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

OBC-ORIENTAL MEDICLAIM POLICY - 2017
PROSPECTUS

1.0 ELIGIBILITY

a. **Maximum Entry Age is 79** years for all members.

b. Age will be **completed age** as on the date of commencement of the policy. Eg. if on a said date, the person is 79 years 364 days old, he will be considered as 79 years old for the purpose of coverage under this policy.

c. The Proposer has to be the Account holder at inception as well as on subsequent renewals.

d. Any Account holder of Oriental Bank of Commerce (OBC), who is 18 years or more (but not exceeding 79 years), can take this Group Policy for self or for self and any one or more of the family members mentioned below:

i. Legally wedded spouse.

ii. Upto three Dependent Children (natural or legally adopted) between the ages of 91days to 18 years. However male child can be covered upto the age of 26 years if he is a bonafide regular student and financially dependent. Female child can be covered until she gets married. Divorced and widowed daughters are also eligible for coverage under the policy, irrespective of age. If during the currency of the policy, the child above 18 years becomes financially independent, or a male child (student) attains the age of 26 years or if the girl child gets married, he/she shall remain covered under the policy for the remainder of the policy period. However, he / she shall be ineligible for coverage in the subsequent renewals.

e. Number of Policies that are allowed:

i. **One Account-One Policy**- (a) Only one policy can be issued on any one Account.
(b) In case of Joint Account holders, any one of the Account holders can be the proposer.

ii. **Multiple Accounts-One policy**- Only one policy can be issued even if the same person has more than one Bank Account.

iii. **One person One Policy**- One person can be covered only under one Bancassurance health insurance Policy of Oriental, whether he is the proposer or otherwise. However, there is no restriction on taking additional mainstream health insurance policies of Oriental.

If at any time an insured person is found to be covered under more than one Bancassurance policy of Oriental, flouting the above mentioned guidelines, all such policies, barring one (in case of a claim, the one under which claim is reported/considered), shall be cancelled and premium forfeited thereunder.

1.1 SALIENT FEATURES

i. This policy can be taken either for the self alone or alongwith the family (as specified in 1.0d above) with Sum Insured on floater basis.
ii. There are 10 Sum Insured slabs ranging from Rs.1lakhs to 10 lakhs, at an interval of 1lakh each.
iii. Pre-existing Diseases are covered after three consecutive Policy periods.
iv. Premium is charged based on the age of the proposer Account holder and the Sum Insured opted.
v. No Pre-acceptance medical check-up is required. However, if the Proposal Form reveals adverse Medical History in respect of any proposed individual, such individual may be subject to pre-insurance Medical tests. In such cases, 50% of the cost shall be borne by the Company, if the proposal in respect of that individual is accepted by the Company.
vi. **Daily Hospital Cash** only in respect of the proposer Account holder: Rs.200 per day of hospitalisation is payable, maximum compensation being Rs.1000 during the policy period, subject to hospitalisation claim being admissible under the policy.
vii. **Organ donor expenses** when Insured Person is the Recipient: The policy covers In-patient Hospitalisation Medical expenses in respect of the organ donor provided that the organ donation is for the Insured Person and organ donation conforms to the Transplantation of Human Organs Act 1994(amended) and any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs.
viii. **Ambulance Charges:** The policy covers ambulance charges upto Rs.1000 during the policy period, subject to claim in respect of hospitalisation being admissible under the policy.
ix. **Funeral Expenses**: Lumpsum amount of Rs.1000 per insured person is payable in case of death of the insured person, subject to hospitalisation claim being admissible under the policy.
x. 116 **Day Care Procedures**
xi. Term of the Policy is one year and is renewable lifelong.
xii. **Cashless facility** is available in network hospitals
xiii. **Grace Period** of 30 days for renewal of policy, subject to conditions
xiv. **Free Look Period** of 15 days from the date of receipt of the policy documents.
xv. Sub-limits shall apply on following procedures, as below

		Sub-limits in INR		
Sl.	Procedure	SI < 2lakhs	SI 2-5 lakhs	SI >5lakhs
1.	Cataract	19000	24000	30000
2.	Total Knee Replacement excluding implant	90000	110000	150000
3.	Hip Replacement excluding implant	90000	110000	150000

Limits for 2&3 above are for unilateral procedures and additional 50% will be considered for bilateral procedures. Amount payable under the policy shall be the actuals (pre-negotiated rates in case of Network providers) or the above stated limits, whichever is lower.

