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

MEDICLAIM INSURANCE POLICY (INDIVIDUAL)

1.1 WHEREAS the insured named in the Schedule hereto, has by a proposal and declaration, (which shall be the basis of this Contract and is deemed to be incorporated herein) applied to THE ORIENTAL INSURANCE COMPANY LIMITED (hereinafter called the COMPANY) for the insurance hereinafter set forth in respect of persons(s) named in the Schedule hereto (hereinafter called the INSURED PERSON(S)) and has paid premium to the Company as consideration for such insurance to be serviced by Third Party Administrator (hereinafter called the TPA) or the Company as the case may be.

NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that, if during the policy period stated in the Schedule, any insured Person shall contract any disease or suffer from any illness / ailment / disease (hereinafter called 'DISEASE') or sustain any bodily injury through accident (hereinafter called 'INJURY') and if such disease or injury shall require, upon the advice of a duly qualified Physician / Medical Specialist/Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') to incur expenses on (a) hospitalisation (as defined hereafter) for medical/surgical treatment at any Nursing Home/Hospital in India as herein defined (hereinafter called 'HOSPITAL') **OR** (b) on domiciliary treatment in India under Domiciliary Hospitalisation Benefits as hereinafter defined, the Company / TPA will pay to the Hospital(s) (only if treatment is taken at Network Hospital(s) with prior written approval of Company / TPA) or reimburse to the insured person, as the case may be, the amount of such admissible expenses as specified hereunder. It is a condition precedent that the expenses incurred in respect of medically necessary treatment, are reasonable and customary; and in any case the liability of the Company shall be upto the limit specified in the policy and/or schedule of the policy, but not exceeding the sum insured as stated in the schedule, for all claims admitted during the policy period mentioned in the schedule**.**

1.2 COVERAGE: The policy covers reasonable and customary charges in respect of Hospitalisation and / or Domiciliary Hospitalisation for medically necessary treatment only for illness / diseases contracted or injury sustained by the Insured Person(s) during the policy period, upto the limit of Sum Insured (SI), as detailed below:

A.	HOSPITALISATION BENEFITS	
	Expenses covered	**Limits of Covered Expense**
a.	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.	Not exceeding 1 % of the Sum Insured per day.
b.	Intensive Care Unit (ICU) expenses as provided by the Hospital/Nursing Home	Not exceeding 2% of the Sum Insured per day.
	Number of days of stay under 'a' and 'b' above should not exceed total number of days of admission in the hospital. Admissibility of all related expenses (c and d), except for medicine / pharmacy bills and body implants, shall also be as per the entitled category vis-à-vis room rent.	
c.	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of the sum insured.
d.	Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, cost of prosthetic devices like Pacemaker implanted during surgical procedures, relevant laboratory / diagnostic tests, X-ray, and similar expenses.	As per the limits of the sum insured.
e.	Ambulance service charges as defined under 2.2	Rs.2,000 OR 1% of the sum insured whichever is less per hospitalization subject to aggregate expenses not exceeding Rs. 4,000 under the policy.
f.	Daily Hospital Cash Allowance, as defined under 2.9	0.1% of the sum insured per day subject to maximum of 6 days per insured person during the entire policy period. Deductible of 2 days shall apply for each hospitalization.
g.	Pre and Post hospitalization expenses	Medical expenses incurred 30 days prior to hospitalisation and upto 60 days post hospitalisation.
	Note: 1. In case of Ayurvedic / Homeopathic / Unani treatment, Hospitalisation expenses are admissible only when the treatment is taken as an in-patient, in a Government Hospital or a hospital associated with a Medical College. 2. Relaxation to 24 hours minimum duration for hospitalization as defined in 2.17, is allowed in i. Day care procedures / surgeries (Appendix I) where such treatment is taken by an insured person in a hospital / day care centre (but not the outpatient department of a hospital) ii. Or any other day care treatment as mentioned in clause 2.11 and for which prior approval from Company / TPA is obtained in writing.	
B.	**DOMICILIARY HOSPITALISATION** (as defined under clause 2.13)	

a.	Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines & Drugs, Diagnostic Material and Dialysis, Chemotherapy, Nursing expenses.	20% of the Sum Insured subject to maximum Rs.50,000 per Insured Person, during the entire policy period.
b.	Treatment for Dog bite (or bite of any other rabid animal like monkey, cat, etc.)	Maximum Rs.5,000 per incident, actually incurred on immunisation injections. This will be part of Domiciliary Hospitalisation limits as given above. For the purpose of this section the conditions for domiciliary hospitalisation benefit shall not apply.

