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

ORIENTAL YOUTH ECO CARE POLICY

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) has applied to THE ORIENTAL INSURANCE COMPANY LIMITED (hereinafter called the Company) for the insurance herein after set forth in respect of person(s) named in the Schedule hereto (herein after 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 maybe.

1. PREAMBLE

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 period of insurance stated in the Schedule any Insured Person(s) shall contract 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 any such Insured Person(s) 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) Hospitalization(as defined hereinafter) for medical/surgical treatment at any Nursing Home/Hospital in India as herein defined (hereinafter called 'HOSPITAL') as an In-patient OR (b) on Domiciliary treatment in India under Domiciliary Hospitalization 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, in respect of one or all the Insured Persons stated in the schedule, shall be up to 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 arising during the Policy Period mentioned in the schedule.

Type of coverage:

The benefits under this Policy are available on Individual/Floater/Floater with Floater Basis under two plans, viz Basic & Premium as opted by the Insured in the proposal form.

Individual Coverage -: In this type of coverage, all persons of the family will have separate individual coverage with separate Sum Insured options chosen at the time of proposal.

Floater Cover-: A single Sum Insured will be provided for all family members which covers your entire

family (as per definition clause 2.16) under a single plan. i.e. anyone can utilize as much amount up to Sum Insured limits.

Floater with floater cover-: Policy holder can opt for coverage on floater basis for different group of members of family within same policy for different Sum Insured limits. For e.g. a policyholder can purchasefloater cover for 10 lakhs for self and spouse and floater cover of 5 lakhs for children within same policy.

• Minimum four persons to be covered under floater with floater cover with minimum two persons in each floater.
• All the members falling within the family definition at 2.16 are eligible to take this coverage.
• Cross combination of parents/Children not allowed and higher Sum Insured shall always be opted for parents.
• Both the floaters under this coverage shall be of same plan either Basic/Premium only.

BASIC PLAN (Clauses applicable are 3.1 to 3.19)

- HOSPITALIZATION EXPENSES
- ROAD AMBULANCE SERVICE CHARGES
- AIR AMBULANCE COVER
- AYUSH TREATMENT
- HIV/ AIDS COVER
- MENTAL ILLNESS COVER
- MODERN TREATMENT
- DOMICILIARY HOSPITALIZATION
- TELEMEDICINE/ONLINE CONSULTATION
  ADDITIONAL SI FOR CRITICAL ILLNESS
- CUMULATIVE BONUS
- ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE RECIPIENT
- ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE DONOR
- CATARACT TREATMENT

PREMIUM PLAN- covers the following in addition to the coverage mentioned in BASIC PLAN **(**Clauses applicable are 3.20 to 3.23)

- DAILY HOSPITAL CASH ALLOWANCE
- MEDICAL SECOND OPINION
- MATERNITY EXPENSES
- ASSISTED REPRODUCTION TREATMENT (ART)

2. DEFINITIONS

STANDARD 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 Hospitalization expenses are admissible under the Policy.

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

2.4 CASHLESS FACILITY Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of 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 pre- authorization is approved.

WA

2.5 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.

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

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

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

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

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

A. has qualified nursing staff under its employment;
B. has qualified medical practitioner/s in charge;
C. has 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.

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

A. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs. Because Of technological advancement, and
B. Which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition. (Insurers may, in addition, restrict coverage to a specified list (refer APPENDIX I))

2.12 DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

2.13 DEDUCTIBLE
Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

2.14 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:

A. the condition of the patient is such that he/she is not in a condition to be moved to a hospital, or
B. The patient takes treatment at home on account of non-availability of room in a hospital.

2.15 DISCLOSURE TO INFORMATION NORM
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

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

2.17 FAMILY consists of the Insured and/ or anyone or more of the family members as mentioned below:

A. Legally wedded spouse.
B. up to four Dependent Children (i.e. natural or legally adopted) between the ages 1 day to 18 years. However male child can be covered up to the age of 25 years if he is a bonafide regular student and

financially dependent. Female child can be covered until she gets married. Divorced and widowed daughter / daughters are also eligible for coverage under the Policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.

C. There is no upper age limit for dependent children who are physically or mentally challenged.

2.17 GRACE PERIOD means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

2.18 HOSPITAL A hospital 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 Clinical Establishments (Registration and Regulation) Act 2010 or under 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 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient 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;

*Following are the enactments specified under the schedule of Section 56 of Clinical Establishment (Registration and Regulation) Act, 2010 as of October 2013. Please refer to the Act for amendments, if any:

- The Andhra Pradesh Private Medical care Establishments (Registration and Regulations) Act, 2002
- The Bombay Nursing Homes Registration Act, 1949
- The Delhi Nursing Home Registration Act, 1953
- The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (RagistrikaranTathaAnugyapan) Adhiniyam, 1973.
- The Manipur Homes and Clinics Registration Act, 1992
- The Nagaland Health Care Establishments Act, 1997
- The Orissa Clinical Establishments (Control and Regulations) Act, 1990
- The Punjab State Nursing Home Registration Act, 1991
- The West Bengal Clinical Establishment Act, 1950

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

A. Central or State Government AYUSH Hospital; or
B. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/ Central Council for Homeopathy; or
C. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
i. Having at least five in- patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.20 AYUSH DAY CARE CENTRE means and includes Community Health Centre (CHC), Primary health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without inpatient services and must comply with all the following criterion:
a. Having qualified registered AYUSH Medical Practitioner (s) in charge.
b. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
c. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.21 HOSPITALISATION means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

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

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

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

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

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

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

2.24 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.

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

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

2.27 MATERNITY EXPENSES means

A. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections) incurred during Hospitalization

B. Expenses towards lawful medical termination of pregnancy during the Policy Period.

2.28 MEDICAL ADVICE Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

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

2.30 MEDICAL EXPENSES 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.

2.31 MEDICAL PRACTITIONER 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 its scope and jurisdiction of license.

2.32 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.