2. COVERAGE

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

A.

Sl.	**Expenses covered**	**Limits**
i.	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.	1 % of the Sum Insured per day
ii	Intensive Care Unit (ICU) Expenses as provided by the Hospital /Nursing Home.	2% of the Sum Insured per day.
	a. Number of days of stay under 'i' and 'ii' above should not exceed total number of days of stay in the Hospital. All related expenses (including iii and iv below) shall also be payable as per the entitled room category based on the Room Rent limit as mentioned above. This restriction shall not apply on medicines / pharmaceuticals and body implants. b. Any expense in excess of reasonable and customary charges as defined under 3.26, or in excess of negotiated prices (in case of network hospitals) shall be borne by the insured.	
iii	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of the Sum Insured.
iv	Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & and similar expenses.	As per the limits of Sum Insured.
v	Ambulance service charges	Reimbursement upto maximum Rs.1000 in any Policy period, subject to claim being admissible under the hospitalisation section of the policy
vi	Daily Hospital Cash Allowance – only in respect of the proposer Account holder.	Rs.200 per day of hospitalisation, maximum compensation being Rs.1000 during the policy period, subject to claim being admissible under the hospitalisation section of the policy.
vii	Funeral Expenses:	Lumpsum payment of Rs.1000 per Insured person in case of death of the insured person, subject to claim being admissible under the hospitalisation section of the policy
viii	Pre and Post Hospitalisation expenses	Medical expenses incurred

		30days prior to Hospitalisation and upto 60 days Post Hospitalisation.
B.	**DOMICILIARY HOSPITALISATION BENEFITS**	
i.	Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines & Drugs, Diagnostic Material and Dialysis, Chemotherapy, Nursing expenses.	10% of Sum Insured, Maximum Rs.25000/- during the Policy period.

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
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 Pharyngitis
    xii. Arthritis, Gout and Rheumatism.

Note: (i) Liability of the Company under Domiciliary Hospitalisation Benefit is limited as stated in 2B.

(ii) Maximum liability of the Company under the policy is the Sum Insured as stated in the schedule.

C. Relaxation to 24 hours minimum duration of hospitalisation is allowed in Specified Day Care procedures / Surgeries where such treatment is taken by an Insured Person in a Hospital / Day Care Centre (but not the Out-Patient department of a hospital), Or any other Day Care Treatment as mentioned in clause 3.10 and for which prior approval from Company / TPA is obtained in writing.

D. In case of Ayurvedic, Yoga & Naturopathy, Unani, Siddha and Homeopathic treatment, Hospitalisation expenses are admissible only when the treatment is taken as an In-patient, as defined in 3.11

3. DEFINITIONS:

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

3.2. Alternative Treatments: are forms of treatments other than 'Allopathy', or 'modern Medicine and include Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy in the Indian context.

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

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

3.5. Bancassurance: means an arrangement entered into by the Company, with one or more Banks, for selling, inter-alia, health insurance policies.

3.6. Cashless Facility: means a facility extended by the insurer or TPA on behalf of the Insurer to the insured, where the payments for 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 is approved.

3.7. **Daily Hospital Cash Allowance**: When an insured account holder is hospitalized and a claim is admitted under the Policy, then the Company shall pay a Daily Hospital Cash Allowance as specified under 2A(vi) above.

3.8. DOMICILIARY HOSPITALISATION BENEFIT: means medical treatment for a period exceeding three days for such 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 medical condition of the patient is such that he/she is not in a position to be moved to a hospital, or

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

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

a. has qualified nursing staff under its employment,
b. has qualified medical practitioner (s) in charge,
c. has a fully equipped operation theatre of its own, where surgical procedures are carried out
d. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

3.10. Day Care Treatment: refers to medical treatment, and/or surgical procedure which is:

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

Procedures / treatments done in Out Patient Department are not payable under the policy even if converted to day care surgery / procedure or as in patient in the hospital for more than 24 hours.

