THE ORIENTAL INSURANCE COMPANY LIMITED,

Regd. Office: Oriental House, P.B. No. 7037, A_25/27, Asaf Ali Road, New Delhi 110002

MEDICLAIM INSURANCE POLICY TOP UP (GROUP) 2022-23

1. WHEREAS the insured named in the Schedule hereto has by a proposal and declaration dated stated in the Schedule (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 persons(s) named in the Schedule hereto (hereinafter called the INSURED PERSON (S))and has paid premium to the Company as consideration for such insurance to be serviced by Third Party Administrator (hereinafter called the TPA) or the Company as the case may be.

1.1 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 shall contract any disease or suffer from any illness / ailment / disease (hereinafter called 'DISEASE') or sustain any bodily injury through accident (hereinafter called 'INJURY') and if such disease or injury shall require, upon the advice of a duly qualified Physician / Medical Specialist/Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') to incur (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) on domiciliary treatment in India under Domiciliary Hospitalisation Benefits as hereinafter defined, the Company/ TPA will pay to the Hospitals (only if treatment is taken at Network Hospital(s) with prior consent of Company/TPA) or re-imburse to the insured person, as the case may be, the amount of such expenses. It is a precondition that these expenses are reasonably and necessarily incurred in respect thereof by or on behalf of such insured person but not exceeding the sum insured in aggregate in any one period of insurance stated in the schedule hereto.

1.2 The policy reimburses the payment of Hospitalisation and / or Domiciliary Hospitalisation expenses only for illness/diseases contracted or injury sustained by the Insured Persons. In the event of any claim becoming admissible under this policy, the Company/TPA will pay to the hospital (only if treatment is taken at network hospitals with prior consent of Company/TPA) or re-imburse to the insured, as the case may be, the amount of expenses reasonably and necessarily incurred under different heads mentioned below thereof by or on behalf of such Insured Person not exceeding the Sum Insured in aggregate in respect of Insured Person as stated in the schedule for all claims admitted during the period of insurance mentioned in the schedule.

FOLLOWING REASONABLE & CUSTOMARY EXPENSES ARE REIMBURSABLE UNDER THE POLICY

a. Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home not exceeding 1 % of the Sum Insured or Rs. 5000 /- per day whichever is less.

b. I.C. Unit expenses not exceeding 2 % of the Sum Insured or Rs. 10,000 /- per day whichever is less.(Room including I.C.U. stay should not exceed total number of admission days).

c. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.

d. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Relevant Laboratory / Diagnostic test, X-Ray etc..

e. Ambulance services - 1% of the sum insured or Rs 2000/- whichever is less shall be reimbursable in case patient has to be shifted from residence to hospital in case of admission in Emergency Ward / I.C.U. or from one Hospital / Nursing home to another Hospital / Nursing Home by registered ambulance only for better medical facilities.

Note:

1. Hospitalization expenses incurred for donating an organ by the donor (excluding cost of organ if any) to the insured person during the course of organ transplant will also be payable. However in any case the liability of the Company will be limited to over all Sum Insured of the Insured Person.

2. DEFINITIONS:

2.1 **HOSPITAL/NURSING HOME:** A hospital/Nursing home means any institution established for in- patient care and day care treatment of sickness 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 at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- 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 will make 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, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel or a similar place.

Note: In case of Ayurvedic / Homeopathic / Unani treatment, Hospitalisation expenses are admissible only when the treatment is taken as in-patient, in a Government Hospital / Medical College Hospital.

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 hours. However,

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

i. Haemo Dialysis,

ii. Parentral Chemotherapy,

iii. Radiotherapy,

iv. Eye Surgery,

v. Lithotripsy (kidney stone removal),

vi. Tonsillectomy,

vii. 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.

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. Or any such disease / procedure agreed by TPA/Company before treatment.

(B) Further if the treatment / procedure / surgeries of above diseases are carried out in,Networked specialised Day Care Centre, means any institution established for day care treatment of illness and / or injuries OR a medical set -up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:- has qualified nursing staff under its employment has qualified medical practitioner (s) in charge has a fully equipped operation theatre of its own where surgical procedures are carried out- 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.

ABOVE ARE ADMISSIBLE SUBJECT TO TERMS & CONDITIONS OF THE POLICY.

NOTE: PROCEDURES / TREATMENTS USUALLY DONE IN OUT PATIENT DEPARTMENT ARE NOT PAYABLE UNDER THE POLICY EVEN IF CONVERTED TO DAY CARE SURGERY / PROCEDURE OR AS IN PATIENT IN THE HOSPITAL FOR MORE THAN 24 HOURS.

