



HAPPY FAMILY FLOATER POLICY

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

NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that, if during the period stated in the Schedule any insured Person(s) shall contract or suffer from any of the diseases /illness / ailment (hereinafter called 'DISEASE') or sustain any bodily injury through accident (hereinafter called 'INJURY')

AND

if such disease or bodily injury shall require any such insured person(s) upon the advice of a duly qualified Physician / Medical Specialist/Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') to incur (a) hospitalisation expenses for medical/surgical treatment at any Nursing Home/Hospital in **India** as herein defined (hereinafter called 'HOSPITAL') as an inpatient OR, (b) domiciliary treatment **in India** under Domiciliary Hospitalisation Benefits as hereinafter defined, the TPA/ Company shall reimburse to the Hospitals (only if treatment is taken at Network Hospital(s) with prior written approval of TPA/Company) or to the insured person(s) (if payment to the hospital is not agreed to or the insured person(s) opts for reimbursement of the claim) the amount of such expenses as are reasonably and necessarily incurred in respect thereof by or on behalf of such insured person(s) up to the limit of liability specified in the policy and or schedule of the policy but not exceeding the sum insured in any one period of insurance for one or all the family member(s) stated in the schedule hereto.

The benefits under this policy are available under either of the two plans, viz Silver or **Gold** as opted by the proposer in the proposal form.

1.2 COVERAGE UNDER THE POLICY

The following reasonable and customary expenses (subject to limits) are payable under the policy for various benefits:

A.	HOSPITALISATION BENEFITS		
BENEFIT	SILVER PLAN (Limit of Reimbursement)	GOLD PLAN (Limit of Reimbursement)	

a.	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.	Not exceeding 1 % of the Sum Insured per day	Not exceeding 1 % of the Sum Insured per day.
b.	Intensive Care(IC) Unit Expenses as provided by the Hospital /Nursing Home.	Not exceeding 2% of the Sum Insured per day.	Not exceeding 2% of the Sum Insured per day.
	No of days of stay under a and b above should not exceed total number of days of admission in the hospital.		
c.	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of the sum insured.	As per the limits of the sum insured.
d.	Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & and similar expenses.	As per the limits of the sum insured.	As per the limits of the sum insured.
e.	Ambulance services charges as defined hereinafter under 2.5	Rs.1,000/- per illness and limited to maximum 1% of the sum insured or Rs. 3,000/- whichever is less, for the entire policy period.	Rs.2,000/- per illness and limited to maximum 1% of the sum insured or Rs. 6,000/- whichever is less, for the entire policy period.
f.	DAILY HOSPITAL CASH ALLOWANCE, AS DEFINED HEREINAFTER under 3.19	NIL.	0.1% of sum insured per day per illness subject to a maximum compensation for 10 days per illness. The overall liability of the Company during the policy period will be limited to 1.5% of the sum insured.
g.	Attendant allowance as hereinafter defined under 3.20	NIL	Rs.500/- per day of hospitalisation per illness and upto 10 days per illness. The overall liability of the Company during the policy period will be limited to compensation for 15 days of hospitalisation.
B.	DOMICILIARY HOSPITALISATION (AS DEFINED HEREINAFTER)		
a.	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 policy period.	Rs.50000/-, during policy period.

b.	Treatment for Dog bite (or bite of any other rabid animal like monkey, cat etc.)	Reasonable expenses limited upto Rs.5,000/- actually incurred for immunisation injections in any one policy	Reasonable expenses limited upto Rs.5,000/- actually incurred for immunisation injections in any one policy
NOTE: FOR THE PURPOSE OF THIS SECTION THE PRE-REQUISITE CONDITIONS FOR DOMICILIARY HOSPITALISATION CLAIM SHALL NOT APPLY.			

1.3. Hospitalization / nursing home charges, surgery, medicines, drugs, pathological tests etc. incurred for donating an organ by the donor to the insured person during the course of organ transplant shall also be payable under this policy. However, cost of organ is not payable / reimbursable under the policy.

1.4 Company's overall Liability in respect of all claims admitted under sections 1.2 and 1.3 during the Period of insurance shall not exceed the Sum Insured per Family mentioned in the Schedule.

