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

OBC - ORIENTAL MEDICLAIM POLICY - 2017
POLICY

1. The basis of the contract is the prospectus, proposal and declaration given by the insured named in the Schedule, and which is deemed to be incorporated herein; and through which the insured 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. The insurance shall be serviced by Third Party Administrator (hereinafter called the TPA) or the Company as the case may be.

   Subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that, if during the policy period stated in the Schedule any Insured Person(s) shall contract or suffer from any illness / ailment / disease (hereinafter called 'DISEASE') or sustain any bodily injury through accident (hereinafter called 'INJURY') and if such disease or injury shall require any such Insured Person(s) upon the advice of a duly qualified Physician / Medical Specialist/Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') to incur expenses on (a) Hospitalisation (as defined hereinafter) for medical/surgical treatment at any Nursing Home/Hospital in **India** (hereinafter called 'HOSPITAL') as an inpatient **OR** (b) on Domiciliary treatment in India under Domiciliary Hospitalisation Benefits as hereinafter defined, the Company will pay to the Hospital(s) (if treatment is taken at Network Hospital(s) with prior written approval of Company) or reimburse to the Insured Person, as the case may be, the amount of such admissible expenses as specified hereunder. It is a condition precedent that the expenses incurred in respect of medically necessary treatment, are reasonable and customary; and in any case the maximum liability of the Company, in respect of one or all the Insured Persons stated in the schedule, shall be upto the limit specified in the policy and/or schedule of the policy, but not exceed the Sum Insured as stated in the schedule, for all claims arising during the policy period mentioned in the schedule

2. **COVERAGE**

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

A.

Sl.	Expenses covered	Limits
i.	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.	1 % of the Sum Insured per day
ii	Intensive Care Unit (ICU) Expenses as provided by the Hospital /Nursing Home.	2% of the Sum Insured per day.
	a. Number of days of stay under 'i' and 'ii' above should not exceed total number of days of stay in the Hospital. All related expenses (including iii and iv below) shall also be payable as per the entitled room category based on the Room Rent limit as mentioned above. This restriction shall not apply on medicines / pharmaceuticals and body implants. b. Any expense in excess of reasonable and customary charges as defined under 3.42, or in excess of negotiated prices (in case of network hospitals) shall be borne by the insured.	
iii	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of the Sum Insured.
iv	Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & and similar expenses.	As per the limits of Sum Insured.
v	Ambulance service charges	Reimbursement upto maximum Rs.1000 in any Policy period, subject to claim being admissible under the hospitalisation section of the policy
vi	Daily Hospital Cash Allowance – only in respect of the insured Account holder	Rs.200 per day of hospitalisation, maximum compensation being Rs.1000 during the policy period, subject to claim being admissible under the hospitalisation section of the policy.
vii	Funeral Expenses	Lumpsum payment of Rs.1000 per Insured person in case of death of the insured person, subject to claim being admissible under the hospitalisation section of the policy
viii	Pre and Post Hospitalisation expenses	Medical expenses incurred 30days prior to Hospitalisation and upto 60 days Post Hospitalisation.

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

Domiciliary Hospitalisation benefit shall, however, not cover expenses in any of the following cases

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

Note: (i) Liability of the Company under Domiciliary Hospitalisation Benefit is limited as stated in 2B.
(ii) Intimation in respect of Domiciliary hospitalisation must be given immediately to the Company.

C. ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE RECIPIENT: The policy covers in-patient Hospitalisation Medical expenses in respect of the organ donor provided that the donation conforms to the Transplantation of Human Organs Act 1994(amended) and/or any other extant Act, Central / State Rules / regulations, as applicable to transplantation of human organs.
Further provided that:

i. the organ donated is for the use of the Insured Person who has been medically advised to undergo organ transplant
ii. The claim of the Insured Person is admissible under the Hospitalisation section of the policy.
iii. The policy does not cover:
   a) cost directly or indirectly associated with the acquisition of the organ and/or cost of organ.
   b) cost towards donor screening
   c) Any Pre and Post Hospitalisation medical expenses of the donor.
   d) Any other medical treatment or complication consequent to organ harvesting, in respect of the donor.