2.4 DOMICILIARY HOSPITALISATION BENEFIT: Domiciliary hospitalization means medical treatment for a period exceeding three days for such an 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 Pharingitis,

xii. Arthritis, Gout and Rheumatism.

Note: Liability of the Company under this clause is restricted as stated in the schedule attached hereto.

3. OTHER DEFINITIONS AND INTERPRETATIONS :

3.1. <u>INSURED PERSON</u>: Means Person(s) named on the schedule of the policy.

3.2. <u>ENTIRE CONTRACT:</u> This policy / proposal and declaration given by the insured constitute the complete contract of this policy. Only Insurer may alter the terms and conditions of this policy. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

3.3. THIRD PARTY ADMINISTRATOR (TPA): means any company who has obtained licence from IRDA to practice as a third party administrator and is appointed 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 for 24 hours

3.6 PRE-HOSPITALISATION EXPENSES: Medical Expenses incurred during the period upto 30 days prior to the date of admission, provided that:

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

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

3.7 POST-HOSPITALISATION EXPENSES: Medical Expenses incurred for a period upto 60 days from the date of discharge from the hospital, provided that:

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

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

3.8 MEDICAL PRACTITIONER: A Medical practitioner is a person who holds a valid registration from the Medical Council of any state 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 his 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 DISEASES: 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.

Further any complications arising from pre-existing ailment / disease / injuries will be considered as a part of that pre existing health condition.

3.11 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 o f 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.

3.12 Injury

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

3.13 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 o f the body is called Internal Congenital Anomaly

b. External Congenital Anomaly

which is in the visible and accessible parts o f the body is called External Congenital Anomaly

3.14 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.

3.15 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 Networked Hospital and the TPA for surgical / medical treatment that is necessary , customary and reasonable for treating the condition for which insured person was hospitalized.

NOTE: Any expenses (as mentioned above) which are not covered under the policy and / or which are not reasonable, customary and necessary, the same have to be borne by the insured person himself.

3.16 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.

3.17I .D. CARD: means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

3.18DAY CARE PROCEDURE: means the course of Medical treatment / surgical procedure listed at 2.3 (A) carried out, in Networked specialised Day Care Centre which is fully equipped with advanced technology and specialised infrastructure where the insured is discharged on the same day, the requirement of minimum beds will be over looked provided other conditions are met.

3.19LIMIT OF INDEMNITY: means the amount stated in the schedule against the name of each insured person which represents maximum liability for any and all claims made during the policy period in respect of that insured person in respect of that insured person in respect of hospitalization taking place during currency of the policy.

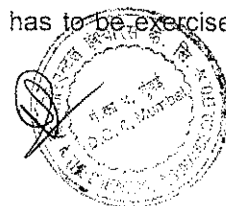
3.20 ANY ONE ILLNESS: Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation OR 105 days from the date of discharge ,whichever is earlier, from the Hospital/Nursing Home where treatment may have been taken.

3.21 **PERIOD OF POLICY:** This insurance policy is issued for a period of one year shown in the schedule.

3.22 MATERNITY EXPENSES AND NEWBORN CHILD COVER BENEFIT EXTENSION:

a. This is an optional cover which can be obtained on payment of 10% of the total basic premium for all the insured persons under the policy. Total basic premium means the total premium computed before applying group discount and /or High Claims Ratio Loading, Low Claim Discount.

b. Option for Maternity Expenses and Newborn Child Cover Benefit Extension has to be exercised at the



time of inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during the currency of the policy.

c. Those insured persons who are already having two or more living children will not be eligible for this benefit

d. Claim in respect of only first two children and/or operations associated therewith will be considered in respect of any one insured person covered under the policy or any valid and effective renewal thereof

e. The maximum benefit allowable under this clause will be upto Rs. 50,000/-and would fall under different heads mentioned under item 1.2.. The sum insured under above benefit shall be a part of basic sum insured.

Special conditions applicable to Maternity Expenses & Newborn Child Cover Benefit Extension

a. These benefits are admissible only if the expenses are incurred in hospital/nursing home as in-patients in India.
b. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine Pregnancy. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency.
c. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.
d. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/nursing home and treatment is taken there.

e. Pre Hospitalisation and post Hospitalisation benefits are not available under this section.

f. Newly born child shall be covered from day one upto the age of 3 months and expenses incurred for treatment taken in hospital as in patient shall only be payable subject to within the specified sum insured of Rs 50,000/- under Maternity benefit extension. Congenital diseases of newly born child shall be excluded.