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

a. has qualified nursing staff under its employment round the clock;
b. has at least 10 inpatient beds, in towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
c. has qualified medical practitioner (s) in charge round the clock;
d. has a fully equipped operation theatre of its own where surgical procedures are carried out
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

In case of AYUSH treatment, if the treatment is taken in a Government hospital or in any institute recognised by Govt. and/or accredited by Quality Council of India of National Accreditation Board on Health OR in :

i. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian medicine (CCIM) and Central Council of Homeopathy (CCH)
ii. AYUSH hospitals having registration with Government authority under appropriate Act in the State / UT and complies with the following as minimum criteria

a. has at least 15 inpatient beds
b. has minimum 5 qualified and registered AYUSH doctors
c. has qualified paramedical staff under its employment round the clock.
d. has dedicated AYUSH therapy sections
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

3.12. 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.

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

3.14. 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.

3.15. 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.

3.16. Insured Person: Means Person(s) named as Insured Person(s) on the schedule of the Policy.

3.17. Maternity Expenses: shall include (a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections) incurred during hospitalisation (b) expenses towards lawful medical termination of pregnancy during the policy period.

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

3.19. 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.

3.20. Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
a. is required for the medical management of the illness or injury suffered by the insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a medical practitioner;
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

3.22. Network Provider: means hospital or health care provider enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured either on payment or by a cashless facility.

3.23. Pre-Hospitalisation Expenses: means medical expenses incurred during the period upto 30 days prior to the date of admission in the hospital provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.24. Post-Hospitalisation Expenses: means medical expenses incurred for a period upto 60 days from the date of discharge from the hospital, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.25. 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

3.26. Reasonable and Customary Charges: means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

3.27. 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.

3.28. Third Party Administrator (TPA): means any person who is licensed under the IRDAI (Third Party Administrators – Health Service) Regulations, 2016, notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those regulations.

3.29. 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.

3.30. Unproven/Experimental Treatment: Treatment including drug experimental therapy which is not based on established medical practice in India.

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

4.1 All Pre-existing Diseases (whether treated / untreated, declared or not declared in the Proposal Form), are excluded upto 36 months of the Policy being in force and shall be covered only after the Policy has been continuously in force for 36 months.

For the purpose of applying this condition, the date of inception of the first OBC-Oriental Mediclaim Policy shall be considered, provided the Renewals have been continuous and without any break in the policy period.

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.

4.2 The expenses on treatment of following ailments / diseases / surgeries, if contracted and / or manifested after inception of first Policy are not payable during the waiting period specified below.

Sl.	Ailment / Disease / Surgery	Waiting Period
i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	12months
ii	Polycystic ovarian diseases.	12months
iii	Surgery of hernia.	24 months
iv	Surgery of hydrocele.	24 months
v	Non infective Arthritis.	24 months
vi	Undescendent Testes.	24 months
vii	Cataract.	24 months
viii	Surgery of benign prostatic hypertrophy.	24 months
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus.	24 months
x	Fissure / Fistula in anus.	24 months
xi	Piles.	24 months
xii	Sinusitis and related disorders.	24 months
xiii	Surgery of gallbladder and bile duct excluding malignancy.	24 months
xiv	Surgery of genito urinary system excluding malignancy.	24 months
xv	Pilonidal Sinus.	24 months
xvi	Gout and Rheumatism.	24 months
xvii	Hypertension.	24 months
xviii	Diabetes.	24 months
xix	Calculus diseases.	24 months
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	24 months
xxi	Surgery of varicose veins and varicose ulcers.	24 months
xxii	Joint Replacement due to Degenerative condition.	36 months
xxiii	Age related osteoarthritis and Osteoporosis.	36 months

Note: i. If the above diseases are pre-existing at the time of inception of the policy, clause.4.1 for Pre-existing Disease shall be applicable to such disease.

ii. If the continuity of the Renewal is not maintained then subsequent cover will be treated as fresh Policy and clauses 4.1 and 4.2shall apply afresh, (whether or not a Proposal is submitted afresh) unless agreed by the Company and suitable endorsement passed on the Policy, by the duly authorised official of the Company. Similarly, if the Sum Insured is enhanced subsequent to the inception of the first Policy, clauses 4.1 and 4.2 shall apply afresh on the enhanced portion of the Sum Insured.

