THE ORIENTAL INSURANCE COMPANY LIMITED

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CIN No. U66010DL1947GOI007158

ORIENTAL CANCER PROTECT

PROSPECTUS

We welcome You as Our Customer. This document explains how the **ORIENTAL CANCER PROTECT could** provide value to You. In the document the word 'You', 'Your' means you, the Insured under the Policy. 'We', 'Our', 'Us' means Insurer i.e The Oriental Insurance Co. Ltd.

1. ORIENTAL CANCER PROTECT is a Policy designed to provide indemnity towards covered expenses reasonably incurred on account of treatment of Cancer of specified severity taken as Inpatient or Outpatient or Day Care.

A. ELIGIBILITY

The Proposer for this Insurance should be between the age of 18 years and 65 years. Children above the age of 3 months can be covered by the parents / guardians provided they are financially dependent on the parents / guardians. On ceasing to be financially dependent on the parents / guardians, they can take a separate Policy on renewal. In such an event the benefits on Continuous Coverage can be ported to the new Policy. This limit will not apply to a mentally challenged child. The persons beyond 65 years can continue their Insurance provided they are insured under the Policy with us without any break.

Midterm inclusion is allowed for Newlywed spouse and New Born Child only.

B. ELIGIBLE FAMILY MEMBERS

Proposer can cover all eligible family members in one policy. The members of the family who could be covered under the Policy are: a) Proposer b) Spouse c) Children d) Parents/Parents in Law(either of them) e) unmarried siblings if financially dependent

Each Insured Person shall be covered with separate Sum Insured.

C. BASE SUM INSURED SLABS

Sum Insured option available for this policy are Rs. 5, 10, 15, 20, 25 & 50 Lakhs. The eligible slabs based on Insured's age at the time of inception of first Policy are as under:

AGE	ELIGIBLE SUM INSURED (INR)
<= 50 years	5, 10, 15, 20, 25 & 50 Lakhs
ABOVE 50 Years	5 & 10 Lakhs

Sr. No.	INSURED COVERAGE/ BENEFIT	LIMIT OF INDEMNITY

Once you have been issued a Policy, you can continue to renew it with the same Sum Insured.

D. SALIENT FEATURES OF THE POLICY

- Most of conventional & advanced methods of Cancer treatment are covered.
- Sum Insured may be enhanced to immediate next eligible Slab after every 3 continuous claim Free Years.
- No Proof of Income is demanded from proposer/ insured for coverage under this policy.
- No Pre Medical Check-up is required for taking the policy.
- Waiting period of only 75 Days.
- Provision of Lump sum payment equivalent to 50% of Sum Insured, upto INR 10 Lacs under Cancer care Benefit in case insured is diagnosed with cancer for first time & is in Stage 4 as per TNM Classification. This payment is in addition to the original Sum Insured under the policy.
- Medical Expenses incurred on follow up check-up are payable up to INR 10000/-.
- Pre Hospitalisation Expenses are covered upto 45 Days
- Post Hospitalisation Expenses are covered upto 90 Days
- Road Ambulance expenses are reimbursable as per limits prescribed in Policy.
- Air Ambulance expenses are reimbursable as per limits prescribed in Policy.
- Emergency Medical Evacuation is reimbursable as per limits prescribed in Policy.
- Option to cover Emergency treatment taken in SAARC countries on reimbursement basis.
- Room rent Charges payable upto 1% of sum insured per Day of Hospitalisation.
- Expenses incurred on treatment in ICU are reimbursable on actuals without any proportional Deduction.
- Expenses incurred towards consultation with another Medical Practitioner to seek advice on the Surgery are payable upto INR 10000/-.
- Cumulative Bonus of 5% is accrued for every Claim free Year.(Max. upto 50%)
- 10% Family discount if 2 family members are covered under single policy
- 10% Portal/Direct Channel sale Discount in case policy is purchased directly from digital platforms without any intermediary.
- Cashless Claim Settlement at all Network Hospitals (TPA serviced policy)
- Free look period option available, 15 days from the receipt of the policy.
- Grace period facility for payment of renewal premium available as per IRDAI guidelines.

2. COVERAGE/BENEFITS

The Policy covers reasonable and customary charges/expenses incurred in respect of Hospitalization and /or Treatment as Outpatient and/ or in a Day Care facility for medically necessary **treatment of Cancer** taken by the Insured Person(s) during the Policy Period, upto the limit of Sum Insured or specific sub limits , as detailed below:

	IN PATIENT HOSPITALISATION EXPENSES/BENEFITS	
i.	Sum Insured	INR 5/10/15/20/25 & 50 **Lakhs**
ii.	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home including nursing care, RMO charges,BMW Charges, IV Fluids/Blood transfusion/injection & administration charges	**a) For Sum Insured of 5, 10 and 15 Lakhs** - 1% of Sum Insured subject to maximum of INR 10000/- per Day or actual expenses incurred, whichever is less **b) For Sum Insured of 20,25 and 50 Lakhs -** 1% of Sum Insured subject to maximum of INR 25000/- per Day or actual expenses incurred, whichever is less
iii.	Intensive Care Unit (ICU) or Specialised Expenses as provided by the Hospital /Nursing Home.	Actuals
iv.	Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of Sum Insured & subject to Proportionate Clause wherever applicable
v.	Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Prosthetic devices implanted during Surgery, Relevant Laboratory / Diagnostic test, X-Ray and similar expenses related to the treatment of Cancer	As per the limits of Sum Insured subject to Proportionate Clause wherever applicable
vi.	Road Ambulance Cover	a) **For Sum Insured of 5, 10 and 15 Lakhs –** INR 3000/- per Hospitalization or actuals, whichever is less b) **For Sum Insured of 20, 25 and 50 Lakhs -** INR 5000/- per Hospitalization or actuals whichever is less ** Detailed terms & conditions as per Clause 2.2
vii.	Air Ambulance Cover	5% of Sum Insured ** Detailed terms & conditions as per Clause 2.3
viii.	Emergency Medical Evacuation Cover	**a) For Sum Insured of 5, 10 and 15 Lakhs** – 2 % of Sum Insured limited to INR 25000/- **b) For Sum Insured of 20, 25 and 50 Lakhs**

