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

HAPPY FAMILY FLOATER PROSPECTUS 2024

WE VALUE YOUR HEALTH & YOUR WEALTH. BUILD A PRODUCTIVE NATION

1. ELIGIBILITY Any person of 18 years or more can take this Policy covering self and /or anyone or more of the family members as mentioned below:

i. Legally wedded spouse.
ii. Dependent Children (i.e. natural or legally adopted) between the ages of 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 daughters, are also eligible for coverage under the policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.
iii. Parents / Parents-in-law (either of them).
iv. Unmarried siblings, if financially dependent.

Minimum two persons (falling within the definition) to be covered under the Policy. Persons becoming ineligible on account of above provision for coverage under the existing Policy, may migrate to another suitable Policy at the expiry of the Policy. Upon such Migration, the credits gained by the concerned Insured Person, for Pre-existing conditions and time-bound exclusions shall be transferred to the migrated policy, provided the Policy has been maintained without a break.

2. FEATURES IN THE POLICY

NEW FEATURES

i. Maternity Expenses Cover under Diamond and Platinum plan

ii. New Born Baby Cover For all SI Level from day one .

iii. Introduction of higher sum insured slabs of Rs. 25.0 lacs , Rs. 30.0, Rs. 40 lacs and Rs. 50 lacs.

iv. Assisted Reproduction Treatment.

v. Waiver of Proportionate deduction Clause.

vi. Introduction of Zone wise premium for Silver Plan.

vii. Expenses incurred on dental treatment and Plastic surgery – necessitated by due to disease or injury.

viii. Modern treatment methods and Advancements in technology- up to a specified amount.

OTHER SALIENT FEATURES

i. Sum Insured from Rs.1 lac to Rs. 50 lacs. Existing Insured Persons covered for Rs.1 lac Sum Insured may continue with the same. Those existing Insured Persons covered for Sum Insured of Rs.1.5 lacs, may also opt for Sum Insured of Rs.1 lac.
ii. Four Plans available – SILVER, GOLD, DIAMOND and PLATINUM.
iii. A floater policy covering the proposer and his / her family under single Sum insured under one Policy.
iv. Maximum Entry Age is 65 years for all members. However, this can be extended to 70 years subject to certain conditions.
v. Under Silver and Gold Plans, Pre-acceptance medical check-up is required for persons aged 60 years and above. However, under Diamond & Platinum Plan, the requirement is for persons aged 55 years and above.
vi. Term of the Policy is one year and is renewable lifelong.
vii. Pre-existing Disease coverage after three consecutive Policy periods.
viii. Option of TPA (Cashless facility in network hospitals) and non TPA services.
ix. Personal Accident cover as optional cover*
x. Free Look Period
xi. Discount of 5.5% in premium if TPA services not opted for (no discount on PA premium).
xii. A discount of 10% (subject to 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.
xiii. Zone wise premium rates for Silver Plan.

3. DEFINITIONS

STANDARD DEFINITIONS

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

3.2 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.

3.3 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.

3.4 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.

3.5 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.

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

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

3.8 CONTRIBUTION is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rate able proportion of Sum Insured. If two or more policies are taken by the insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/ benefit offered:

A. is fixed in nature;
B. does not have any relation to the treatment costs;

3.9 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.

3.10 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)

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

3.12 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.

3.13 FAMILY consists of the Insured and/ or anyone or more of the family members as mentioned below: A. Legally wedded spouse.

B. Dependent Children (i.e. natural or legally adopted) between the ages 91daysto 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. Parents / Parents-in-law (either of them).
D. Unmarried siblings, if financially dependent.

3.14 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.

3.15 HOSPITAL/NURSING HOME 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 inpatient beds in all other places;
C. has qualified medical practitioner(s) in charge round the clock;
D. has a fully equipped operation theatre of its own where surgical procedures are carried out;
E. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

*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

3.16 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.

3.17 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.

3.18 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.

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

3.20 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

3.21I .D. CARD means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

3.22INJURY 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.

3.23INTENSIVE CARE UNIT means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

3.24IN-PATIENT means an Insured Person who is admitted to Hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / Illness / disease / Injury / accident during the currency of the Policy.

3.25IN-PATIENT CARE means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

3.26ICU (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.

3.27MATERNITY EXPENSES shall include

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.

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

3.29 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.

3.30 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.

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

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

3.32 NEW BORN BABY means baby born during the Policy Period and is covered from day 1 .

3.33 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.

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

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

3.36 OPHTHALMIC COVER It covers Ophthalmic ailments arising out of trauma/ infection/ age related diseases/ foreign body removals and excludes cosmetic eye surgeries, Lasik, cost of spectacles and contact lenses.

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

3.38 PRE-HOSPITALISATION MEDICALEXPENSES means medical expenses incurred during the period up to 30 days prior to the date of admission in the Hospital, provided that:

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

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

3.39 POST-HOSPITALISATION EXPENSES means medical expenses incurred for a period up to 60 days from the date of discharge from the Hospital, provided that:

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

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

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

A. That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the policy or its reinstatement,

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

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

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

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

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

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

3.47 THIRD PARTY ADMINISTRATOR (TPA) means any person who is licensed under the IRDAI (Third

Party Administrators – Health Service) Regulations, 2016 & its amendments by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

3.48UNPROVEN/EXPERIMENTAL TREATMENT means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

3.49MIGRATION means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

3.50PORTABILITY 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.

SPECIFIC DEFINITIONS

3.51 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.

3.52 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.