1.5 REGISTRATION CHARGES: are not payable under either silver or gold plans.

1.6 ADD ON COVERS (OPTIONAL, SUBJECT TO EXTRA PREMIUM)

	ITEM	SILVER PLAN	GOLD PLAN
a.	PERSONAL ACCIDENT as defined hereinafter 3.22	Sum insured in multiples of Rs.1,00,000/- and upto Rs.5,00,000/- per person aged 18 years and above . 50% of this limit for persons less than 18 years.	Sum Insured in multiples of Rs.2,00,000/-, and upto Rs.10,00,000/- per person aged 18 years and above. 50% of this limit for persons less than 18 years.
b.	LIFE HARDSHIP SURVIVAL BENEFIT AS DEFINED HEREINAFTER 3.21	NIL	Plans of benefit AS DEFINED HEREINAFTER

2. DEFINITIONS:

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

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

The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest and / or recuperation, a place for the aged persons, a rehabilitation centre for drug addicts or alcoholics, a hotel or a similar place.

Note: In case of Ayurvedic / Homeopathic / Unani treatment, the liability of the Company SHALL be restricted to 10% of the Sum Insured for the entire policy period for the family as a whole if the treatment is taken in hospitals other than Government hospitals and Medical college hospitals.

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

2.3 HOSPITALISATION PERIOD: Expenses on Hospitalisation are admissible only if hospitalisation is for a minimum period of 24 (twenty four) hours. However,

(A) This time limit SHALL not apply to following specific treatments taken in the Network Hospital / Nursing Home where the Insured is discharged on the same day. Such treatment SHALL be considered to be taken under Hospitalisation Benefit.

- i. Dialysis (haemo dialysis, Peritoneal dialysis)
- ii. Parental Chemotherapy (injectible)
- iii. Radiotherapy,
- iv. Eye Surgery,
- v. Lithotripsy (kidney stone removal),
- vi. Tonsillectomy,
- vii. Dilation and Curettage (D&C)
- viii. Dental surgery following an accident
- ix. Hysterectomy
- x. Coronary Angioplasty
- xi. Coronary Angiography
- xii. Surgery of Gall bladder, Pancreas and bile duct
- xiii. Surgery of Hernia
- xiv. Surgery of Hydrocele.
- xv. Surgery of Prostrate.
- xvi. Gastrointestinal Surgery.
- xvii. Genital Surgery.
- xviii. Surgery of Nose.
- xix. Surgery of throat and ear.
- xx. Surgery of Appendix.
- xxi. Surgery of Urinary System.
- xxii. Treatment of fractures / dislocation excluding hair line fracture, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalisation.
- xxiii. Arthroscopic Knee surgery.
- xxiv. Laproscopic therapeutic surgeries.
- xxv. Any surgery under General Anaesthesia.
- xxvi. Any such disease / procedure agreed by TPA/Company before treatment.

(B) Further if the treatment / procedure / surgeries of above diseases are carried out in Day Care Centre, which means any institution established for day care treatment of illness and / or injuries OR a medical set -up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-

1. has qualified nursing staff under its employment,
 2. has qualified medical practitioner (s) in charge,
 3. has a fully equipped operation theatre of its own, where surgical procedures are carried out-
 4. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel,
- the requirement of minimum beds is overlooked.

(C) This condition of minimum 24 hours Hospitalisation will also not apply provided,

medical treatment, and/or surgical procedure is:

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

2.4 DOMICILIARY HOSPITALISATION BENEFIT:

Domiciliary hospitalization means medical treatment for a period exceeding three days for such 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:

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

Subject however to the condition that Domiciliary Hospitalisation benefit shall not cover

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

2.5 AMBULANCE SERVICES: Means ambulance service charges reasonably and necessarily incurred in case the insured person is to be shifted from residence to hospital or from one hospital to another hospital. The ambulance service charges are payable only if the hospitalisation expenses are admissible. Further the ambulance service charges are admissible only if such expenses are paid to registered ambulance services providers.