		– 2 % of Sum Insured limited to INR 50000/- ** Detailed terms & conditions as per Clause 2.4
ix.	Reconstruction of Affected Body Part Post Cancer Surgery	Within the aggregate of the Sum Insured and Cumulative Bonus, if any, of the Insured Person receiving the organ. ** Detailed terms & conditions as per Clause 2.5
x.	Organ Donor Expenses – When Insured Person is Recipient	Within the aggregate of the Sum Insured and Cumulative Bonus, if any, of the Insured Person receiving the organ. ** Detailed terms & conditions as per Clause 2.6
PRE AND POST HOSPITALISATION EXPENSES/BENEFITS		
xi.	Pre and Post Hospitalisation expenses	Medical expenses incurred 45 days prior to hospitalisation and upto 90 days post hospitalisation. **Detailed terms & conditions as per Clause 2.7 & 2.8
OUT PATIENT DEPARTMENT (OPD) EXPENSES/BENEFITS		
xii.	Expenses incurred on Treatment of Cancer in OPD	Within the aggregate of the Sum Insured and Cumulative Bonus, if any.
DAY CARE CENTRE EXPENSES/BENEFITS		
xiii.	Expenses incurred on Treatment of Cancer in Day Care	Within the aggregate of the Sum Insured and Cumulative Bonus, if any.
OTHER ADMISSIBLE EXPENSES/BENEFITS		
xiv.	Second Opinion for Surgery	a) **For Sum Insured of 5, 10 and 15 Lakhs –** INR 5000/- subject to terms & conditions as per Clause b) **For Sum Insured of 20, 25 and 50 Lakhs -** INR 10000/- subject to terms & conditions as per Clause ** Detailed terms & conditions as per Clause 2.9
xv.	Post Treatment Follow Up	**a) For Sum Insured of 5, 10 and 15**

		Lakhs – INR 5000/- **b) For Sum Insured of 20, 25 and 50 Lakhs** - INR 10000/- ** Detailed terms & conditions as per Clause 2.10
xvi.	CANCER CARE BENEFIT	50% of the aggregate Sum Insured and Cumulative Bonus, if any. Limited to INR 10 Lacs. ** Detailed terms & conditions as per Clause 2.11
xvii.	CUMULATIVE BONUS	5% of Sum Insured at each renewal in respect of each claim free year of Insurance, subject to maximum of 50%. ** Detailed terms & conditions as per Clause 2.12
xviii.	Geographical Extension to SAARC Countries	Within the aggregate of the Sum Insured and Cumulative Bonus, if any, of the Insured Person receiving the organ. ** Detailed terms & conditions as per Clause 2.13
xix.	Telemedicine & Teleconsultation Expenses	**a) For Sum Insured of 5, 10,15 and 20 Lakhs** – INR 2000/- per insured for a policy period. **b) For Sum Insured of 25 and 50 Lakhs** - INR 5000/- per insured for a policy period. ** Detailed terms & conditions as per Clause 2.14

NOTE –

A . PROPORTIONATE CLAUSE:

If the Insured Person is admitted in the hospital in a room where the room category or the Room Rent incurred is higher than the eligibility as specified in the Policy Schedule/ Certificate of Insurance, then the Policyholder/ Insured Person shall bear a rateable proportion of the total & specified Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to the Room Rent actually incurred. However, this will not be applicable in respect of

Medicines/Pharmacy/ Drugs,Consumables,Medical Devices/ implants and Cost of Diagnostics.

B. **ASSOCIATED MEDICAL EXPENSES :**

· Doctor's fees / Consultant fees/RMO fees

· Nursing expenses including administration charges/ transfusion charges/ injection charges

· Surgeon fees / Asst Surgeon fees

· Anesthesia fees

· **Procedure charges of any kind which includes :-**

I) Chemotherapy/Radiotherapy charges

II) Nebulisation

III) Haemodialysis

IV) PICC line insertion

V) Catheterisation charges

VI)Tracheostomy .

VII) IV charges

VIII) Blood transfusion charges

IX) Dialysis

X) Surgery Charges

XI) OT charges including OT gas, equipment charges

2.1 TREATMENT METHODS :

The policy shall cover treatment for Cancer taken as Inpatient or Outpatient or Day Care. Following Conventional and Advanced Treatment shall be covered in the Policy:

1. Chemotherapy

2. Radiotherapy

3. Organ transplant, as part of Cancer treatment

4. Onco-surgery (Surgeries for excision of cancerous tissue or removal of organs/ tissues)

5. Proton Treatment

6. Personalised & Targeted therapy

7. Hormonal Therapy or Endocrine manipulation

8. Immunotherapy including immunology agents

9. Stem cell transplantation

10. Bone marrow transplantation

2.2 ROAD AMBULANCE COVER :

The Policy covers the costs incurred up to the limit as specified in the Policy Schedule or Certificate of Insurance on transportation of the Insured Person by road Ambulance to a Hospital for treatment of Cancer in an Emergency which occurs during the Policy Period. It becomes payable only if a claim has been admitted under Hospitalisation cover and the expenses are related to treatment of Cancer only.

Policy will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified in the Policy Schedule or Certificate of Insurance:

(i) it is medically required to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;

(ii) it is medically required to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of speciality treatment in the existing Hospital.

Following limits of indemnity/Incidents are applicable for Road Ambulance Cover:

For Sum Insured of 5, 10 and 15 Lakhs – INR 3000/- per Hospitalization or actuals, whichever is less and can be availed upto three times during policy period.

For Sum Insured of 20, 25 and 50 Lakhs - INR 5000/- per Hospitalization or actuals whichever is less and can be availed upto four times during policy period.

2.3 AIR AMBULANCE COVER :

The Policy covers Reasonable and Customary Charges incurred during the Policy period towards emergency transportation of the Insured Person to a Hospital by an air ambulance or to move the Insured Person from one healthcare facility to another healthcare facility **within India only** up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. Such Transportation is solely & directly related to treatment of Cancer.

ii. Such Transportation must be duly recommended/prescribed by Oncologist & to be utilised only in Life threatening & or Emergency Conditions when any other mode of transport is not available/may prejudice chances of survival of a Cancer Patient.

iii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment's vital to monitoring and treating the Insured Person suffering from Cancer such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers.

iv. The Aircraft used as Air Ambulance must be in possession of all applicable and valid approvals/License on the date of transportation.

v. The facility of emergency transportation by Air Ambulance can only be availed twice during the entire Policy Lifetime.