3.53 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 Vigyan Avum 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 Sirappu Maruthuvam;

4. BENEFITS COVERED UNDER THE POLICY

4.1 COVERAGE The benefits under this Policy are available under four plans, viz Silver, Gold, Diamond and Platinum as opted by the Insured 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:

Sl. No	Expenses covered	SILVER	GOLD	DIAMOND	PLATINUM
		Limits of covered Expenses	Limits of covered Expenses	Limits of covered Expenses	Limits of covered Expenses
A.	HOSPITALISATION BENEFITS				
i.	Sum Insured Available	Rs.1, 2,3,4 & 5 lakh	Rs.6,7,8,9 & 10 lakh	Rs.12, 15, 18 and 20 lacs	Rs.,25,30, 40 and 50 lacs
ii.	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.	1 % of the Sum Insured per day	1 % of the Sum Insured per day	1% of the Sum Insured per day	1% of the Sum Insured per day
iii.	Intensive Care Unit (ICU) Expenses as provided by the Hospital /Nursing Home.*	2% of the Sum Insured per day.	2% of the Sum Insured per day.	2% of the Sum Insured per day	2% of the Sum Insured per day
iv.	Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of Sum Insured subject to “a” and “b” below	As per the limits of Sum Insured subject to “a” and “b” below	As perthe limits of Sum Insured subject to “a” and “b” below	As perthe limits of Sum Insured subject to “a” and “b” below
v.	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	As per the limits of Sum Insured subject to “a” and “b” below	As per the limits of Sum Insured subject to “a” and “b” below	As per the limits of Sum Insured subject to “a” and “b” below	As per the limits of Sum Insured subject to “a” and “b” below

	expenses.				
	a. Number of days of stay under 'ii' & iii above should not exceed total number of days of admission in the Hospital. All related expenses (including iv& v 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 as defined under 3.43, or, in excess of the negotiated prices (in case of network hospitals) shall not be borne by the insurer.				
vi.	Ambulance service charges as herein after defined.	Per Illness - Rs.1000 maximum & Per policy period 1% of Sum Insured, Subject to maximum Rs.3000.	Per Illness Rs.2000 maximum & Per policy period 1% of Sum Insured, Subject to maximum Rs.6000.	Per Illness - Rs.3000 maximum & Per policy period 1% of Sum Insured, Subject to maximum Rs.8000.	Per Illness - Rs.5000 maximum& Per policy period 1% of Sum Insured, Subject to maximum Rs.15000.
vii.	Daily Hospital Cash Allowance as hereinafter defined. (Refer clause 4.1.2 below)	Not Available	0.1% of Sum Insured per day of Hospitalization, subject to a maximum compensation for 10 days per illness & Overall liability of the Company during the Policy Period will be limited to 1.5% of the Sum Insured.	0.1% of Sum Insured per day of Hospitalization, subject to a maximum compensation for 10 days per illness. Overall liability of the Company during the Policy Period will be limited to 1.5% of the Sum Insured.	0.1% of Sum Insured per day of Hospitalization, subject to a maximum compensation for 10 days per illness. Overall liability of the Company during the Policy Period will be limited to 1.5% of the Sum Insured.

viii	Attendant allowance as hereinafter defined. (Refer clause 4.1.3 below)	Not Available	Rs500/- per day of Hospitalization, subject to maximum compensation for 10 days per illness & Overall liability of the Company during the Policy Period will be limited to compensation for 15 days of Hospitalization.	Rs1000/- per day of Hospitalization, subject to maximum compensation for 10 days per illness. Overall liability of the Company during the Policy Period will be limited to compensation for 15 days of Hospitalization.	Rs. 1500/- per day of Hospitalization, subject to maximum compensation for 10 days per illness. Overall liability of the Company during the Policy Period will be limited to compensation for 15 days of Hospitalization.
ix	Maternity expenses as hereinafter defined. (Refer clause 4.1.4 A below & special conditions mentioned therein)	Not Available	Not Available	Medical Expenses for a delivery (including caesarean section) or lawful medical termination of pregnancy limited to two deliveries or terminations or either during the lifetime of the Insured Person, after the policy (Diamond Plan) has been continuously in force for 24 (twenty four) months Liability of the Company limited to2.5% of the Sum Insured.	Medical Expenses for a delivery (including caesarean section) or lawful medical termination of pregnancy limited to two deliveries or terminations or either during the lifetime of the Insured Person, after the policy (Diamond or Platinum Plan)has been continuously in force for 24 (twenty four)months Liability of the Company limited to2.5% of the Sum Insured

x	New Born Baby cover. (Refer clause 4.1.4 B below & special conditions mentioned therein)	Medical expenses incurred on treatment taken in Hospital as an In-patient in respect of the new born baby from day one upto SI	Medical expenses incurred on treatment taken in Hospital as an In-patient in respect of the new born baby from day one upto SI.	Medical expenses incurred on treatment taken in Hospital as an In-patient in respect of the new born baby from day one upto SI	Medical expenses incurred on treatment taken in Hospital as an In-patient in respect of the new born baby from day one upto SI.
xi (a)	Assisted Reproduction Treatment. (Refer clause 4.1.5 below)	Not available	Not Available	Not Available	Cover as defined below in clause 4.1.5 below
xii (b)	Donor Expenses when Insured Person is Recipient. (Refer clause 4.1.8 below)	Maximum up to full Sum Insured	Maximum up to full Sum Insured	Maximum up to full Sum Insured	Maximum up to full Sum Insured
xiii.	Donor Expenses when Insured Person is DONOR. (Refer clause 4.1.7 below)	lump sum payment of 10% of Sum Insured	lump sum payment of 10% of Sum Insured	lump sum payment of 10% of Sum Insured	lump sum payment of 10% of Sum Insured
xiv.	Restoration of Sum Insured(Refer clause 4.2.2 below)	2 options-(i) 50% of the Sum Insured (ii) 100% of the Sum Insured	2 options-(i) 50% of the Sum Insured (ii) 100% of the Sum Insured	Not available	Not available
xv	Medical Second Opinion for 11 specified major Illnesses - taken from anywhere in the world. (Refer clause 4.1.6 below)	Maximum Rs.5000 in a Policy period.	Maximum Rs.10,000 in a Policy period	Maximum Rs.15,000 in a Policy period	Maximum Rs.25,000 in a Policy period

