBITRATIONCLAUSE: If any dispute or difference shall arise as to the quantum to be paid under the Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties; or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act,1996.It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

OTHER TERMS & CONDITIONS

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

- Newly wed spouse within 90 days of marriage or at the time of renewal of the Policy.
- Newborn child from 1 day of birth to Max 90 days or at the time of renewal of the Policy.

For members subsequently added, Exclusion No. 6.1, 6.2 and 6.3 shall apply from the date of their inclusion in the Policy.

7.29 ENHANCEMENT OF SUMINSURED: The insured may seek enhancement of Sum Insured in writing before payment of premium for renewal. Before granting such request for enhancement of Sum Insured, if deemed necessary by the Underwriting Authority. The Company has the right to have the insured examined by a Medical Practitioner authorized by the Company or the TPA. The cost of such medical examination will be borne by the insured/s. Block of two claim free years is necessary for Enhancement of Sum Inured.

Enhancement of Sum Insured shall be allowed based on the following table:

Age<=45 years	Enhancement up to maximum Sum Insured available.
Age 46-60 Years	Enhancement by two slabs
Age 61-65 Years	Enhancement by one slab.

Age above 65 Years	No Enhancement of Sum Insured allowed.

In respect of any increase in Sum Insured, exclusion 6.1, 6.2 and 6.3 would apply to the enhanced Sum Insured afresh from the date of such increase.

7.30 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 ratable proportion of the total & specified below 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.

7.31 ASSOCIATED MEDICAL EXPENSES (Indicative only)

- 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 :-
- Chemotherapy/Radiotherapy charges Nebulization
- Hemodialysis PICC
- line insertion
- Catheterization charges Tracheostomy etc.
- IV charges
- Blood transfusion charges
- Dialysis
- Surgery Charges
- OT charges including OT gas, equipment charges.

7.32 GRACE PERIOD: In the event of delay in renewal of the Policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/Injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease.

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

7.34 QUALITY OF TREATMENT: The insured hereby acknowledges and agrees that pre-authorization or payment of any claim by or on behalf of the Company shall not constitute on part of the Company, a guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the Insured Person. It being agreed and recognized by the Insured Person that the Company is in no way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a Network Hospital).

7.35 ID CARD: The card is issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital only. Upon the cancellation or nonrenewal of this Policy, all ID cards shall immediately be returned to the TPA at the insured's expense and each Insured Person agrees to hold and keep harmless, the Company and the TPA against any or all costs, expenses, liabilities and claims arising in respect of use or misuse of such ID cards prior to their return to the TPA.

7.36 DISCOUNT

- **Online Discount-**A discount of 10%(maximum Rs. 2000/-) on premium is allowed, if the Policy is purchased on-line and no Intermediary is involved. This discount is also applicable in

case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.

- **TPA Discount –** 5.5% if TPA services are not opted for.
- **Family discount** – 10%
  - Applicable if more than one members are covered under a single policy and opted for sum insured on individual member wise only.
  -Flat discount of 10% shall be given on the total premium for the family.

7.37 IRDAI REGULATION: This Policy is subject to IRDAI (Protection of Policy holders' interest) Regulation, 2017andIRDAI (Health Insurance) Regulations2016and Guidelines on Standardization in health insurance, IRDA Master Circular 2020 as amended from time to time.

7.38 JURISDICTION: All disputes or differences under or in relation to the Policy shall be determined by the Indian Courts and in accordance with the Indian Laws.

7.39 HOW TO APPLY FOR INSURANCE: The Proposer has to complete the Proposal Form and Enrolment Form in duplicate and submit Insured Person's details of each member. The proposer has to affix colored stamp size photographs of each of the members to be insured on the Enrolment Form against the name of the person. These photographs will be utilized by Third Party Administrator for preparing ID card for each of the members insured.

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.

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:

i. 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.

ii. 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.