2.4 EMERGENCY EVACUATION COVER:

In case Insured person named in the policy is stuck at a place within India due to Natural calamities not limited to Flood, Earthquake, Tsunami or due to Lockdown/Curfew/Emergency declared by State/Central Government during the Policy period and if adequate medical facilities are not available locally, Policy will cover reasonable expenses incurred up to the Sub Limits specified in the Policy for this Benefit towards the arrangement of an Emergency evacuation of the Insured Person to the nearest medical facility capable of providing adequate care, provided that:

i. Insured's medical condition warrants immediate Transportation from the place where insured is stuck due to reasons mentioned above to the nearest Hospital/Medical Facility where appropriate emergency medical treatment can be obtained.

ii. Such Evacuation is necessary to prevent the immediate and significant effects of Cancer which if left untreated could result in a significant deterioration of health.

iii. Emergency medical evacuation specifically excludes transportation for planned surgeries/treatment of Cancer.

iv. The Emergency medical evacuation is pre-authorised by TPA medical team. If it is not possible for pre-authorisation to be sought before the evacuation takes place, authorization must be sought as soon as possible thereafter, but not later than 7 days after evacuation. The Company will only authorize those medical evacuations, after the evacuation has occurred, where it was not reasonably possible for authorization to be sought before the evacuation took place.

v. In making such determinations, The Company will consider the nature of the Emergency, the Insured Person's medical condition and ability to travel, as well as other relevant circumstances including airport availability, Government Directives, Local Rail/Road Transport system, weather conditions and distance to be covered etc.

vi. The Insured Person's medical condition must require the accompaniment of a qualified Medical Practitioner during the entire course of the evacuation to be considered an Emergency and requiring Emergency evacuation.

vii. Transportation must be undertaken by medically equipped specialty aircraft, commercial airline, train or Ambulance depending upon the medical needs and available transportation specific to each case.

viii. This Benefit will be available for evacuation within India only.

ix. All Transportation arrangements made for evacuating the insured person must be by the most direct and economical route possible.

x. The facility of emergency Medical Evacuation can only be availed once during the entire Policy Lifetime.

2.5 **RECONSTRUCTION OF AFFECTED BODY PART POST SURGERY:**

Policy Covers reasonable & customary Medical Expenses incurred for the reconstruction of affected body part to restore essential physical functioning as a direct result of Cancer Surgery, provided the claim for cancer surgery is admissible and the policy is in force without a break.

Limit of indemnity will be the aggregate of the Sum Insured and Cumulative Bonus, if any, of the Insured Person receiving the organ.

2.6 ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE RECIPIENT :

The policy covers in-patient hospitalisation expenses in respect of the person donating the organ to the insured person, provided that the donation conforms to the Transplantation of Human Organs Act 1994 (or as amended from time to time) and/or any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. Further provided that:

i. the organ donated is for the use of the Insured Person who has been medically advised to undergo organ transplant solely as a part of Cancer Treatment

ii. The claim of the Insured Person is admissible under the hospitalisation section of the policy.

The policy does not cover:

a) costs directly or indirectly associated with the acquisition of the organ and/or cost of organ.

b) costs towards donor screening

c) Pre & post hospitalisation medical expenses of the donor.

2.7 PRE – HOSPITALISATION MEDICAL EXPENSES COVER:

The Policy covers, on a reimbursement basis, the Insured Person's Pre-hospitalization Medical Expenses incurred due to Cancer that occurs during the Policy Period upto 45

Days and upto the amount limit as specified in the Policy Schedule or Certificate of Insurance Or actual expenses incurred, whichever is less, provided that:

(i) Claim for In-patient Hospitalization is admissible under terms/conditions of policy

(ii) The Pre-hospitalisation Medical Expenses are related to Cancer Only & same illness incident for which claim of In Patient Hospitalisation was admitted.

(iii) The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Any One Illness.

2.8 POST – HOSPITALISATION MEDICAL EXPENSES COVER:

The Policy covers, on a reimbursement basis, the Insured Person's Post-hospitalization Medical Expenses incurred due to Cancer that occurs during the Policy Period upto 90 Days and upto the amount limit as specified in the Policy Schedule or Certificate of Insurance Or actual expenses incurred, whichever is less, provided that:

(i) Claim for In-patient Hospitalization is admissible under terms/conditions of policy

(ii) The Post-hospitalisation Medical Expenses are related to Cancer Only & same illness incident for which claim of In Patient Hospitalisation was admitted.

(iii) The date of Discharge from the Hospital for the purpose of this Benefit shall be the date of the Insured Person's Last Discharge from the Hospital in relation to the same Any One Illness.

2.9 SECOND OPINION FOR SURGERY:

In case any Insured Person requires to undergo a Surgery as advised by a Medical Practitioner, the expenses incurred towards consultation with another Medical Practitioner to seek advice on the Surgery shall be payable:

a) Upto INR 5,000 for Sum Insured of INR 5, 10 & 15 Lakhs.

b) Upto INR 10,000 for Sum Insured of INR 20,25 & 50 Lakhs.

Cashless facility for availing such second opinion may be provided by the TPA with enlisted Network Providers.

2.10 POST TREATMENT FOLLOWUP:

Medical Expenses incurred on follow up check-up shall be payable once in a policy period, provided the Insured has gone into a state of complete remission and the treatment for Cancer has been discontinued on recommendation of Medical Practitioner for at least six months with "No evidence of disease (NED)". Limits of Indemnity will be as under :

a) Upto INR 5,000 for Sum Insured of INR 5, 10 & 15 Lakhs

b) Upto INR 10,000 for Sum Insured of INR 20, 25 & 50 Lakhs.

2.11 CANCER CARE BENEFIT:

If during the Period of Insurance, any Insured Person is diagnosed for Cancer for the first time and is in Stage IV (based on TNM classification) or Advanced Metastatic Cancer, 50% of the Sum Insured would be paid as Critical Care Benefit in addition to the admissible claim amount.

Cancer Care Benefit is payable only once in the lifetime & Limited to INR 10 Lacs for each Insured Person. It will not be applicable for whom it is a Pre- Existing Condition. Any payment under this Clause would be in addition to the Sum Insured.

2.12 CUMULATIVE BONUS:

The Sum Insured under Policy shall be increased by 5% at each renewal in respect of each claim free year of Insurance, subject to maximum of 50%. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it is accrued.

Cumulative bonus will be lost if policy is not renewed before or within 30 days from the date of expiry. In case Sum Insured under the policy is reduced at the time of renewal, the percentage of Cumulative Bonus shall be applicable on such reduced Sum Insured.

2.13 GEOGRAPHICAL EXTENSION TO SAARC COUNTRIES:

The Policy can be extended to cover Insured Persons visiting other SAARC (South Asian Association for Regional Co-operation) countries - Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka.