xvi	Air Ambulance Cover (Refer Clause 4.1.9 below)	Not available	Not available	Not available	Maximum upto 5% of the SI for medical emergency cases only. Details as per Clause 1.9 of the policy document
xvii	Accidental Death Benefit and Total Permanent Disability cover (Refer clause 4.1.10 below)	Not available	Not available	Not available	10% of Sum Insured.
xviii	OPD benefit for Dental and Ophthalmic cover (Refer clause 4.1.11 below)	Not available	Not available	Not available	Maximum Rs. 5,000/- on reimbursement basis in a block of every three years.
xix.	Additional Sum Insured for critical illnesses (Details as per Clause 4.1.12 below)	Not available	Not available	Not available	Additional 10% SI for Critical Illnesses on exhaustion of base SI.
xx.	Maximum Entry Age	65yearsfor all members	65years for all members	65 years for all members	65 years for all members
xxi.	Pre and Post Hospitalization expenses	Medical expenses incurred 30 days prior to Hospitalization and up to 60 days post Hospitalization.			
	Compulsory co- payment	10% of each & every claim	NIL	NIL	NIL
	1. The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.				
	2. Relaxation to 24 hours minimum duration for Hospitalization is allowed in a. 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),Or b. Any other day care treatment as mentioned and for which prior approval from Company / TPA is obtained in writing.				
B.	DOMICILIARY HOSPITALISATION BENEFITS				

i.	Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines &Drugs, Diagnostic Material and Dialysis, Chemotherapy, Nursing expenses.	10% of Sum Insured, Maximum Rs.25000/- during the Policy Period.	Maximum Rs. 50,000/- during the Policy Period.	Maximum Rs. 50,000 during the Policy Period.	Maximum Rs. 50,000 during the Policy Period.
ii.	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. This will be part of Domiciliary Hospitalization limits as specified. For the purpose of this clause the conditions for Domiciliary Hospitalization benefit shall not apply.			

i.

4.1.1 DOMICILIARY HOSPITALIZATION benefit shall, however, not cover expenses in any of the following cases:

A. if the treatment lasts for a period of three days or less
B. incurred on treatment of any of the following diseases:

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

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

4.1.2 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, as mentioned above.

4.1.3 ATTENDANT ALLOWANCE When an Insured Person above the age of 90days and up to the age of 10 years is Hospitalized and a claim is admitted under the GOLD or DIAMOND or PLATINUM plan of the Policy, a sum as mentioned above will become payable under the Policy.

4.1.4 MATERNITY EXPENSES UNDER DIAMOND & PLATINUM PLAN AND NEW BORN BABY COVER UNDER ALL PLANS

A. 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. This benefit is applicable only in Diamond and Platinum Plan, and available only to the Insured or his spouse, provided that:

i. Diamond / Platinum Plan 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. Company's maximum liability per delivery or termination shall be limited to 2.5% of the Sum Insured as stated in the Schedule and in no case shall the Company's liability under this clause exceed 2.5% of the Sum Insured, in any one Policy Period.

Special conditions applicable to Maternity Expenses

i. These benefits are admissible only if the expenses are incurred in Hospital/Nursing Homes as in-patients in India.

ii. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.

iii. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.

iv. Pre Hospitalization and Post Hospitalization benefits are not available under these two clauses.

v. Subject to the terms &conditions, the Policy covers New Born Baby from day 1 only on payment of requisite premium.

B.NEW BORN BABY COVER: New born Baby shall be covered from day one and Medical expenses incurred for treatment taken in Hospital as in patient shall be payable, subject to terms and conditions of the policy.

Special conditions applicable to New Born Baby Cover

i. These benefits are admissible only if the expenses are incurred in Hospital/Nursing Homes as in-patients in India.

ii. The Policy covers New Born Baby from day 1 only on payment of requisite premium.

iii. In case claim is spread over two Policy Periods, the aggregate liability of the Company, for all claims in respect of the New Born Baby, shall be limited to the Sum Insured of the Policy under which claim was reported

4.1.5 ASSISTED REPRODUCTION TREATMENT (ART) Assisted Reproduction Treatment is defined as the set of techniques and medical treatments that allow couples to start a family when it cannot be achieved naturally due to infertility problems. It should 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 Company will 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. Automatic Restoration of Basic Sum Insured, Recharge benefit shall not be applicable for this benefit.

v. If this benefit is opted by the insured, then exclusion under 5.17 will be deleted.

Note: To be eligible for this benefit both partners should stay insured continuously without break under this policy for every block. This coverage is available for Platinum Plan only. 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.

4.1.6 MEDICAL SECOND OPINION If the Insured Person is diagnosed with one of the specified major Illnesses listed below, and takes Medical Second Opinion (including opinion obtained from overseas)whether before starting the treatment or during the course of treatment, the Policy covers Medical Expert's fees to the extent given in clause above. Claim under this clause would be admissible subject to the Hospitalization claim being admissible. This expense is payable only once per Illness per Insured Person during the life time of the Insured Person.

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

4.1.7 ORGAN DONOR BENEFIT- WHEN INSURED PERSON IS THE DONOR A lump sum payment of 10% of Sum Insured, to take care of medical and other incidental expenses is payable to 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 (Happy Family Floater Policy-2021) having been continuously in force for at least 12 (twelve) months in respect of that Insured Person.

4.1.8 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.

4.1.9 AIR AMBULANCE COVER(Available for Platinum Plan Only) The policy covers Air Ambulance cost maximum up to 5% of the policy sum insured, provided that:

i. 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.

ii. Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency.

iii. It is prescribed by the Medical Practitioner and is medically necessary. iv. The insured person is in India.

v. The cover will be available in case of the following ailments:-

a. Cardio – Vascular diseases

b. Central nervous system related cases

c. Accidental Trauma Cases

vi. This cover can be availed only once during the entire policy lifetime.

vii. Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s.

4.1.10 ACCIDENTAL DEATH BENEFIT AND TOTAL PERMANENT DISABILITY (Available for Platinum Plan Only) If an insured person suffers an Accident during the policy period and this is the sole and direct cause of his death OR total permanent disability within 365 days from the date of the accident, then the policy will pay a fixed amount of 10% of the base sum insured. This benefit is not applicable for the dependent children covered in the policy. This benefit is in addition to the optional PA cover if opted by the insured.

4.1.11 OPD BENEFIT FOR DENTAL AND OPHTHALMIC COVER(Available only for platinum variant)(Refractive Error- Code- ExcI15 shall not apply for this benefit) The policy will reimburse OPD expenses Maximum up to Rs. 5,000 in a block of every three years for Dental and Ophthalmic care with respect of

i. Out-patient consultations by a medical practitioner.

ii. Diagnostic tests prescribed by a medical practitioner. iii.