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

a) if the treatment lasts for a period of three days or less
b) incurred on pre and post hospitalisation treatment and
c) incurred on treatment of any of the following diseases :
    i. Asthma
    ii. Bronchitis,
    iii. Chronic Nephritis and Nephritic Syndrome,
    iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis,
    v. Diabetes Mellitus and Insipidus,
    vi. Epilepsy,
    vii. Hypertension,
    viii. Influenza, Cough and Cold,
    ix. All Psychiatric or Psychosomatic Disorders,
    x. Pyrexia of unknown origin for less than 10 days,
    xi. Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharingitis,
    xii. Arthritis, Gout and Rheumatism.

Note: Liability of the Company under this clause is restricted to limits as stated in Clause 1.2B.

1.3 DONOR EXPENSES: The policy covers in-patient hospitalisation Medical expenses in respect of organ donor provided that the donation conforms to the Transplantation of Human Organs Act 1994(amended) and other applicable laws and rules and

i. the organ donated is for the use of the insured person who has been medically advised to undergo organ transplant
ii. The claim of the insured person is admissible under the hospitalisation section of the policy.

The policy does not cover:

a. cost directly or indirectly associated with the acquisition of the organ and/or cost of organ.
b. cost towards donor screening
c. Any pre and post hospitalisation medical expenses of the donor.
d. Any other medical treatment or complication consequent to organ harvesting, in respect of the donor.

Company's overall Liability in respect of all claims admitted under sections **1.2, 1.3 and 1.4** during the Policy period shall not exceed the Sum Insured of the Insured Person mentioned in the Schedule.

1.4 VOLUNTARY CO-PAYMENT: (OPTIONAL)

i. If the insured opts for a Co-payment of 10% or 20%, he is eligible for a corresponding premium discount of 10% and 20% respectively. This option is available only for insured person(s) having Sum Insured of Rs 2 lacs and above. Co-payment cannot be opted on selective basis. All insured persons under a policy have to compulsorily opt for the same (except for insured persons with Sum Insured below Rs.2lacs, where Co-payment option is not available), and the Co-payment percentage has to be uniform across all insured persons.

ii. Co-payment is applicable on each and every claim, which means the insured shall bear 10% / 20% (as opted by him) of each and every admissible claim.

1.5 OPTIONAL COVER: available on payment of additional premium.

PERSONAL ACCIDENT as defined under Clause 3	Sum Insured in multiples of Rs. 2,00,000 upto Rs. 10,00,000 per insured person above 18yrs of age. However for persons below 18 years of age, maximum coverage of Rs.4lacs is allowed.

2. DEFINITIONS:

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

2.2 AMBULANCE SERVICES: means ambulance service charges reasonably and necessarily incurred in shifting the insured person from residence to hospital for admission in emergency ward / ICU or from one Hospital / Nursing Home to another HospitaL / Nursing Home, by registered ambulance only. The ambulance service charges are payable only if the hospitalisation expenses are admissible under the policy.

2.3 ANY ONE ILLNESS: means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital /Nursing Home where treatment may have been taken.

2.4 ALTERNATIVE TREATMENTS: are forms of treatments other than 'Allopathy', or 'modern medicine' and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

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

2.6 CONGENITAL ANOMALY: refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
a. Internal Congenital Anomaly: which is not in the visible and accessible parts of the body
b. External Congenital Anomaly: which is in the visible and accessible parts of the body

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

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

2.9 DAILY HOSPITAL CASH ALLOWANCE: When an insured person is hospitalized and a claim is admitted under the policy, then the insured person shall be paid a daily cash allowance as specified in section 1.2 A (f). However, a deductible of 2 days per hospitalisation shall apply, i.e Daily cash allowance will become payable from the third day onwards of continuous hospitalization.