No additional premium will be charged for this extension. 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.

Cashless service will not be available for treatment taken in countries outside India and such claims shall be considered only on re-imbursement basis on the return of the insured person to India. All other terms & conditions in respect of claim shall apply as such.

2.14 TELEMEDICINE/TELECONSULTATION :

Expenses incurred by insured on telemedicine/Teleconsultation with a Registered medical practitioner for Diagnosis & treatment of a disease/illness covered under the Policy. Such reasonable incurred expenses will be reimbursable wherever consultation with a Registered medical practitioner is allowed in the terms and conditions of policy contract and shall be subject to Limits/Sublimits 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 limits of amount payable for telemedicine are :

c) **For Sum Insured of 5, 10,15 and 20 Lakhs –** INR 2000/- per insured for a policy period.

d) **For Sum Insured of 25 and 50 Lakhs -** INR 5000/- per insured for a policy period.

2.15 WAITING PERIOD:

The Policy has a waiting period of 75 days. If the Insured is diagnosed with Cancer during the waiting period,. the premiums are returned and policy is cancelled. However, this shall not apply in case of renewal.

3. DEFINITIONS

3.1 ADVANCED METASTATIC CANCER means the diagnosis of Stage IV (based on TNM classification) or advanced metastatic cancer, evidenced by spread of cancer to other organs or parts of the body which are not directly connected with each other based on confirmation by histopathological evidence &/or radiological evidence like PET, CT, MRI. Spread of cancer to lymph nodes only is not covered under this definition

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

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

3.4 CANCER OF SPECIFIED SEVERITY means:

I. A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. 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

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix. All tumours in the presence of HIV infection.

3.5 CASHLESS FACILITY means a facility extended by the Companys to the Insured person where the Company, to the extent preauthorization approved, directly make the payment of the cost of treatment taken by the Insured person in accordance with the policy terms and conditions, to the network provider.

3.6 CLAIM FREE YEAR means coverage under the Oriental Cancer Protect Policy for a period of a year during which, no claim is paid or shall be payable under the terms and conditions of the Policy in respect of any Insured Person.

3.7 CONDITION PRECEDENT shall mean a policy term or condition upon which the Company's liability under the policy is conditional upon.

3.8 CONGENITAL ANOMALY means to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

3.8.1 CONGENITAL INTERNAL ANOMALY means a Congenital Anomaly, which is not in the visible and accessible parts of the body.

3.8.2 CONGENITAL EXTERNAL ANOMALY means a Congenital Anomaly, which is in the visible and accessible parts of the body.

3.9 CONTRIBUTION means 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 rateable 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 CUMULATIVE BONUS means any increase or addition in the Sum Insured granted by the Company without an associated increase in premium

3.11 DATE OF DIAGNOSIS refers to the date of histopathology report, based on which Medical Practitioner confirms the initial diagnosis of Cancer.

3.12 DAY CARE CENTRE means any institution established for Day Care Treatment of Cancer or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- has qualified nursing staff under its employment;

- has qualified Medical Practitioner/s in charge;

- Has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

- Maintains daily record of patients and will make these accessible to the insurance company's authorized personnel.

3.13 DAY CARE TREATMENT refers to medical treatment, and/or Surgical Procedure which is:

- Undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than twenty-four hours because of technological advancement, and

- Which would have otherwise required a Hospitalization of more than twenty-four hours.

3.14 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.

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

3.16 FAMILY consists of the Insured and/ or anyone 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 daughter / daughters are also eligible for coverage under the Policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.

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

d) Unmarried siblings, if financially dependent.

3.17 GRACE PERIOD means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-

existing diseases. Coverage is not available for the period for which no premium is received.

3.18 HOSPITAL means any institution established for Inpatient Care and Day Care Treatment of Cancer and which has been registered as a Hospital with the local authorities under the Clinical Establishment (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:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;

- has qualified nursing staff under its employment round the clock;

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

- has a fully equipped operation theatre of its own where Surgical Procedures are carried out

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

3.19 HOSPITALISATION means admission in a Hospital for a minimum period of twenty-four (24) consecutive hours of Inpatient Care except for specified procedures / treatments as mentioned in Annexure I, where such admission could be for a period of less than twenty-four consecutive hours.

3.20 INSURED PERSON means person(s) named as insured person(s) in the schedule of the policy.

3.21 ILLNESS:

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

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

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

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

2. it needs ongoing or long-term control or relief of symptoms

3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

4. it continues indefinitely

5. it recurs or is likely to recur

3.22 ID CARD means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

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 Cancer during the currency of the Policy.

3.24 INPATIENT CARE means treatment of Cancer for which insured person has to stay in a Hospital for more than twenty-four hours.

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

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

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

3.28 INSURED PERSON means the insured and each of the others who are covered under this Policy as shown in the Schedule.

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

3.30 MEDICAL EXPENSES means those expenses that Insured person has necessarily and actually incurred for medical treatment on account of Cancer 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 Medical Practitioner in the same locality would have charged for the same medical treatment.

3.31 MEDICALLY NECESSARY TREATMENT means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- is required for the medical management of the Cancer suffered by insured;

- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;

- must have been prescribed by a Medical Practitioner;

- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

Note: The Medical Practitioner should not be the Insured or close family members.

3.33 MIGRATION 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, with the same insurer.

3.34 NETWORK PROVIDER means Hospitals or health care providers enlisted by an insurer, TPA or jointly by insurer and TPA to provide medical services to insured by a cashless facility. The list is available with insurer/TPA and subject to amendment from time to time.

3.35 NEW BORN BABY means baby born during the Policy Period and is aged upto 90 days..

3.36 NON-NETWORK PROVIDER means any Hospital, Day Care Centre or other provider that is not part of the Network.

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

3.38 OPD TREATMENT means the 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.

3.39 PERIOD OF INSURANCE means the period for which this Policy is issued, as specified in the Schedule.

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

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
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 issued by the insurer or its reinstatement.
(Life Insurers may define norms for applicability of PED at reinstatement).

3.41 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during Forty Five days preceding the Insured person's Hospitalisation, provided that:

i. Such Medical Expenses are incurred for Cancer, and

ii. The Inpatient Hospitalization claim is admissible under the policy.

3.42 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during ninety days immediately after insured is discharged from the Hospital provided that:

i. Such Medical Expenses are incurred for Cancer, and

ii. The Inpatient Hospitalisation claim is admissible under the policy.