4 EXCLUSIONS:

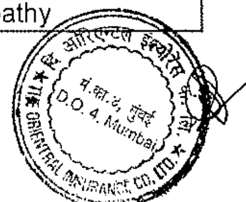
The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

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), when the cover incepts for the first time are excluded upto 4 years of this policy being in force continuously.

This exclusion will also apply to any complications arising from pre existing ailment / diseases / injuries. Such complications will be considered as a part of the pre existing health condition or disease.

Further to this if any 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 Bleeds/ 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
		Hypertensive Nephropathy
		Internal Bleeds/ Haemorrhages

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.

4.2 Any disease other than those stated in clause 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 During the period of insurance cover, the expenses on treatment of following ailment / diseases / surgeries for specified periods are not payable if contracted and / or manifested during the currency of the policy.

i	**Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.**	1 year
ii	**Polycystic ovarian diseases .**	1 year
iii	Surgery of hernia.	2 years
iv	Surgery of hydrocele.	2 years
v	**Non infective Arthritis.**	2 years
vi	**Undescendent Testes.**	2 Years
vii	Cataract.	2 Years

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

If the continuity of the renewal is not maintained, then subsequent cover will be treated as fresh policy and clauses 4.1., 4.2, 4 .3 will apply unless agreed by the Company and suitable endorsement passed on the policy.

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

4.5 Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be

necessitated due to any accident), vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

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

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

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

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

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

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

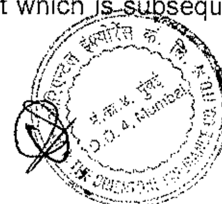
4.12 Any Treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy. .

4.13 Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.

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

4.15 Genetical disorders and stem cell implantation / surgery.

4.16 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 equipment which is subsequently used at home etc.. Exhaustive list available on the website.



4.17 All non medical expenses including Personal comfort and convenience items or services such as telephone, television, Aya / barber or beauty services, diet charges, baby food, cosmetics, napkins , toiletry items etc, guest services and similar incidental expenses or services etc..

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

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

4.20 Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company.

4.21 Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.

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

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

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

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

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

4.27 Treatment which is continued before hospitalization and continued even after discharge for an ailment / disease / injury different from the one for which hospitalization was necessary.

5 CONDITIONS:

5.1 **ENTIRE CONTRACT:** the policy, 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 (except relating to claim) 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 RENEWAL OF POLICY:

I)The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. After the due date) of the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever.

II) Not withstanding 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.

III) The Company normally sends renewal notice but not sending it will not tantamount to deficiency in services.

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 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 notice should be given within 48 hours of admission or before discharge from Hospital / Nursing Home.

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

a. Original bills, receipts and discharge certificate / card from the hospital.

b. Medical history of the patient recorded by the Hospital.

c. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.

d. Original receipt, pathological and other test reports from a pathologist / radiologist including film etc

e. Attending consultants / Anaesthetists / Specialist certificates regarding diagnosis and bill / receipts etc.

f. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.

g. Any other information required by TPA / Insurance Company.

All document must be duly attested by the Insured.

In case of post hospitalisation treatment (limited to 60 days) all supporting claim papers / documents as listed above should also be submitted within 7 days after completion of such treatment (upto 60 days or actual period whichever is earlier) 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.

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 will be through the Company / TPA provided admission is in a listed hospital in the agreed list of the networked Hospitals / Nursing Homes and is subject to pre admission authorization. The Company /TPA shall, upon getting the related medical details / relevant information from the insured person / network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorisation letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as in-patient.

ii) The Company /TPA reserves the right to deny pre-authorisation in case the hospital / insured person is unable to provide the relevant information / medical details as required by the Company /TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of 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 Company /TPA for reimbursement within 7 days of the discharge from Hospital / Nursing Home.

iii) Should any information be available to the Company /which makes the claim inadmissible or doubtful requiring investigations, the authorisation of cashless facility may be withdrawn. However this shall be done by the Company /TPA before the patient is discharged from the Hospital.

5.7 REPUDIATION :

(A) 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 5.7 (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.

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

5.9 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..

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

5.11 **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-expirkirtika.s@mediassist.ined 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

5.12 **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.

5.13 **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.