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

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 will make these accessible to the Insurance company's authorized personnel.

2.11 DAY CARE TREATMENT: refers to medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required a hospitalization of more than 24 hours.

Procedures / treatments usually done in out patient department are not payable under the policy even if converted to Day Care surgery / procedure or taken as an in patient in a hospital for more than 24 hours.

2.12 DEDUCTIBLE: is a cost-sharing requirement under this policy that provides that the Company will not be liable for a specified period, which will apply before any Benefits are payable by the Company. A deductible does not reduce the Daily Cash Benefit Period. Deductible is applicable per event.

2.13 DOMICILIARY HOSPITALISATION : means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

i the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

ii the patient takes treatment at home on account of non availability of a room in a hospital.

2.14 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 he is a bonafide regular student and financially dependent on the proposer. Female child can be covered until she gets married. Divorced and widowed daughters, are also eligible for coverage under the policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.
iii. Parents / Parents-in-law (either of them).
iv. Unmarried siblings, if financially dependent on the Insured.

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

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

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 inpatient beds, in towns having a population of less than 10,00,000 and atleast 15 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 makes these accessible to the Insurance company's authorized personnel.

2.17 HOSPITALISATION : means admission in a Hospital for a minimum period of twenty four (24) in-patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours**.**

2.18 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.

2.19 INSURED PERSON : means person(s) named in the schedule of the policy

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

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

b. Chronic condition - is a disease, illness, or injury that has one or more of the following characteristics:

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

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

2.22 IN-PATIENT: means an Insured person who is admitted to hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

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

2.24 MEDICAL ADVICE: means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

2.25 MEDICAL EXPENSES: means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of disease 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.

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

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

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

2.28 NETWORK PROVIDER: means hospitals or healthcare providers enlisted by an insurer or by a TPA and insurer together, to provide medical services to an insured on payment, by a cashless facility.

2.29 NOTIFICATION OF CLAIM: is a process of notifying a claim to the Insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

2.30 OUT-PATIENT TREATMENT: is one in which the Insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

2.31 PRE-HOSPITALISATION EXPENSES: means medical expenses incurred during the period upto 30 days prior to the date of admission in the hospital, 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 Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.32 POST-HOSPITALISATION EXPENSES: means medical expenses incurred for a period upto 60 days from the date of discharge from the hospital, 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 Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.33 PRE EXISTING DISEASE: means any condition, ailment or injury or related condition(s) for which the insured person(s) had signs or symptoms, and / or was diagnosed, and / or received medical advice / treatment within 48 months prior to the first policy issued by the insurer

2.34 POLICY PERIOD : means the period of coverage as mentioned in the schedule

2.35 PORTABILITY: means transfer by an individual health insurance policy holder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

2.36 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.

2.37 REASONABLE AND CUSTOMARY CHARGES : means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved .

2.38 RENEWAL: Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

2.39 ROOM RENT: means the amount charged by a hospital for the occupancy of a bed on per day (24hours) basis and shall include associated medical expenses.

2.40 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.

2.41 SURGERY/ SURGICAL OPERATION: means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or a day care centre by a medical practitioner

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

2.43 UNPROVEN/EXPERIMENTAL TREATMENT: Treatment including drug experimental therapy which is not based on established medical practice in India.

2A. DISCOUNTS AND LOADING: The policy has provision for the following discounts and loading:

Sl.No.	Feature	%
1.	Family Discount refer 10 (c)	10%
2.	Voluntary Co-payment discount refer 10 (d)	10% / 20%
3.	Entry load refer 10(b)	10%

3. PERSONAL ACCIDENT COVER: (WORLD – WIDE)

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

Sl.No.	Benefits covered	Amount payable
1.	Accidental Death only	100 % of CSI
2.	Loss of two entire limbs, or sight of two eyes or one entire limb and sight of one eye.	100 % of CSI
3.	Loss of one entire limb or Sight of one eye	50 % of CSI
4.	Permanent Total Disablement resulting in totally and absolutely disabling the person insured from engaging in any employment or occupation whatsoever.	100 % of CSI

The overall liability in the event of one or more of the eventualities (listed above) occurring shall be restricted to the CSI.