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

3.44 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. .

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

3.46 REASONABLE AND CUSTOMARY CHARGES mean 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.

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

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

3.49 SUM INSURED is the maximum amount of coverage opted for each Insured Person and as shown in the Schedule.

3.50 SUBROGATION means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

3.51 SURGERY OR SURGICAL PROCEDURE means manual and/or operative procedure(s) required for treatment of Cancer, correction of deformities and defects, diagnosis and cure of Cancer, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

3.52 TPA (THIRD PARTY ADMINISTRATORS) means any person who is registered under the IRDAI (Third Party Administrators - Health Services) Regulation, 2016 notified by the Authority, and is engaged, for a fee or remuneration by the Company, for the purposes of providing Health Services defined in those Regulations.

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

4. 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 :

4.1 Any Treatment other than for Cancer.

4.2 Pre-Existing Condition for Cancer for which Insured Person :

a) was diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer, or its reinstatement.

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

4.3 Insured person Diagnosed of suffering from Cancer during the first Seventy Five days of the commencement date of first Policy.

4.4 Any treatment for Cancer caused by or arising from or attributable to War, invasion, Act of Foreign enemy, War like operations (whether war be declared or not), nuclear weapon/ ionising radiation, contamination by Radioactive material, nuclear fuel or nuclear waste or from the combustion of nuclear fuel. .

4.5 Cost of external prosthetic devices, non-durable implants external medical equipment.

4.6 Dental treatment or Surgery of any kind unless necessitated due to treatment of Cancer.

4.7 Kaposi Sarcoma.

4.8 **Investigation & Evaluation- Code- Excl. 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.

4.9 Non Allopathic treatment.

4.10 Any expenses relating to cost of items detailed in List 1 of **Annexure A.** .

4.11 Any kind of Service charges, Surcharges, Luxury Tax and similar charges levied by the Hospital.

4.12 Treatment including investigation/diagnostic services availed outside India

4.13 **Rest Cure, rehabilitation and respite care- Code- Excl. 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 as 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.

4.14 **Cosmetic or plastic Surgery: Code- Excl. 08:**

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following 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

4.15 **Breach of law: Code- Excl. 10**

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

4.16 **Excluded Providers: Code- Excl. 11**

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 policyholders are not admissible. However, in case of life threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.17 **Code- Excl. 13**

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.

4.18 Code- Excl. 14

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

4.19 Unproven Treatments: Code- Excl. 16

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.

4.20 Specified healthcare providers:

- Treatment rendered by a Medical Practitioner, which is outside his discipline or the discipline for which he is licensed.
- Treatments rendered by a Medical Practitioner, who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.

4.21 Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments that are not supported by treating doctor's prescription.

4.22 Charges related to a Hospital stay not expressly mentioned as being covered in this Policy, including but not limited to charges for admission, discharge, administration, registration, documentation and filing.

5. CONDITIONS

5.1 BASIS OF INSURANCE:

This Policy is issued based on the truth and accuracy of statements in the Proposal. If there is any misrepresentation or non-disclosure of material facts, The Company will treat the Policy as void ab initio.

5.2 ENTIRE CONTRACT:

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

5.3 COMMUNICATION :

Every notice or communication to be given or made under this Policy shall be delivered in writing at the address of the Policy issuing office / Third Party Administrator as shown in the Schedule.

5.4 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 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 authorized official of the Company.

5.5 PLACE OF TREATMENT AND PAYMENT:

- This Policy covers Medical/ Surgical treatment and/or services rendered only in India except specifically endorsed to extend coverage to SAARC countries.

- Admissible claims shall be payable only in Indian Rupees.

- Payment shall be made directly to Network Hospital if Cashless facility is availed. If request for Cashless facility is not availed/approved, bills and Mandatory documents will be required to be submitted for reimbursement.

Note: Cashless facility is only a mode of claim payment and cannot be demanded in every claim. In case admissibility of a claim is disputed at the initial stage and warrants further verification/investigation of treatment, records etc., request for Cashless facility may be declined. Insurer's decision in this regard will be final.

Denial of Cashless facility would not imply denial of claim. If Cashless facility is denied, Insured may submit the papers on completion of treatment and admissibility of the claim would be subject to the terms, conditions and exclusions of the Policy.

5.6 CLAIMS PROCEDURE:

A. NOTIFICATION 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 / Injury and Name and Address of the attending Medical Practitioner / Hospital /Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home by fax, e-mail or by any other mode of communication.

Such notice should be Communicated/ delivered to Company by Insured/Insured's representative within prescribed time lines as under :

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization

- Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the insurer that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.
-

B. PROCEDURE FOR AVAILING CASHLESS TREATMENT/ SERVICES IN NETWORK HOSPITAL/NURSING HOME:

i. Cashless Treatment may be availed through TPA in a network provider/PPN hospital and is subject to preauthorization by the TPA. List of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is also available on website of the company (https://orientalinsurance.co.in)

ii. The name and complete contact details of policy servicing TPA are mentioned on the front page of policy schedule. In case of more details, insured can log on to website of TPA or details can be accessed by logging on to The Company's website under the below mentioned path :

www.orientalinsurance.org.in - Products - Health insurance - Empanelled TPA

iii. Insured may call TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.

iv. On admission in the network provider/PPN hospital, produce the ID card issued by the TPA or Policy Schedule at the Hospital Insurance-desk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for pre- authorization.

V. The Company / TPA shall, upon getting the related medical details / relevant information from the Insured Person / Network Hospital / Nursing Home, verify that the person is eligible to claim under the Policy and after satisfying itself will issue a pre- authorization letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as in-patient.

vi. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorisation date at a Network Provider and pre-authorisation shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre-authorised by Insurer or the associated TPA, Insurer will make the payment of the amounts assessed directly to the Network Provider.

vii. In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalization to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under point no. iv above.

viii. At the time of discharge, the insured person shall verify and sign the discharge papers and final bill and pay for non-medical and inadmissible expenses.

