THE ORIENTAL INSURANCE COMPANY LIMITED,

Regd. Office : Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi – 110002

HAPPY FAMILY FLOATER POLICY - 2015- PROSPECTUS

WE VALUE YOUR HEALTH & YOUR WEALTH…BUILD A PRODUCTIVE NATION

- **ELIGIBILITY**

Any person of 18 years or more can take this Policy covering self and/or any one or more of the family members as mentioned below:

a) Legally wedded spouse.

b) Dependent Children (i.e. natural or legally adopted) between the age 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 the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.

c) Parents / Parents-in-law(either of them).

d) Unmarried siblings, if financially dependent.

Minimum two persons (falling within the definition) to be covered under the Policy.

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

1.1A NEW FEATURES IN THE POLICY

a) Extension (on request) to SAARC countries without any additional premium.
b) Diamond Plan introduced- Sum Insured Rs.12lacs to Rs.20lacs
c) Organ Donor Benefit- When Insured Person is the donor
d) Medical Second Opinion -Reimbursement
e) Maternity Expenses Cover
f) New Born Baby Cover
g) Life Hardship Survival Benefit under all Plans*
h) Restoration of Sum Insured*
i) Increase in Day Care Procedure List
j) Telemedicine Expenses

1.1B OTHER SALIENT FEATURES AT A GLANCE

- Sum Insured from Rs.2lacs to Rs.20lacs. Existing Insured Persons covered for Rs.1lac Sum Insured may continue with the same. Those existing Insured Persons covered for Sum Insured of Rs.1.5lacs, may also opt for Sum Insured of Rs.1lac.
- Three Plans available- SILVER, GOLD and DIAMOND.
- A floater policy covering the proposer and his/her family under one Sum Insured under one Policy.

- Maximum Entry Age is 65years for all members. However, this can be extended to 70years subject to conditions.
- Under Silver and Gold Plans, Pre-acceptance medical check-up is required for persons aged 60 years and above. However, under Diamond Plan, the requirement is for persons aged 55years and above.
- Term of the Policy is one year and is renewable lifelong.
- Pre-existing Disease coverage after four consecutive Policy periods.
- Option of TPA (Cashless facility in network hospitals) and non TPA services.
- Personal Accident cover as optional cover*
- Free Look Period
- Discount of 5.5% in premium if TPA services not opted for (no discount on PA premium).
- A discount of 5% on premium is allowed, if the Policy is purchased On-line and no Intermediary is involved. This discount is also applicable in case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.

*Available at the option of the proposer.

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SL. No.	Features/ Plan	SILVER	GOLD	DIAMOND
i.	Sum Insured (SI)	Rs.1,2,3,4,&5 lacs	Rs.6,7,8,9,&10 lacs	Rs.12,15,18,20 lacs
ii.	Daily Hospital Cash Allowance	Not available	0.1% of sum insured (Rs.600to Rs.1000) per day of Hospitalisation subject to a maximum compensation for 10 days per illnes. Overall liability of the Company during the policy period will be limited to 1.5% of the sum insured.	0.1% of sum insured (Rs.600to Rs.1000) per day of Hospitalisation subject to a maximum compensation for 10 days per illnes. Overall liability of the Company during the policy period will be limited to 1.5% of the sum insured.
iii.	Attendant Allowance	Not available	Rs. 500/- per day of Hospitalisation subject to maximum compensation for 10 days per illness. Overall liability of the Company during the policy period will be limited to compensation for 15 days of Hospitalisation.	Rs. 500/- per day of Hospitalisation subject to maximum compensation for 10 days per illness. Overall liability of the Company during the policy period will be limited to compensation for 15 days of Hospitalisation.