CSI means Capital Sum Insured opted under the Personal Accident section and mentioned in the schedule..

EXCLUSIONS: The Company shall not be liable under this section for disablement / death of the Insured Person

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

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 All Pre-existing Disease (whether treated / untreated, declared or not declared in the proposal form), which are excluded upto 48 months of the policy being in force. Pre-existing diseases shall be covered only after the policy has been continuously in force for 48 months.

For the purpose of applying this condition, the date of inception of the first indemnity based health policy taken shall be considered, provided the renewals have been continuous and without any break in period, subject to portability condition.

This exclusion shall also apply to any complication(s) arising from pre existing diseases. Such complications will be considered as part of the pre existing health condition or disease. To illustrate if a person is suffering from hypertension or diabetes or both hypertension and diabetes at the time of taking the policy, then policy shall be subject to following exclusions.

Diabetes	Hypertension	Diabetes & Hypertension
Diabetic Retinopathy	Cerebro Vascular accident	Diabetic Retinopathy
Diabetic Nephropathy	Hypertensive Nephropathy	Diabetic Nephropathy

Diabetic Foot /wound	Internal Bleed/ Haemorrhages	Diabetic Foot
Diabetic Angiopathy	Coronary Artery Disease	Diabetic Angiopathy
Diabetic Neuropathy		Diabetic Neuropathy
Hyper / Hypoglycaemic shocks		Hyper / Hypoglycaemic shocks
Coronary Artery Disease		Coronary Artery Disease
		Cerebro Vascular accident
		Hypertension Nephropathy
		Internal Bleeds/ Haemorrhages

4.2 Any disease other than those stated in clause 4.3, contracted by the Insured person during the first 30 days from the inception date of fresh policy. This shall, however, not apply in case the insured person is hospitalised for injuries suffered in an accident, which occurred after inception of the policy.

4.3 The expenses on treatment of following ailments / diseases / surgeries, if contracted and / or manifested after inception of first policy (subject to continuity being maintained), are not payable during the waiting period specified below.

	Ailment / Disease / Surgery	Waiting Period
i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	**1** year
ii	Polycystic ovarian diseases .	**1** year
iii	Surgery of hernia.	**2** years
iv	Surgery of hydrocele.	**2** years
v	Non infective Arthritis.	**2** years
vi	Undescendent Testes.	**2** Years
vii	Cataract.	**2** Years
viii	Surgery of benign prostatic hypertrophy.	**2** Years
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus.	**2** Years

x	Fissure / Fistula in anus.	**2** Years
xi	Piles.	**2** Years
xii	Sinusitis and related disorders.	**2** Years
xiii	Surgery of gallbladder and bile duct excluding malignancy.	**2** Years
xiv	Surgery of genito urinary system excluding malignancy.	**2** Years
xv	Pilonidal Sinus.	**2** Years
xvi	Gout and Rheumatism.	**2** Years
xvii	Hypertension.	**2** Years
xviii	Diabetes.	**2** Years
xix	Calculus diseases.	**2** Years
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	**2** Years
xxi	Surgery of varicose veins and varicose ulcers.	**2** Years
xxii	Congenital internal diseases.	**2** Years
xxiii	Joint Replacement due to Degenerative condition.	**4** Years
xxiv	Age related osteoarthritis and Osteoporosis.	**4** Years

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

Note: If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh policy and clauses 4.1., 4.2, 4 .3 shall apply afresh, unless agreed by the Company and suitable endorsement passed on the policy, by the duly authorised official of the Company. Similarly, if the sum insured is enhanced subsequent to the inception of the first policy, the exclusion 4.1,4.2 and 4.3 will apply afresh for the enhanced portion of the sum insured.

4.4 Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.

