THE ORIENTAL INSURANCE COMPANY LIMITED

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

Oriental Super Health Top-Up!

SALES LITERATURE

1. Who can buy this Policy?
   - Any person between the ages of 18 to 65 years (both ends inclusive) may buy the policy in respect of self and / or eligible family members.
   - Maximum entry age under the policy is 65years for all members. However, persons above the age of 65 years and upto the age of 70 years can also take this policy. However, in all such cases, a 10% loading will be charged on premium applicable to the age of such proposed insured person. This 10% loading will also apply on each subsequent renewal thereof. No such loadings shall, however, apply in respect of insured persons who had entered the policy at the age of 65years or earlier.

2. What is the term of the policy?
   - Policy period is one year and is thereafter renewable lifelong.

3. Is it necessary to have a Health insurance policy covering hospitalisation expenses, to be eligible for this cover?
   - Not at all! You can avail this policy even if you do not have any health insurance policy.

4. How is this Policy different from other Hospitalisation type Health Insurance policies?
   - This works like a Topping! which means it works best when you either have a Base Health insurance policy or when you have other means to finance your Health care needs (like your Company is paying for you, or you are willing to meet some amount of expenses out of your own pocket). So, this policy addresses the gap between what you can pay and the actual amount incurred, in an unfortunate event of an unexpected, expensive hospitalisation.

5. Why do I require a Super Top-Up policy?
   - Your base Health insurance policy (in case you have one) will pay only upto a certain amount as per the Sum Insured (SI) chosen by you. If the hospitalisation expenses exceed the SI under the Base policy, a Super Top-Up policy can come to your rescue.
   - Even if you do not have a Base policy, this Super Top-up policy will come to your rescue if the hospitalisation expenses exceed what you can comfortably bear from other sources. .Premium for a Super Top Up policy is much lower than that of a base policy for an equal amount of Sum Insured.
   - You can take this policy either just for yourself or also for your whole family.

6. Why should I take Oriental Super Heath Top-Up !?
   - Because this is a customer friendly policy with low premiums, is simple to understand, has no hidden charges/conditions.
   - This Policy offers various options to choose from, as per your requirement.
   - This policy gives you the option to remove Room rent cappings, albeit with an additional premium!

7. What are the benefits offered by Oriental Super Heath Top-Up!?
   - In patient hospitalisation expenses
   - AYUSH treatments
   - Day Care treatments
   - Pre & post hospitalisation expenses for 30days and 60days respectively.
   - This policy triggers when the aggregate of all admissible expenses incurred in respect of any one or more claims (either for an Individual in case of Individual Plan, or for one or more than one insured member, in case of a Family Floater Plan) in a policy period, exceed the Deductible chosen.
   - **Insured as Donor**: This policy pays a lumpsum amount of 10% of Sum Insured when the Insured person is an Organ Donor, donation being carried out as per the applicable extant laws, subject to waiting period of 24months. This lumpsum payment will be made even if the Deductible has not been exceeded, and will be in addition to any amount payable under this head in any other Policy (like our Happy Family Floater Policy-2015). However, this payment will be within the Sum Insured limit of the Policy.
   - **Insured as Recipient**: The policy covers in-patient hospitalisation expenses in respect of the person donating an organ to the insured person, donation being carried out as per the applicable extant laws, in respect of transplantation of human organs.
   - This Policy provides coverage in respect of (i) **maternity expenses (**waiting period of 12months apply, also covers pre natal and post natal expenses if there is hospitalisation. Cover under this section is not available to those insureds who already have two or more living children) and (ii) **new born baby cover** from day one.
     Sub-limits of 10% & 5% of Sum Insured respectively apply for the two covers**.**
   - **Treatment in SAARC countries viz:** Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka, considered only on re-imbursement basis

