THE ORIENTAL INSURANCE COMPANY LIMITED

Regd. Office : Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi - 110 002

CIN No.U66010DL1947GOI007158

AROGYA SANJEEVANI POLICY -ORIENTAL- PROSPECTUS

1. SALIENT FEATURES OF THE POLICY

i. The Policy covers Hospitalisation Expenses for In-Patient Care or Day Care Treatment incurred for treatment of an Illness contracted/ Injury sustained during the Policy Period.

ii. The Policy provides for Cashless Facility and/or reimbursement of Hospitalisation expenses for treatment of illness or injury. Cashless Facility will be available in Network hospitals only if TPA's service is opted in the Policy.

iii. Sum Insured (SI) available from Rs.1lac to Rs.5lacs, in multiples of Rs. 50,000.

iv. All pre-existing diseases covered after 48 months of continuous coverage, subject to the same being declared at the time of application and accepted by insurer.

v. Life long renewals allowed.

vi. The Policy term is one year and is available to any proposer between the age of 18 to 65 years for treatment taken in India.

vii. Maximum Entry age for any member, is 65 years.

viii. No medical examination for persons upto the age of 55 years.

ix. In case of fresh covers, 50% of the Pre-insurance medical check-up cost reimbursable, subject to acceptance of the Proposal.

x. Life-long renewals allowed with no exit age.

xi. Policy can be issued, as per the option of the Proposer, on

- Individual Basis (i.e., Sum Insured and Cumulative Bonus shall apply separately on each Insured Person)
- Floater Basis (i.e., Sum Insured and Cumulative Bonus shall apply cumulatively to cover all Insured Persons)

xii. Ambulance charges covered, maximum of Rs. 2000/- per hospitalization.

xiii. Cumulative Bonus of 5% of sum insured for each claim free year maximum upto 50% of sum insured, provided the policy is renewed without any break.

xiv. Specified modern and advanced treatments upto 50% of sum insured for all modern treatments/procedures combined, either as in-patient or as part of day care treatment.

xv. Dental treatment covered, necessitated due to disease and injury.

xvi. Plastic surgery payable, necessitated due to disease or injury.

xvii. AYUSH Treatment covered upto sum insured, without any sub-limits undertaken for inpatient care in AYUSH hospitals.

xviii. Free Look Period- A period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and return the same, if not acceptable.

xix. Grace period facility for payment of renewal premium available.

- 30 days grace for annual premium.
- 15 days for half yearly, quarterly and monthly modes of premium payment.

xx. Migration facility to other retail Health products of Oriental available, with all accrued benefits intact.

xxi. Portability facility available subject to IRDAI Guidelines for portability.

xxii. Discount of 5.5% in premium if TPA services not opted for.

2.1 FAMILY: Family consists of the proposer and any one or more of the family members as mentioned below:

i. Legally wedded spouse.
ii. Dependent Children (i.e. natural or legally adopted) between the age 3months to 18 years. However male child can be covered upto the age of 25 years. If the child above 18 years is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
iii. Parents and
iv. Parents-in-law.

2.1 A INCLUSION OF NEW MEMBERS: Addition of members is allowed only at the time of renewal of the policy. However, mid-term inclusion is permitted for a newly married spouse and /or a child attaining the age of 3 months during the currency of the policy, on payment of pro-rata premium.
For members subsequently added, Exclusion No. 4.1 and 4.3 shall apply from the date of their inclusion in the policy.

2.2 SUM INSURED

i. Minimum sum insured is Rs 100,000 and in multiples of Rs 50,000 upto Rs 5,00,000.
ii. The policy is available on individual basis as well as floater basis.
- On Individual basis –SI shall apply to each individual family member.
- On floater basis – SI shall apply to the entire family.