D. Relaxation to 24 hours minimum duration of hospitalisation is allowed in specified Day Care procedures / Surgeries (as per appendix-I) where such treatment is taken by an Insured Person in a Hospital / Day Care Centre (but not the Out-Patient department of a hospital), Or any other Day Care

Treatment as mentioned in clause 3.14 and for which prior approval from Company / TPA is obtained in writing.

E. In case of Ayurvedic,Yoga and Naturopathy, Unani, Siddha and Homeopathic treatment, Hospitalisation expenses are admissible only when the treatment is taken as an In-patient, as defined in 3.17.

F. Sub-limits shall apply on the following procedures, as below

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

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

NOTE: Maximum liability of the Company under the policy is the Sum Insured as stated in the schedule.

3. DEFINITIONS:

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

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

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

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

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

3.6 Cashless Facility: means a facility extended by the insurer or TPA on behalf of the Insurer to the insured, where the payments for the costs of the treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent of pre- authorization is approved.

3.7 Congenital Anomaly: refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a. Internal Congenital Anomaly: which is not in the visible and accessible parts of the body
b. External Congenital Anomaly**:** which is in the visible and accessible parts of the body

3.8 Condition Precedent: means a policy term or condition upon which the Insurer's liability under the policy is conditional.

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

a) is fixed in nature:
b) does not have any relation to the treatment costs;

3.10 Daily Hospital Cash Allowance: When the Insured account holder is hospitalized and a claim is admitted under the Policy, then the Company shall pay a Daily Hospital Cash Allowance as specified under 2A above.

3.11 Dental Treatment: is treatment carried out by Dental Practitioner, including examination, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

3.12 Domiciliary Hospitalisation Benefit: means medical treatment for a period exceeding three days for such disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

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

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

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

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

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

3.15 Family: consists of the Insured or Insured and any one or more of the family members as mentioned below:

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

3.16 Grace Period: means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

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

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

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

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

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

3.18 Hospitalisation: means admission in a Hospital for a minimum period of twenty four (24) in-patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

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

3.20 Illness: means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

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

b. Chronic condition - is a disease, illness, or injury that has one or more of the following characteristics:

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

3.21 In-Patient: means an Insured Person who is admitted to Hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

3.22 In-Patient Care: means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

3.23 Intensive Care Unit: means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

3.24 IRDAI: means Insurance Regulatory and Development Authority of India, and regulates the insurance business in India.

3.25 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.

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

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

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

3.29 Medical Expenses: means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

3.30 Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

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

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

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

3.33 Non-Network: Any Hospital, day care centre or other provider that is not part of the Network

3.34 Notification of Claim: is a process of notifying a claim to the Insurer or TPA by specifying the timelines as well as the address/telephone number, to which it should be notified.

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

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

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

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

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

3.38 Pre Existing Disease: means any condition, ailment or injury or related condition(s) for which the Insured Person(s) had signs or symptoms, and / or was diagnosed, and / or received medical advice / treatment within 48 months prior to the first policy issued by the insurer.

3.39 Policy Period: means the period of coverage as mentioned in the schedule

3.40 Portability: means transfer by an individual health insurance Policy holder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

3.41 Qualified Nurse: means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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

3.43 Renewal: Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

3.44 Room Rent: means the amount charged by a Hospital for the occupancy of a bed on per day (24hours) basis and shall include associated medical expenses.

3.45 Surgery/ Surgical Operation: means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or a Day Care centre by a Medical Practitioner

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

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

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

4.1 All Pre-existing Disease (whether treated / untreated, declared or not declared in the proposal form), are excluded upto 36 months of the policy being in force. Pre-existing diseases shall be covered only after the policy has been continuously in force for 36 months.
For the purpose of applying this condition, the date of inception of the first OBC-Oriental Mediclaim policy shall be considered, provided the renewals have been continuous and without any break in the policy period.

This exclusion shall also apply to any complication(s) arising from pre existing diseases. Such complications will be considered as part of the pre existing health condition or disease.

4.2 The expenses on treatment of following ailments / diseases / surgeries, if contracted and / or manifested after inception of first policy (subject to continuity being maintained), are not payable during the waiting period specified below.