8. What is the significance of Deductible under the Policy?
   - The policy would trigger only after the deductible, as opted by the Insured, has been exceeded.
   - Deductible decides the Room rent limit under the Policy. Daily Room rent limit under the policy is 1% of the Deductible Amount as opted at the time of taking the Policy. Also, all related hospitalisation expenses are worked out based on the Daily Room rent limit. However, you can get the capping on room rent removed by paying additional premium.
   - Claim admissibility will be decided based on the terms and conditions of this Policy. Admissibility of claim would be worked out only if the insured expenses, in aggregate, have exceeded or are likely to exceed the Deductible. If the claim is admissible as per the policy terms and conditions, the maximum amount payable (admissible claim amount)

under the policy would be that amount which is in excess of the Deductible, subject to Company's liability not exceeding the Sum Insured. Eg:

- Deductible chosen – Rs.3lakhs
- Sum Insured chosen – Rs.5lakhs

		How the Claim payment will be considered
Case 1:	There is one single hospitalisation in the policy period. Hospitalisation expenses incurred is Rs.3lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.4lakhs	Scenario 1: Admissible expenses is Rs.2.50lakhs, which is within the Deductible so nothing is payable under the policy. Scenario 2: Admissible expenses is Rs.3.50lakhs, which has exceeded the Deductible by Rs.50,000, so the amount payable under the policy is Rs.50,000.
Case 2:	There are multiple claims under the policy. Claim no.1: Hospitalisation expenses incurred is Rs.2lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.3lakhs Claim no.2: Hospitalisation expenses incurred is Rs.1.75lakhs Pre & post hospitalisation expenses incurred is Rs.0.5lakh.	Scenario 1: There are two claims under the policy, Claim Nos.1&2: Admissible expenses under Claim no.1 is Rs.2.lakhs and under Claim no.2, it is Rs.1.40lakhs. So the total admissible expenses under the policy considering both the claims is 3.40lakhs, which has exceeded the Deductible by Rs.40,000, so the amount payable under the policy is Rs.40,000 in respect of Claim no.2. Scenario 2: The above is an example where Room rent is 1% of the Deductible. Now suppose, the insured's policy does not have room rent capping, then Admissible expenses under Claim no.1 is Rs.2.75lakhs and under Claim no.2 it is Rs.2lakhs. Thus the total admissible expenses under the policy considering both the claims, is 4.75lakhs, which has exceeded the Deductible by Rs.1.75lakhs, so the amount payable under the policy is Rs.1.75lakhs in respect of Claim no.2.

	Total incurred expenses – Rs.2.25lakhs	
Case 3:	Claim no.1: This is the first hospitalisation in the policy period. Hospitalisation expenses incurred in respect of a pre-existing disease, is Rs.4.50lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.5.50lakhs Claim no.2: Hospitalisation expenses incurred is Rs.1.75lakhs. Pre & post hospitalisation expenses incurred is Rs.0.65lakhs. Total incurred expenses – Rs.2.40lakhs Claim no.3: Hospitalisation expenses incurred is Rs.1.75lakhs. Pre & post hospitalisation expenses incurred is Rs.0.75lakhs. Total incurred expenses – Rs.2.50lakhs	Scenario 1: Claim No.1 relates to pre-existing disease and is not admissible since it relates to Pre-existing disease. Claim No.2 has not exceeded the Deductible, hence nothing is payable, though the disease does not fall under any exclusion. In working out the payable amount for claim No.2, we will not consider Claim no.1 at all, since it falls under exclusion of pre-existing disease and is not admissible under the policy. It is of no concern whether or not the insured's claim (no.1) has been paid under the Base policy. Aggregate of Claim Nos. 2&3 has exceeded the Deductible Admissible expenses under Claim no.2, Rs.2.10lakhs and under Claim no.3 it is Rs.2.20lakhs. Now the aggregate is Rs.4.30lakhs, which has exceeded the Deductible by Rs.1.30lakhs. So the amount payable under the policy is Rs.1.30lakhs in respect of Claim no.3. Scenario 2: The above is an example where Room rent is 1% of the Deductible. Now suppose, the insured's policy does not have room rent capping, then Admissible expenses under Claim no.2 is Rs.2.20lakhs and under Claim no.3 it is Rs.2.30lakhs. Thus the total admissible expenses under the policy considering both the claims, is 4.50lakhs, which has exceeded the Deductible by Rs.1.50lakhs, so the amount payable under the policy is Rs.1.50lakhs in respect of Claim no.3.