2.2 A CHANGE OF SUM INSURED

i. Sum Insured can be changed (increased/ decreased) only at the time of Renewal or any time, subject to discretion of the Company.
ii. Mid term increase in SI to be allowed only in case of mid term inclusion (as explained as per clause 2.1A above).
iii. For the incremental portion of the SI, the Waiting Periods specified in Section 6 shall start afresh. Coverage on increased SI shall be available after the completion of Waiting Periods.
iv. Increase in SI shall be allowed by one slab at a time.

2.3 A PRE -ACCEPTANCE MEDICAL CHECKUP:

Any person beyond 55 years of age proposing to take insurance cover has to submit following medical reports from listed Diagnostic Centre or any other medical report(s) required by the company in case of fresh proposal or in case of renewal where there is a break in policy period. This list is available with the underwriting office from where the policy is intended to be taken, and also displayed on Company's website. The cost shall be borne by the insured.

i. Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification.
ii. Blood sugar: fasting/ post prandial/ HBA1C
iii. Lipid profile
iv. Serum creatinine
v. Urine routine and microscopic examination
vi. ECG
vii. Eye checkup (including retinoscopy)
viii. Any other investigation required by the Company

In case of fresh proposals 50% cost of Medical Check up after acceptance of the proposal shall be reimbursed by the Company. This benefit will also be allowed in cases where continuity benefits are not restored and the policy is treated as fresh (and not as renewal) after the break in policy period.

2.4 COVERAGE

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.

ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.

iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.

iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs,costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

2.4.1 OTHER EXPENSES

i. Expenses incurred on treatment of cataract subject to the sub limits.

ii. Dental treatment, necessitated due to disease or injury

iii.Plastic surgery necessitated due to disease or injury.

iv.All the day care treatments.

v.Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

NOTE:

i. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.

ii. In case of admission to a room/lCU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

2.5 AYUSH TREATMENT

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda,Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

2.5.1 CATARACT TREATMENT

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured orRs.40,000/-, whichever is lower, per each eye in one policy year.

2.5.2 PRE-HOSPITALISATION

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

2.5.3 POST-HOSPITALISATION

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

2.6 The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
ii. Balloon Sinuplasty
iii. Deep Brain stimulation
iv. Oral chemotherapy
v. Immunotherapy- Monoclonal Antibody to be given as injection
vi. Intra vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. Bronchical Thermoplasty
x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

2.7 CUMULATIVE BONUS

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the suns insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, suns insured will be maintained and will not be reduced in the policy year.

NOTE:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same insured Person.
ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the insured Persons.CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
iii. If the insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
iv. In case of floater policies where insured Persons Renew their expiring policy by splitting the Sum insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies ill the proportion of the Sum insured of each Renewed Policy
v. If the Sum insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
vi. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
vii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance Of Renewal premium any awarded CB shall be withdrawn.

2.8 FREE LOOK PERIOD:

This policy shall have a free look period. The free look period shall be applicable at the inception of the fresh policy and the insured will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

If the insured has not made any claim during the free look period, the insured shall be entitled to

i. A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or

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

iii. The free look period is not applicable in case of renewal of policy.

3 DEFINITIONS:

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

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

3.2 Age means age of the Insured person on last birthday as on date of commencement of the Policy.

3.3 Any One Illness means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.

3.4 AYUSH Treatment refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

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

a. Central or State Government AYUSH Hospital or

b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy;or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical pactitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

3.7 Break in Policy means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

3.8 Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terns and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

3.9 Condition Precedent means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

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

i. Internal Congenital Anomaly: Congenital anomaly which is not in the visible and accessible parts of the body.
ii. External Congenital Anomaly: Congenital anomaly which is in the visible and accessible parts of the body.

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

3.12 Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

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

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner(s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.14 Day Care Treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and
ii. which would have otherwise required a hospitalisation of more than twenty four hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.15 Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

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

3.17 Emergency Care: 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.

3.18 Family means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

i. legally wedded spouse.
ii. Parents and Parents-in-law.
iii. dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

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

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

i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorizec personnel.