	Ailment / Disease / Surgery	Waiting Period
i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	**1** year
ii	Polycystic ovarian diseases.	**1** year
iii	Surgery of hernia.	**2** years
iv	Surgery of hydrocele.	**2** years
v	Non infective Arthritis.	**2** years
vi	Undescendent Testes.	**2** Years
vii	Cataract.	**2** Years
viii	Surgery of benign prostatic hypertrophy.	**2** Years
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus.	**2** Years
x	Fissure / Fistula in anus.	**2** Years
xi	Piles.	**2** Years
xii	Sinusitis and related disorders.	**2** Years
xiii	Surgery of gallbladder and bile duct excluding malignancy.	**2** Years
xiv	Surgery 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.	**3** Years
xxiii	Age related osteoarthritis and Osteoporosis.	**3** Years

If the above diseases are pre-existing at the time of inception of first OBC-Oriental Mediclaim policy, Exclusion no.4.1 for pre-existing disease shall be applicable.

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

4.3 Injury or disease directly or indirectly caused by or arising from or attributable to war, invasion, act of Foreign enemy, war like operations (whether war be declared or not) or by nuclear weapons / materials.

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

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

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

4.7 Convalescence, general debility, “run down” condition or rest cure, congenital internal and external diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders and diseases / accident due to, and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc, any disease or injury as a result of committing or attempting to commit a breach of Law with criminal intent.

4.8 All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or 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..

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

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

4.11 Any treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy, except in the case of abdominal operation for extra uterine pregnancy (ectopic pregnancy) which is proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner, if left untreated.

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

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

4.14 Private nursing charges, Referral fee to family doctors, out station consultants / Surgeons fees, etc.

4.15 Genetic disorders and stem cell implantation / surgery.

4.16 Cost of external and or durable medical / non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, APDS, Infusion pump etc., Ambulatory devices i.e. walker, Crutches, Belts, Collars, Caps, splints, slings, braces, Stockings etc. of any kind, Diabetic foot wear, Glucometer, Thermometer, Blood Pressure monitoring machine and similar related items and also any medical equipment which is subsequently used at home. Exhaustive list available in appendix II.

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

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

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

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

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

4.22 Any treatment required arising from Insured’s participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing and similar other activities, unless specifically agreed and endorsed on the policy.

4.23 Treatment taken in an Establishment which is a place for rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel, convalescent home, convalescent Hospital, health hydro, or similar establishments.

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

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

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

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

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

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

5. CONDITIONS

5.1 CONDITIONS PRECEDENT TO CONTRACT

i. **Material Facts:** The proposer is required to declare all material facts in the Proposal Form / any other document. Any misrepresentation or concealment of material facts shall render the policy void ab initio. A material fact is one which can influence the insurer's judgement to accept or reject the Proposal or the terms of acceptance.

ii. **Payment of Premium**: The premium under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the company. Advance premium payment shall be condition precedent to the contract.

5.2 CONDITIONS APPLICABLE SUBSEQUENT TO CLAIMS

i. **Notification Of Claim:** Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of Insured Person in respect of whom claim is made, Nature of disease / injury and Name and Address of the attending Medical Practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home by fax, e-mail, etc. Such notice should be given within 48 hours of admission but before discharge from Hospital / Nursing Home, unless waived in writing.

ii.**Medical Records:**

a. The Insured Person hereby agrees to and authorises the disclosure, to the Company / TPA or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from which the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company / TPA in connection with any claim made under this policy or the Company's liability there under.
b. The Company / 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 Company's liability there under.
c. Any Medical Practitioner authorised by the Company / TPA 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 Company / TPA.

iii. Procedure for availing Cashless Access services in Network Hospital/Nursing Home:

a. Claim in respect of Cashless Access Services will be through the Company / TPA provided admission is in a network Hospital / Nursing Home and is subject to pre admission authorization. The Company / TPA shall, upon getting the related medical details / relevant

information from the Insured Person / Network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-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 an in-patient.

b. The Company / TPA reserves the right to deny pre-authorisation in case the Hospital / Insured Person is unable to provide the relevant information / medical details as required by the Company / TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of liability. The Insured Person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the Company / TPA within 15 days of the discharge from Hospital / Nursing Home for consideration of Company / TPA.

c. Should any information be available with the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorisation of cashless facility may be withdrawn. However this shall be done by the Company / TPA before the patient is discharged from the Hospital and notice to this effect given to the treating Hospital and insured.

d. Liability under the policy in respect of all expenses incurred in a Network Provider shall be subject to the pre-agreed rates between the Company/TPA and the Network Provider. This is irrespective of the claim being under cashless or re-imbursement

e. List of network Hospitals is available on our official website-www.orientalinsurance.org.in and will also be provided by the concerned TPA.