Medicines/drugs prescribed by a medical practitioner.

4.1.12 ADDITIONAL SUM INSURED FOR CRITICAL ILLNESS(Available for Platinum Plan Only) If an insured person suffers from any critical illness as defined by the IRDAI during the policy period and the selected basic sum insured is exhausted in the treatment of that critical illness, then the basic sum insured shall be increased by 10%, only for treatment of the critical illness, provided that Diagnosis of the critical illness is supported by the clinical, radiological, histological and laboratory evidence acceptable to the company.

4.1.13 TELEMEDICINE Expenses incurred by insured on telemedicine/Tele-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 is maximum Rs. 2,000/- per family, for a policy period.

4.1.14 HIV/ AIDS COVER The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-Patient Care, Pre and Post Hospitalization Expenses related to HIV infection.

4.1.15 MENTAL ILLNESS COVER MENTAL ILLNESS COVER The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalization Expenses) only under certain conditions as:-

i. Illness covered under definition of mental illness mentioned under definitions clause*. ii.

Hospitalization in Mental Health Establishment as defined under definitions clause*. iii.

Hospitalization as advised by Mental Health Professional as defined under definitions clause*.

iv. Mental Conditions associated with the abuse of alcohol and drugs are excluded.

v. Mental Retardation and associated complications arising therein are excluded.

vi. 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.

* For starred items, please refer Specific Definitions.

4.1.16 ADVANCED TREATMENTS All the following procedures, will be covered in the policy, if treated as inpatient care or as a part of domiciliary hospitalization or as day care treatment in the hospital, within the sublimits in the complete policy period which is as defined below:

Name of the Procedure	Sub limits for suminsured slabfrom Rs.1.0 lac to Rs. 10.0 lacs	Sub limits for sum insured slab from Rs.12.0 lac to Rs. 50.0 lacs
A. Uterine Artery Embolization and HIFU	Per policy period: Up to INR 50,000.	
B. Balloon Sinuplasty	Per policy period: Up to INR 40,000.	

C. Deep Brain stimulation	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
D. Oral chemotherapy	Per policy period 25% of SI, subject to maximum INR 50,000.	Per policy period: Up to INR 1,50,000.
E. Immunotherapy- Monoclonal Antibody to be given as injection	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
F. Intra vitreal injections	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
G. Robotic surgeries	Per policy period 10% of SI, subject to maximum INR 1,00,000.*	Per policy period 10% of SI, subject to maximum INR 2,00,000.*
	*(The sub limit is on the cost incurred due to modern treatment methods of robotics and associated expenses and this amount is over and above the limit for conventional surgery for that ailment).	
H. Stereotactic radio surgeries	Per policy period 10% of SI, subject to maximum INR 1,00,000.	Per policy period 10% of SI, subject to maximum INR 2,00,000.
I. Bronchial Thermoplasty	Per policy period 10% of SI, subject to maximum INR 1,00,000.	Per policy period 10% of SI, subject to maximum INR 2,00,000.
J. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
K. IONM - (Intra Operative Neuro Monitoring)	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.	Per policy period 10% of SI, subject to maximum INR 50,000.	Per policy period 10% of SI, subject to maximum INR 1,50,000.

4.2 OPTIONAL COVERS

4.2.1 GEOGRAPHICAL EXTENSION TO SAARC COUNTRIES: The Policy can be extended to cover Insured Persons visiting other SAARC (South Asian Association for Regional Co-operation) countries - Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka. No additional premium will be charged for this extension. However, the Insured Person has to make a request for such extension, in writing, before leaving the country, duly informing the duration, purpose and country (ies) of visit. Endorsement for such extension will be issued by the Company. It is further stated that Cashless service will not be available for treatment taken in countries outside India and such claims, shall be considered only on re-imbursement basis.

4.2.2 Following coverage can be taken on payment of additional premium.

i. Amount payable under this section will be in addition to the Sum Insured.

ii. Co-payment will not apply on Personal Accident and Life Hardship Survival Benefit covers.

A. RESTORATION OF SUM INSURED: If during the Policy Period the Sum Insured gets reduced or exhausted on account of a claim under the Policy, the Sum Insured is automatically restored to the extent of the claim amount but not exceeding the Restoration limit opted (50% / 100% of Sum Insured) at the

inception of the Policy. The benefit is available only under Silver and Gold Plan.. The above is subject to the following:

i. Aggregate of all the restored amounts during the Policy Period shall not exceed 50% / 100% of the Sum Insured, as opted by the Insured.

ii. At no point of time during the Policy Period, will the available coverage be more than the Sum Insured mentioned in the Schedule. iii. Aggregate of all the claims payable for any one Insured Person under the Policy shall not be more than the Sum Insured.

iv. During a Policy Period, the maximum amount for any one claim payable shall be the Sum Insured and the aggregate of all claims payable shall not exceed the sum of the Sum Insured and Restored Sum Insured.

B. PERSONAL ACCIDENT COVER: (WORLD – WIDE): If at any time during the currency of the Policy, the Insured Person sustains any bodily Injury, resulting solely and directly from sudden, unforeseen and involuntary event caused by external, visible and violent means anywhere in the world, and if such Injury, within 12 months of its occurrence be the sole and direct cause of death or disability, as covered under the Policy, then the Company undertakes to pay to the insured or his nominee or in the absence of nominee, the legal heir, as the case may be, the following sums:

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

i. Overall liability in the event of one or more of the eventualities (listed above) occurring shall be restricted to the CSI of the Insured Person.

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

iii. Family Discount of 10% if more than one member is covered under this section.