iv.	Organ Donor Benefit when insured person is the donor- waiting period 12 months	Lump sum payment of 10% of the sum insured	Lump sum payment of 10% of the sum insured	Lump sum payment of 10% of the sum insured
v.	Medical Second Opinion for 11 specified major illnesses- taken from anywhere in the world.	Maximum Rs. 5000 in a policy period.	Maximum Rs. 10,000 in a policy period.	Maximum Rs. 15,000 in a policy period.
vi.	Maternity expenses (available only for the Proposer or his spouse). Both proposer &his/her spouse should be covered under the policy for atleast 24 months.	Not available	Not available	Medical expenses for a delivery (including caesarean section) or lawful medical termination of pregnancy limited to two deliveries or terminations or either during the lifetime of the Insured person, after the policy (Diamond Plan) has been continuosly in force for 24 (twenty four) months. Liability of the company limited to 2.5% of the sum insured.
vii.	New born Baby cover. This is subject to claim being admitted under Maternity Expenses cover.	Not available	Not available	Medical expenses incurred on treatment taken in Hospital as an In-patient in respect of the new born baby from day one up to the age of 90 days. Liability of the company limited to 2.5% of the sum insured. Coverage beyond 90 days only on payment of requisite premium.
viii.	Restoration of sum insured for sum insured between Rs.3-10 lacs, both slabs inclusive.	2 options-(i) 50% of the sum insured (ii)100% of the sum insured.	2 options-(i) 50% of the sum insured (ii)100% of the sum insured.	Not available

ix.	Compulsory co-payment	10% of each and every claim.	NIL	NIL
x.	Maximum Entry Age	65 years for all members	65 years for all members	65 years for all members
xi.	Extension of Maximum Entry age	Up to 70 years, with compulsory Co-payment of 20% of each and every claim (in addition to the 10% compulsory co-payment under the Plan). Co-payment to apply on all subsequent renewals also.	Up to 70 years, with compulsory Co-payment of 20% of each and every claim. Co-payment to apply on all subsequent renewals also.	Not Available

- **COVERAGE**

The policy covers reasonable and customary charges in respect of Hospitalisation and/or Domiciliary Hospitalisation for Medically Necessary treatment only for illnesses / diseases contracted/suffered or injury sustained by the Insured Person(s) during the Policy period, upto the limit of Sum Insured, as detailed below:

Domiciliary Hospitalisation benefit shall, however, not cover expenses in any of the following cases

a) if the treatment lasts for a period of three days or less, and
b) incurred on treatment of any of the following diseases:

- Asthma,
- Bronchitis,
- Chronic Nephritis and Nephritic Syndrome,
- Diarrhoea 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 10 days,
- Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis,
- Arthritis, Gout and Rheumatism.

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

1.3A ORGAN DONOR EXPENSES

When Insured Person is the Recipient: The policy covers In-patient Hospitalisation Medical expenses in respect of the organ donor provided that the organ donation is for the Insured Person and 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.

1.3B ORGAN DONOR BENEFIT

When Insured Person is the Donor: A lumpsum payment of 10% of the Sum Insured (to take care of medical and other incidental expenses) is payable to the Insured Person donating an organ in accordance with, and the organ donation having been carried out in accordance with the extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. A waiting period of 12months from the date of taking Happy Family Floater Policy-2015 shall, however, apply.

1.3C Telemedicine

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

The limit of amount payable for telemedicine is Maximum Rs. 2,000/- per insured &/or per family, for a policy period.

NOTE: Maximum liability of the Company under the policy is the Sum Insured as stated in the schedule.

1.3D HIV/ AIDS Cover

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

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

1.3E MENTAL ILLNESS COVER

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

1. Illness covered under definition of mental illness mentioned under clause 3.29.
2. Hospitalization in Mental Health Establishment as defined under clause 3.30.
3. Hospitalization as advised by Mental Health Professional as defined under clause 3.31.
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.

1.3F All the following procedures, will be covered in the policy, if treated as in-patient care or as a part of domiciliary hospitalization or as day care treatment in the hospital, within the sub-limits in the complete policy period which is as defined below:

1.4 OPTIONAL COVERS

1.4A GEOGRAPHICAL EXTENSION TO SAARC COUNTRIES

The Policy can be extended to cover Insured Persons visiting other South Asian Association for Regional Co-operation (SAARC) countries -Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka. No additional premium will be charged for this. However, the Insured Person has to make a request for such extension, in writing, before leaving the country, duly informing the duration, purpose and country(ies) of visit. Endorsement for such extension will be issued by the Company.

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

I. RESTORATION OF SUM INSURED

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

The above is subject to the following:

i. Aggregate of all the restored amounts during the policy period shall not exceed 50% /100% of the Sum Insured, as opted by the Insured.

ii. At no point of time during the Policy period, will the available coverage be more than the Sum Insured mentioned in the Schedule.

iii. Aggregate of all the claims payable for any one Insured Person under the Policy shall not be more than the Sum Insured.