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

2.34 NETWORK PROVIDER means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

2.35 NON-NETWORK PROVIDER means any hospital, day care centre or other provider that is not part of the network.

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

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

2.38 PRE-HOSPITALISATION MEDICAL EXPENSES means medical expenses incurred during the period up to 45 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 Hospitalization was required, and

B. the In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.39 POST-HOSPITALISATION MEDICAL EXPENSES means medical expenses incurred for a period up to 90 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 Hospitalization was required, and

B. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.40 PRE-EXISTING DISEASE (PED) means any condition, ailment, injury or disease:

A. That is/are diagnosed by a physician within 12 months prior to the effective date of the policy issued by the insurer, or its reinstatement.
B. for which medical advice or treatment was recommended by, or received from, a physician within 12 months prior to the effective date of the policy or its reinstatement,

2.41 PORTABILITY means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for preexisting conditions and time bound exclusions, from one insurer to another insurer.

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

2.43 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

2.44 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.

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

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

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

2.48 THIRD PARTY ADMINISTRATOR (TPA) means any person who is licensed under the IRDAI (Third Party Administrators – Health Service) Regulations, 2016 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

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

SPECIFIC DEFINITIONS

2.50 MENTAL ILLNESS means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

2.51 MENTAL HEALTH ESTABLISHMENT means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friends.

2.52 MENTAL HEALTH PROFESSIONAL

A. a psychiatrist or

B. a professional registered with the concerned State Authority under section 55; or

C. a professional having a post-graduate degree (Ayurveda) in Mano VigyanAvum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post- graduate degree (Siddha) in SirappuMaruthuvam;

2.53 DAILY HOSPITAL CASH ALLOWANCE

When an Insured Person is hospitalized and a claim is admitted under the Policy, then the Insured Person shall be eligible for a Daily Cash Allowance for every continuous and completed period of 24 hours of Hospitalization, subject to a maximum of 7 days per hospitalization and 14 days per policy period, provided, there is a valid claim for hospitalization under this policy and 3 day deductible will be applicable.

3 COVERAGE UNDER THE POLICY

ELIGIBILITY Any person aged between 18 years and 45 years residing in India can take this insurance.

SUM INSURED

Minimum Sum Insured INR. 3.0 lac and Maximum Sum Insured INR. 100.0 lacs.
(SI Bands - 3,5,7,10,15,20,25,30,35,40,45,50,75,100 lacs).
Sum Insured is available as per the option of the Proposer, on Individual/Floater/Floater with Floater Basis only.

BASIC PLAN

Hospitalization Cover

COVERAGE The benefits under this Policy are available on Individual/Floater/Floater with floater Basis under two plans, viz BASIC PLAN & PREMIUM PLAN as opted in the proposal form. The Policy covers reasonable and customary charges in respect of Hospitalization and / or Domiciliary Hospitalization for medically necessary treatment only for Illnesses / diseases contracted / suffered or Injury sustained by the Insured Person(s) during the Policy Period, up to the limit of Sum Insured or mentioned sublimit, as detailed below:

3.18 Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.

Sum Insured Slabs	Limit per day
Up to 5 lakhs	Single Room up to 1% of Sum Insured, maximum up to Rs 5,000/- per day
7- 10 lakhs	Single Room, maximum up to Rs. 10,000/- per day.
Above 10 lakhs	Actuals Expenses.

3.19 Intensive Care Unit (ICU) Expenses as provided by the Hospital /Nursing Home.

Sum Insured Slabs	Limit per day
Up to 5 lakhs	Maximum up to Rs.10,000/- per day
7- 10 lakhs	Maximum up to Rs. 20,000/- per day
Above 10 lakhs	Actual expenses.

3.20 Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees as per the limits of Sum Insured (subject to A & B below).

3.21 Anesthesia, 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 (subject to A & B below).

Note:-

A) Number of days of stay under 3.1 & 3.2 above should not exceed total number of days of admission in the Hospital. All related expenses (including 3.3 & 3.4 above) shall also be payable as per the entitled room category based on the Room Rent limit as mentioned above. This will not apply on pharmaceuticals, consumables, diagnostics, medical devises and body implants.

B) Any expenses in excess of reasonable and customary charges under definitions 2.46 or, in excess of the negotiated prices (in case of network hospitals) shall not be borne by the insurer.

C) Relaxation to 24 hours minimum duration for Hospitalization is allowed in Day care procedures / surgeries (Appendix I) where such treatment is taken by an Insured Person in a Hospital / day care centre (but not the Out-patient department of a Hospital).

3.22 Pre and Post Hospitalization- Medical expenses incurred 45 days prior to Hospitalization and up to 90days post Hospitalization.

3.23 Road Ambulance Expenses

Subject to an admissible hospitalization claim, Emergency Road Ambulance expenses incurred is payable as per below table-

Sum Insured Slabs	**Limits**
Up to 10 lakhs	Up to 5,000/- per occurrence maximum up to 10,000/- per policy period.
15-25 lakhs	Up to 10,000/- per occurrence maximum up to 20,000/- per policy period.
Above 25 lakhs	Up to 25,000/- per occurrence maximum up to 50,000/- per policy period.

3.24 Air Ambulance Cover

Expenses incurred towards transportation by an Air Ambulance for treatment of a disease / illness / injury in case of an emergency that requires admission to a Hospital. The necessity of an ambulance must be certified by the treating Medical Practitioner. Policy does not provide cover for the return transportation of Insured Person's to his home by air ambulance. Limits are as below-:

Sum Insured Slabs	**Limits**
Up to 10 lakhs	Maximum up to 10% of Sum Insured
15-25 lakhs	Maximum up to 25% of Sum Insured
Above 25 lakhs	Actual expenses Incurred.

- The policy covers Air Ambulance cost as per limits above Subject to an admissible hospitalization claim.
- This cover is available only for life threatening medical emergency condition/s which requires immediate and rapid ambulance transportation to the hospital / medical centre that ground transportation cannot provide.
- Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency.
- It is prescribed by the Medical Practitioner and is medically necessary.
- The insured person is in India.
- The cover will be available in case of the following ailments:-
- Cardio – Vascular diseases
- Central nervous system diseases.
- Accidental Trauma Cases
- This cover can be availed only once during the entire policy lifetime.
- Such Air ambulance should have been duly licensed to operate.

3.25 AYUSH TREATMENT

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda,Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year

up to Sum Insured as specified in the policy schedule in any AYUSH Hospital.