Note: (Applicable to 5.6 B): Cashless facility for Hospitalization expenses shall be limited exclusively to Medical Expenses incurred solely for Treatment of Cancer undertaken in a Network Provider/ PPN hospital which is covered under the Policy. For all cashless authorisations, the Insured Person will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and / or opted Deductible (Per claim/ Aggregate/ Corporate) (if applicable), directly with the Hospital.

ix. The TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medical details. Denial of a Pre-authorisation request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA/Insurer for possible reimbursement within 15 days of the discharge from Hospital / Nursing Home for consideration of TPA/Insurer.

x. In case of admission in PPN hospitals, duly filled and signed PPN declaration format available with the hospital must be submitted.

xi. Should any information be available with the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorization of cashless facility may be withdrawn. However this shall be done by the Company / TPA before the patient is discharged from the Hospital and notice to this effect given to the treating Hospital/Insured.

xii. Claims for Pre and Post-Hospitalisation (as per limits prescribed in the policy) will be settled on reimbursement basis on production of cash receipts alongwith supporting documents.

C. **PROCEDURE FOR REIMBURSEMENT OF CLAIMS:**

In case insured has availed treatment In non-network hospitals payment must be made up-front and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/company (if claim is processed by the company) within the prescribed time limit.

D . **CLAIM DOCUMENTS:**

Final claim along with original Bills/ Cash memos/reports, claim form and documents as listed below should be submitted to the Company / TPA within Fifteen (15) days of discharge from the Hospital / Nursing Home:

i. Duly completed claim form

ii. Photo ID and Age proof;

iii. All previous consultation papers indicating history and treatment details for current ailment;

iv. Copy of indoor case papers with nursing sheet(If Available) detailing medical history of the Insured Person, treatment details and the Insured Person's progress;.

v. Numbered Bill, Receipt and Discharge certificate / card from the Hospital.

vi. Numbered Cash Memos from the Hospitals(s) / Chemists(s), supported by proper prescriptions.

vii. Numbered Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such tests.

viii. Surgeon's certificate stating nature of operation performed and Surgeons' numbered bill and receipt.

ix. Attending Medical Practitioner's / Anaesthetist's numbered bill and receipt, and certificate regarding diagnosis.

x. Copy of PAN Card and NEFT Details.

xi. Documents in respect of organ donation claim, shall be in accordance with the extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of Human Organs.

xii. Authorisation Letter to TPA to obtain medical and other records from any Hospital, Laboratory or other agency.

xiii. Any other information/document/data required by Insurer/TPA

Note: All the documents have to be in original & Self attested. If the originals have been submitted to some other company, certified & self attested true copy of the same along with the settlement note should be submitted.

In case of Post-Hospitalisation treatment (limited to ninety days), all claim documents should also be submitted to TPA/Insurer within fifteen (15) days after completion of such treatment.(Upto Ninety Days or actual period, whichever is less)

Time Limit for Submission of Claim Documents will be as as under :

Type of claim	**Time limit for submission of documents to company/TPA**
Where Cashless Facility has been authorised	Immediately after discharge
Reimbursement of hospitalisation and pre hospitalisation expenses (limited to 45 days)	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses (limited to 90 days)	Within 15 (fifteen) days from completion of post hospitalisation treatment

The above stipulations are not intended to prejudice insured's claim, but their compliance is of utmost importance and necessity for insurer/TPA to identify and verify all facts and surrounding circumstances relating to a claim and determine its admissibility as per terms & conditions of the policy.

Waiver of delay in submission of claim documents may be considered in genuine cases of hardship, but only if it is proved to insurer's satisfaction that it was not possible for insured or any other person to comply with the prescribed time-limit.

The Insured person shall give the TPA/Insurer any additional information and assistance as the TPA / Insurer may require.

E . **SCRUTINY OF CLAIM DOCUMENTS:**

i. TPA/ Insurer shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/ Network Provider as the case may be. If the deficiency in the necessary claim documents is not met or is partially met in 10 working days of the first intimation, Insurer/TPA will send a maximum of 3 (three) reminders. Insurer /TPA may, at its sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if insurer observes that such a claim is otherwise valid under the Policy.

ii. In case a reimbursement claim is received when a pre-authorisation letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorisation has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.

iii. The Pre-Hospitalisation Medical Expenses Cover claim and Post- Hospitalization Medical Expenses Cover claim shall be processed only after decision of the main Hospitalization claim.

iv In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.

v. In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each.

vi. The claim shall be eligible for repudiation if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder. If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.

F. **CLAIM PAYMENT TERMS:**

i. 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.

G. Claim Settlement (provision for Penal interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. ln the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2o/o above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- ln such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. ln case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

v. Insurer shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.

vi. Insurers are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice or guidance provided by a Medical Practitioner.

vii. The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.

vii. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.

viii. **For Cashless claims,** the payment shall be made to the Network Provider whose discharge would be complete and final.

ix. **For Reimbursement claims,** the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, insurers will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of insurer's liability under the Policy.

5.7 CONTRIBUTION:

i) If the Insured Person is covered under more than one Policy issued by the Company or by any other Insurer, where such policies indemnify treatment cost, the Insured Person shall have the right to require a settlement of his claim in terms of any of his policies, provided the admissible claim is within the limits of and according to the terms of the chosen policy.

ii) If the amount to be claimed exceeds the Sum Insured under a single Policy after considering Deductibles or Co-payments, the Insured Person shall have the right to choose Insurer by whom the claim is to be settled. In such cases the Company shall not be liable to pay or contribute more than its rateable proportion of the admissible claim.

iii) The Insured Person is duty bound to disclose such other insurance at the time of making a claim under this policy.

5.8 CLAIM FALLING IN TWO POLICY PERIODS:

If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available Sum Insured of the expiring Policy only.

Sum Insured of the Renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

5.9 REPUDIATION/REJECTION OF CLAIM:

a) If Insurer, for any reasons, decides to reject a claim under the policy, insurer shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be.

b) Where a rejection is communicated by Insurer, the Insured Person may, if so desired, within 15 days from the date of receipt of the claims decision, represent to insurer for reconsideration of the decision.

c) The Insured Person shall have the right to appeal / approach the Customer Service department of the Company at its Policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office.

d) If the insured is not satisfied with the reply of the Customer Service department under 5.9 (c), 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 INR 20 Lakhs.

5.10 DISCLAIMER OF CLAIM:

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

5.11 ARBITRATION CLAUSE :

i. If any dispute or difference shall arise as to the quantum to be paid under the Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties;

or

if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act,1996.

ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy.

iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

5.12 FRAUD :

lf any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

5.13 MEDICAL RECORDS:

a) The Insured Person hereby agrees to and authorizes the disclosure, to the Company/ TPA or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from which the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company / TPA in connection with any claim made under this Policy or the Company's liability thereunder.

b) The Company / TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (a) above and will only use it in connection with any claim made under this Policy or the Company's liability thereunder.

c) ***Independent*** Medical Practitioner authorized by the Company / TPA shall be allowed to examine the Insured Person in case of any Treatment/claim preferred under this policy ,when and so often as the same may reasonably be required on behalf of the Company/TPA..