Sl. No	Features / Plans	SILVER	GOLD	DIAMOND	PLATINUM
i	PERSONAL ACCIDENT (Refer 3.2.2(B))	CSI in multiples of Rs.1,00,000/- up to Rs.5,00,000/-per Insured Person aged 18 years and above. However, for Insured Person below 18 years of age maximum CSI of Rs.3lacs is allowed subject to this being lower than the CSI of the Insured	CSI in multiples of Rs.1,00,000/up to Rs.10,00,000/- per Insured Person aged 18 years and above. However, for Insured Person below 18 years of age maximum CSI of Rs.5lacs is allowed subject to this being lower than the CSI of the Insured	CSI in multiples of Rs.1,00,000/- up to Rs.15,00,000/- per Insured Person aged 18 years and above. However, for Insured Person below 18 years of age maximum CSI of Rs.10lacs is allowed subject to this being lower than the CSI of the Insured	CSI in multiples of Rs.1,00,000/- up to Rs.20,00,000/- per Insured Person aged 18 years and above. However, for Insured Person below 18 years of age maximum CSI of Rs.10lacs is allowed subject to this being lower than the CSI of the insured

EXCLUSIONS: The Company shall not be liable under the Personal Accident section for injuries/ death on account of

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

C. LIFE HARDSHIP SURVIVAL BENEFIT PLAN: If during the Policy Period, any Insured Person is diagnosed with any of the 11 critical Illnesses defined here under and which results in admissibility of a claim under the Policy, then a survival benefit as mentioned below, shall become payable to the Insured Person. However, this benefit shall not be available for the Illness which the Insured Person is already suffering from (irrespective of the stage of the disease) at the time of opting for this cover for the first time.

i. Limits under this section indicate the aggregate liability of the Company for one or more claims under the Policy in respect of one or all the Insured Persons covered under the Policy.

ii. Further, for a particular disease, the above benefit shall be paid only once during the lifetime of the Insured Person.

	Total amount payable	Amount payable on survival for 180 days and above from the date of discharge from the Hospital (the first discharge date when more than one Hospitalization is involved).	Amount payable on survival for 270 days and above from the date of discharge from the Hospital (the first discharge date when more than one Hospitalization is involved).	D. WAIVER OF
A	15 % of Sum Insured under the Policy	5% of the Sum Insured	10% of the Sum Insured	
B	25 % of Sum Insured under the Policy	10% of the Sum Insured	15% of the Sum Insured	

PROPORTIONATE DEDUCTION CLAUSE All related expenses (including Surgeon, anesthetist, medical practitioner, consultants, blood, anesthesia, OT, etc.) in the policy are payable as per the entitled room category based on the Room Rent/ ICU limit. By paying additional premium as explained below, the proportionate deductions related to the room rent category shall be waived as under:

i. For Silver Plan i.e. Sum Insured of Rs. 1.0 lac to Rs. 5.0 lacs, the room rent limit can be enhanced by maximum 50% on payment of additional premium.

ii. For Gold, Diamond and Platinum Plan i.e. Sum Insured of Rs. 6.0 lacs and above the room rent limit can be enhanced by 50% or 100%, as selected by the insured, on payment of additional premium as mentioned in the policy.

In above such cases, room rent and expenses in respect of I & ii above will be paid as per the enhanced room rent limit only, subject to other terms & conditions of the policy.

E. WAIVER OF 10 % CO-PAY under silver plan is available on payment of extra premium.

4.2.3 CRITICAL ILLNESSES COVERED:

A. CANCER OF SPECIFIED SEVERITY: A malignant tumor characterized by the uncontrolled growth &spread of malignant cells with invasion &destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy &confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma. The following are excluded –

i. Tumors showing the malignant changes of carcinoma in situ & tumors which are histologically described as premalignant or noninvasive, including but not limited to: Carcinoma in situ of breasts, cervical dysplasia CIN-1, CIN -2 & CIN-3.

ii. Any skin cancer other than invasive malignant melanoma

iii. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classificationT2N0M0.....

iv. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter

v. Chronic lymphocytic leukemia less than RAIstage3

vi. Micro carcinoma of the bladder

B. FIRST HEART ATTACK - OF SPECIFIED SEVERITY

i. The first occurrence of 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 this will be evidenced by all of the following criteria

 A history of typical clinical symptoms consistent with the diagnosis of Acute myocardial Infarction (for e.g. typical chest pain) New characteristic electro cardiogram changes

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

ii. The following are excluded:

 Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponins I or T

 Other acute Coronary Syndromes Any type of angina pectoris.

C. OPEN CHESTCABG

I. The actual undergoing of open chest Surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft(CABG).The diagnosis must be supported by a coronary angiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:

 Angioplasty and/or any other intra-arterial procedures

Any keyhole or laser Surgery.

D. OPEN HEART REPLACEMENT OR REPAIR OF HEARTVALVES 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 technique including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

E. COMA OF SPECIFIED SEVERITY

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

- No response to external stimuli continuously for atleast96 hours.
- Life support measures are necessary to sustain life ;and
- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

b. The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

F. KIDNEY FAILURE REQUIRING REGULARDIALYSIS: End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

G. STROKE RESULTING IN PERMANENTSYMPTOMS Any cerebrovascular incident producing permanent neurological squeal. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolization from an extra cranial 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. The following are excluded:

- Transient ischemic attack(TIA)
- Traumatic Injury of Brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

H. MAJOR ORGAN/BONE MARROWTRANSPLANT the actual undergoing of a transplant of one of the following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ, or Human bone marrow using hematopoietic stem cells. The undergoing of a transplant as to be confirmed by a specialist Medical Practitioner The following are excluded:

- Other stem cell transplants
- Where only islets of Langerhans are transplanted

I. PERMANENT PARALYSIS OFLIMBS 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 3months.

J. MOTOR NEURON DISEASE WITH PERMANENTSYMPTOMS 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 cortico-spinal 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.

K. MULTIPLE SCLEROSIS WITH PERSISTENTSYMPTOMS The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months ; and well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart. Other causes of neurological damage such as SlE are excluded.

5. 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

5.1 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 36 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

5.2 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.	3 Years
Xxiii	Age related osteoarthritis and Osteoporosis.	3 Years

*If the above diseases are pre-existing at the time of inception, Exclusion no.5.1 for pre-existing disease shall be applicable.

5.3 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 5.1., 5.2, 5.3 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 5.1, 5.2 and 5.3 shall apply afresh on the enhanced portion of the Sum Insured.