3.26 HIV/ AIDS COVER

The Company shall indemnify the Hospital or the Insured the Medical Expenses incurred (including Pre and Post Hospitalization Expenses) for treatment as an Inpatient /Day Care related to following stages of HIV infection

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

3.27 MENTAL ILLNESS COVER

The Company shall indemnify the Hospital or the Insured the Medical Expenses incurred (including Pre and Post Hospitalization Expenses) for treatment as an inpatient/daycare under certain conditions with following limits as below:-

1. Illness covered under definition of mental illness mentioned under clause2.52.
2. Hospitalization in Mental Health Establishment as defined under clause2.53.
3. Hospitalization as advised by Mental Health Professional as defined under clause2.54.
4. Mental Conditions associated with the abuse of alcohol and drugs are excluded.
5. Mental Retardation and associated complications arising therein are excluded.
6. Any kind of Psychological counseling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalization is not necessary shall not be covered.

Sum Insured Slabs	**Limit per policy period**
Up to 10 lakhs	up to 50% of Sum Insured
Above 10 lakhs	As per the limits of Sum Insured

3.28 MODERN TREATMENT

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital/Day care centre, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy - Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchial Thermoplasty
J. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)

K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

Following limits will be applied-

Sum Insured Slabs	**Limit per policy period**
Up to 10 lakhs	up to 25% of Sum Insured
Above 10 lakhs	As per the limits of Sum Insured

3.29 DOMICILIARY HOSPITALIZATION

A. Expenses for Domiciliary Hospitalization i.e. treatment at home , if medical treatment is continuously required for more than three (3) days, in which case the cost of medical treatment for the eligible period shall be payable up to 10% of Sum Insured subject to maximum up to Rs 50000/- per Individual/family per policy period subject to:

(i) The condition of the patient is such that he/she is not in a condition to be moved to a Hospital, Or

(ii) The patient takes treatment at home on account of non-availability of room in a Hospital.

.

B. Treatment for Dog bite (or bite of any other rabid animal like monkey, cat etc.)- Maximum Rs.5,000/- actually incurred on immunization injections in any one Policy Period. (Exclusion Clause 4.24 shall not apply)

This 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. 3 day deductible will be applicable

C. incurred on treatment of any of the following diseases:

- Asthma
- Bronchitis
- Chronic Nephritis and Nephritic Syndrome
- Diarrhea and all types of Dysenteries including Gastro-enteritis
- Diabetes Mellitus and Insipidus
- Epilepsy
- Hypertension
- Influenza, Cough and Cold
- Pyrexia of unknown origin for less than 10days
- Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis
- Arthritis, Gout and Rheumatism.

Note: Liability of the Company under Domiciliary Hospitalization Benefit is restricted as stated above.

3.30 TELEMEDICINE/ONLINE CONSULTATION

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

Sum Insured Slabs	**Limit**
Up to 10 lakhs	Max 2 consultations per policy period, max Rs. 1000 per consultation
Above 10 lakhs	Max 3 consultations per policy period, max Rs. 1500 per consultation

3.31 ADDITIONAL Sum Insured FOR CRITICAL ILLNESS (List as per APPENDIX II)

Extra benefit on account of consumption of Sum Insured due to defined 11 critical illness shall be available for insured whose Sum Insured is 10 lacs or above only after waiting period of 2 years. The provision of extra Sum Insured (up to specified limit) available only for critical illness maximum up to 10% of Sum Insured, only once in the policy period. This will be a separate cover and availing this benefit will not affect base Sum Insured. This benefit will not apply to the accrued enhanced Sum Insured due to Cumulative Bonus.

Illustration: Insured has the continuous coverage under the policy for more than 2 year and has a base SI of INR 20 lakhs. Then the additional Sum Insured for critical illness of 10% i.e. INR 2 lakhs (10% of Base SI i.e. INR 20 lakhs) is applicable. If a person claimed INR 18 lakhs for critical illness in first incidence and again Rs. 4 lakhs for other critical illness in second incidence. Then the policy will pay INR 18 lakhs from his opted SI in first incidence but later to pay the claim in second incidence, out of INR 4 lakhs, 2 lakhs will be paid from the basic Sum Insured and additional 2 lakhs will be paid from additional critical illness Sum Insured.

3.32 CUMULATIVE BONUS

Sum insured (excluding Cumulative Bonus) shall be increased by 10% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 100% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.

3.33 ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE RECIPIENT

The Policy covers in-patient Hospitalization Medical expenses in respect of the organ donor provided that the donation conforms to the Transplantation of Human Organs Act 1994(amended) and/or any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. Further provided that:

i. the organ donated is for the use of the Insured Person who has been medically advised to undergo organ transplant
ii. The claim of the Insured Person is admissible under the Hospitalization section of the Policy.

The Policy does not cover:

- Cost directly or indirectly associated with the acquisition of the organ and / or cost of organ.
- cost towards donor screening
- Any Pre and Post Hospitalization medical expenses of the donor.
- Any other medical treatment or complication consequent to organ harvesting, in respect of the donor.

NOTE: Company's overall Liability in respect of all claims admitted under this clause during the Policy Period shall not exceed the Sum Insured mentioned in the Schedule.

3.34 ORGAN DONOR BENEFIT- WHEN INSURED PERSON IS THE DONOR Actual expenses up to 10% of Sum Insured, to take care of medical and other incidental expenses is payableto the Insured Person donating an organ provided that the 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. This benefit is subject to the Policy having been continuously in force for at least 12 (twelve) months in respect of that Insured Person. This benefitwill not apply to the accrued enhanced SI due to Cumulative Bonus.

3.35 CATARACT TREATMENT

The Company shall indemnify medical expenses incurred for treatment of Cataract, The specified limits also includes pre-post hospitalization if any as per below table-

Sum Insured Slabs	**Limits**
Up to 10 lakhs	up to Rs 50,000/- per eye including IOL.
Above 10 lakhs	up to Rs 1,00,000/- per eye including IOL.