3.21 Hospitalisation means admission in a hospital for a minimum period of twenty four(24) consecutive `In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

3.22 I1ness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

i. Acute Condition means a disease, illness or injury that is likely to response 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.
ii. Chronic Condition means a disease, illness, or injury that has one or more of the following characteristics
    a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    b) it needs ongoing or long-term control or relief of symptoms
    c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
    d) it continues indefinitely
    e) it recurs or is likely to recur

3.23 Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

3.24 In-Patient Care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

3.25 Insured Person means person(s) named in the schedule of the Policy.

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

3.27 ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

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

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

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

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

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

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

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

3.34 Non- Network Provider means any hospital that is not part of the network.

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

3.36 Out-Patient (OPD) Treatment means treatment 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.

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

i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or

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

3.38 Pre-hospitalisation Medical Expenses means medical expenses incurred during the period of 30days preceding the hospitalisation of the Insured Person, provided that:

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

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the insurance Company.

3.39 Post-hospitalisation Medical Expenses means medical expenses incurred during the period of 60days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and

ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

3.40 Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the insured person.

3.41 Policy period means period of one policy year as mentioned in the schedule for which the Policy is issued

3.42 Policy Schedule means the Policy Schedule attached to and forming part of Policy

3.43 Policy year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

3.44 Portability means the right accorded to an individual health insurance policyholder (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 Renewal: Renewal means the terms on which the contract of insurance can be renewed on mutual consent with

a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

3.48 Sub-limit means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.

3.49 Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

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

3.51 Third Party Administrator (TPA) means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

3.52 Waiting Period means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

4. WAITING PERIOD

The Company shall not be liable to make any payment under the policy in connection with or in respect of the following expenses till the expiry of waiting period mentioned below:

4.1 Pre-Existing Diseases(Code- Excl01)

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months Of continuous coverage after the date of inception of the first policy with us.

ii. In case of enhancement of suns insured the exclusion shall apply afresh to the extent of sum insured increase.

iii. If the insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.

iv. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2 First Thirty Days Waiting Period(Code- Exc103)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.3 Specific Waiting Period: (Code- Exc102)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) 24 Months waiting period:

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tyrnpanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. lnternalCongenitalAnomalies

g) 48 Months waiting period:

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

5. EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses Incurred in connection with or in respect of:

5.1 Investigation & Evaluation(Code- Exc104)

i. Expenses related to any admission primarily for diagnostics and evaluation purposes.
ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

5.2. Rest Cure, rehabilitation and respite care(Code- ExclO5)

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

5.3. Obesity/ Weight Control (Code- Exc106)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions :

i. Surgery to be conducted is upon the advice of the Doctor
ii. The surgery/Procedure conducted should be supported by clinical protocols
iii. The member has to be 18 years of age or older and
iv. Body Mass Index (BMI);
    a) greater than or equal to 40 or
    b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss :
        i. Obesity-related cardiomyopathy
        ii. Coronary heart disease
        iii. Severe Sleep Apnea
        iv. Uncontrolled Type2 Diabetes

5.4. Change-of-Gender treatments: (Code- Exc107)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5.5. Cosmetic or plastic Surgery: (Code- ExclO8)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

5.6. Hazardous or Adventure sports: (Code- Excl09)

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

5.7. Breach of law: (Code- ExcI10)

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

5.8. Excluded Providers: (Code-ExcllI)

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

5.9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.(Code-Excl12)

5.10. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code- Exel 13)

5.11. Dietary supplements and subustances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure (Code- Exc1 14)

5.12. Refractive Error:(Code- Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

5.13. Unproven Treatments:(Code- Exc116)

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.

5.l4. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

5.15. Maternity Expenses (Code - Excl 18):

i. Medical treatment expenses traceable to childbirth(including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

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

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

i. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
ii. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
iii. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

5.18. Any expenses incurred on Domiciliary Hospitalization and OPD treatment.

5.19. Treatment taken outside the geographical limits of India

5.20. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule(based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

6. MORATORIUM PERIOD:

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy 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 as per the policy.