3. OTHER DEFINITIONS AND INTERPRETATIONS:

3.1 INSURED PERSON: Means Person(s) named on the schedule of the policy which includes family comprising of the proposer, his /her legally wedded spouse, dependent unemployed children between 3 (three months) to the age of 25 years, unmarried daughters including divorcee, and widowed daughters and dependent Parents or parents-in-law (either of them only). The minimum number of persons to be covered under the policy shall be the proposer plus one family member.

3.2 ENTIRE CONTRACT: This policy, schedule, proposal/ declaration given by the insured constitute a complete contract. Only Insurer may alter the terms and conditions of the policy and such alterations made by the insurer shall only be evidenced by a duly signed endorsement on the policy with the Company stamp.

- 3.3 TPA (THIRD PARTY ADMINISTRATOR):** means any company / body who has obtained licence from IRDA to practice as a third party administrator and is appointed as TPA by the Company.
- 3.4 NETWORK PROVIDER:** means hospitals or healthcare providers enlisted by an insurer, or by a TPA and insurer together, to provide medical services to an insured on payment , by a cashless facility.
- 3.5 HOSPITALISATION PERIOD:** The period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24 hours except for specified procedures/ treatment where such admission could be for a period of less than 24 consecutive hours.
- 3.6 PRE-HOSPITALISATION:** Medical Expenses incurred during the period upto 30 days prior to the date of admission, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- 3.7 POST-HOSPITALISATION:** Medical Expenses incurred for a period upto 60 days from the date of discharge from the hospital, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- 3.8 MEDICAL PRACTITIONER:** A Medical practitioner is a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
- 3.9 QUALIFIED NURSE:** Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
- 3.10 PRE EXISTING HEALTH CONDITION OR DISEASE:** Any condition, ailment or injury or related condition(s) for which the insured had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months prior to the first policy issued by the insurer.
- 3.11 IN-PATIENT:** 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.
- 3.12 REASONABLE AND CUSTOMARY CHARGES:** 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 .

For a networked hospital means the rate pre-agreed between Network Hospital and the TPA / Company, for surgical / medical treatment that is necessary for treating the insured person who was hospitalized.

NOTE: Any expenses other than the above have to be borne by the insured person himself.

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

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

3.15 CO-PAYMENT: A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

3.16 HOSPITALISATION: Means admission in a Hospital for a minimum period of 24 in patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

3.17 ILLNESS: Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

a Acute condition - 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:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms—it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

3.18 INJURY

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

3.19 MEDICAL ADVICE

Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

3.20 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.

3.21 PRE EXISTING HEALTH CONDITION OR DISEASE: Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer.

3.22 CONGENITAL ANOMALY

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 is called Internal Congenital Anomaly

b. External Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly.

3.23 LIMIT OF INDEMNITY: means the amount stated in the schedule which represents maximum liability for any and all claims admissible during the policy period in respect of that insured family.

3.24 ANY ONE ILLNESS: Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation OR 105 days from the date of discharge, whichever is earlier, from the Hospital/Nursing Home where treatment may have been taken.

3.25 PERIOD OF POLICY: This insurance policy is issued for the period as shown in the schedule.

3.26 DAILY HOSPITAL CASH ALLOWANCE: When an insured member of the family is hospitalized and a claim is admitted under the GOLD plan of the policy, then the insured person SHALL be paid a daily cash allowance as specified in section 1.2 A f of the policy.

3.27 ATTENDANT ALLOWANCE: When an insured member of the family aged between three months to 10 years is hospitalized and a claim is admitted under the GOLD plan of the policy, a sum as mentioned in the table of benefit under 1.2 A g will become payable under the policy.

3.28 LIFE HARDSHIP SURVIVAL BENEFIT: If this benefit is opted for (under the GOLD plan only), and if a claim for the specified diseases listed hereunder is admitted under section 1.2 A of the policy, then a survival benefit as mentioned hereunder, SHALL be paid the insured.

DISEASES COVERED:

1. Cancer of Specified Severity: A malignant tumour characterised 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. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, 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 tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.....

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

v. Chronic lymphocytic leukaemia less than RAI stage 3

vi. Microcarcinoma of the bladder

vii. All tumours in the presence of HIV infection.