Case 4	There is one single hospitalisation in the policy period. Hospitalisation expenses incurred is Rs.8.50 lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.9.50lakhs	Admissible expenses is Rs.8.30 lakhs, which has exceeded the Deductible by Rs.5.30lakhs. Sum Insured is Rs.5lakhs. So, the admissible expenses after considering the Deductible, is Rs.5.30lakhs, which is greater than the Sum Insured (Rs.5lakhs). However, the maximum admissible claim amount payable cannot exceed the Sum Insured under the policy. Hence amount payable in this case under the policy is Rs.5lakhs only and not Rs.5.30lakhs.
Case 5:	There is one single hospitalisation in the third policy (i.e in the second renewal) in respect of donation of one kidney by the insured to his father. Hospitalisation expenses incurred is Rs.0.45 lakhs. Pre & post hospitalisation Rs.1lakh. Total incurred expenses – Rs.1.45 lakhs	Since this relates to Organ Donor by the Insured Person, hospitalisation in respect of him, does not get paid. However, the policy would still pay him a lumpsum of 10% of the Sum Insured, as per clause 2A2 which would be Rs.50,000 in this case.

9. Is this an Individual Policy or a Family floater type policy?
   - We offer two Plans- Individual and Family Floater. In Individual Plan, each covered member has a separate Sum Insured and Deductible. Also, the family members have the freedom to opt for any Sum Insured / deductible, i.e there is no compulsion to have a uniform Sum Insured / Deductible.
   - In the Family Floater plan a single Sum Insured is available individually and collectively for all the insured members covered under the Policy.

10. Do I have to submit any income proof for taking this policy?
    - No income proof is required. You are free to choose any Plan and any Sum Insured/ deductible, from the available options.

11. After what age are pre-insurance Medical tests required?
    - In following cases, pre-insurance Medical Check-up will be required:

Age	Pre-insurance Medical tests
>55years	Required in all cases
Person with adverse Medical History	Required irrespective of age

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

1	General Physical Examination
2	CBC with ESR
3	Lipid Profile
4	HbA1c
5	S. Creatinine
6	Urine-Routine & Molecular
7	ECG
8	TSH
9	X-Ray Chest
10	USG
11	Eye Examination – Fundus & Glaucoma

- Medical reports upto 30 days prior to the date of proposal, are only valid.
- In case of adverse medical history, the Company may ask for additional tests depending on the medical condition.

12. Do I get re-imbursed for the cost of Pre-insurance Medical tests done?
    - In case of fresh proposals, 50% of the cost of Medical Check-up shall be reimbursed by the Company only on acceptance of the proposal.

13. Can I take this policy for my entire family?
    - Yes. You can take Family Floater plan or an Individual plan (Individual Sum Insured basis) for your entire family. In case you take Individual plan you get a Family discount of 10% on premium if two or more family members are covered.
    - Family consists of the proposer and / or any one or more of the family members as mentioned below:
        i. legally wedded spouse
        ii. Parents / Parents-in-law (either of them)
        iii. Dependent Children- natural or legally adopted, between the ages of 91days to 18 years. However male child can be covered upto the age of 25 years if he is a bonafide regular student and financially dependent. Female child can be covered until she gets married. Divorced and widowed daughters are also eligible for coverage under the policy, irrespective of age. If during the currency of the policy, the child above 18 years becomes financially independent, or a male child (student) attains the age of 25 years or if the girl child gets married, he/she shall

remain covered under the policy for the remainder of the policy period. However, he / she shall be ineligible for coverage in the subsequent renewals and will have to apply for coverage under an independent policy.

iv. There is no upper age limit for dependent children who are physically or mentally challenged.