3.36 COST OF HEALTH CHECKUP

The Insured shall be entitled for reimbursement of cost of Health checkup undertaken once at the expiry of a block of every THREE continuous underwriting years provided there are no claims reported during the block. 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 benefit will not apply to the accrued enhanced Sum Insured due to Cumulative Bonus. This provision is applicable only in respect of continuous insurance without break under Oriental's Youth Eco Care policy

For individual-:

Sum Insured(without Cumulative Bonus)	**Benefit**

Upto 10 lakhs	Upto Rs 1,500
15-25 lakh	Upto Rs 2,000
Above 25 lakh	Upto Rs 3,000

For Family-:

Sum Insured(without Cumulative Bonus)	**Benefit**
Upto 10 lakhs	Upto Rs 3,000
15-25 lakh	Upto Rs 4,000
Above 25 lakh	Upto Rs 6,000

PREMIUM PLAN (In addition to coverage under BASIC PLAN)

3.37 DAILY HOSPITAL CASH ALLOWANCE

When an Insured Person is hospitalized and a claim is admitted under the Policy, then the Insured Person shall be eligible for a Daily Cash Allowance for every continuous and completed period of 24 hours of Hospitalization, subject to a maximum of 7 days per hospitalization and 14 days per policy period, provided, there is a valid claim for hospitalization under this policy and 3 day deductible will be applicable.

Following limits will be applicable:

Sum Insured Slabs	**Limit(INR)**
Up to 5 lakhs	500 per day
Above 5 lakhs	1000 per day

3.38 MEDICAL SECOND OPINION

Policy provides for a Medical Second Opinion whether before starting the treatment or during the course of treatment, post the diagnosis of a specified Critical Illness or has been advised for a surgery during the policy year .The Policy covers Medical Expert's fees to the extent given below. Claim under this clause would be admissible subject to the Hospitalization claim being admissible.

Major Illnesses covered:

i. Cancer
ii. Renal Disease
iii. Stroke resulting in permanent symptoms
iv. Coma
v. All Cardiac conditions/surgeries
vi. Major Organ / Bone Marrow transplantation
vii. Paralysis of limbs

viii. Motor Neuron disease
ix. All Brain related conditions /surgeries
x. Multiple Sclerosis
xi. Liver failure

Sum Insured Slabs	**Limit(in INR)**
Up to 10 lakhs	5,000/- per policy period
15-25 lakhs	10,000/- per policy period
Above 25 lakhs	25,000/- per policy period

3.39 MATERNITY EXPENSES

The Company shall pay the Medical Expenses incurred as an In-patient for a delivery (including caesarean section) or lawful medical termination of pregnancy during the Policy Period limited to two deliveries or terminations or either during the lifetime of the Insured Person provided that:

i. Policy has been continuously in force for a period of minimum 24 months in respect of both the Insured and his/her spouse.
ii. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.
iii. These benefits are admissible only if the expenses are incurred in Hospital/Nursing Homes as in- patients in India.
iv. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.
v. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.
vi. Pre Hospitalization and Post Hospitalization benefits are not available under these two clauses
vii. If this benefit is opted by the insured, then exclusion under 4.18 will not apply..
viii. Company's maximum liability per delivery or termination shall be limited as below table.

The maximum liability under maternity expenses shall be as below:-

Sum Insured Slabs	**Limit per event(Maternity expenses)**
Up to 10 lakhs	Up to Rs 50,000
15 -25 lakhs	Up to Rs 75,000
Above 25 lakhs	Up to Rs 1,00,000

3.40 ASSISTED REPRODUCTION TREATMENT (ART)

Assisted Reproduction Treatment is defined as set of techniques and medical treatments that allow couples to start a family when it cannot be achieved naturally due to infertility problems. Itshould be proven by the specialized doctor that it is not possible to conceive through natural process due to established sub-fertility/ infertility problems of the couple. For the scope of this policy, ART will be covering any treatment or procedure that involves the in-vitro handling of human oocytes and sperm or embryos for the purpose of establishing a pregnancy. The Companywill reimburse expenses incurred on Assisted Reproduction Treatment, where indicated as mentioned above, for sub-fertility/ infertility subject to:

i. A waiting period of 36 months from the date of first inception of this policy with the Company for the insured persons (both spouses). The benefit is only payable if the treatment has been initiated after the specified waiting period.
ii. The maximum liability of the Company for such treatment shall be limited to Rs. 2, 00,000/-. This benefit (2 Lakhs) will be a part of the basic SI, not in addition to it.
iii. For the purpose of claiming under this benefit, in-patient treatment is not mandatory.
iv. If this benefit is opted by the insured, then exclusion under 4.17 will not apply.

Note: To be eligible for this benefit both partners should stay insured continuously without break under this policy. This cover is limited for one child once in lifetime only. If the couple has one living child this benefit will not be available. This benefit of Rs. 2, 00,000/- will only be given once in a lifetime.

4. 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:

STANDARD EXCLUSIONS

4.1 Pre-existing Diseases - code -ExcI0 1

A. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with the insurer.

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

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

D. Coverage under the policy after the expiry of 12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

4.2 Specified disease / procedure waiting period- code- ExcI02

A. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of the specified waiting period of the continuous coverage after the date of inception of the

first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

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

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

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

F. 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 ofgenito-urinary system excluding malignancy.	2 Years
Xv	Pilonidal Sinus.	2 Years
Xvi	Gout and Rheumatism.	2 Years
Xvii	Hypertension.	90 days*
Xviii	Diabetes.	90 days*
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	Joint Replacement due to Degenerative condition.	2 Years

Xxiii	Age related osteoarthritis and Osteoporosis.	2 Years

***If the above diseases are pre-existing at the time of inception, then the longer of the two waiting periods shall apply.**

4.3 30 day waiting period- code – ExcI03

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

b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

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

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

4.4 Investigation & Evaluation – Code – ExcI04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.5 Rest Cure, rehabilitation and respite care – Code -ExcI05

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such a bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.6 Obesity/Weight Control : Code- EscI06 Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor.

b. The surgery /Procedure conducted should be supported by clinical protocols.

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI):

- greater than or equal to 40 or

- greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failures of less invasive methods of weight loss:
    i. Obesity – related cardiomyopathy
    ii. Coronary heart diseases
    iii. Severe Sleep Apnea.
    iv. Uncontrolled Type 2 Diabetes.

4.7 Change of Gender Treatments: Code – ExcI07 Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite.

4.8 Cosmetic or Plastic Surgery- Code- ExcI08 Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident burns(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical practitioner.