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

v. **Claim Documents:** Final claim along with original Bills/Cash memos/reports, claim form and documents as listed below should be submitted to the Company / TPA within 15 days of discharge from the Hospital / Nursing Home.

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

l. Any other information required by Company / TPA.

- All documents must be duly attested by the Insured /Claimant.
- In case of Post Hospitalisation treatment (limited to 60 days) all supporting claim papers / documents as listed above should also be submitted within 15 days from completion of such treatment (upto 60 days or actual period whichever is less) to the Company / T.P.A. In addition insured should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.
- Waiver of above condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.

vi. **Disclosure to Information Norm: Non-disclosure, concealment or mis-statement** in the Claim Form or any other document, or if the claim be in any manner- intentionally or fraudulently or otherwise misrepresented or concealed or involves making false statement or submitting false bills / documents whether by the Insured Person or any other person/ Institution/ Organisation on his behalf. Company shall be at liberty to take suitable legal action against such Insured Person/ Institution/ Organisation as per the laws.

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

i. In all such cases, the insurer who has issued the chosen policy, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Claim under other policy/policies can be made after exhaustion of the sum insured in the earlier chosen policy/policies. However, the insured shall also have the right to prefer claim from other policy/policies for the amounts disallowed under the earlier chosen policy/policies even if the sum insured is not exhausted.

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

In case of any delay in the payment, (30days / 45 days as the case may be), Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed.

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

Claim for any of the Insured Person will be payable in the name of the insured accountholder and discharge voucher signed by him will be considered valid. However, in the unfortunate event of

demise of the insured, the claim shall be payable to the Nominee as declared by the insured accountholder in the Proposal form.

Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured. In case of any delay in the payment, the Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed.

x. Grievance Redressal:

a. The Company shall repudiate the claim if not payable under the policy. The Company shall mention the reasons for repudiation in writing to the Insured Person. The Insured Person shall have the right to appeal / approach the Customer Service department of the Company at its policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, New Delhi-110002. E-mail id is csd@orientalinsurance.co.in
b. If the insured is not satisfied with the reply of the Customer Service department under 'a' above, he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto Rs.20 lacs. Region-wise list of Ombudsman offices is available at the Company's website www.orientalinsurance.org.in.

xi. **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 as amended from time to time.
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.

xii. **Disclaimer Of Claim**: If the Company shall disclaim liability and communicate in writing to the Insured in respect of any claim hereunder and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a Court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.3 CONDITIONS APPLICABLE FOR RENEWAL OF THE CONTRACT

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

a. On Renewal, Sum Insured can be increased to the immediate higher slab.
b. If size of the family increases on Renewal, Sum Insured can be increased to maximum two slabs higher.
c. If there are no claims reported in the two immediate preceding Policy Periods, increase upto any available Sum Insured is allowed.
d. Notwithstanding above provisions, no increase in Sum Insured is allowed in policies

- where there are claims reported consecutively in the two immediate preceding Policy Periods. OR
- where any one of the insured persons is above the age of 80 years.

ii. **Grace Period**: In the event of delay in renewal of the policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease under the renewed policy.

iii. **Renewal Of Policy:** The Company shall not be responsible or liable for non-renewal of policy due to non-receipt **or** delayed receipt of premium **or** the proposal form **or** of the Medical Practitioner's report wherever required or due to any other reason whatsoever. Further

a. The Company shall not ordinarily deny the renewal of this policy unless on grounds of fraud, moral hazard, misrepresentation or non-cooperation by the insured.

b. If the policy is renewed for enhanced Sum Insured then clauses (4.1 & 4.2) as applicable to a fresh policy shall apply to additional Sum Insured as if a separate policy has been issued for the difference. In respect of Pre-existing Diseases or for a disease / ailment / injury for which treatment has been taken in the earlier policy period, the enhanced Sum Insured will be available only after three continuous renewals with the increased Sum Insured. In case of addition of new members, the policy will be treated as fresh with respect to the newly added members.