PREMIUM CHART:-

SI\Age Bracket	Premium (Per Insured) (Basic Plan)(Excluding GST)										
	0-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	Above 65
300,000	2,369	3,308	4,107	5,665	5,899	7,910	10,047	12,265	15,686	18,184	22,207
500,000	2,792	4,769	5,490	6,786	6,865	9,985	12,178	15,544	21,437	27,213	31,385
700,000	3,783	6,169	6,617	7,759	7,912	11,890	14,152	18,111	25,633	32,003	36,749
1,000,000	4,856	7,015	7,360	8,722	9,120	13,148	15,489	20,076	29,325	35,568	41,677
1,500,000	5,680	8,223	8,429	10,311	10,624	15,128	17,554	22,857	34,068	41,618	47,826
2,000,000	6,176	8,516	8,670	10,524	11,297	16,859	19,411	24,740	37,344	45,821	52,100
2,500,000	6,561	9,766	9,917	11,955	13,401	17,905	20,506	26,202	39,885	49,081	55,416
3,000,000	8,540	10,199	10,335	12,393	13,886	18,762	21,403	27,397	41,963	51,747	58,127
3,500,000	8,870	10,563	10,696	12,762	14,295	19,484	22,158	28,406	43,718	53,998	60,416
4,000,000	9,157	10,878	10,997	13,081	14,649	20,109	22,813	29,279	45,238	55,948	62,399
4,500,000	9,410	11,156	11,265	13,362	14,961	20,661	23,390	30,050	46,579	57,668	64,149
5,000,000	10,200	11,405	13,199	14,685	16,321	21,154	23,907	30,740	47,778	59,207	65,713
7,500,000	11,123	12,460	14,736	16,422	17,989	23,054	25,896	33,393	52,395	65,130	71,736
10,000,000	11,779	13,556	16,067	18,522	20,719	24,403	27,307	35,277	55,671	69,333	76,010

SI\Age Bracket	Premium (Per Insured) (Basic Plan)(Including GST)										
	0-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	Above 65
300,000	2,795	3,903	4,846	6,685	6,961	9,334	11,855	14,473	18,509	21,457	26,204
500,000	3,295	5,627	6,478	8,007	8,101	11,782	14,370	18,342	25,296	32,111	37,034
700,000	4,464	7,279	7,808	9,156	9,336	14,030	16,699	21,371	30,247	37,764	43,364
1,000,000	5,730	8,278	8,685	10,292	10,762	15,515	18,277	23,690	34,604	41,970	49,179
1,500,000	6,702	9,703	9,946	12,167	12,536	17,851	20,714	26,971	40,200	49,109	56,435
2,000,000	7,288	10,049	10,231	12,418	13,330	19,894	22,905	29,193	44,066	54,069	61,478
2,500,000	7,742	11,524	11,702	14,107	15,813	21,128	24,197	30,918	47,064	57,916	65,391
3,000,000	10,077	12,035	12,195	14,624	16,385	22,139	25,256	32,328	49,516	61,061	68,590
3,500,000	10,467	12,464	12,621	15,059	16,868	22,991	26,146	33,519	51,587	63,718	71,291
4,000,000	10,805	12,836	12,976	15,436	17,286	23,729	26,919	34,549	53,381	66,019	73,631
4,500,000	11,104	13,164	13,293	15,767	17,654	24,380	27,600	35,459	54,963	68,048	75,696
5,000,000	12,036	13,458	15,575	17,328	19,259	24,962	28,210	36,273	56,378	69,864	77,541
7,500,000	13,125	14,703	17,388	19,378	21,227	27,204	30,557	39,404	61,826	76,853	84,648
10,000,000	13,899	15,996	18,959	21,856	24,448	28,796	32,222	41,627	65,692	81,813	89,692

SI\Age Bracket	Premium (Per Insured) (Premium Plan) (Excluding GST)										
	0-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	Above 65
300,000	2,432	3,932	4,732	6,289	6,524	8,535	10,672	12,889	16,174	18,247	22,270
500,000	2,802	5,340	6,061	7,357	7,436	10,556	12,749	16,115	21,872	27,222	31,395
700,000	3,873	6,820	7,268	8,410	8,563	12,541	14,803	18,762	26,148	32,093	36,839
1,000,000	4,875	7,595	7,941	9,302	9,700	13,728	16,070	20,657	29,770	35,588	41,696
1,500,000	5,700	9,016	9,222	11,104	11,417	15,921	18,347	23,650	34,725	41,637	47,846