2. End Stage Renal Disease (ESRD): 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.

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

The following are excluded:

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

Benefits:

Plan	Total amount payable	Amount payable on survival for 180 days and above from the date of discharge from the hospital (the first discharge date in case of more than one hospitalisations are involved).	Amount payable on survival for 270 days and above from the date of discharge from the hospital (the first discharge date in case of more than one hospitalisations are involved).
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

The limit of liability SHALL be applicable for all the insured persons severally or jointly. The benefit under this section shall be paid only once under this policy or subsequent renewal

3.29 PERSONAL ACCIDENT COVER: (WORLD – WIDE)

SCOPE OF COVER:

If at any time during the currency of the policy the insured sustains any bodily injury resulting solely and directly from sudden, unforeseen and involuntary event caused by external, visible and violent means anywhere in the world, then the Company undertakes to pay the insured or the nominee or the legal personal representative in the absence of nominee, as the case may be, the following sums :

<u>BENEFIT COVERED</u>	<u>DESCRIPTION</u>	<u>AMT. PAYABLE</u>
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 the insured becoming totally disabled in engaging in any Employment or Occupation whatsoever. 100 % of CSI

The overall liability in the event of one or more of the eventualities occurring SHALL be restricted to the CSI.

CSI means capital sum insured opted for the personal accident section

EXCLUSIONS: THE COMPANY SHALL NOT BE LIABLE UNDER Personal Accident benefits for injuries / death on account of:

- a) Self - injury, suicide or attempted suicide.
- b) Whilst under the influence of alcoholic drinks or drugs.
- c) Engaging in aviation activities other than travelling as a passenger (in a duly licensed standard type of aircraft) anywhere in the world.
- d) Venereal disease or insanity.
- e) Whilst committing any breach of law with criminal intent.
- f) War and allied perils.
- g) Nuclear explosion.
- h) Pregnancy, childbirth or consequences thereof.

3.30 NO CLAIM DISCOUNT / LOADING: A discount of 5% on the premium, in respect of each claim free year, subject to a maximum of 20 % SHALL be allowed provided the policy is renewed with the company without any break. In case any claim is admitted under the policy, the entire No Claim Discount earned SHALL be forfeited in the next renewal of the renewal of the policy. However, the No Claim Discount SHALL continue to accrue afresh from the next claim free year.

In case any claim is admitted under the policy, where No Claim Discount has not accrued or the earned No Claim Discount has been forfeited, a loading SHALL be levied on the renewal premium @5% for each claim occurred year subject to a maximum of 20%.

The position of No Claim Discount (NCD) / Loading on premium SHALL be as per illustration below:

Status of No Claim Discount (NCD) /Loading in the expiring policy	In the event of NO CLAIM , the position of No. Claim Discount (NCD) / Loading in renewal policy	In the event of CLAIM , the position of No. Claim Discount (NCD) / Loading in renewal policy
0 % NCD / Loading	5 % NCD	5 % Loading
5 % NCD	10 % NCD	0 % NCD / Loading
10 % NCD	15% NCD	0 % NCD / Loading
15 % NCD	20% NCD	0 % NCD / Loading
20 % NCD	20% NCD	0 % NCD / Loading
5 % Loading	0 % NCD / Loading	10 % Loading
10 % Loading	5 % Loading	15 % Loading

15 % Loading	10 % Loading	20 % Loading
20 % Loading	15 % Loading	20 % Loading

3.31 GRACE PERIOD: It 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 no premium is received.

4. EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 Pre-existing health condition or disease or ailment / injuries

Any ailment / disease / injuries / health condition which are pre-existing (treated / untreated, declared / not declared in the proposal form), in case of any of the insured person of the family, when the cover incepts for the first time, are excluded for such insured person upto 4 years of this policy being in force continuously.

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

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

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

4.2 Expenses incurred on any disease, except as specified under point 4.3, contracted by the Insured person during the first 30 days from the commencement date of the policy except treatment for accidental external injuries.

4.3 The expenses on treatment of following ailment / diseases / surgeries for the specified periods are not payable if contracted and / or manifested during the currency of the policy.