4.3 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.

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

4.5 Surgery for correction of eye sight, cost of spectacles, contact lenses, cochlear implant, hearing aids, and similar other external aids / implants.

4.6 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.

4.7 Convalescence, general debility, "run down" condition or rest cure, congenital internal and 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., any disease or injury as a result of committing or attempting to commit a breach of Law with criminal intent.

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

4.9 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.

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

4.11 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.

4.12 Any unproven procedure or treatment, experimental or alternative medicine (other than Ayurveda, Yoga and Naturopathy, Siddha, Unani & Homeopathy as expressed in clause 2 D) and related treatment including acupressure, acupuncture, magnetic and such other therapies.

4.13 Expenses for investigation/treatment irrelevant to the disease in respect of which the insured person has been admitted or diagnosed.

4.14 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, APDS, 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 with the policy).

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.

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

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

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

4.21 Treatment in respect sleep apnoea and immuno modulator drugs for cancer treatment

4.22 Any treatment required arising from 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.

4.23 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, or similar establishments.

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

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

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

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

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

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

5. CONDITIONS

5.1 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 shall be condition precedent to the contract.

5.2 Due Observance: 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.

5.3 A. Midterm inclusion: Midterm inclusion of members under the Policy is permitted only on written request and only in respect of

i. Newly wed spouse, within 90days of marriage or at the time of renewal of the Policy.
ii. New Born / adopted Child from 91st day of birth / legal adoption or at the time of renewal of the Policy.

B. Enhancement of Sum Insured: Increase in Sum Insured under the Policy is allowed only at the time of Renewal. Increase shall be as given below:

i. On Renewal, Sum Insured can be increased to the immediate higher slab.
ii. If size of the family increases on Renewal, Sum Insured can be increased to maximum two slabs higher.
iii. If there are no claims reported in the two immediate preceding Policy Periods, increase upto any available Sum Insured is allowed.
iv. Notwithstanding above provisions, no increase in Sum Insured is allowed in policies
   a. where there are claims reported consecutively in the two immediate preceding Policy Periods OR
   b. where any one of the insured persons is above the age of 80 years.

5.4 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:

1. 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
2. If the insured has not made any claim during the free look period, the insured shall be entitled to
   a. 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;
   b. 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;
   c. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

Premium on cancellation shall be refunded within 15days from the date of receipt of request for Free look cancellation.

5.5 Portability: This being a group policy, in the event of the Insured Person intending to port to any other insurer, the Insured Person must first migrate to the Retail health policy of the Company. After one year of such policy, the insured can port to a health policy of any other Insurer of his choice as per the portability provisions.

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

5.7 Procedure for availing cashless access services in network hospital/nursing home:

i. Claim in respect of Cashless Access Services will be through the Company / TPA provided admission is in a network Hospital / Nursing Home and is subject to pre admission authorization.
ii. The Company / TPA reserves the right to deny pre-authorisation in case the Hospital / Insured Person is unable to provide the relevant information / medical details as required by the Company / TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of liability.
iii. Should any information be available with the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorisation of Cashless facility may be withdrawn.
iv. Liability under the policy in respect of all expenses incurred in a Network Provider shall be subject to the pre agreed rates between the Company/TPA and the Network Provider. This is irrespective of the claim being under cashless or re-imbursement.

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

5.9 Payment of Claim: All medical treatments (including diagnostic tests) for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency only.

5.10 Protection of Policyholders' Interests: Company shall offer a settlement of claim to the insured / claimant (or convey repudiation, if a claim warrants so) within 30days of receipt of all necessary information / documents. Where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate and complete such investigation at the earliest, in any case not later than 30days from the date of receipt of last necessary document. In such cases, the claim shall be settled within 45days from the date of receipt of last necessary document.