14. Is TPA services mandatory under the policy?
    - Yes.

15. Can I have a TPA of my own choice?
    - No. Only the TPA, the name of which appears in the Policy Schedule can service your Policy.

16. Do I get any other benefit under this policy if I also have Oriental's domestic health insurance policy as a base policy?
    - Yes, in that case you get a Loyalty discount of 10% in premium (discount is available only if you have Oriental's retail health policy or Oriental's Bancassurance Health policy) as a base policy. This discount is only available to the particular member(s) who has such a base policy. For example, if out of the five members, such a policy exists in respect of two members, only those two will get Loyalty discount and the remaining three members will not get any Loyalty discount. This discount would be applicable on renewal only if the base policy also exists then, i.e if the base policy has been discontinued / terminated, Loyalty discount would be withdrawn on renewal.

17. Is there any other discount available under this policy?
    - Yes, following additional discounts on premium are available under the policy:
    - Family Discount (If two or more members are covered in an Individual Plan) - 10% to each member
    - Portal Discount – 10% discount on total premium, subject to maximum of Rs.2000, is available if the Policy is taken On-line using our Portal and where no Intermediary is involved. This discount is applicable only when this policy is taken for the first time, and is not allowed on renewals
    - Staff discount of 33% is available to the employees (serving & retired) of the Company. However, No commission and no other discount like family discount, loyalty discount (except Portal discount, if applicable) is allowed in such cases.
    - Family discount and Staff discount shall be available on renewals also.

18. What are the various Plans and Sum Insured options available?
    - There are two Plans available viz – Individual & Family Floater, with Deductible / Sum Insured slabs as given under 'Premium Table'.

19. Can I subsequently revise the benefits (the Deductible and / or the Sum Insured)?
    - Only the Sum Insured can be revised, that too only at the time of renewal. However, pre-existing exclusion & time-bound exclusion clauses would apply afresh on the enhanced

portion of the Sum Insured. However, Deductibles cannot be lowered on renewal, though one may increase the Deductible on renewal.

20. How can I make a claim under the Policy?

- All claims will be processed and settled through the specified Third Party Administrator (TPA) only and shall be subject to the terms & conditions of this policy.
- Documents (bills included) of all earlier hospitalisations (during this policy period) under the Base Health Insurance Policy, have to be provided to the TPA. Even if there is no Base Policy, details of all the expenses incurred on earlier hospitalisations (during this policy period), have to be provided. This would enable the TPA to find out if the Deductible has exceeded / or is likely to exceed in the current claim.
- Intimation of Hospitalisation: is to be given immediately to the TPA when the Insured Person realizes that the expenses, either in aggregate or in respect of a single hospitalisation, are likely to exceed the Deductible.
- Availing Cashless: Pre-authorisation request to be sent to TPA, immediately when the Insured Person(s) realizes that the expenses either in aggregate or in respect of a single hospitalisation are likely to exceed the Deductible.
- Submission of Bills: All bills / documents as given in the Policy, are required to be submitted within the time lines stated in the policy, to the concerned TPA.

21. Does this policy cover pre-existing diseases?

- The policy covers pre-existing diseases only after 4 continuous policy periods. Existence or otherwise of a Base Health Policy will not have any impact on pre-existing diseases clause under this Policy.

22. Does this policy pay for expenses in respect of treatments taken outside India?

- The policy pays if the treatments and hospitalisation is within India.
- The Policy also pays if treatment is taken in SAARC countries. Coverage in SAARC countries is automatic and no prior intimation / endorsement on the policy is required in respect of travel to a SAARC country, viz- Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka.
- In case of treatment taken in a SAARC country, currency conversion rate prevailing on the date of admission to the Hospital would apply, for the purpose of claim settlement.