If these diseases are pre-existing at the time of proposal the exclusion no 4.1 for pre-existing condition SHALL be applicable in such cases.

I	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	1 year
ii	Polycystic ovarian diseases .	1 year
iii	Surgery of hernia.	2 years
iv	Surgery of hydrocele.	2 years
v	Non infective Arthritis.	2 years
vi	Undescendent Testes.	2 Years
vii	Cataract.	2 Years
viii	Surgery of benign prostatic hypertrophy.	2 Years
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus.	2 Years
x	Fissure / Fistula in anus.	2 Years
xi	Piles.	2 Years
xii	Sinusitis and related disorders.	2 Years
xiii	Surgery of gallbladder and bile duct excluding malignancy.	2 Years
xiv	Surgery of genito- urinary system excluding malignancy.	2 Years
xv	Pilonidal Sinus.	2 Years
xvi	Gout and Rheumatism.	2 Years
xvii	Hypertension.	2 Years
xviii	Diabetes.	2 Years
xix	Calculus diseases.	2 Years
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	2 Years
xxi	Surgery of varicose veins and varicose ulcers.	2 Years
xxii	Joint Replacement due to Degenerative condition.	4 Years
xxiii	Age related osteoarthritis and Osteoporosis.	4 Years

If the continuity of the renewal is not maintained then subsequent cover SHALL be treated as fresh policy and clauses 4.1., 4.2, 4 .3 SHALL apply unless agreed by the Company and suitable endorsement passed on the policy. Similarly if the sum insured is enhanced subsequent to the inception of the policy, the exclusions 4.1, 4.2 and 4.3 will apply afresh for the enhanced portion of the sum insured for the purpose of this section.

- 4.4** Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.
- 4.5** Circumcision (unless necessary for treatment of a disease not excluded under the policy or as may be necessitated due to any accident), vaccination, inoculation, cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
- 4.6** Surgery for correction of eye sight, cost of spectacles, contact lenses, hearing aids etc.
- 4.7** Any dental treatment or surgery, unless arising from injury and which requires hospitalisation, which is corrective, cosmetic or of aesthetic in nature, filling of cavity, root canal treatment including treatment for wear and tear etc
- 4.8** Convalescence, general debility, “run down” condition or rest cure, congenital external and internal diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted

conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders and diseases / accident due to and / or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.

- 4.9** Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
- 4.10** All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.
- 4.11** Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period OR expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalisation or primary reasons for admission, referral fee to family doctors, out station consultants / Surgeons fees, Doctor's home visit charges/ Attendant / Nursing charges during pre and post hospitalisation period. etc.
- 4.12** Expenses incurred on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician and / or all non medical expenses including personal comfort and convenience items or services.
- 4.13** Any Treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy.
- 4.14** Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.
- 4.15** Genetic disorders and stem cell implantation / surgery.
- 4.16** Cost of external and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker , Crutches, Belts ,Collars ,Caps , splints, slings, braces ,Stockings etc. of any kind, Diabetic foot wear, Glucometer / Thermometer and similar related items etc. and also any medical / non medical equipment which is subsequently used at home. Exhaustive list available on the website.
- 4.17** Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme, services or supplies etc...
- 4.18** Change of treatment from one system to another system of medicine unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.
- 4.19** Any treatment arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company.

- 4.20** Out patient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.
- 4.21** Massages, Steam bathing, Shirodhara and like treatment under Ayurvedic treatment.
- 4.22** Any kind of Service charges/Surcharges, unless payable to the Govt. Authority, levied by the hospital.
- 4.23** **Compulsory Co-Payment:** Under the SILVER plan the insured has to bear 10% of admissible claim amount in each and every claim.

5 CONDITIONS

5.1 ENTIRE CONTRACT: the policy, schedule, proposal form, prospectus and declaration given by the insured shall constitute the complete contract of insurance. Only insurer may alter the terms and conditions of this policy/ contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

5.2 COMMUNICATION: Every notice or communication to be given or made under this policy shall be delivered in writing at the address of the policy issuing office / Third Party Administrator as shown in the Schedule.