4.5 Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination(except as covered under 1.2 B(b)),inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

4.6 Surgery for correction of eye sight cost of spectacles, contact lenses, hearing aids etc.

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

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

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

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

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

4.12 Any treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy except in the case of abdominal operation for extra uterine pregnancy (ectopic pregnancy) which is proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner, if left untreated.

4.13 Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine (other than Ayurveda, Unani & Homeopathy as expressed in clause 1.2 A) and related treatment including acupressure, acupuncture, magnetic and such other therapies.

4.14 Expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalisation or primary reasons for admission. Private nursing charges, Referral fee to family doctors, Out station consultants / Surgeons fees etc,

4.15 Genetic disorders and stem cell implantation / surgery.

4.16 Cost of external and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker, Crutches, Belts,Collars ,Caps , splints, slings, braces ,Stockings etc of any kind, Diabetic foot wear, Glucometer / Thermometer, Blood Pressure monitoring machine and similar related items and also any medical equipment which is subsequently used at home. Exhaustive list available on our website (www. orientalinsurance.org.in).

4.17 All non medical expenses including Personal comfort and convenience items or services such as wi-fi/internet charges telephone, television, Ayah / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items etc, guest services

and similar incidental expenses or services etc. Exhaustive list available on our website (www. orientalinsurance.org.in).

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

4.19 Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme, and similar services or supplies.

4.20 Any treatment required because of Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing and similar other activities, unless specifically agreed and endorsed on the policy.

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

4.22 Any stay in the hospital for any domestic reason or where no active regular treatment is given by the specialist.

4.23 Out patient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

4.24 Massages, Steam bathing, Shirodhara and like treatment under Ayurvedic treatment.

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

4.26 Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalisation period.

4.27 Pre and post hospitalisation expenses unrelated with disease / injury for which hospitalisation claim has been admitted under the policy.

5. CONDITIONS

5.1 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.

5.2 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.

5.3 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.

5.4 NOTICE OF CLAIM: Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of insured person in respect of whom claim is made, Nature of disease / injury and Name and Address of the attending medical practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home by Fax, Email. Such notice should be given within 48 hours of admission but before discharge from Hospital / Nursing Home, unless waived in writing.

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

a. Original bills, all receipts and discharge certificate / card from the hospital.
b. All documents pertaining to the illness, starting from the date it was first detected, i.e Doctor's consultations reports / history
c. Medical history of the patient recorded by the Hospital.
d. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.
e. Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending Medical Practitioner / Surgeon demanding such tests.
f. Original attending Consultants / Anaesthetists / Specialist certificates regarding diagnosis and bills / receipts etc.
g. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
h. MLC/FIR/Post Mortem Report,(if applicable)
i. Disability certificate, Death certificate (if applicable)
j. Details of previous policies, if the details are already not with TPA.
k. Any other information required by Company/TPA.

All documents must be duly attested by the Insured person/claimant.

In case of post hospitalisation treatment (limited to 60 days) all supporting claim papers / documents as listed above should also be submitted within 15 days from completion of such treatment (upto 60 days or actual period whichever is less) to the Company / T.P.A. In addition insured Person should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.

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

Company shall settle claims including its rejection within 30 days of the receipt of the last 'necessary' document, except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms & conditions shall be deemed necessary.

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

i) Claim in respect of Cashless Access Services will be through the Company / TPA provided admission is in a networked Hospital / Nursing Home and is subject to pre admission authorization. The Company / TPA shall, upon getting the related medical details / relevant information from the insured person / network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorisation 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.

ii) The Company / TPA reserves the right to deny pre-authorisation in case the hospital / insured person is unable to provide the relevant information / medical details as required by the Company / TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of liability. The insured person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the TPA/Insurer within 15 days of the discharge from Hospital / Nursing Home for consideration of Company / TPA.

iii) Should any information be available to the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorisation 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.

iv) List of network hospitals is available on our official website- www.orientalinsurance.org.in and will also be provided by the concerned TPA.

5.7 MEDICAL RECORDS:

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

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

(iii) Any medical practitioner authorised by the Company / TPA shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the Company / TPA.