5.14 CANCELLATION CLAUSE:

The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

A) CANCELLATION BY INSURER:

Insurer may at any time, cancel this Policy (on grounds of fraud, moral hazard, misrepresentation or non-co-operation), by sending the Insured 30 (Thirty) days notice by registered post at the Insured's last known address and in such an event, the Company shall refund to the Insured a pro-rata premium for un-expired Policy Period only.

The policy shall be null and void, and no benefits shall be payable in case of Fraud, misrepresentation, mis-description or nondisclosure of any material fact / particular. Premium paid shall also stand forfeited.

B) CANCELLATION BY INSURED:

The policyholder may request for cancellation of the policy at any time by giving 15 days notice in writing. In such case the Company shall refund the percentage of premium for the unexpired Policy Period on short period scale as per the table below:

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED (RETAINED)
Up to one month	1/4th of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice.

There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

If insured under policy is diagnosed with Cancer during the first Seventy Five days of the commencement date of first Policy, Policy shall be cancelled ab-initio and entire premium will be refunded. If there are more than one Insured Person covered in the Policy, cover shall seize for that Insured Person and the premium collected for him/her shall be refunded.

Premium shall be refunded for only those insured/s who have not registered a claim under the Policy upto the date of cancellation.

5.15 NOMINATION :

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be

communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. Ill the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

6. OTHER TERMS AND CONDITIONS:

6.1 FAMILY SIZE :

a) Policy offers coverage on individual basis, so no minimum family size is mandated. All eligible family members as per definition of family 3.16 may be covered under a single policy.

b) Persons becoming ineligible on account of above provision for coverage under the existing Policy, may migrate to another suitable Policy at the expiry of this 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 any break.

6.2 SUM INSURED:

Sum Insured option available for this policy are Rs. 5, 10, 15, 20, 25 & 50 Lakhs.

The eligibility of the Sum Insured based on Insured's age at the time of inception of first policy is as under :

AGE	ELIGIBLE SUM INSURED (INR)
<= 50 years	5, 10, 15, 20, 25 & 50 Lakhs
ABOVE 50 Years	5 & 10 Lakhs

6.3 ENTRY AGE:

The Proposer for this Insurance should be between the age of 18 years and 65 years. Children above the age of 3 months can be covered by the parents / guardians provided they are financially dependent on the parents / guardians.

6.4 MIDTERM INCLUSION:

Midterm inclusion of following members is permitted under the Policy, on payment of pro-rata premium only for

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

ii. Newborn child from 91st day of birth or at the time of renewal of the Policy.

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

6.5 ENHANCEMENT OF SUM INSURED:

Insured may seek enhancement of Sum Insured in writing on Renewal upto the Next applicable Slab of Sum Insured**,** which may be granted subject to the underwriting guidelines. Enhancement of Sum Insured shall be allowed based on the following table:

Age<=50 years	Enhancement up to Sum Insured of 50 Lakhs
Age Above 50 Years	Enhancement up to Sum Insured of 10 Lakhs

Enhancement of Sum Insured will be subject to:

1) No claim has been reported by Insured Persons seeking enhancement during three immediate preceding policy periods.

2) No enhancement can be granted for Insured Person/s who are diagnosed for Cancer (including Cancer survivors).

In respect of any increase in Sum Insured, exclusion 4.1, 4.2 and 4.3 would apply to the additional Sum Insured from the date of such increase.

6.6 FREE LOOK PERIOD:

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

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

lf the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person 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 person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

6.7 GRACE PERIOD:

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

6.8 RENEWAL OF POLICY:

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

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

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

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

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

v.There will be no loading on renewals on Individual claims experience basis.

6.9 PORTABILITY:

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

For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4257&flag=1

6.10 CHANGE OF ADDRESS:

Insured must inform the Company immediately in writing of any change in the address.

6.11 QUALITY OF TREATMENT:

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

6.12 ID CARD:

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

6.13 WITHDRAWAL OF THE POLICY:

i.ln 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. lnsured 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.

6.14 DISCOUNTS

a) FAMILY DISCOUNT:

A discount of 10% if more than 1 member covered under same policy.

6.15 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDAI (Protection of Policyholders' Interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations2016 & Guidelines on Standardization in health insurance, as amended from time to time.

6**.16 GRIEVANCE REDRESSAL:**

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

Website: www.orientalinsurance.org.in

Toll free: 1800118485 Or 011- 33208485

E-mail: csd@orientalinsurance.co.in

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:
Customer Service Department
4th Floor, Agarwal House
Asaf Ali Road,
New Delhi-110002.

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

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

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

6.17 MULTIPLE POLICY:

i. Proposer is not allowed to take multiple policies of Oriental Cancer Protect. This condition shall be applicable to all the Insured persons covered under Oriental Cancer Protect Policy.

ii. ln case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. ln all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

iii. lnsured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iv. lf the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

v. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

6.18 ASSIGNMENT :As per the provisions of Sec. 38 (1) of Insurance Act, 1938.

6.19 DISCLOSURE TO NFORMATION NORM:

The Policy shall be void, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

6.20 TERRITORIAL JURISDICTION:

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

6.21 **Condition Precedent to Admission of Liability** The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

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

6.23 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 policyatleast 3O days before the policy renewal date as per IRDAI guidelines on Migration.

lf such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration. For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4157&flag=1

6.24 MORATORIUM :

After completion of eight continuous years under the 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 8 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.

6.25 Possibility of Revision of Terms of the Policy lncluding the Premium Rates :

Possibility of Revision of Terms of the Policy lncluding the Premium Rates The Company, with prior approval of IRDAl, 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.