7. CONDITIONS:

7.1A. PAYMENT OF PREMIUM:

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

7.1 B. Premium Payment in Installments

If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days would be given to pay the installment premium due for the Policy.
ii. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.
iii. The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the installment premium is not paid on due date.
v. In case of premium due not received within the grace Period, the Policy will get cancelled.

72. RENEWAL OF POLCY:

The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. after the due date including the grace period of 30 days Or 15 days, as the case may be) of premium or the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever. The Company shall not ordinarily deny the renewal of this policy unless on grounds of fraud, moral hazard, misrepresentation or non-cooperation by the insured.

73. PREMIUM REVISION:

The rates applied are valid only for the period of this policy. The company may revise the premium rates and / or the terms & conditions of the policy, upon renewal thereof, only after due approval from IRDAI. Renewal of this policy is not automatic; premium due must be paid to the Company before the due date. Any revision or modification in the policy will be notified to the policyholders three months in advance.

7.4. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA(if applicable) as under:

i. Within24hours 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.

7.5. CLAIM PROCEDURE:

1.1 Procedure for Cashless claims:

(i) Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.

(ii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.

(iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.

(iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

(v) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details,

(vi) In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

1.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

S.No	Type of Claim	Prescribed Time limit
1	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within thirty days of date of discharge from hospital
2	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

7.6 CLAIM DOCUMENTS:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed(for surgical cases).
ix. Sticker/Invoice of the Implants, wherever applicable.
x. MLR(Medico Legal Report copyif carried out and FIR (First information report) if registered, where ever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML

Guidelines

xiii. Legal heir/succession certificate , wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment ofthe claim.
[Note: Insurer may specify the documents required in original and waive off any of above required as per their claim procedure]

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

7.7. PAYMENT OF CLAIM:

All medical treatment for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency only.

8. CO-PAYMENT

Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

9. CANCELLATION

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

Refund %	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	**1 Year**
Up to 30 days	**75.00%**
31 to 90 days	**50.00%**
3 to 6 months	**25.00%**
6 to 12 months	**0.00%**

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

b) The Company may cancel the Policy at any time on grounds of mis-represenation, 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 mis-represenation non-disclosure of material facts or fraud.

10. MIGRATION:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuos preceding years of coverage of the insured Person under the previous health insurance Policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrured bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply any other additional increased Sum insured.

11. PORTABILITY:

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/l-lealth insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

12. TERMS AND CONDITIONS OF THE POLICY

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document. The Prospectus contains salient features of the policy. For details, reference is to be made to the policy. In case of any difference between the prospectus and the policy, the terms and conditions of the policy shall prevail.

13. Possibility of Revision of Terms of the Policy including the Premium Rates

With prior approval of IRDAI, the Company may revise or modify the terms of the policy including the premium rates. The insured shall be notified three months before the changes are effected.

14. TERRITORIAL JURISDICTION:

All disputes or differences under or in relation to the policy shall be determined by the Indian Courts and according to the Indian laws.

15. Multiple Policies

1 In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. Ill all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terns of the chosen policy.
2. Policyholder 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(s) shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

16. DISCLOSURE TO INFORMATION NORM:

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

17. HOW TO APPLY FOR INSURANCE:

The Proposer has to complete the proposal form and enrolment form in duplicate and submit insured person's details of each member. The proposer has to affix a coloured stamp size photographs of each of the members to be insured on the enrolment form against the name of the person. These photographs will be utilised by Third Party Administrator for preparing ID card for each of the members insured. The prospectus and proposal form are part of the policy. Hence please read the prospectus carefully and sign the same. The proposal form is to be completed in all respects for each insured person. Both the prospectus and the proposal form are to be submitted to the office or to the agent.

INSURANCE ACT 1938 SESCTION 41 – PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938 provides as follows :

1. No person shall allow, or offer to allow, either directly of indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or the tables of the insurer.
2. Any person making default in complying with the provisions of this Section shall be liable for a penalty which may extend to 10 lacs rupees.

Note: For legal interpretation only English version will be valid.