5.3 FREE LOOK PERIOD:

This policy shall have a free look period. The free look period shall be applicable at the inception of the fresh policy and:

1. The insured will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable
2. If the insured has not made any claim during the free look period, the insured shall be entitled to
 - a. A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;
 - b. where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;
 - c. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

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

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

5.6 CLAIM DOCUMENTS: Final claim along with originals of hospital Bills/Cash memos/reports, claim form and list of documents as listed below should be submitted to the Company / TPA within 7 (seven) days of discharge from the Hospital / Nursing Home.

- i. Original bills, receipts and discharge certificate / card from the hospital.
- ii. Medical history of the patient recorded by the Hospital.
- iii. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.
- iv. Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending medical practitioner / surgeon demanding such tests.
- v. Attending Consultants' / Anaesthetists' / Specialists' certificates regarding diagnosis and bill / receipts etc. in original.
- vi. Surgeons' original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
- vii. Any other information required by TPA / the Company.

All documents must be duly attested by the insured person.

In case of post hospitalisation treatment all supporting claim papers / documents as listed above should also be submitted within 7 (seven) days after completion of such treatment to the Company / T.P.A. In addition, insured should also provide to the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.

NOTE: 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 / TPA has a right to reject the claim.

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

- i) Claim in respect of Cashless Access Services SHALL be through the TPA/ Insurer provided treatment is undertaken in a network hospital / Nursing Homes and is subject to pre admission authorization. The TPA/ Insurer 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 SHALL 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 in-patient.
- ii) The TPA/ Insurer 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 TPA/ Insurer. In such circumstances denial of Cashless Access should in no way be construed as denial of claim. The insured person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the TPA/ Insurer for reimbursement within 7 (seven) days of the discharge from Hospital / Nursing Home.
- iii) Should any information be available to the TPA/ Insurer which makes the claim inadmissible or doubtful requiring investigations, the authorisation of cashless facility may be withdrawn. However this shall be done by the TPA/Insurer before the patient is discharged from the Hospital and notice to the effect given to the treating hospital / the insured.

5.8 Any medical practitioner authorised by the TPA/Company shall have deemed permission to examine the Insured Person in case of any alleged injury or Disease requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the TPA/Company.

5.9 **SUBROGATION:** Subrogation shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

5.10 DISCLOSURE TO INFORMATION NORM:

The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

5.11 REPUDIATION:

A (I): The Insurer, shall repudiate the claim if not covered / not payable under the policy. The Insurer shall mention the reasons for repudiation in writing to the insured person. The insured person shall have the right to appeal / approach the **Grievance Redressal Cell of the company at its policy issuing office, concerned Divisional Office, concerned Regional Office or the Grievance Cell of the Head Office of the Company, situated at A-25/27, Asaf Ali Road, New Delhi-110002.** against the repudiation.

B If the insured is not satisfied with the decision / of the reply of the Grievance Cell under 5.11 (A), he / she may approach the Ombudsman of Insurance, established by the Central Government for redressal of grievances. The Ombudsman of Insurance is empowered to adjudicate on personal lines of insurance claims upto Rs.20 lacs.

5.12 **CANCELLATION CLAUSE:** Company may at any time, cancel this Policy by sending the Insured 30 (Thirty) days notice by registered letter at the Insured's last known address and in such an event the Company shall refund to the Insured a pro-rata premium for un-expired Period of Insurance. (Such cancellation by the Company shall be only on grounds of moral hazards such as intentional misrepresentation / malicious suppression of facts intended to misleading the Company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy). The Company shall, however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given here below) provided no claim has occurred during the policy period up to date of cancellation.

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

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

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

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

- 5.14 **DISCLAIMER OF CLAIM:** It is also hereby further expressly agreed and declared that if the TPA/Company shall disclaim liability in writing to the Insured for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.
- 5.15 **PAYMENT OF CLAIM:** The policy covers illness, disease or accidental bodily injury sustained by the insured person during the policy period any where in India and all medical / surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.
- 5.16 Mid term inclusion permitted for NEWLY WED spouse only. Spouse can be included within three months of marriage or at the time of renewal of the policy.
- 5.17 **CONTRIBUTION:** In case of insured having two or more policies during a period from one or more insurers to indemnify the treatment cost, the policyholder shall have the right to seek settlement of his claim in terms of any of his policies. In such cases,
i. The insurer shall be obliged to settle the claim without insisting on contribution clause as long as the claim is admissible within the policy limits.
ii. If the claim amount exceeds the sum insured after considering the deductions or co-pay, the policy holder shall have the right to choose insurers by whom the claim is to be settled. In such cases, contribution clause shall apply.