4.9 Hazardous or Adventure sports- Code- ExcI09 Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports including but not limitedto, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

4.10 Breach of law – Code –ExcI10 Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.11 Excluded Providers- Code – ExcI11 Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website /notified to the policy holders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not complete claim.

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

4.13 Treatments received in health hydro's, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.- **Code- ExcI13**

4.14 Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.- **Code- ExcI14**

4.15 Refractive Error- Code- ExcI15 Expenses related to the treatment for correction of eye sightdue to refractive error less than 7.5 diopters.

4.16 Unproven Treatments- Code – ExcI16 Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.17 Sterility and Infertility- Code- ExcI17 Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization.

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI. This exclusion does not apply to Plan-B to the limits mentioned therein.

iii. Gestation Surrogacy

iv. Reversal of sterilization.

4.18 Maternity- Code- ExcI18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean sections incurred during hospitalization) except ectopic pregnancy.

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

NOTE: - The exclusion 4.17 & 4.18 do not apply for PREMIUM PLAN.

SPECIFIC EXCLUSIONS:-

4.19 Hormone Replacement Therapy Expenses for hormone replacement therapy, unless part of Medically Necessary Treatment, except for Puberty and Menopause related Disorders

4.20 General Debility, Congenital External Anomaly General debility, congenital external anomaly.

4.21 Self Inflicted Injury Treatment for intentional self-inflicted injury, attempted suicide.

4.22 Stem Cell Surgery Stem Cell Surgery (except Hematopoietic stem cells for bone marrow transplant for hematological conditions).

4.23 Circumcision unless necessary for treatment of a disease (if not excluded otherwise) or necessitated due to an accident.

4.24 Vaccination or Inoculation. Vaccination or inoculation unless forming part of treatment and requires Hospitalization. (Does not apply to clause 3.12 (B)).

4.25 Massages, Steam Bath, Alternative Treatment (Other than Ayurveda and Homeopathy) Massages, steam bath, expenses for alternative or AYUSH treatments (other than Ayurveda and Homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.

4.26 Dental treatment Dental treatment, unless necessitated due to an Injury.

4.27 Out Patient Department (OPD) Any expenses incurred on OPD (Excludes ART under PREMIUM Plan)

4.28 Stay in Hospital which is not Medically Necessary. Stay in hospital which is not medically necessary.

4.29 Spectacles, Contact Lens, Hearing Aid, Cochlear Implants Spectacles, contact lens, hearing aid, cochlear implants.

4.30 Non Prescription Drug Drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses (as listed in respective Appendix-III).

4.31 Treatment not related to Disease for which Claim is Made Treatment which the insured person was on before Hospitalization for the Illness/Injury, different from the one for which claim for Hospitalization has been made.

4.32 Equipment's External/durable medical/non-medical equipment's/instruments of any kind used for diagnosis/ treatment including CPAP, CAPD, infusion pump, ambulatory devices such as walker, crutches, belts, collars, caps, splints, slings, braces, stockings, diabetic foot-wear, glucometer, thermometer and similar related items (as listed in respective Appendix-III) and any medical equipment which could be used at home subsequently.

4.33 Items of personal comfort Items of personal comfort and convenience (as listed in respective Appendix-III) including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.

4.34 Service charge/ registration fee Any kind of service charges including surcharges, admission fees, registration charges and similar charges (as listed in respective Appendix-III) levied by the hospital.

4.35 Home visit charges Home visit charges during Pre and Post Hospitalization of doctor, attendant and nurse.

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

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

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or .

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

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

4.38 Treatment taken outside the geographical limits of India.

4.39 Permanently Excluded Diseases In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on the insured's consent), policyholder is not entitled to get the coverage for specified ICD coded as listed below:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9

2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemiavera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.

7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classifiedelsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta- (super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

5 TERMS & CLAUSES

STANDARD GENERAL TERMS & CLAUSES

5.1 DISCLOSURE OF INFORMATION: The policy shall be void and all premium paid thereon shallbe forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of

any material fact by the policyholder. (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

5.2 CONDITION PRECEDENT TO ADMISSION OF LIABILITY: The terms and conditions of thepolicy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

CLAIM SETTLEMENT (provision for Penal Interest):

- The Company shall settle or reject a claim, as the case may be, within 15 days from the date of submission of claim.
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- However, where the circumstance of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above bank rate from the date of receipt of last necessary document to the date of payment of claim.
  ("Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

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

5.4 FRAUD: If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited. Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

i. the suggestion as a fact of that which is not true and which the Insured Person does not believe to be true;
ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
iii. any other act fitted to deceive; and
iv. any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis- statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

5.5 CANCELLATION CLAUSE: The Insured may cancel this Policy by giving 7 days' written notice.

Refund by Insurer :

1) Proportionate premium for unexpired policy period, in case of Annual policies, subject to no claim having been made during the policy period.

2) Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy. The Company may cancel the Policy at any time on grounds of misrepresentation, non- disclosure of material facts fraud by the insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on groundsof misrepresentation non- disclosure.

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

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

5.7 FREE LOOK PERIOD: The free look period shall be applicable on new health insurance Policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look period of 30 days from the date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable. If the Insured has not made any claim during the free look period, the Insured shall be entitled to

- A refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Persons and the stamp duty charges or
- where the risk has already commenced and the option of return of the Policy is exercised by the Insured person, a deduction towards the proportionate risk premium for period on cover or
- Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

5.8 RENEWAL OF POLICY: The policy shall ordinarily be renewable lifelong except in case of

fraud, misrepresentation or non-disclosure by the insured person.

- The company shall send a Renewal Notice a least 30days in advance from the due date.
  - Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
  - Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
  - At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
  - the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period
  - No loading shall apply on renewals based on individual experience.

5.9 PORTABILITY: The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. For Detailed Guidelines on Portability, kindly refer the link: https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

5.10 WITHDRAWAL OF POLICY

- In the likelihood of this product being withdrawn in future, the Company will intimate the Insured person about the same 90 days prior to expiry of the policy.
- Insured person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. As per IRDAI guidelines, provided the policy has been maintained without a break.