23. Does this policy pay if I am hospitalised for taking other than Allopathic treatment?

- Yes. In case of Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy treatment, Hospitalisation expenses are admissible only when the treatment is taken in a Government hospital or in any institute recognised by Govt. and/or accredited by Quality Council of India or National Accreditation Board on Health; **OR i**n

i. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian medicine (CCIM) and Central Council of Homeopathy (CCH)

ii. AYUSH hospitals having registration with Government authority under appropriate Act in the State / UT and complies with the following as minimum criteria
   a. has at least 15 inpatient beds
   b. has minimum 5 qualified and registered AYUSH doctors
   c. has qualified paramedical staff under its employment round the clock.

d. has dedicated AYUSH therapy sections
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

24. Can I return the policy if on receiving the documents I find the terms & conditions unsatisfactory?

- Yes. The policy provides for a 'Free look period' of 15 days from the date you receive the policy document, only if you have not made any claim. This means within this period you can return the policy. Proportionate premium, after deducting (i) the expenses incurred and (ii) the risk premium (if the Policy has already started), will be refunded.
- Free look period is applicable only for fresh policies and not on renewals.

25. Can I cancel this policy mid-term? What about refund in such a case?

- Yes, you can. In such an event the Company shall charge premium at Company's short period rates as per the table below and make refund, provided no claim has been reported during the policy period up to date of cancellation.

Period on Risk	Premium to be charged
Upto 1 month	¼ of Annual Premium
Upto 3 months	½ of Annual Premium
Upto 6 months	¾ of Annual Premium
Exceeding 6 months	Full Annual Premium

Company may at any time, cancel this Policy (on grounds of fraud, moral hazard, misrepresentation or non-co-operation), by giving the Insured 15 (fifteen) days' notice, and no refund shall be made upon such cancellation, except in case of cancellation on ground of non-co-operation, where refund shall be made on pro-rata basis.

26. Do I get any grace period for renewal of the policy?

- Yes. A grace period of 30 days from the date of expiry of the policy is available within which period you can renew the policy. However, no coverage will be available for the break period.

27. Will the premium and the terms of the policy remain same on renewal?

- The premium rates and the terms & conditions of the policy may be modified on renewal (after due approval from the Insurance Regulatory and Development Authority of India-IRDAI) for which you will be informed atleast three months in advance.

28. Will this product always remain on your menu?

- May be. However, the product may be withdrawn from the market, but only after obtaining due approval from the IRDAI and you will be informed of other suitable products available, to which you may migrate in case of withdrawal of the product.

29. Can I port into this policy without losing my continuity benefits earned under the previous Insurer's policy?

- Yes, you can port in to this product and all the credits earned under your previous policy would be maintained, in accordance with the portability conditions prescribed by IRDAI.

30. What are the basic things to be kept in mind while porting a policy?

- Portability is allowed only at the time of renewal and not mid-term.
- You may port in this policy or port out to some other insurer's policy.
- You must approach the insurer where you want in to port, atleast 45days in advance (while porting in or porting out) to avoid any break in the policy coverage due to delays in acceptance of the policy by the insurer.

31. What are the exclusions under the policy?
- Following is the list of Exclusions under the Policy:

i. All Pre-existing Diseases (whether treated / untreated, declared or not declared in the Proposal Form), are excluded upto 48 months of the Policy being in force and shall be covered only after the Policy has been continuously in force for 48 months.
This exclusion shall also apply to any complication(s) arising from Pre-existing Diseases.

ii. Any disease other than those stated in clause iii below, contracted by the Insured Person during the first 30 days from the inception date of fresh policy. This shall, however, not apply in case the Insured Person is hospitalised for injuries suffered in an accident, which occurred after inception of the policy.