iv. **Revision In Premium / Terms**: The premium rates are valid only for the Policy period. The Company may revise the premium rates and / or the terms & conditions of the Policy, upon Renewal thereof, only after due approval from IRDAI. Renewal of this Policy is not automatic; premium due must be paid to the Company on or before the due date. Any revision or modification in the Policy will be notified to the policyholders three months in advance.

v. **Migration:** Any person insured under this Policy may migrate to Happy Family Floater Policy-2015 or Mediclaim Insurance Policy (individual) at the time of renewal of this policy. Upon such migration, the credits gained by the concerned Insured Person, for pre-existing conditions and time-bound exclusions shall be maintained under the policy to which he / she has migrated, provided there is no break in the Policy.

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

5.4 CONDITIONS SUBSEQUENT TO CONTRACT

i **Entire Contract:** This policy /prospectus/ proposal form and declaration given by the insured constitute the complete contract. Insurer may alter the terms and conditions of this policy/contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.
Due 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.

ii **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 / TPA as shown in the Schedule.

iii Free Look Period: This policy provides for a free look period. The free look period shall be applicable at the inception of the fresh policy and the insured is 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.

If the Insured has not made any claim during the free look period, and exercises this option, the Insured shall be entitled to

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 Insured, a deduction towards the proportionate risk premium for period on cover or
c. where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

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

iv. Family Size: The Account holder can take the policy either for the self alone or alongwith his family (as defined in the Policy). Maximum upto five members (including self) can be covered under the policy.

v. Sum Insured: Policy has 10 Sum Insured slabs ranging from Rs.1lakhs to 10 lakhs, at an interval of 1lakh each.

vi. Entry Age: Maximum Entry Age under the policy is 79 years for all members. Age will be **completed age** as on the date of commencement of the policy. Eg. If on the date of proposal, the person is 79 years 364 day old, he will be considered as 79 years old and therefore eligible for cover. This means that a person aged 80 years or above, is not eligible to take a fresh OBC-Oriental Mediclaim policy. However, renewals are allowed lifelong.

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

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

viii. Maximum Policies Allowed:

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

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

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

If at any time during the currency of the policy, the Insured Person is found to be covered under more than one Bancassurance health policies of Oriental, claim will be entertained only under one policy, (the one under which claim is reported/considered) and all other bancassurance policies will automatically stand cancelled and premium forfeited thereunder.

ix. Cancellation Clause: Company may at any time cancel this Policy (on grounds of fraud, moral hazard, misrepresentation or non-co-operation), by sending the Insured 30 (Thirty) days notice by registered post at the Insured's last known address. Also, anytime during the currency of the policy, if violation of 5.4 (viii) comes to the notice, the Company shall cancel all policies, but one, choice of such one policy shall be with the affected Account holder.

No refund of premium shall be made when cancellation is on grounds of fraud, moral hazard or misrepresentation or violation of 5.4 (viii).

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 below) provided no claim has been reported during the policy period up to date of cancellation.

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

x. Change of Address: Insured must inform the Company immediately in writing of any change in the address.

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

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

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

xiv. **Jurisdiction:** All disputes or differences under or in relation to the policy shall be determined by the Indian Courts and in accordance with the Indian laws.

Appendix I

	Day care procedures / surgeries
A	Microsurgical Operations on the Middle Ear
1	Stapedotomy
2	Stapedectomy
3	Revision of a stapedectomy
4	Myringoplasty (Type -I Tympanoplasty)
5	Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
6	Revision of a tympanoplasty
B	Other operations on the middle & internal ear
7	Myringotomy
8	Removal of a tympanic drain
9	Incision of the mastoid process and middle ear
10	Mastoidectomy
11	Reconstruction of the middle ear
12	Fenestration of the inner ear
13	Revision of a fenestration of the inner ear
14	Incision (opening) and destruction (elimination) of the inner ear
C	Operations on the nose & the nasal sinuses
15	Excision and destruction of diseased tissue of the nose
16	Operations on the turbinates (nasal concha)
17	Nasal sinus aspiration
D	Operations on the eyes
18	Incision of tear glands
19	Incision of diseased eyelids
20	Excision and destruction of diseased tissue of the eyelid
21	Operations on the canthus and epicanthusv
22	Corrective surgery for entropion and ectropion
23	Corrective surgery for blepharoptosis
24	Removal of a foreign body from the conjunctiva
25	Removal of a foreign body from the cornea
26	Incision of the cornea
27	Operations for pterygium
28	Removal of a foreign body from the lens of the eye
29	Removal of a foreign body from the posterior chamber of the eye
30	Removal of a foreign body from the orbit and eyeball
31	Operation of cataract
E	Operations on the skin & subcutaneous tissues
32	Incision of a pilonidal sinus
33	Free skin transplantation, donor site
34	Free skin transplantation, recipient site
35	Revision of skin plasty