5.11 MORATORIUM PERIOD After completion of five continuous years under this policy no look back to be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of five continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for established fraud. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

5.12 POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUM RATES: The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

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

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

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at: Customer Service Department, Corporate Office, Block - 4, Plate-A, NBCC Office Complex, Kidwai Nagar East, New Delhi - 110023. For updated details of grievance officer, kindly refer the link: **https://orientalinsurance.org.in/grievance-redressal.**

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

5.15 NOMINATION: The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Nomination can be changed at any time during the term of the policy.

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

SPECIFIC TERMS & CLAUSES:-

5.17 ENTIRE CONTRACT: This Policy /Prospectus/ Proposal Form/Schedule and declaration given by the insured constitute the complete contract. Insurer may alter the terms and conditionsof 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.

5.18 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.

5.19 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 fulfillment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this

Policy. No waiver of any terms, provisions, conditions and endorsements of this Policy shall be valid, unless made in writing and signed by an authorized official of the Company.

5.20 NOTIFICATION 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, e-mail. Such notice should be given within 48 hours of admission but before discharge from Hospital / Nursing Home, unless waived in writing.

5.21 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.

- Original bills, all receipts and discharge certificate / card from the Hospital.
- All documents pertaining to the Illness, starting from the date it was first detected, i.e. Doctor's consultations reports/history
- Medical history of the patient recorded by the Hospital.
- Original Cash-memo from the Hospital (s) / chemist (s) supported by proper prescription.
- 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.
- Original attending Consultants / Anesthetists/ Specialist certificates regarding diagnosis and bills / receipts etc.
- Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
- MLC/FIR/Post Mortem Report,(if applicable)
- Disability certificate, Death certificate (if applicable)
- Documents in respect of organ donation claim, shall be in accordance with the extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs
- Details of previous policies, if the details are already not with TPA.
- Any other information required by TPA /Company.

a. All documents must be duly attested by the Insured Person/Claimant.
b. In case of Post Hospitalization treatment (limited to 90 days) all supporting claim papers / documents as listed above should also be submitted within 15 days from completion of such treatment to the Company / T.P.A. in addition insured should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.
c. Waiver of the 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.
d. On receipt of the last document /clarification, the Company/TPA shall within a period of 30 days offer a settlement of the claim to the insured. If the Company/TPA, for any reasons to be recorded in writing and communicated to the insured, decides to reject a

claim under the Policy, it shall do so within a period of 30 days from the receipt of the last document/ clarification.

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

- 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. The Company / TPA shall, upon getting the related medical details / relevant information from the Insured Person / Network Hospital / Nursing Home, verify that the person is eligible to claim under the Policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which theperson is seeking to be admitted as an in-patient. The Company / TPA reserves the right to deny pre-authorization 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 Company / TPA within 15 days ofthe discharge from Hospital / Nursing Home for consideration of Company /TPA.
- Should any information be available with the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorization of cashless facility may be withdrawn. However this shall be done by the Company / TPAbefore the patient is discharged from the Hospital and notice to this effect given to the treating Hospital / insured.
- List of network Hospitals is available on our official website-www.orientalinsurance.org.inand will also be provided by the concerned TPA on demand.
- Turn Around Time (TAT) for Cashless:
- For pre-authorisation of cashless facility: immediately but not later than One hour from the receipt of request.
- For cashless final Bill authorization: within three hours of receipt of discharge authorization from the hospital.

5.23 MEDICAL RECORDS:

- The Insured Person hereby agrees to and authorizes the disclosure, to the Company/ TPA or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from which the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company / TPA in connection with any claim made under this Policy or the Company's liability there under.
- 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.
- Any Medical Practitioner authorized by the Company / TPA shall be allowed to examine the Insured Person in case of any alleged Injury or disease requiring Hospitalization when and so often as the same may reasonably be required on behalf of the Company/ TPA.

5.24 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. The Company

shall settle the claim within 30 days from the date of the receipt of last necessary documents in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016. 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. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document. In case 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 settled.

5.25 MULTIPLE POLICIES

- In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen (known as Primary insurer) by the insured person shall be obliged to settle the claim as long as the claim is withinthe limits of and according to the terms of the chosen policy.
- Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

a) Indemnity Policies:

A policyholder can file for claim settlement as per his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer.
In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

b) Benefit based Policies:

On occurrence of the insured event, the policyholders can claim from all Insurers under all policies.

In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

5.26 REPUDIATION:

- 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 Customer Service department of the Company at its Policy issuing office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, NewDelhi-110002.
    - If the insured is not satisfied with the reply of the Customer Service department under 5.13 , 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.50 lacs.

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

OTHER TERMS & CONDITIONS

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

- Newly wed spouse within 90 days of marriage or at the time of renewal of the Policy.
- Newborn child from the day of birth to Max 90 days or at the time of renewal of the Policy.

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

5.29 ENHANCEMENT OF SUM INSURED: The insured may seek enhancement of Sum Insured in writing before payment of premium for renewal. Before granting such request for enhancement of Sum Insured, if deemed necessary by the Underwriting Authority the Company has the right to have the insured examined by a Medical Practitioner authorized by the Company or the TPA. The cost of such medical examination will be borne by the insured/s. Block of two claim free years is necessary for Enhancement of Sum Inured.

Enhancement of Sum Insured shall be allowed based on the following table:

Age<=45 years	Enhancement up to maximum Sum Insured available.
Age 46-60 Years	Enhancement by two slabs.
Age 61-65 Years	Enhancement by one slab.
Age above 65 Years	No enhancement of Sum Insured allowed

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

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

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

5.31 ASSOCIATED MEDICAL EXPENSES (Indicative only)

- Doctor's fees / Consultant fees/RMO fees
- Nursing expenses including administration charges/ transfusion charges/ injection charges
- Surgeon fees / Asst Surgeon fees
- Anesthesia fees
- Procedure charges of any kind which includes :-
- Chemotherapy/Radiotherapy charges Nebulization
- Hemodialysis PICC
- line insertion
- Catheterization charges Tracheostomy etc.
- IV charges
- Blood transfusion charges
- Dialysis
- Surgery Charges
- OT charges including OT gas, equipment charges.