iii. 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
a	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty.	12 months
b	Polycystic ovarian diseases .	12 months
c	Surgery of hernia.	24 months
d	Surgery of hydrocele.	24 months
e	Non infective Arthritis.	24 months
f	Undescendent Testes.	24 months
g	Cataract.	24 months
h	Surgery of benign prostatic hypertrophy.	24 months
i	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus.	24 months
j	Fissure / Fistula in anus.	24 months
k	Piles.	24 months
l	Sinusitis and related disorders.	24 months
m	Surgery of gallbladder and bile duct excluding malignancy.	24 months
n	Surgery of genito urinary system excluding malignancy.	24 months

o	Pilonidal Sinus.	24 months
p	Gout and Rheumatism.	24 months
q	Hypertension.	24 months
r	Diabetes.	24 months
s	Calculus diseases.	24 months
t	Surgery for prolapsed inter vertebral disk unless arising from accident.	24 months
u	Surgery of varicose veins and varicose ulcers.	24 months
v	Congenital internal diseases.	24 months
w	Joint Replacement due to Degenerative condition.	48 months
x	Age related osteoarthritis and Osteoporosis.	48 months

Note: a. If the above diseases are pre-existing at the time of inception of the policy, clause i above for Pre-existing Disease shall be applicable to such disease. which means the above diseases will be covered only after the policy has been continuously in force for 48 months.

b. If continuity of Renewal is not maintained then subsequent cover will be treated as fresh Policy and clauses i, ii, iii above shall apply afresh, (whether or not a Proposal is submitted afresh) unless agreed by the Company and suitable endorsement passed on the Policy, by the duly authorised official of the Company. Similarly, if the Sum Insured is enhanced subsequent to the inception of the first Policy, clauses i, ii and iii shall apply afresh on the enhanced portion of the Sum Insured.

c. Ported policy shall also be considered as continuous policy for the purpose of clauses i, ii & iii.

iv. Injury or disease directly or indirectly caused by or arising from or attributable to war, invasion, act of Foreign enemy, war like operations (whether war be declared or not) or by nuclear weapons / materials.

v. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination (including animal bite unless resulting in hospitalisation), inoculation or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

vi. Surgery for correction of eye sight, cost of spectacles, contact lenses, cochlear implant, hearing aids, and other external aids / implants. used for the correction of eyesight or of hearing prowess

vii. Any dental treatment or surgery which is corrective, cosmetic or aesthetic procedure, filling of cavity, crowns, root canal treatment including treatment for wear and tear., unless arising from disease or injury and which requires hospitalisation for treatment.

viii. Convalescence, general debility, "run down" condition or rest cure, congenital external diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders; diseases / accident due to, and /or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction.

ix. All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.

x. Expenses incurred at Hospital primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period.

xi. Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending physician.

xii. Any treatment (except as covered under Maternity benefit Clause) arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy. However, miscarriage due to accident or abdominal operation for extra uterine pregnancy (ectopic pregnancy) which is proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner, if left untreated, do not fall under this exclusion clause.

xiii. Any unproven and / or experimental procedure or treatment, acupressure, acupuncture, magnetic therapies.

xiv. Expenses for investigation/treatment irrelevant to the disease for which the insured person has been admitted or diagnosed. Private nursing charges, Referral fee to family doctors.

xv. Stem cell implantation / surgery.

xvi. Cost of external and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, APDS, Infusion pump., Ambulatory devices i.e. walker, Crutches, Belts, Collars, Caps, splints, slings, braces, Stockings. of any kind, Diabetic foot wear, Glucometer, Thermometer, Blood Pressure monitoring machine and also any medical equipment which is subsequently used at home. (Exhaustive list available with the policy).

xvii. All non-medical expenses, personal comfort and convenience items or services, wi-fi/internet charges, telephone, television, ayah / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items, guest services (Exhaustive list available with the policy)

xviii. Change of treatment from one system of medicine to another unless agreed / allowed and recommended by the Medical Practitioner/consultant under whom the treatment is being taken.

xix. Treatment for Age Related Macular Degeneration (ARMD), treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

xx. Treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control programme,

xxi. Treatment in respect sleep apnoea and immune-modulator drugs for cancer treatment

xxii. Any treatment required arising from Insured's participation in any hazardous activity including but not limited to aviation or ballooning, speed contests or racing on any kind(other than on foot), bungee jumping, parasailing, parachuting, ski-diving, BASE jumping, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, solo climbing, ice climbing, ice canoeing, scuba diving, Caving, cave diving, potholing, abseiling, snowboarding, waveski surfing, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports and other hazardous activities or involving military, air force or naval operations, or whilst mounting into, dismounting from or travelling in any aircraft other than as a passenger (fare paying or otherwise), in any duly licensed standard type of aircraft, anywhere in the world., .