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

II. PERSONAL ACCIDENT COVER: (WORLD - WIDE)

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

a) CSI means Capital Sum Insured opted under the Personal Accident section.
b) CSI may vary for different members and is available separately for each member.
c) 10% family discount will be allowed in case more than one member is covered.
d) Overall liability in the event of one or more of the eventualities (listed above) occurring shall be restricted to the CSI of the Insured Person as mentioned in the schedule.

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

- Intentional self-injury, suicide or attempted suicide.
- Whilst under the influence of intoxicating liquor or drugs
- Engagement in aviation or ballooning, speed contests or racing on any kind(other than on foot), bungee jumping, parasailing, parachuting, ski-diving, BASE jumping, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, solo climbing, ice climbing, ice canoeing, scuba diving, caving, cave diving, potholing, abseiling, snowboarding, waveski surfing, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports and similar other hazardous activities or involving military, air force or naval operations, or whilst mounting into, dismounting from or travelling in any aircraft other than as a passenger (fare paying or otherwise), in any duly licensed standard type of aircraft, anywhere in the world, unless specifically covered and endorsed on the policy.
- Directly or indirectly caused by venereal disease(s) or insanity
- Arising or resulting from insured committing breach of Law with criminal intent
- War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainments of people
- Directly or indirectly caused by or arising from ionizing radiations or contamination by radioactivity from any nuclear fuel, nuclear weapon material, or from any nuclear waste from the combustion of nuclear fuel
- Directly or indirectly caused by, contributed by, aggravated or prolonged by childbirth or from pregnancy or in consequence thereof.

III. LIFE HARDSHIP SURVIVAL BENEFIT PLAN

If during the Policy period, any Insured Person is diagnosed with any of the 11 Critical Illnesses defined hereunder and which results in admissibility of a claim under clause 1.2 A of the Policy, then a Survival Benefit as mentioned below, shall become payable to the Insured Person. However, this benefit shall not be available for the illness which the Insured Person is already suffering from (irrespective of the stage of the disease) at the time of opting for this cover for the first time.

i. Limits under this section indicate the aggregate liability of the Company for one or more claims under the Policy in respect of one or all the Insured Persons covered under the Policy.

- Further, for a particular disease, the above benefit shall be paid only once during the lifetime of the Insured Person.

CRITICAL ILLNESSES COVERED:

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

The following are excluded -

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0...

iv. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
v. Chronic lymphocyctic leukaemia less than RAI stage 3
vi. Microcarcinoma of the bladder
vii. All tumours in the presence of HIV infection.

2. FIRST HEART ATTACK - OF SPECIFIED SEVERITY

I. The first occurrence of myocardial infarction which means the death of a portion of the Heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria

i. A history of typical clinical symptoms consistent with the diagnosis of Acute myocardial Infarction (for e.g typical chest pain)

ii. New characteristic electrocardiogram changes

- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of troponin I or T

ii. Other acute Coronary Syndromes

- Any type of angina pectoris.

3. OPEN CHEST CABG

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

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

ii. Any keyhole or laser surgery.

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

5. COMA OF SPECIFIED SEVERITY

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

- No response to external stimuli continuously for atleast 96 hours.
- Life support measures are necessary to sustain life; and

iii Permanent neurological deficit which must be assessed atleast 30 days after the onset of the coma.

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

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

i. Transient ischemic attack (TIA)

ii. Traumatic injury of Brain

- Vascular disease affecting only the eye or optic nerve or vestibular functions

8. MAJOR ORGAN/BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner

II. The following are excluded:

i. Other stem cell transplants

ii. Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

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

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

11. MULTIPLE SCLEROSIS WITH PERSISTENT SYMPTOMS

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

i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of atleast 6 months; and

iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

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

2. OTHER MAJOR FEATURES:

A. MINIMUM SUM INSURED: Sum Insured of Rs.1lac and 1.5 lacs have been discontinued in Happy Family Floater Policy-2015. Minimum Sum Insured under the Policy is now Rs.2lacs. However,

a. Those Insured Persons who were already covered for Rs.1lac Sum Insured under Happy Family Floater Policy are being offered two options:

i. They may opt for Sum Insured of Rs.2lacs and as a one-time benefit, Company will allow 25% discount on the total premium of Rs.2lacs Sum Insured (No discount is offered if the Insured opts for a Sum Insured above Rs.2lacs). This premium benefit is available only in case of first renewal into Happy Family Floater Policy-2015. No discount will be allowed on subsequent renewals.