5.32 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.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

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

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

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

5.36 DISCOUNT

- **Online Discount-**A discount of 10%(maximum Rs. 2000/-) on premium is allowed, if the Policy is purchased on-line and no Intermediary is involved. This discount is also applicable in case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.
- **TPA Discount –** 5.5% if TPA services are not opted for.
- **Family discount** – 10%
- **NO CLAIM BONUS DISCOUNT: 2%**
  The Insurer may reward the policyholders who do not make claim in the form of No Claim Bonus (NCB). Such NCB shall be paid as per the choice/ express consent of the policyholder in the following forms at the time of every renewal:

a) Cumulative Bonus: Addition in the Sum Insured without an associated increase in premium and/or

b) 2% Discount in renewal Premium.

Applicable if more than one members are covered under a single policy and opted forsum insured on individual member wise only.

-Flat discount of 10% shall be given on the total premium for the family.

5.37 IRDAI REGULATIONS: This Policy is subject to IRDAI Health Insurance Regulations 2016, IRDAI (Insurance Products) Regulations 2024, Master Circular on Health Insurance Business 2024 and Master Circular on Protection of Policy holders' Interests, 2024.

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

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
7	Other operations on the auditory ossicles
8	Other microsurgical operations on the middle ear
B	**Other operations on the middle & internal ear**
9	Myringotomy
10	Removal of a tympanic drain
11	Incision of the mastoid process and middle ear
12	Mastoidectomy
13	Reconstruction of the middle ear
14	Fenestration of the inner ear
15	Revision of a fenestration of the inner ear
16	Incision (opening) and destruction (elimination) of the inner ear
17	Other excisions of the middle and inner ear
18	Other operations on the middle and inner ear
C	**Operations on the nose & the nasal sinuses**
19	Excision and destruction of diseased tissue of the nose
20	Operations on the turbinates (nasal concha)
21	Nasal sinus aspiration
22	Other operations on the nose

D	**Operations on the eyes**
23	Incision of tear glands
24	Incision of diseased eyelids
25	Excision and destruction of diseased tissue of the eyelid
26	Operations on the canthus and epicanthus
27	Corrective Surgery for entropion and ectropion
28	Corrective Surgery for blepharoptosis
29	Removal of a foreign body from the conjunctiva
30	Removal of a foreign body from the cornea
31	Incision of the cornea
32	Operations for pterygium
33	Removal of a foreign body from the lens of the eye
34	Removal of a foreign body from the posterior chamber of the eye
35	Removal of a foreign body from the orbit and eyeball
36	Operation of cataract
37	Anterior Chamber Paracentesis / Cyclodiathermy /Cyclocryotherapy / Goniotomy/Trabeculotomy and Filtering and Allied Operations To Treat Glaucoma
38	Diathermy/cryotherapy To Treat Retinal Tear
39	Other operations on Cornea
E	**Operations on the skin & subcutaneous tissues**
40	Incision of a pilonidal sinus
41	Free skin transplantation, donor site
42	Free skin transplantation, recipient site
43	Revision of skin plasty
44	Simple restoration of surface continuity of the skin and subcutaneous tissues
45	Destruction of diseased tissue in the skin and subcutaneous tissues
46	Local excision of diseased tissue of the skin and subcutaneous tissues
47	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
48	ChemoSurgery to the skin
49	Excision Of Soft Tissue Rhabdomyosarcoma
50	Other incisions of the skin and subcutaneous tissues
51	Other excisions of the skin and subcutaneous tissues
F	**Operations on the tongue**
52	Incision, excision and destruction of diseased tissue of the tongue
53	Partial glossectomy
54	Glossectomy
55	Reconstruction of the tongue
56	Other operations on the tongue

G	**Operations on the salivary glands & salivary ducts**
57	Incision and lancing of a salivary gland and a salivary duct
58	Excision of diseased tissue of a salivary gland and a salivary duct
59	Resection of a salivary gland
60	Reconstruction of a salivary gland and a salivary duct
61	Other operations on the salivary glands and salivary ducts
H	**Other operations on the mouth & face**
62	External incision and drainage in the region of the mouth, jaw and face
63	Incision of the hard and soft palate
64	Excision and destruction of diseased hard and softpalate
65	Incision, excision and destruction in the mouth
66	Plastic Surgery to the floor of the mouth
67	Palatoplasty
68	Other operations in the mouth except dental unless necessitated due to an injury.
I	**Operations on the tonsils & adenoids**
69	Transoral incision and drainage of a pharyngeal abscess
70	Tonsillectomy without adenoidectomy
71	Tonsillectomy with adenoidectomy
72	Excision and destruction of a lingual tonsil
73	Adenoidectomy
74	Adenoidectomy With Grommet Insertion
75	Adenoidectomy Without Grommet Insertion
76	Other operations on the tonsils and adenoids
J	**Trauma Surgery and orthopaedics**
77	Incision on bone, septic and aseptic
78	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
79	Reduction of dislocation under GA
80	Arthroscopic knee aspiration
81	Abscess Knee Joint Drainage
82	Arthroscopic Meniscectomy - Knee
83	Carpal Tunnel Release
84	Elbow Arthroscopy
85	Repair Of Ruptured Tendon
86	Repair/ graft Achilles Tendon
87	Surgery For Ligament Tear
88	Surgery For Meniscus Tear
89	Tennis Elbow Release
90	Thyroid Abscess Incision and Drainage

91	Suture and other operations on tendons and tendon sheath
K	**Operations on the breast**
92	Incision of the breast
93	Operations on the nipple
94	Excision Of Single Breast Lump
L	**Operations on the digestive tract**
95	Incision and excision of tissue in the perianal region
96	Surgical treatment of anal fistulas
97	Surgical treatment of haemorrhoids
98	Division of the anal sphincter (sphincterotomy)
99	Ultrasound guided aspirations
100	Sclerotherapy etc
101	Lap Appendicectomy
102	Lap Cholecystectomy and Choledocho-jejunostomy/Duodenostomy / Gastrostomy / Exploration Common Bile Duct
103	Colonoscopy ,lesion removal
104	Colonscopy Stenting Of Stricture
105	Esophagoscopy, Gastroscopy, Duodenoscopy With Polypectomy/Removal Of Foreign Body/diathermy Of Bleeding Lesions
106	Oesophageal varices Sclerotherapy
107	UGI Sco py and Injection Of Adrenaline, Sclerosants Bleeding Ulcers
108	UGI Sco py and Polypectomy Oesophagus/stomach
109	Other operations on the anus
M	**Operations on the female sexual organs**
110	Incision of the ovary
111	Insufflation of the Fallopian tubes
112	Dilatation of the cervical canal
113	Conisation of the uterine cervix
114	Incision of the uterus (hysterotomy)
115	Therapeutic curettage
116	Culdotomy
117	Incision of the vagina
118	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
119	Incision of the vulva
120	Operations on Bartholin’s glands (cyst)
121	Endoscopic Polypectomy
122	Hymenectomy(imperforate Hymen)
123	Hysteroscopic adhesiolysis
124	Hystero scopic Removal Of Myoma