xxiii. Treatment taken in an Establishment which is a place for rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel, convalescent home, convalescent hospital, health hydro, nature care clinic.

xxiv. Any stay in the hospital for any reason or where no active regular treatment is given by the Medical Practitioner.

xxv. All out patient treatments including diagnostic, medical or surgical procedures, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

xxvi. Massages, Steam bathing, Shirodhara under Ayurvedic treatment and all other external therapies which are not essential to the treatment of any disease.

xxvii. Any kind of Service charges, Surcharges, Admission fees / Registration charges, RMO charges levied by the hospital.

xxviii. Doctor's home visit charges, Attendant / Nursing charges during Pre and Post Hospitalisation period.

xxix. Pre and Post Hospitalisation expenses unrelated with disease / injury for which Hospitalisation claim has been admitted under the policy.

xxx. Hospital stay which is beyond regular, usual and customary limits for the treatment undertaken for the given disease / condition.

xxxi. Any illness or injury arising or resulting from insured committing breach of Law with criminal intent

32. Premium Table:

i. INDIVIDUAL PLAN

Sl.	**Deductible (INR)**	**Sum Insured (INR)**	**Age in completed years***			
			0-35	**36-45**	**46-60**	**Above 60**
1	3,00,000	3,00,000	1778	2576	3651	6642
2	3,00,000	5,00,000	2446	3451	4646	8283
3	5,00,000	5,00,000	1523	1936	2480	4127
4	5,00,000	7,00,000	1790	2240	2888	5167
5	6,00,000	6,00,000	1398	1707	2310	4127
6	6,00,000	8,00,000	1650	1993	2643	5006
7	8,00,000	8,00,000	1387	1570	2230	4641
8	8,00,000	10,00,000	1655	1859	2576	5397
9	10,00,000	10,00,000	1409	1560	2089	4641
10	10,00,000	15,00,000	2052	2272	2982	6073
11	15,00,000	10,00,000	1325	1449	1955	3471
12	15,00,000	15,00,000	1968	2160	2848	4641
13	18,00,000	10,00,000	1306	1437	1967	3029
14	18,00,000	12,00,000	1563	1722	2325	3471
15	20,00,000	10,00,000	1294	1432	1979	2795
16	20,00,000	20,00,000	2506	2785	3682	4899
17	20,00,000	30,00,000	3652	4076	5310	6936

Taxes as applicable shall be extra.

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

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

Insured Member's age	Premium to be charged
Member with highest age	100% of the premium as applicable to that age & Deductible/Sum Insured combination.
Member with second highest age	50% of the premium as applicable to that age & Deductible/Sum Insured combination.
All other members with lower ages	40% of the premium as applicable to that age & Deductible/Sum Insured combination.

IMP: The Policy gets triggered only when the aggregate of all the claims, or any single claim, in any Policy period exceed(s) the Deductible opted under the Policy.

iii. Loadings / Discounts applicable in relevant cases:

a. Loadings:

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

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

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

b. Discounts:

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

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

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

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

NOTE:

i. All loadings and discounts shall be applied successively in the same order as they appear above and not on cumulative basis.
ii. First the loadings, given above and as applicable shall apply
iii. Then subsequently, on the loaded premium (if applicable), the discounts shall be applied.

Sales Literature only contains salient features of the Policy. For details, reference is to be made to the Policy. In case of any difference between the Sales Literature and the Policy, the terms and conditions of the Policy shall prevail.

33. INSURANCE ACT 1938 **SECTION 41 - PROHIBITION OF REBATE**
Section 41 of the Insurance Act 1938 provides as follows:

Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to Ten Lakh Rupees.
No person shall allow, or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.