ii. Those Insured Persons who wish to continue with the old Sum Insured of Rs.1lac, may continue with the same. However, no discount will be allowed if on subsequent renewal the Insured opts for a Sum Insured of Rs.2lacs.

b. Those Insured Persons who were covered for a Sum Insured of Rs.1.5 lacs in Happy Family Floater Policy, are also being offered two options:

i. They may opt for Sum Insured of Rs.2lacs and as a one-time benefit, Company will allow 25% discount on the total premium of Rs.2lacs Sum Insured(No discount is offered if the Insured opts for a Sum Insured above Rs.2lacs). This premium benefit is available only in case of first renewal into Happy Family Floater Policy-2015. No discount will be allowed on subsequent renewals.

ii. If for any reason, the Insured is unwilling to move to higher Sum Insured, he will have the option to take the Sum Insured of Rs.1lac. However, no discount shall be available to the Insured in this case.

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

i. Newly wed spouse within 90days of marriage or at the time of renewal of the Policy.

ii. New Born Child from 91st day of birth or at the time of renewal of the Policy.

For members subsequently added, clauses 4.1, 4.2 and 4.3 shall apply from the date of their inclusion in the policy.

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

i. The discount on account of 'No Claim', which would have been earned by the Insured Person on renewal of the Happy Family Floater policy, would be allowed when the Policy is renewed for the first time, into Happy Family Floater Policy-2015. However, there will be no change in discount even if there are no claims reported under the subsequent Happy Family Floater Policy-2015 policy(ies). This discount shall continue till a claim is reported under the policy and upon reporting of a claim, any discount earned on account of 'No Claim' shall be forfeited. However, claim under PA section will not affect No Claim Discount earned thus far.

- The Insured Persons with claim loading(s) on their previous policies will not have any loading on the premium on renewal into Happy Family Floater Policy-2015, i.e loadings on account of claims are discontinued.

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

i. On Renewal, Sum Insured can be increased to the immediate higher slab.

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

E. DISCOUNT ON OMP PREMIUM: A discount of 15% on the premium of Overseas Mediclaim Policy would be allowed when an Insured Person covered under this Policy, takes the Overseas Mediclaim Policy from the Company, provided this Policy is valid as on the date of taking the Overseas Mediclaim Policy of the Company.

F. PRE -ACCEPTANCE MEDICAL CHECKUP: Any person above the age of 60 years proposing to take insurance cover for the first time under Silver or Gold Plan, and above the age of 55 years under Diamond Plan, has to submit following medical reports, or any other additional medical report(s) required by the Company, from listed Diagnostic Centres. Pre-Acceptance Medical Check-up is required in case of fresh proposals and in cases where there has been a break in the Policy Period.
Also, based on the information provided in the Proposal Form, the Company may require any proposed member, irrespective of his/her age, to undergo medical tests.
The list of Diagnostic centres is available with the underwriting office from where the Policy is intended to be taken. The cost shall be borne by the insured.

1 MEDICAL 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

In case of fresh proposals 50% cost of Medical Check up shall be reimbursed if the proposal has been accepted by the Company. This benefit will also be allowed in cases where continuity benefits are not restored and the Policy is treated as fresh (and not as renewal) after the break in Policy Period.
Validity period of medical reports is up to 30 days from the date of proposal.

3. DEFINITIONS:
3.1 ACCIDENT: means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
3.2 AMBULANCE SERVICES: means ambulance service charges reasonably and necessarily incurred in shifting the Insured Person from residence to Hospital for admission in emergency ward / ICU or from one Hospital / Nursing Home to another Hospital / Nursing

Home, by registered ambulance only. The ambulance service charges are payable only if the Hospitalisation expenses are admissible under the Policy.

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

3.4 ANY ONE ILLNESS: means continuous period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital /Nursing Home where treatment was taken.

3.5 CASHLESS FACILITY: means a facility extended by the insurer to the insured where the payments of the costs of the treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent of pre- authorization approved.

3.6 CONGENITAL ANOMALY: refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure orposition.

a. Internal Congenital Anomaly: which is not in the visible and accessible parts of the body

b. External Congenital Anomaly: which is in the visible and accessible parts of the body

3.7 CONDITION PRECEDENT: means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

3.8 CO-PAYMENT: is a cost-sharing requirement under a health insurance Policy that provides that the Policy holder/insured will bear a specified percentage of the admissible claim amount. A co- payment does not reduce the Sum Insured.