In case of any delay in the payment, (30days / 45 days as the case may be), 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.

5.11 Contribution: If two or more policies are taken by an insured during a period from one or more Insurers to indemnify treatment costs, the insured shall have the right to require a settlement of his claim in terms of any of his policies

i. In all such cases, the insurer who has issued the chosen policy, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Claim under other policy/policies can be made after exhaustion of the sum insured in the earlier chosen policy/policies. However, the insured shall also have the right to prefer claim from other policy/policies for the amounts disallowed under the earlier chosen policy/policies even if the sum insured is not exhausted.

5.12 Renewal of Policy:

i. 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 Practitioner's report wherever required or due to any other reason whatsoever

iii. 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

5.13 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 under the renewed policy.

5.14 Revision in Premium / Terms: The premium rates are valid only for the Policy period. 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 on or before the due date. Any revision or modification in the Policy will be notified to the policyholders three months in advance.

5.15 Grievance Redressal:

i. The Company shall repudiate the claim if not payable under the policy, mentioning the reasons for repudiation in writing to the Insured / claimant. The Insured / claimant shall have the right to appeal / approach the Customer Service department of the Company at its policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, New Delhi-110002. E-mail id is csd@orientalinsurance.co.in.

ii. If the insured is not satisfied with the reply of the Customer Service department, he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto Rs.20 lakhs.

5.16 Arbitration: 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, and subsequent amendments.

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.

5.17 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. Also, anytime during the currency of the policy, if violation of 1.0 (e) comes to the notice, the Company shall cancel all policies, but one, choice of such one policy shall be with the affected Account holder.
No refund of premium shall be made when cancellation is on grounds of fraud, moral hazard or misrepresentation or violation of 1.0(e).

The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium after retaining premium at Company's short period rates (as per table given below) provided no claim has occurred during the policy period up to the date of Cancellation.

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

5.18 Product Withdrawal: This product may be withdrawn in future with due approval of IRDAI. However, in the event of withdrawal of the product, the insured shall be informed of the options available.

5.19 IT Exemption: The premium under the Policy is eligible for Income Tax exemption in accordance with the extant IT Act.

5.20 Disclosure of Information Norm: Non – disclosure, concealment or misrepresentation of material facts or making false statements in the Proposal Form or any other document submitted therewith, 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.

5.21 IRDAI Regulations: This Policy is subject to IRDAI (Protection of policy holders' interest) Regulation, 2002 & 2017 and IRDAI (Health Insurance) Regulations 2013 & 2016 and Guidelines on Standardisation in Health Insurance as amended from time to time.

5.22 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.

5.23 How to apply for Insurance: The Proposer has to complete the Proposal Form in duplicate and submit Insured Person's details in respect of each member. The proposer has to affix coloured stamp size photograph of each member proposed to be insured on the Proposal Form against the name of the person. These photographs will be utilised by TPA for preparing ID cards.

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

The Prospectus and Proposal Form are part of the Policy. Hence please read the Prospectus carefully and sign the same. The Proposal Form is to be completed in all respects for each person proposed for insurance. Both the Prospectus and the Proposal Form are to be submitted to the office or to the agent.

Name of the Proposer: Signature

Address:

Place: Date:

5.24 INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938 provides as follows:
1. No person shall allow, or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate except such rebate as may be allowed in accordance with the published Prospectus or tables of the Insurer.

2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to Ten Lakh Rupees.

5.25 Premium Chart

SI/Age in years	0-40	41-60	61 and above
100000	2511	2575	5169
200000	4408	4475	8776
300000	6105	6150	11962
400000	7342	7500	14902
500000	8393	8670	16599
600000	10165	11113	19798
700000	11009	12000	21072
800000	11796	12250	22175
900000	12538	12716	23148
1000000	13240	14029	24018

a Premium is in Indian rupees.
b Premium is to be charged based on the age of the proposer Accountholder
c Taxes as applicable shall be extra.
d Above Premium is irrespective of the family size of upto five members.