5.8 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.

Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured. In the cases of any delay in the payment, the Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed.

5.9 SUBROGATION: In the event of a claim paid under the policy, the Company shall assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

5.10 CONTRIBUTION: Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a 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:

i. is fixed in nature:
ii. does not have any relation to the treatment costs;

5.11 REPUDIATION:

i. The Company, shall repudiate the claim if not payable under the policy. The Company / TPA shall mention the reasons for repudiation in writing to the insured person. The insured person shall have the right to appeal / approach the Grievance Redressal Cell of the company at its policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, New Delhi-110002.
ii. If the insured is not satisfied with the reply of the Grievance Cell under 5.11 (i), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal lines of insurance claims upto Rs.20 lacs.

5.12 DISCLAIMER OF CLAIM: If the Company shall disclaim liability and communicates 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.

5.13 ARBITRATION CLAUSE: If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

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

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

5.14 FRAUD / MISREPRESENTATION / CONCEALMENT: Non – disclosure, concealment or misrepresentation of material facts or making false statements in the Proposal Form and/ or in the Claim Form or any other documents, shall render the policy null and void ab initio and the Company shall not be liable under this policy. The Company shall, also not be liable under the policy in respect of any claim, if such claim be in any manner- intentionally or fraudulently or otherwise misrepresented or concealed or involves making false statement or submitting false bills whether by the insured person or any Institution/ Organisation on his behalf. Company shall be at liberty to take suitable legal action against the Insured person/ Institution/ Organisation as per the laws.

5.15 CANCELLATION CLAUSE: Company 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 Insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given below) provided no claim has occurred during the policy period up to date of cancellation.

Period on Risk	**Rate of premium to be charged**
Upto 1 Month	1/4th of the annual rate
Upto 3 Months	1/2 of the annual rate
Upto 6 Months	3/4th of the annual rate
Exceeding 6 months	Full annual rate

6. 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
(ii). 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
(iii). Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

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

7. SUM INSURED:

i. Minimum sum insured is Rs 100,000 and in multiples of Rs 50,000 upto Rs 5,00,000. Beyond the Sum Insured of Rs. 5,00,000 in multiples of Rs. 1,00,000 upto Rs 10,00,000.

ii. The sum insured of each of the insured person in a policy may vary.

iii. Maximum sum insured that can be opted by a person joining after the age of 65 years is Rs.5 lacs. Any increase in sum insured will be allowed as per 'iv' & 'v' below.

iv. Sum insured under the policy can be increased only at the time of renewal and at the discretion of the Company. The maximum increase allowed at each renewal is Rs. 2 lacs per insured person upto the age of 45years. Beyond 45 years, maximum increase allowed at each renewal is Rs.1lac per insured person. For increased sum insured, pre-existing disease clauses 4.1,4.2 and 4.3 of the policy, shall apply afresh.

v. No increase in sum insured is allowed for insured persons above 70 years of age.

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

9. RENEWAL OF POLICY: 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) of premium or the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever

i. The company may revise the premium rates and / or the terms & conditions of the policy, upon renewal thereof, only after due approval from IRDA. 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.

ii. 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.

10. PREMIUM LOADING / DISCOUNTS

(a) MAXIMUM ENTRY AGE: Maximum Entry age for any member, is 65years.

(b) ENTRY LOAD: Maximum entry age (65years) under the policy can be extended upto 70 years. In all such cases, a 10% loading will be charged on premium applicable to the age of the insured. This 10% loading will also apply on each subsequent renewal thereof. The loading shall also apply on PA cover, if opted for.

(c) FAMILY DISCOUNT: of 10% (including on Optional PA cover) if more than one person is covered under the policy.

(d) VOLUNTARY CO-PAYMENT DISCOUNT: If the insured opts for a Co-payment of 10% or 20% (each and every claim), he is eligible for a corresponding premium discount of 10% and 20% respectively.