5.4 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.

5.5 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.

5.6 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.

5.7 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.

5.8 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.

5.9 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 limited to, parajumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

5.10 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.

5.11 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.

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

5.13 Code- ExcI13 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.-

5.14 Code- ExcI14 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.-

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

5.16 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.

5.17 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 platinum plan up to the limits mentioned therein.

iii. Gestation Surrogacy

iv. Reversal of sterilization.

5.18 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 above exclusion does not apply for diamond and platinum plan.

SPECIFIC EXCLUSIONS:-

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

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

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

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

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

5.24 Vaccination or Inoculation. Vaccination or inoculation unless forming part of treatment and requires Hospitalization, except as and to the extent provided for under Section 3.1.10 (Anti Rabies Vaccination) and Section 3.1.11.iv (Maternity).

5.25 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.

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

Out Patient Department (OPD) Any expenses incurred on OPD (Except OPD benefit for Dental and Ophthalmic cover in Platinum Plan).

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

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

5.29 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-II).

5.30 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.

5.31 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-II) and any medical equipment which could be used at home subsequently.

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

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

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

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

5.36 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 death.

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.

5.37 Treatment taken outside the geographical limits of India

5.38 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 code as listed below:

Disease	ICD Code
Sarcoidosis	D86.0-D86.9
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• C40C41 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 • D10D36 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
Epilepsy	G40 Epilepsy
Heart Ailment Cor heart disease and v 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.

Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
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.
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)
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
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
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;
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.
Demyelinating disease	G.35 to G 37

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
Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
Avascular necrosis (osteonecrosis)	M 87 to M 87.9

5.39 Compulsory Co-Payment: Under the SILVER plan the insured has to bear 10% of admissible claim Amount in each and every claim.

6 TERMS & CLAUSES

STANDARD GENERAL TERMS & CLAUSES

6.1 DISCLOSURE OF INFORMATION: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder. (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)

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

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 receipt of last necessary document.
- 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)

6.3 COMPLETE DISCHARGE: Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall be a valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

6.4 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.

6.5 CANCELLATION CLAUSE:
Cancellation by insured - Any time during the term, by giving 7 days' notice in writing. Refund by Insurer :

a. proportionate premium for unexpired policy period, in case of Annual policies, subject to no claim (s)having been made during the policy period.

b. 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 grounds of misrepresentation non- disclosure.

6.6 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

6.7 FREE LOOK PERIOD: The free look period shall be applicable on new individual health insurance Policies and not on renewals or at the time of porting/migrating the policy.the insured person shall be allowed free look period of 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.

Also, as a onetime option, the Insured who have, upon renewal, got the Happy Family Floater Policy 2021, for the first time, will also get the option of the free look period as stated above.

6.8 RENEWAL OF POLICY: The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person and non-disclosure by the insured person

- The company shall endeavor to give notice for renewal 30 days in advance
- 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.

6.9 PORTABILITY: The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 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

6.10 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.

6.11 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 proven fraud. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

6.12 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.

6.13 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.**

6.14 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.

6.15 NOMINATION: The policyholder is required at the inception of the policy to make a nomination and can be changed at any time during the term of the policy for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. Ill the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

SPECIFIC TERMS & CLAUSES:-

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

6.17 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.

6.18 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.

For Silver Plan, the premium in the policy will be charged on the basis of the 2 Zones, as defined below:
Zones are as defined below:

Zone I	Gujarat, Mumbai, Greater Mumbai, and Delhi NCR
Zone II	Rest of India

Insured Person can choose the Zone at the time of proposal, and can also change it at the time of renewal.
For other Plans, I.e. Gold, Diamond and Platinum Plans the premium rates will be same Pan India.

6.19 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.

6.20 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 filmetcsupported 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 60 days) all supporting claim papers / documents as listed above should also be submitted within 15 days from completion of such treatment (upto 60 days or actual period whichever is less) to the Company / T.P.A. in addition insured 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.

6.21 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 the person 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 of the 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 / TPA before 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

6.22 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.

  - PAYMENT OF CLAIM: All medical treatment for the purpose of this insurance will have to be taken in India only (except where the Policy has been extended to SAARC countries) and all claims shall be payable in Indian currency only. For the purpose of claims settlement, currency conversion rate on the date of admission to Hospital would apply. 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.

- **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 by the insured person(known as Primary insurer) shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- 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.
  - **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.
  - **Benefit Based Policies:** On occurrence of the insured event, the policyholders can claim from all Insurers under all policie.

6.25 CLAIM FALLING IN TWO POLICY PERIODS: If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Periods, including the Deductibles for each Policy Period. Such eligible claim amount to be payable to the Insured, shall be reduced to the extent of premium to be received for the renewal/due date of premium of Health Insurance Policy, if not received earlier.

6.26 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 Divisional 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 5.11 (i), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims uptoRs.50lacs.

6.27 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

6.29 FAMILY SIZE: Minimum two persons (falling within the definition at 3.15) to be covered under the Policy. Persons becoming ineligible on account of above provision for coverage under the existing Policy, may migrate to another suitable Policy at the expiry of this Policy. Upon such migration, the credits gained by the concerned Insured Person, for pre-existing conditions and time-bound exclusions shall be transferred to the migrated Policy, provided the Policy has been maintained without a break.

6.30 SUM INSURED: Policy has four Plans-Silver Plan-Sum Insured uptoRs.5lacs, Gold Plan up to Rs.10 lakhs, Diamond Plan up to Rs.20lacs and Platinum Plan up to Rs. 50 lakhs.

6.31 ENTRY AGE: Maximum Entry Age under the Policy is 65years for all members. However, with a compulsory co-payment of 20% of each and every claim, persons above the age of 65 and up to 70 years of age can also be covered under Silver or Gold Plan, but not under Diamond and Platinum Plan. For such Insured Persons the co- payment will apply in all subsequent Renewals also.

6.32 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 1 day of birth or at the time of renewal of the Policy.

For members subsequently added, Exclusion No. 5.1, 5.2 and 5.3 shall apply from the date of their inclusion in the Policy.