125	Hystero scopic Resection Of Endometrial Polyp
126	LLETZ
127	Other Operations on Fallopian tubes
128	Other Operations on uterine cervix
N	**Operations on the prostate & seminal vesicles**
129	Incision of the prostate
130	Transurethral excision and destruction of prostate tissue
131	Transurethral and percutaneous destruction of prostate tissue
132	Open surgical excision and destruction of prostate tissue
133	Radical prostatovesiculectomy
134	Incision and excision of periprostatic tissue
135	Operations on seminalvesicles
136	Other excision and destruction of prostate tissue
137	Other operations on the prostate
O	**Operations on the scrotum & tunica vaginalis testis**
138	Incision of the scrotum and tunica vaginalis testis
139	Operation on a testicular hydrocele
140	Excision and destruction of diseased scrotal tissue
141	Plastic reconstruction of the scrotum and tunica vaginalis testis
142	Other operations on the scrotum and tunica vaginalis testis
P	**Operations on the testes**
143	Incision of the testes
144	Excision and destruction of diseased tissue of the testes
145	Unilateral orchidectomy
146	Bilateral orchidectomy
147	Orchidopexy
148	Abdominal exploration in cryptorchidism
149	Surgical repositioning of an abdominal testis
150	Reconstruction of the testis
151	Implantation, exchange and removal of a testicular prosthesis
152	Detorsion Of Torsion Testis
153	Other operations on the testis
Q	**Operations on the spermatic cord, epididymis und ductus deferens**
154	Surgical treatment of a varicocele and a hydrocele of the spermatic Cord
155	Excision in the area of the epididymis
156	Epididymectomy
157	Reconstruction of the spermatic cord
158	Reconstruction of the ductus deferens and epididymis

159	Other operations on the spermatic cord,epididymis and ductus deferens.
R	**Operations on the penis**
160	Operations on the foreskin
161	Local excision and destruction of diseased tissue of the penis
162	Amputation of the penis
163	Plastic reconstruction of the penis
164	Other operations on the penis
S	**Operations on the urinary system**
165	Cystoscopical removal of stones
166	Cystoscopic Litholapaxy
167	Cystoscopy and "SLING" Procedure.
168	Cystoscopy and Removal Of Foreign Body
169	Cystoscopy and Removal Of Polyp
170	Cystoscopy with Deflux Injection in VUR
171	Excision Of Urethral Diverticulum
172	Excision Of Urethral Prolapse
T	**Other Operations**
173	Lithotripsy
174	Coronary angiography
175	Haemodialysis
176	Radiotherapy for Cancer
177	Cancer Chemotherapy
178	Axillary/cervical Lymphadenectomy
179	Drainage Of Pyonephrosis/perinephric Abscess
180	External Arterio-venous Shunt

Appendix II

CRITICAL ILLNESSES COVERED:

1. CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive,

including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

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

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

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood
supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

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

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

5. COMA OF SPECIFIED SEVERITY

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

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

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

II. The following are excluded:

i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

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

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

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

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

APPENDIX III

List I – List of which coverage is not available in the policy	
Sl	**Item**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY
	HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES

12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets

54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
List II – Items that are to be subsumed into Room Charges	
Sl	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES

23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES
List III – Items that are to be subsumed into Procedure Charges	
Sl	**Item**
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment	
Sl	**Item**
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING
	CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET
	CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

ANNEXURE I: CONTACT DETAILS OF INSURANCE OMBUDSMEN

Office Details	**Jurisdiction of Office (Union Territory, District)**
AHMEDABAD – Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu

BENGALURU – Office of the Insurance Ombudsman, JeevanSoudha Building, PID No. 57-27-N- 19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078 Tel.: 080 - 26652048 / 26652049 **Email: bimalokpal.bengaluru@ecoi.co.in**	Karnataka
BHOPAL – **Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003** **Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203** **Email: bimalokpal.bhopal@ecoi.co.in**	Madhya Pradesh Chattisgarh
BHUBANESHWAR – **Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009 Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429** **Email: bimalokpal.bhubaneswar@ecoi.co.in**	Orissa
CHANDIGARH – **Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017** **Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274** **Email: bimalokpal.chandigarh@ecoi.co.in**	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigar
CHENNAI - **Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018** **Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664** **Email: bimalokpal.chennai@ecoi.co.in**	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI – **Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002** **Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858** **Email: bimalokpal.delhi@ecoi.co.in**	Delhi

GUWAHATI - Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 **Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937** **Email: bimalokpal.guwahati@ecoi.co.in**	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004 **Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599** **Email: bimalokpal.hyderabad@ecoi.co.in**	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
JAIPUR – **Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005** **Tel.: 0141 - 2740363** **Email: bimalokpal.jaipur@ecoi.co.in**	Rajasthan
ERNAKULAM - **Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015** **Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336** **Email: bimalokpal.ernakulam@ecoi.co.in**	Kerala, Lakshadweep, Mahe - a part of Pondicherry
KOLKATA – **Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072** **Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341** **Email: bimalokpal.kolkata@ecoi.co.in**	West Bengal, Sikkim, Andaman & Nicobar Islands

LUCKNOW – **Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001** **Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310** **Email: bimalokpal.lucknow@ecoi.co.in**	Districts of Uttar Pradesh : Laitpur, Jhansi,Mahoba, Hamirpur,Banda,Chitraoot,Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI - **Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054** **Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052** **Email: bimalokpal.mumbai@ecoi.co.in**	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA – **Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301** **Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in**	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur

PATNA – **Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006 Tel.: 0612-2680952** **Email: bimalokpal.patna@ecoi.co.in**	Bihar, Jharkhand
PUNE – **Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030** **Tel.: 020-41312555** **Email: bimalokpal.pune@ecoi.co.in**	Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region