3.9 CONTRIBUTION: Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a ratable proportion of Sum Insured. If two or more policies are taken by the insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/ benefit offered:

a) is fixed in nature:

b) does not have any relation to the treatment costs;

3.10 DAY CARE CENTRE: means any institution established for day care treatment of Illness and/or injuries OR a medical set -up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:-

a) has qualified nursing staff under itsemployment,

b) has qualified Medical Practitioner (s) in charge,

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

d) maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

3.11 DAY CARE TREATMENT: 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 a Hospitalization of more than 24 hours.

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

3.12 DENTAL TREATMENT: Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.

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

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

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

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

3.16 HOSPITAL/NURSING HOME: means any institution established for in- patient care and day care treatment of Illness and /or injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
a) has qualified nursing staff under its employment round theclock;
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 otherplaces;
c) has qualified Medical Practitioner (s) in charge round theclock;
d) has a fully equipped operation theatre of its own where surgical procedures are carried out
e) maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

3.17 HOSPITALISATION: means admission in a Hospital for a minimum period of twentyfour
(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.

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

3.19 ILLNESS: means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.
a) Acute condition - is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ Illness/ Injury which leads to full recovery.
b) Chronic condition - is 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 comes back or is likely to comeback.

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

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

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

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

3.24 IN-PATIENT CARE: means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

3.25 MATERNITY EXPENSES: 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.

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

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

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

3.29 MEDICALLY NECESSARY TREATMENT: any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which
i. is required for the medical management of the Illness or Injury suffered by the insured:

ii. must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity:
iii. must have been prescribed by a Medical Practitioner:
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.30 NEW BORN BABY: means a baby born during the Policy Period and is aged up to 90 days.

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

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

3.33 NOTIFICATION OF CLAIM: means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

3.34 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.

3.35 PRE-HOSPITALISATION EXPENSES: means medical expenses incurred during the pre- defined number of days preceding the hospitalization of the insured person, provided that:
i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.36 POST-HOSPITALISATION EXPENSES: means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged, provided that:
i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.37 PRE EXISTING DISEASE: means any condition, ailment or Injury or disease :
a).That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or, it reinstatement.
b). For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy or its reinstatement.

3.38 POLICY PERIOD: means the period of coverage as mentioned in theschedule

3.39 QUALIFIED NURSE: means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.40 REASONABLE AND CUSTOMARY CHARGES: means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the

prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/Injury involved .

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

3.42 ROOM RENT: means the amount charged by a Hospital towards room and boarding expenses and shall include the associated medical expenses.

3.43 SURGERY/ SURGICAL OPERATION: means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or a day care centre by a Medical Practitioner

3.44 THIRD PARTY ADMINISTRATOR (TPA): means any person who is licensed under the IRDAI (Third Party Administrators – Health Service) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing healthservices.

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

3.46 AYUSH Hospital: An AYUSH Hospital is a healthcare facility wherein medical/surgical/para- surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(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.

3.47 AYUSH Day Care Centre: AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without inpatient services and must comply with all the following criterion:
i. Having qualified registered AYUSH Medical Practitioner (s) in charge.

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

3.49 Portability: "Portability" means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

3.50 Mental Illness: "mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise 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 characterised by sub normality of intelligence.

3.51 Mental Health Establishment: "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, organisation 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, organisation 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.

3.52 Mental health professional:
(i) a psychiatrist or
(ii) a professional registered with the concerned State Authority under section 55; or
(iii) 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. EXCLUSIONS: Waiting Period:
The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

Pre-existing Diseases - code –ExcI 01
a). Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with the insurer or its reinstatement.
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 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer or its reinstatement.

Specified disease / procedure waiting period- code- ExcI 02
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). incase 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.

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

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

30 day waiting period- code – ExcI 03
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 hi

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

Investigation & Evaluation – Code – ExcI 04

a). Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b). Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

Rest Cure, rehabilitation and respite care – Code –ExcI 05
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. 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.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

Obesity/Weight Control : Code- EscI 06
Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:
1). Surgery to be conducted is upon the advice of the Doctor.
2). The surgery /Procedure conducted should be supported by clinical protocols.
3). The member has to be 18 years of age or older and
4). Body Mass Index (BMI):
a). greater than or equal to 40 or
b). greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failures of less invasive methods of weight loss:
i). Obesity – related cardiomyopathy
ii). Coronary heart diseases
iii). Severe Sleep Apnea.
iv). Uncontrolled Type 2 Diabetes.