11. COST OF HEALTH CHECK UP: The Insured shall be entitled for reimbursement of cost of Health check up undertaken once at the expiry of a block of every THREE continuous underwriting years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 0.75% of the average sum Insured (SI for Personal Accident section is not to be considered), or Rs.3000/- per insured person, whichever is less, during the block of THREE claim free underwriting years.

This benefit is available to the insured person after three claim free years, till the expiry of the fourth year of the policy. If the benefit is not claimed in the fourth year of the policy, then in future at the time of the insured claiming this benefit, last three claim free years preceding the year in which the benefit is claimed, shall be taken into consideration.

This clause shall apply separately to each insured person i.e for any insured person, if there is no claim reported for the preceding three years, he would be eligible for this benefit even when there is a claim reported for other person(s) covered under the policy.

This provision is applicable only in respect of continuous insurance without break under Oriental's Mediclaim Insurance Policy (individual).

12. PRODUCT WITHDRAWAL: This product may be withdrawn in future with due approval of IRDA. However, in the event of withdrawal of the product, the insured shall be informed of the options available.

13. PORTABILITY: In the event of the insured person porting to any other insurer, insured person must apply with details of the policy and claims to the insurer where the insured person wants to port, atleast 45 days before the date of expiry of the policy.

Portability shall be allowed in the following cases:

i. All individual health insurance policies, including family floater policies, issued by non-life insurers.
ii. Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, the insured person shall be accorded the right to port to another non-life insurance company.

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

15. **QUALITY OF TREATMENT :** The insured hereby acknowledges and agrees that pre-authorisation 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).

16. **ID CARD:** The card is issued to the insured person by the TPA to avail cash less facility in the Network Hospital only. Upon the cancellation or non renewal 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.

17. **MEDICLAIM WITH OMP:**

In case an insured person covered under this policy goes abroad by taking Oriental's Overseas Mediclaim Policy (OMP), this Policy becomes inoperative for the period the OMP is in force while he / she is abroad.

The proportionate premium under this policy for the inoperative period shall be adjusted against the renewal premium of the said insured person. The insured person must inform the company in writing before leaving India stating the details of visit(s) abroad and the OMP policy.

18. **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.

19. **IRDA REGULATION :** This policy is subject to IRDA (Protection of policy holders' interest) Regulation and IRDA (Health Insurance) Regulations 2013 and Guidelines on Standardisation in health insurance as amended from time to time.

20. **DISCLOSURE TO INFORMATION NORM :** The policy shall be void in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Appendix I

	Day care procedures / surgeries
A	**Microsurgical Operations on the Middle Ear**
1	Stapedotomy
2	Stapedectomy
3	Revision of a stapedectomy
4	Myringoplasty (Type -I Tympanoplasty)
5	Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
6	Revision of a tympanoplasty
B	**Other operations on the middle & internal ear**
7	Myringotomy
8	Removal of a tympanic drain
9	Incision of the mastoid process and middle ear
10	Mastoidectomy
11	Reconstruction of the middle ear
12	Fenestration of the inner ear
13	Revision of a fenestration of the inner ear
14	Incision (opening) and destruction (elimination) of the inner ear
C	**Operations on the nose & the nasal sinuses**
15	Excision and destruction of diseased tissue of the nose
16	Operations on the turbinates (nasal concha)
17	Nasal sinus aspiration
D	**Operations on the eyes**
18	Incision of tear glands
19	Incision of diseased eyelids
20	Excision and destruction of diseased tissue of the eyelid
21	Operations on the canthus and epicanthusv
22	Corrective surgery for entropion and ectropion
23	Corrective surgery for blepharoptosis
24	Removal of a foreign body from the conjunctiva
25	Removal of a foreign body from the cornea
26	Incision of the cornea
27	Operations for pterygium
28	Removal of a foreign body from the lens of the eye
29	Removal of a foreign body from the posterior chamber of the eye
30	Removal of a foreign body from the orbit and eyeball