6.33 NO CLAIM DISCOUNT /LOADING: This is a one-time benefit for those Insured Persons covered under Happy Family Floater Policy. Happy Family Floater Policy had the provision of No Claim Discount / Loading, which has been discontinued under Happy Family Floater Policy-2015.However, The discount on account of 'No Claim' that would have been earned by the Insured on renewal of the Happy Family Floater Policy, would be allowed when the Policy is renewed for the first time, into Happy Family Floater Policy-2021. However, there will be no change in discount even if there are no claims reported under the subsequent Happy Family Floater Policy-2021 Policy (ies). This discount shall continue till a claim is reported under the Policy and upon reporting of a claim, any discount earned on account of 'No Claim' shall be forfeited. However, claim under PA section will not affect NCD earned thus far. The insured persons with claim loading(s) on their previous policies will not have any loading on the premium on renewal into Happy Family Floater Policy -2021, i.e. loadings on account of claims are discontinued.

6.34 ENHANCEMENT OF SUMINSURED: Increase in Sum Insured under the Policy may be considered by the Company only at the time of renewal. If at all allowed, increase shall be as given below:

- On renewal, Sum Insured can be increased to the immediate higher slab.
- If, on renewal, the size of the family increases, Sum Insured can be increased to maximum two slabs higher.
- If there are no claims reported in the two immediate preceding Policy Periods, change to the next Plan (Silver to Gold, Gold to Diamond and Diamond to Platinum) at the initial SI slab, or two steps higher from the current SI, whichever is more, is allowed at the option of Insured.
- Change of Plan is not allowed for a Policy covering any person above the age of 70 years. However, Increase in Sum Insured within the same Plan is allowed as per above provisions.
- Notwithstanding above provisions, no increase in Sum Insured is allowed in policies where there are claims reported in two successive Policy Periods.

6.35 PROPORTIONATE CLAUSE - If the Insured Person is admitted in the hospital in a room where the room category or the Room Rent incurred is higher than the eligibility as specified in the Policy Schedule/ Certificate of Insurance, then the Policyholder/ Insured Person shall bear a ratable proportion of the total & specified Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to the Room Rent actually incurred. However, this will not be applicable in respect of Medicines/Pharmacy/ Drugs, Consumables, Medical Devices/ implants and Cost of Diagnostics.

6.36 ASSOCIATED MEDICAL EXPENSES:

- Doctor's fees / Consultant fees/RMO fees
- Nursing expenses including administration charges/ transfusion charges/ injection charges
- Surgeon fees / Asst Surgeon fees
- Anesthesia fees
- Procedure charges of any kind which includes :- □ 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.

6.37 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.

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

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

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

6.41 DISCOUNT ON OMP PREMIUM: A discount of 15% on the premium of Overseas Mediclaim Policy would be allowed when an Insured Person covered under this Policy, takes the Overseas Mediclaim Policy from the Company, provided this Policy is valid as on the date of taking the Overseas Mediclaim Policy of the Company.

6.42 ON-LINE 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.

6.43 PRE -ACCEPTANCE MEDICAL CHECKUP: Any person above the age of 60 years proposing to take insurance cover for the first time under Silver or Gold Plan, and above the age of 55 years under Diamond or Platinum Plan, has to submit following medical reports, or any other additional medical report(s) required by the Company, from listed Diagnostic Centers. Pre-Acceptance Medical Check-up is required in case of fresh proposals and in cases where there has been a break in the Policy Period. Also, based on the information provided in the Proposal Form, the Company may require any proposed member, irrespective of his/her age, to undergo medical tests.

The list of Diagnostic centres is available with the underwriting office from where the Policy is intended to be taken. The cost shall be borne by the insured.

- MEDICAL EXAMINATION
- CBC WITH ESR
- LIPID PROFILE
- HbA1c

- S.CREATININE
- URINE-ROUTINE & MOLECULAR
- ECG 8 TSH
- X-RAY CHEST
- USG
- EYE EXAMINATION-FUNDUS & GLAUCOMA

In case of fresh proposals 50% cost of Medical Check up shall be reimbursed if the proposal has been accepted by the Company. This benefit will also be allowed in cases where continuity benefits are not restored and the Policy is treated as fresh (and not as renewal) after the break in Policy Period. Validity period of medical reports is up to 30 days from the date of proposal.

6.44 IRDAI REGULATION: **IRDAI REGULATION:** This Policy is subject to IRDAI (Protection of Policy holders' interest) Regulation, 2024, IRDAI (Insurance Product) Regulation, 2024 and IRDAI (Health Insurance) Regulations 2024, as amended from time to time.

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

6.46 HOW TO APPLY FOR INSURANCE: The Proposer has to complete the Proposal Form and Enrolment Form in duplicate and submit Insured Person's details of each member. The proposer has to affix colored stamp size photographs of each of the members to be insured on the Enrolment Form against the name of the person. These photographs will be utilized by Third Party Administrator for preparing ID card for each of the members insured.

The Prospectus contains salient features of the Policy. For details, reference is to be made to the Policy. In case of any difference between the Prospectus and the Policy, the terms and conditions of the Policy shall prevail. The Prospectus and Proposal Form are part of the Policy. Hence please read the Prospectus carefully and sign the same. The Proposal Form is to be completed in all respects for each insured Person. Both the Prospectus and the Proposal Form are to be submitted to the office or to the agent.