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

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

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

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

Excluded Providers- Code – ExcI 011
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website /notified to the policy

holders are not admissible. However, in case of life threatening situations or following an accident, expenses upto the stage of stabilization are payable but not complete claim.

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

Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.- Code- ExcI013

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- ExcI014

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

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

Sterility and Infertility- Code- ExcI 017
Expenses related to sterility and infertility. This includes:
i). Any type of contraception, sterilization.
ii). Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI.
iii). Gestation Surrogacy.
iv). Reversal of sterilization.

Maternity- Code- ExcI 018
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.
(The above exclusion is not applicable in Diamond Plan to the extent given under 1.5)

War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any

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

Any expenses incurred on OPD treatment.

Treatment taken outside the geographical limits of India.

Compulsory Co-Payment: Under the SILVER plan the insured has to bear 10% of admissible claim amount in each and every claim.gher sum insured subsequently.

6. If the proposer is suffering or has suffered from any of the following diseases, as per serial no 1-16 listed in the below table at the time of taking the policy, the specific ICD codes mentioned therein will be permanently excluded from the policy coverage:

6. CONDITIONS

6.1 FREE LOOK PERIOD: The insured person is allowed free look period of fifteen days from the date of receipt of the Policy document to review the terms and conditions of the Policy and to return the same if not acceptable. If the Insured has not made any claim during the free look period, and exercises this option,the Insured shall be entitled to
i. 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
ii. where the risk has already commenced and the option of return of the Policy is exercised by the Insured, a deduction towards the proportionate risk premium for period on cover or
iii. where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

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

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

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

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

6.4 PAYMENT OF PREMIUM: The premium under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the Company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this Policy shall be valid, unless made in writing and signed by an authorised official of the Company.

6.5 NOTICE OF CLAIM: Immediate written notice of claim with particulars relating to Policy number, ID Card no., Name of insured person in respect of whom claim is made, nature of disease/illness/injury and name and address of the attending Medical Practitioner/ Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home by fax, email. Such written notice should be given within 48 (forty eight) hours of admission or before discharge from Hospital /Nursing Home, whichever is earlier unless waived in writing.

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

i. Claim in respect of Cashless Access Services will be through the Company/TPA provided admission is in a network Hospital / Nursing Home and is subject to pre-admission authorization.

ii. The Company/TPA reserves the right to deny pre-authorisation 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.

iii. Should any information be available with the Company/TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorisation of Cashless facility may be withdrawn.

6.7 CLAIM DOCUMENTS: Final claim along with documents stated in the policy, should be submitted to the Company/TPA within 15 days of discharge from the Hospital/Nursing Home.

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

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

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

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

III. The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. After the due date) of the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever.
IV. Not withstanding this, however, the decision to accept or reject for coverage any person upon renewal of this insurance shall rest solely with the Company. The company may at its discretion revise the premium
V. rates and / or the terms & condition of the policy every year upon renewal thereof. Renewal of this policy is not automatic;
VI. Premium due must be paid by the proposer to the company before the due date.
VII. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give notice for renewal.

6.10 REPUDIATION:

i. The Company, shall repudiate the claim if not payable under the Policy. The Company/TPA shall mention the reasons for repudiation in writing to the Insured Person. The Insured Person shall have the right to appeal / approach Customer Service Department of the Company at its Policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, New Delhi-110002.

ii. If the Insured is not satisfied with the reply of the Customer Service Department under 5.10(i), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto Rs.30 lacs.

GRIEVANCE REDRESSAL:

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

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

Insured person may also approach the grievance cell at any of the company's branches with the d details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

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

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

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

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

6.11 CANCELLATION CLAUSE:

a). 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
Upto 1 Month	1/4th of the annual rate
Upto 3 Months	1/2 of the annual rate
Upto 6 Months	3/4th of the annual rate
Exceeding 6 months	Full annual rate

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

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

Withdrawal of Policy

i. 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.

ii. 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.

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.

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.

NOMINATION:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. 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.

IRDA REGULATION: This Policy is subject to IRDAI (Protection of Policy holders' interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations 2016 and Guidelines on Standardization in health insurance, as amended from time to time.

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)

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.

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 coloured 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 utilised 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:
1. 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.

2. 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.