31	Operation of cataract
E	**Operations on the skin & subcutaneous tissues**
32	Incision of a pilonidal sinus
33	Free skin transplantation, donor site
34	Free skin transplantation, recipient site
35	Revision of skin plasty
36	Simple restoration of surface continuity of the skin and subcutaneous tissues
37	Destruction of diseased tissue in the skin and subcutaneous tissues
38	Local excision of diseased tissue of the skin and subcutaneous tissues
39	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
40	Chemosurgery to the skin
F	**Operations on the tongue**
41	Incision, excision and destruction of diseased tissue of the tongue
42	Partial glossectomy
43	Glossectomy
44	Reconstruction of the tongue
G	**Operations on the salivary glands & salivary ducts**
45	Incision and lancing of a salivary gland and a salivary duct
46	Excision of diseased tissue of a salivary gland and a salivary duct
47	Resection of a salivary gland
48	Reconstruction of a salivary gland and a salivary duct
H	**Other operations on the mouth & face**
49	External incision and drainage in the region of the mouth, jaw and face
50	Incision of the hard and soft palate
51	Excision and destruction of diseased hard and soft palate
52	Incision, excision and destruction in the mouth
53	Plastic surgery to the floor of the mouth
54	Palatoplasty
I	**Operations on the tonsils & adenoids**
55	Transoral incision and drainage of a pharyngeal abscess
56	Tonsillectomy without adenoidectomy
57	Tonsillectomy with adenoidectomy
58	Excision and destruction of a lingual tonsil
J	**Trauma surgery and orthopaedics**
59	Incision on bone, septic and aseptic
60	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
61	Reduction of dislocation under GA
62	Arthroscopic knee aspiration
K	**Operations on the breast**
63	Incision of the breast
64	Operations on the nipple
L	**Operations on the digestive tract**
65	Incision and excision of tissue in the perianal region

66	Surgical treatment of anal fistulas
67	Surgical treatment of haemorrhoids
68	Division of the anal sphincter (sphincterotomy)
69	Ultrasound guided aspirations
70	sclerotherapy
M	**Operations on the female sexual organs**
71	Incision of the ovary
72	Insufflation of the Fallopian tubes
73	Dilatation of the cervical canal
74	Conisation of the uterine cervix
75	Incision of the uterus (hysterotomy)
76	Therapeutic curettage
77	Culdotomy
78	Incision of the vagina
79	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
80	Incision of the vulva
81	Operations on Bartholin's glands (cyst)
N	**Operations on the prostate & seminal vesicles**
82	Incision of the prostate
83	Transurethral excision and destruction of prostate tissue
84	Transurethral and percutaneous destruction of prostate tissue
85	Open surgical excision and destruction of prostate tissue
86	Radical prostatovesiculectomy
87	Incision and excision of periprostatic tissue
88	Operations on seminal vesicles
O	**Operations on the scrotum & tunica vaginalis testis**
89	Incision of the scrotum and tunica vaginalis testis
90	Operation on a testicular hydrocele
91	Excision and destruction of diseased scrotal tissue
92	Plastic reconstruction of the scrotum and tunica vaginalis testis
P	**Operations on the testes**
93	Incision of the testes
94	Excision and destruction of diseased tissue of the testes
95	Unilateral orchidectomy
96	Bilateral orchidectomy
97	Orchidopexy
98	Abdominal exploration in cryptorchidism
99	Surgical repositioning of an abdominal testis
100	Reconstruction of the testis
101	Implantation, exchange and removal of a testicular prosthesis
Q	**Operations on the spermatic cord, epididymis und ductus deferens**
102	Surgical treatment of a varicocele and a hydrocele of the spermatic Cord
103	Excision in the area of the epididymis
104	Epididymectomy

105	Reconstruction of the spermatic cord
106	Reconstruction of the ductus deferens and epididymis
R	**Operations on the penis**
107	Operations on the foreskin
108	Local excision and destruction of diseased tissue of the penis
109	Amputation of the penis
110	Plastic reconstruction of the penis
S	**Operations on the urinary system**
111	Cystoscopical removal of stones
T	**Other Operations**
112	Lithotripsy
113	Coronary angiography
114	Haemodialysis
115	Radiotherapy for Cancer
116	Cancer Chemotherapy