Name: Signature

Address:

Place: Date:

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

INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938 provides as follows:

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

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

PREMIUM SCHEDULE - HAPPY FAMILY FLOATER POLICY – 2024

Zone 1 - Silver Plan(Exclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Silver	100,000	1391	2305	2714	3304	3481	5767	7391	9401	11208	12303	12594
Silver	200,000	1939	3328	4022	4881	5384	8673	11736	15248	17232	18573	20122
Silver	300,000	2444	4046	5065	6436	7121	11381	15807	19811	22712	24166	25774
Silver	400,000	2927	4556	6032	7900	8706	13729	18195	22774	25932	27564	29376
Silver	500,000	3377	4952	6935	9098	10071	15718	20310	25371	28584	30337	32429

Zone 1 - Silver Plan(Inclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Silver	100,000	1642	2721	3202	3899	4108	6805	8722	11094	13226	14518	14861
Silver	200,000	2288	3927	4746	5760	6353	10234	13848	17993	20334	21916	23745
Silver	300,000	2884	4774	5976	7595	8403	13429	18652	23377	26801	28517	30413
Silver	400,000	3453	5376	7118	9323	10273	16200	21471	26874	30600	32526	34663
Silver	500,000	3985	5843	8183	10735	11883	18547	23966	29938	33729	35798	38266

Zone 2 - Silver Plan(Exclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Silver	100,000	1265	2172	2614	3149	3338	5426	7169	8820	10552	11556	11894
Silver	200,000	1873	3157	3884	4738	5230	8486	11393	14459	16895	17682	18944
Silver	300,000	2288	3800	4828	6283	7009	11370	15499	18410	22009	22134	24352
Silver	400,000	2771	4320	5883	7690	8645	13612	17909	21730	24924	25982	27177
Silver	500,000	3201	4743	6710	8591	10065	15705	19895	24994	27848	28886	30318

Zone 2 - Silver Plan(Inclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Silver	100,000	1493	2564	3085	3716	3938	6403	8459	10408	12452	13636	14035
Silver	200,000	2209	3725	4582	5591	6172	10013	13443	17062	19936	20865	22354
Silver	300,000	2700	4483	5696	7414	8270	13417	18288	21724	25971	26117	28735
Silver	400,000	3270	5097	6941	9074	10201	16062	21132	25641	29410	30660	32069
Silver	500,000	3778	5596	7918	10138	11877	18531	23475	29492	32861	34085	35776

Gold Plan(Exclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Gold	600,000	3862	5730	8245	11649	12776	19583	25058	32061	35897	37770	40852
Gold	700,000	4235	6373	9288	13616	14841	22238	28441	36475	40745	42697	45889
Gold	800,000	4570	7005	10278	15174	16503	24403	31293	39823	44228	46247	49552
Gold	900,000	4895	7482	11263	16688	18116	26367	33738	42412	46910	48998	52425
Gold	1,000,000	5211	7908	12240	18087	19624	28299	36111	44884	49441	51614	55127

Gold Plan(Inclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Gold	600,000	4557	6761	9729	13746	15076	23108	29568	37833	42358	44568	48205
Gold	700,000	4997	7520	10960	16068	17513	26241	33561	43040	48080	50383	54149
Gold	800,000	5393	8267	12127	17905	19473	28796	36926	46991	52189	54571	58472
Gold	900,000	5776	8829	13290	19692	21377	31113	39810	50046	55355	57817	61861
Gold	1,000,000	6150	9331	14443	21343	23157	33392	42610	52963	58341	60904	65050

Diamond Plan(Exclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Diamond	1,200,000	5800	8768	14108	20781	22442	32206	40597	49508	54114	56392	60046
Diamond	1,500,000	6612	10076	16549	24242	26047	36856	45718	54738	59408	61834	65696
Diamond	1,800,000	7398	11360	18752	27097	29034	40665	49826	58900	63605	66204	70930
Diamond	2,000,000	7883	12207	19998	28693	30761	42898	52200	61302	66023	68721	74987

Diamond Plan(Inclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Diamond	1,200,000	6844	10346	16648	24522	26482	38003	47904	58420	63854	66542	70854
Diamond	1,500,000	7802	11890	19528	28605	30735	43490	53947	64590	70102	72964	77522
Diamond	1,800,000	8730	13405	22128	31975	34261	47984	58795	69503	75054	78121	83697
Diamond	2,000,000	9302	14404	23597	33858	36298	50620	61596	72336	77908	81091	88484

Platinum Plan(Exclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Platinum	2,500,000	10499	15252	23922	33548	35966	49428	59111	68469	73352	76372	83060
Platinum	3,000,000	11459	16276	25448	35716	38421	52654	62395	71806	76732	79983	87950
Platinum	4,000,000	12289	17382	27196	38336	41572	56448	66298	75763	80770	84485	92610
Platinum	5,000,000	12858	18175	28191	39890	43428	58378	69168	78682	83740	87858	97088

Platinum Plan(Inclusive GST)

Premium figures in INR

Plan	SI/Age Band	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-50 yrs	Age is 51-55 yrs	Age is 56-60 yrs	Age is 61-65 yrs	Age is 66-70 yrs	Age is 71-75 yrs	Age is 76-80 yrs	Age is above 80 yrs
Platinum	2,500,000	12389	17998	28228	39587	42439	58325	69750	80794	86555	90119	98011
Platinum	3,000,000	13521	19206	30028	42145	45337	62131	73626	84731	90543	94380	103781
Platinum	4,000,000	14500	20511	32091	45237	49054	66609	78231	89400	95309	99692	109279
Platinum	5,000,000	15172	21446	33265	47069	51245	68886	81618	92844	98814	103673	114564

Computation of Office Premium shall continue in the same manner as before:

- Charge 100% premium for the primary and secondary members
- Charge 50% premium for the tertiary member i.e. give a discount of 50% on third member's premium
- Charge 40% premium for other members i.e. give a discount of 60% on additional members' premium
- Eldest member of the family is the primary member. Second eldest is secondary member, while third eldest is the tertiary member.

Add-on covers:

Restoration of SI:

	Office Premium Restoration of SI (% applicable on base product office premium)	
Sum Insured	Option 1: 50%	Option 2: 100%
1 Lac	15%	25%
2-4 Lacs	12%	22%
5-10 Lacs	10%	18%

Waiver of proportionate clause:

	Office Premium Waiver of Proportionate Clause (% applicable on base product office premium)	
Plan	Option 1: 50%	Option 2: 100%
Silver	20%	-
Gold	15%	30%
Diamond	15%	25%
Platinum	15%	25%

Removal of Co-Pay:

Plan	Office Premium Removal of Co-Pay (% applicable on base product office premium)
Silver	17%

Personal Accident:

- Premium Rate: Rs.60 per lac per person.

Life Hardship Survival Benefit:

Plan	Premium
Plan A	3% of Total Basic Premium
Plan B	5% of Total Basic Premium

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