5.14 **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.

6 **BONUS - LOW CLAIM RATIO DISCOUNT:** Low claim ratio discount at the following scale will be allowed on the total premium at renewal only, depending upon the incurred claims ratio for the entire group insured under the group Mediclaim insurance policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the group Mediclaim insurance policy has not been in force for three completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims Ratio under Group Policy	Discount
Not exceeding 60%	5%
Not exceeding 50%	15%
Not exceeding 40%	25%
Not exceeding 30%	35%
Not exceeding 25%	40%

7 **MALUS - HIGH CLAIM RATIO LOADING:** The total premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the group Mediclaim insurance policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the group Mediclaim policy has not been in force for three completed years, such shorter period of completed years, excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims Ratio under Group Policy	Loading
Between 70% and 100%	25%
Between 101% and 125%	55%
Between 126% and 150%	90%
Between 151% and 175%	120%
Between 176% and 200%	150%
Above 200%	cover to be reviewed

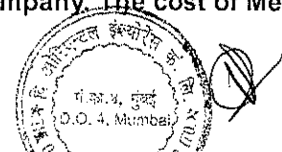
Note: Low claim ratio discount (Bonus) or High Claim ratio loading (Malus) will be applicable to the premium at renewal of the policy depending on the incurred claims ratio for the entire group insured.

Incurred claims would mean claims paid plus claims outstanding in respect of the entire group insured under the policy during the relevant period

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

9 **RENEWAL OF POLICY:**

If 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 will apply to additional sum insured) as if a separate policy has been issued for the difference, subject to medical check up as per norms of the Company. The cost of Medical



check up shall be borne by the insured.

11 **SUM INSURED:** The Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the sum insured opted by the Insured person. Minimum sum insured is Rs 50,000/- and in multiples of Rs 25,000/- upto Rs 2, 00,000/-. Beyond the Sum Insured of Rs. 200000/- in multiples of Rs. 50000/- upto Rs 500000/-.

12 Portability

THIS POLICY IS PORTABLE TO THE EXTENT THAT THE INSURED MEMBER MAY OPT OUT OF THE GROUP AND SWITCH FROM GROUP INSURANCE PLAN TO INDIVIDUAL/FAMILY INSURANCE COVER WITH THE SAME INSURER(THE GROUP INSURER). PORTABILITY MAINTAINS THE CREDIT GAINED BY THE INSURED FOR PRE-EXISTING CONDITIONS AND TIME BOUND EXCLUSIONS.

13 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 will preserve the confidentiality of any documentation and information that comes into their possession pursuant to a) above and will only use it in connection with any claim made under this policy or the insurer's liability thereunder

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

15 **QUALITY OF TREATMENT** : The insured hereby acknowledges and agrees that 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.

16 **ID CARDS:** The card issued the Insured Person by the TPA to avail cashless 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 holders expenses 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.

The following are the tailormade terms and conditions which overrides abovebmentioned standard terms and conditions:

Plan 'B' (TOP UP POLICY)

1) **Sum Insured** : FLOATER from Rs. 5 Lacs TO Rs 30 Lacs in multiples of 5 lacs as opted by Insured.
2) **CAPPING ON ROOM RENT & ICU**

   For S.I. Rs. 5 lacs : Rs. 5000/- & Rs. 7500/- for Room Rent & ICU respectively

   S.I. Rs. 10 lacs: Rs. 10000/-& Rs.12500/- for Room Rent & ICU respectively

   Above S.I. Rs. 10 lacs : Rs. 12000/- & Rs.14500/- for Room Rent & ICU respectively

3) **Family Size :**

   For Members : For Member upto the age of 65years (1+4 = Member of the Club + Spouse + first 3 Dependent Children upto the age of 25years,)

   Unmarried daughter will be covered without age limit for Existing Members(Not applicable for parent Policy)

   For Members above 65 years onwards(i.e. Date of Birth earlier than 30.06.1957) it is 1+1 i.e. Self & Spouse only (for existing members in the currunt policy)

   For Parents : 1+ 1 (Self & Spouse) Parents/Parents- In- Laws covered .No cross selection allowed. Age restriction for new parents/enrollment is upto 65 years.

   However, for new members and dependents enrolling for the first time the age restriction is 65 years(age to be considered as on 1st July 2022)

3 a) Minimum 50 new members with 95% enrollment of existing members in the policy.