IMPORTANT

6 **PERIOD OF POLICY:** This insurance policy is issued for a period of one year.

7 RENEWAL OF POLICY:

- a) The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. After the due date) of the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever.
- b) Notwithstanding this, however, the decision to accept or reject for coverage any person upon renewal of this insurance shall rest solely with the Company. The company may at its discretion revise the premium rates and / or the terms & condition of the policy every year upon renewal thereof. Renewal of this policy is not automatic; premium due must be paid by the proposer to the company before the due date.
- c) The Company shall not ordinarily deny the renewal of this policy unless on moral hazard grounds of the insured such as intentional misrepresentation / malicious suppression of facts intended to mislead the Company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy.

- d) In case the policy is to be renewed for enhanced sum insured then the restrictions as applicable to a fresh policy (condition 4.1, 4.2 & 4.3 SHALL apply to additional sum insured) as if a separate policy has been issued for the difference.

In case of increase in Sum insured, treatment for pre-existing disease (after specified time) and for a disease / ailment / injury for which treatment has been taken in the earlier policy period, the enhanced sum insured will be applicable only after four continuous renewals with the increased sum insured.

- e) In the event of break in the policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/ condition contracted in the break in period will not be covered and will be treated as Pre-existing condition.

8 PRODUCT WITHDRAWAL CLAUSE: This product may be withdrawn in future. However, in such an event the policy holder shall be duly informed of the options available.

9 SUM INSURED: The Company's liability in respect of all claims admitted in during the period of Insurance shall not exceed the sum insured opted under the policy.

10 AUTHORITY TO OBTAIN RECORDS:

- a) The insured person hereby agrees to and authorises the disclosure to the insurer or the TPA or any other person nominated by the insurer 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 either the insurer or the TPA in connection with any claim made under this policy or the insurer's liability thereunder.

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

11. QUALITY OF TREATMENT : The insured hereby acknowledges and agrees that payment of any claim by or on behalf of the insurer shall not constitute on part of the insurance 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 policy holder that insurer is not in any way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a network hospital) whether pre-authorized or not.

12. ID CARD: The card issued to the insured person by the TPA to avail cash less facility in the Network Hospital only. Upon the cancellation or non renewal of this policy, all ID cards shall immediately be returned to the TPA at the policy holder's expense and the policy holder and each insured person agrees to hold and keep harmless, the insurer and the TPA against any or all costs, expenses, liabilities and claims (whether justified or not) arising in respect of the actual or alleged use, misuse of such ID cards prior to their return.

13. MEDICLAIM WITH Overseas Mediclaim Policy:

In case where THE WHOLE FAMILY covered under THE FAMILY FLOATER Policy goes abroad by taking Oriental's Overseas Mediclaim Policy his / her FAMILY FLOATER Policy becomes suspended for the period he / she is abroad.

AND may be extended by number of days, the insured FAMILY was abroad subject to written request being made by the insured before leaving India. THE EXTENSION WOULD NOT BE APPLICABLE UNLESS THE ENTIRE FAMILY TAKES THE OVERSEAS MEDICLAIM POLICY FROM THE COMPANY.

DISCOUNT ON OMP PREMIUM :

A DISCOUNT OF 15% ON Overseas Mediclaim Policy PREMIUM WOULD BE ALLOWED WHEN EVEN A SINGLE FAMILY member COVERED under the Happy Family Floater Policy, TAKES THE Overseas Mediclaim Policy FROM the Company, provided the happy family floater policy is valid as on the date of taking the Overseas Mediclaim Policy of the Company.

14. IRDA REGULATION NO 5: This policy is subject to regulation 5 of IRDA (Protection of Policy Holder interest) regulation.