2,000,000	6,196	9,309	9,463	11,317	12,090	17,652	20,204	25,533	38,001	45,840	52,120
2,500,000	6,580	10,559	10,711	12,748	14,194	18,698	21,299	26,995	40,543	49,101	55,436
3,000,000	8,589	11,234	11,370	13,429	14,922	19,797	22,438	28,433	42,863	51,796	58,176
3,500,000	8,920	11,598	11,731	13,797	15,330	20,519	23,194	29,441	44,617	54,047	60,466
4,000,000	9,206	11,913	12,032	14,116	15,684	21,144	23,848	30,315	46,137	55,998	62,449
4,500,000	9,459	12,191	12,300	14,398	15,996	21,696	24,426	31,086	47,478	57,718	64,198
5,000,000	10,250	12,440	14,234	15,721	17,357	22,189	24,942	31,775	48,678	59,257	65,763
7,500,000	11,173	13,495	15,772	17,457	19,024	24,089	26,931	34,429	53,294	65,179	71,786
10,000,000	11,828	14,591	17,102	19,558	21,754	25,438	28,343	36,312	56,570	69,382	76,060

SI\Age Bracket	**Premium (Per Insured) (Premium Plan) (Including GST)**										
	0-20	**21-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**Above 65**
300,000	2,870	4,640	5,584	7,421	7,698	10,071	12,593	15,209	19,085	21,531	26,279
500,000	3,306	6,301	7,152	8,681	8,774	12,456	15,044	19,016	25,809	32,122	37,046
700,000	4,570	8,048	8,576	9,924	10,104	14,798	17,468	22,139	30,855	37,870	43,470
1,000,000	5,753	8,962	9,370	10,976	11,446	16,199	18,963	24,375	35,129	41,994	49,201
1,500,000	6,726	10,639	10,882	13,103	13,472	18,787	21,649	27,907	40,976	49,132	56,458
2,000,000	7,311	10,985	11,166	13,354	14,266	20,829	23,841	30,129	44,841	54,091	61,502
2,500,000	7,764	12,460	12,639	15,043	16,749	22,064	25,133	31,854	47,841	57,939	65,414
3,000,000	10,135	13,256	13,417	15,846	17,608	23,360	26,477	33,551	50,578	61,119	68,648
3,500,000	10,526	13,686	13,843	16,280	18,089	24,212	27,369	34,740	52,648	63,775	71,350
4,000,000	10,863	14,057	14,198	16,657	18,507	24,950	28,141	35,772	54,442	66,078	73,690
4,500,000	11,162	14,385	14,514	16,990	18,875	25,601	28,823	36,681	56,024	68,107	75,754
5,000,000	12,095	14,679	16,796	18,551	20,481	26,183	29,432	37,495	57,440	69,923	77,600
7,500,000	13,184	15,924	18,611	20,599	22,448	28,425	31,779	40,626	62,887	76,911	84,707
10,000,000	13,957	17,217	20,180	23,078	25,670	30,017	33,445	42,848	66,753	81,871	89,751

Computation of Premium will be done on the basis of Primary policy holder's Age and chosen SI:

- Charge 100% premium for the primary member.
- Charge 75% premium for the secondary adult member.
- Charge 50% premium for children i.e. give a discount of 50% on Child's premium.
- Eldest member of the family is the primary member. Second eldest is second member.

Computation of premium on floater with floater basis shall be done as follows:

Floater 1:

- Charge 100% premium for the primary member.
- Charge 75% premium for the second member.
- Charge 50% premium for other members.
- Eldest member is the primary member. Second eldest is second member.

Floater 2:
- Charge 100% premium for the primary member.
- Charge 75% premium for the second member.
- Charge 50% premium for other members.
- Eldest member is the primary member. Second eldest is second member.

The following discount factors shall be applicable:

- **On-line Discount – 10% (subject to maximum INR 2,000).**
- **TPA Discount – 5.5% if TPA services are not opted for.**
- **Family discount – 10% (**Applicable if more than one members are covered under a single policy and opted for sum insured on individual member wise only. Flat discount of 10% shall be given on the total premium for the family.