4) If the Insured occupies a room with a room rent limit over his eligibility as per the Insurance policy, then all the other charges shall be limited to the charges applicable for the eligible room rent or actual, whichever is lower accordingly enhanced difference in room rent and all expenses shall be borne by the Insured/member only,in same proportion except medicine.
5) GIPSA PPN Rate applicable for network hospital.
6) 30% Co-pay on each and every claim

Capping on cataract Rs.50,000/- per eye.

7) All benefits will be as per standard GMC policy based on sum Insured opted.
8) No Maternity Benefits
9) New Born Baby covered from Day One. This is subject to declaration of baby details within 30 days from the date of birth or at the time of renewal (Not applicable for parent Policy)

10) For new joinees, Chemotherapy or any other therapy for cancer and Dialysis are not covered .

Any pre-existing disease also not covered for the 1st year of enrollment.

11) Only in case of Cardiac Arrest and Cardiac Ambulance being used.Ambulance charges payable shall be actual expenses incurred subjet to maximum of Rs.12500/- .In all other cases Ambulance charges will be restricted to Rs. 2500/-

12) Angioplasty and Oral Chemotherapy will be included in day care procedures in this Mediclaim Policy.

13) No addition/deletion of members are allowed under the policy.

14) Members enrolled from year 2021 will be with a deductible of 10 lacs. Deductible of Rs.10 lacs will be applicable per person per year.

15) Warranted that in case the person covered under the policy has lodged any claim under the previous policy and the sum insured is enhanced under the current policy,for a further claim for the same disease during the current policy, the earlier limit of Sum Insured shall be applicable and not the enhanced sum insured. Increase Sum Insured will not be used for Pre-exisiting disease.

16) Any claim/s in respect of covered expenses specified shall be payable by the company only,if the aggregate of covered expenses in respect of hospitalisation/s of Insured person exceeds the Threshold Level of Rs. 5 lacs for existing members and Rs. 10 lacs for new Joinees and all limits of reimbursement under any other Health Insurance Policy/Reimbursement Scheme available to the Insured person have been exhausted.

I) The claim payable under this Policy will be the amount by which the aggregate of such covered expenses iin respect of hospitalisations with dates of admission falling within the policy period exceeds the higher of the following :

a) The Threshold Level opted for the insured person/family as applicable and stated in the schedule OR

b) The amount received/receivable under any/ all Health Insurance Policies (Whether or not issued by the Company)/Reimbursement Scheme and including any amount paid earlier under this policy covering the insured person/family as applicable for such Covered Expenses.

II) In no case shall the Company be liable to pay any sum in excess of the Sum Insured in aggregate of all claims during the period of this policy.

18) In case of claim for critical illness (11 critical illnesses as per IRDAI) additional sum insured for critical illness will come into force only when basic Sum Insured under Base Policy and Top Up policy gets exhausted. Additional sum insured will be equivalent to the base plan sum insured of the member. Additional Sum Insured for Critical illness will be available only to members already covered in 2020-21 & 2021-22 in continuation. New members will not have this benefit under policy.

Following are the 11 critical Illness :

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 leukaemia, 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 Micro carcinoma of the bladder

vii All tumours in the presence of HIV infection.

2. 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:

i. A history of typical clinical symptoms consistent with the diagnosis of Acute myocardial Infarction (for e.g typical chest pain)

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of troponin I or T

ii. Other acute Coronary Syndromes

iii. Any type of angina pectoris.

3. OPEN CHEST CABG

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.

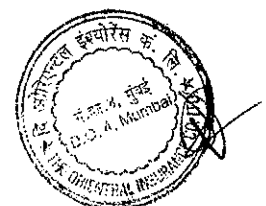
II. The following are excluded:

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

ii. Any keyhole or laser Surgery.

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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.



5. COMA OF SPECIFIED SEVERITY

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

i. No response to external stimuli continuously for atleast 96 hours.

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

iii Permanent neurological deficit which must be assessed atleast 30 days after the onset of the coma.

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

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS:

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS:

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

8. MAJOR ORGAN/BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of

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

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

II. The following are excluded:

i. Other stem cell transplants

ii . Where only islets of Langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

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

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

11. MULTIPLE SCLEROSIS WITH PERSISTENT SYMPTOMS

I. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following :

i) Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

ii) There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of atleast 6 months; and

iii) well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

II Other causes of neurological damage such as SIE and HIV are excluded

17) All Benefit will be as per Standard GMC Policy when no specific condition is mentioned.

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

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