ORIENTAL CANCER PROTECT - PREMIUM SCHEDULE

(Male Non-Tobacco) (INR)						
Age Band / SI	**500,000**	**1,000,000**	**1,500,000**	**2,000,000**	**2,500,000**	**5,000,000**
<20	419	583	678	789	947	1,153
21-35	768	1,133	1,395	1,625	1,766	2,412
36-45	1,071	1,402	1,674	1,911	2,042	2,775
46-55	2,274	3,484	4,158	4,689	5,352	7,515
56-60	4,166	6,142	7,313	8,209	8,787	10,652
61-70	7,498	11,202	13,366	14,981	16,086	19,639

71-80	11,787	19,102	23,336	26,446	28,671	35,792
>80	18,608	28,889	34,815	39,157	42,289	52,322

(Female Non-Tobacco) (INR)						
Age Band / SI	**500,000**	**1,000,000**	**1,500,000**	**2,000,000**	**2,500,000**	**5,000,000**
<20	421	616	729	853	917	1,380
21-35	1,007	1,308	1,497	1,738	1,887	2,712
36-45	1,533	2,032	2,433	2,764	2,965	4,367
46-55	3,244	5,099	6,525	7,281	8,705	11,641
56-60	5,328	8,814	10,402	11,602	12,408	15,005
61-70	6,819	11,312	13,294	14,780	15,786	19,029
71-80	10,422	16,508	18,740	20,937	22,470	27,398
>80	14,055	22,819	26,999	30,082	32,261	39,267

(3rd Gender Non-Tobacco) (INR)						
Age Band / SI	**500,000**	**1,000,000**	**1,500,000**	**2,000,000**	**2,500,000**	**5,000,000**
<20	463	678	802	938	1,009	1,518
21-35	1,108	1,439	1,646	1,912	2,076	2,983
36-45	1,686	2,236	2,677	3,040	3,262	4,804
46-55	3,569	5,609	7,177	8,009	9,576	12,806
56-60	5,861	9,696	11,443	12,763	13,648	16,506
61-70	7,500	12,443	14,624	16,259	17,365	20,932
71-80	11,464	18,159	20,614	23,031	24,717	30,138
>80	15,461	25,101	29,699	33,090	35,487	43,194

(Male Tobacco) (INR)						
Age Band / SI	**500,000**	**1,000,000**	**1,500,000**	**2,000,000**	**2,500,000**	**5,000,000**
<20	419	583	678	789	947	1,153
21-35	876	1,294	1,595	1,853	2,014	2,754
36-45	1,224	1,604	1,917	2,182	2,332	3,171
46-55	2,607	3,998	4,772	5,375	6,136	8,620
56-60	4,782	7,053	8,400	9,421	10,085	12,226
61-70	8,614	12,872	15,361	17,210	18,479	22,562
71-80	13,546	21,957	26,825	30,394	32,952	41,138
>80	21,391	33,213	40,027	45,012	48,612	60,147

Office Premium (Female Tobacco) (INR)						
Age Band / SI	**500,000**	**1,000,000**	**1,500,000**	**2,000,000**	**2,500,000**	**5,000,000**
<20	421	616	729	853	917	1,380
21-35	1,151	1,496	1,712	1,983	2,154	3,099

36-45	1,755	2,329	2,789	3,162	3,393	5,002
46-55	3,723	5,855	7,494	8,356	9,993	13,366
56-60	6,119	10,127	11,952	13,324	14,249	17,233
61-70	7,832	12,999	15,278	16,979	18,134	21,860
71-80	11,976	18,975	21,540	24,059	25,821	31,484
>80	16,154	26,232	31,039	34,576	37,081	45,134

(3rd Gender Tobacco) (INR)						
Age Band / SI	**500,000**	**1,000,000**	**1,500,000**	**2,000,000**	**2,500,000**	**5,000,000**
<20	463	678	802	938	1,009	1,518
21-35	1,266	1,646	1,884	2,182	2,369	3,408
36-45	1,931	2,562	3,068	3,479	3,733	5,502
46-55	4,095	6,440	8,243	9,191	10,992	14,702
56-60	6,730	11,139	13,147	14,656	15,674	18,956
61-70	8,616	14,299	16,806	18,677	19,948	24,046
71-80	13,174	20,872	23,694	26,465	28,403	34,633
>80	17,770	28,855	34,143	38,033	40,789	49,647

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ANNEXURE I: LIST OF DAY CARE PROCEDURES

Sr. No.	Treatment	Sr No.	Treatment
1	2D Radiotherapy	30	Interstitial Brachytherapy
2	3D Brachytherapy	31	Intracavity Brachytherapy
3	3D Conformal Radiotherapy	32	Intraluminal Brachytherapy
4	Adjuvant Chemotherapy	33	Intravesical Brachytherapy
5	Adjuvant Radiotherapy	34	IV Push Chemotherapy
6	After loading Catheter Brachytherapy	35	LDR Brachytherapy
7	Cancer Chemotherapy	36	Maintenance Chemotherapy
8	CCRT concurrent Chemo + RT	37	Muscle Biopsy
9	Conditioning Radiotherapy For BMT	38	Neoadjuvant Chemotherapy
10	Consolidation Chemotherapy	39	Neoadjuvant Radiotherapy
11	Continuous Infusional Chemotherapy	40	Nerve Biopsy

12	Electron Therapy	41	Palliative Chemotherapy
13	Epidural Steroid Injection	42	Palliative Radiotherapy
14	External Mould Brachytherapy	43	Radical Chemotherapy
15	Extracorporeal Irradiation Of Blood Products	44	Radical Radiotherapy
16	Extracorporeal Irradiation To The Homologous Bone Grafts	45	Radiotherapy for Cancer
17	FSRT fractionated SRT	46	Rotational Arc Therapy
18	Gamma knife SRS	47	SBRT stereotactic Body Radiotherapy
19	HBI hemi body Radiotherapy	48	SC Administration Of Growth Factors
20	HDR Brachytherapy	49	SRS stereotactic Radiosurgery
21	Helical Tomotherapy	50	SRT stereotactic ARC Therapy
22	IGRT Image Guided Radiotherapy	51	TBI Total Body Radiotherapy
23	Implant Brachytherapy	52	Tele Gamma Therapy
24	IMRT DMLC	53	Telecesium Therapy
25	IMRT Step & Shoot	54	Telecobalt Therapy
26	Induction Chemotherapy	55	Template Brachytherapy
27	Infusional Bisphosphonates	56	TSET total Electron Skin Therapy
28	Infusional Chemotherapy	57	VMAT volumetric Modulated Arc Therapy
29	Infusional Targeted Therapy	58	X knife SRS

Annexure-A

List I – Items for which coverage is not available in the policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES

49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT

28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT

11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

ANNEXURE II: CONTACT DETAILS OF INSURANCE OMBUDSMEN

Area of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu.	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka.	Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh Chattisgarh.	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Orissa.	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in

Delhi.	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan.	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363
Area of Jurisdiction	**Office of the Insurance Ombudsman**
Kerala, Lakshad weep, Mahe-a part of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur,	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj,

Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in

Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in