36	Simple restoration of surface continuity of the skin and subcutaneous tissues
37	Destruction of diseased tissue in the skin and subcutaneous tissues
38	Local excision of diseased tissue of the skin and subcutaneous tissues
39	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
40	Chemosurgery to the skin
F	Operations on the tongue
41	Incision, excision and destruction of diseased tissue of the tongue
42	Partial glossectomy
43	Glossectomy
44	Reconstruction of the tongue
G	Operations on the salivary glands & salivary ducts
45	Incision and lancing of a salivary gland and a salivary duct
46	Excision of diseased tissue of a salivary gland and a salivary duct
47	Resection of a salivary gland
48	Reconstruction of a salivary gland and a salivary duct
H	Other operations on the mouth & face
49	External incision and drainage in the region of the mouth, jaw and face
50	Incision of the hard and soft palate
51	Excision and destruction of diseased hard and soft palate
52	Incision, excision and destruction in the mouth
53	Plastic surgery to the floor of the mouth
54	Palatoplasty
I	Operations on the tonsils & adenoids
55	Transoral incision and drainage of a pharyngeal abscess
56	Tonsillectomy without adenoidectomy
57	Tonsillectomy with adenoidectomy
58	Excision and destruction of a lingual tonsil
J	Trauma surgery and orthopaedics
59	Incision on bone, septic and aseptic
60	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
61	Reduction of dislocation under GA
62	Arthroscopic knee aspiration
K	Operations on the breast
63	Incision of the breast
64	Operations on the nipple
L	Operations on the digestive tract
65	Incision and excision of tissue in the perianal region
66	Surgical treatment of anal fistulas
67	Surgical treatment of haemorrhoids
68	Division of the anal sphincter (sphincterotomy)
69	Ultrasound guided aspirations
70	sclerotherapy
M	Operations on the female sexual organs

71	Incision of the ovary
72	Insufflation of the Fallopian tubes
73	Dilatation of the cervical canal
74	Conisation of the uterine cervix
75	Incision of the uterus (hysterectomy)
76	Therapeutic curettage
77	Culdotomy
78	Incision of the vagina
79	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
80	Incision of the vulva
81	Operations on Bartholin’s glands (cyst)
N	Operations on the prostate & seminal vesicles
82	Incision of the prostate
83	Transurethral excision and destruction of prostate tissue
84	Transurethral and percutaneous destruction of prostate tissue
85	Open surgical excision and destruction of prostate tissue
86	Radical prostatovesiculectomy
87	Incision and excision of periprostatic tissue
88	Operations on seminal vesicles
O	Operations on the scrotum & tunica vaginalis testis
89	Incision of the scrotum and tunica vaginalis testis
90	Operation on a testicular hydrocele
91	Excision and destruction of diseased scrotal tissue
92	Plastic reconstruction of the scrotum and tunica vaginalis testis
P	Operations on the testes
93	Incision of the testes
94	Excision and destruction of diseased tissue of the testes
95	Unilateral orchidectomy
96	Bilateral orchidectomy
97	Orchidopexy
98	Abdominal exploration in cryptorchidism
99	Surgical repositioning of an abdominal testis
100	Reconstruction of the testis
101	Implantation, exchange and removal of a testicular prosthesis
Q	Operations on the spermatic cord, epididymis und ductus deferens
102	Surgical treatment of a varicocele and a hydrocele of the spermatic Cord
103	Excision in the area of the epididymis
104	Epididymectomy
105	Reconstruction of the spermatic cord
106	Reconstruction of the ductus deferens and epididymis
R	Operations on the penis
107	Operations on the foreskin
108	Local excision and destruction of diseased tissue of the penis
109	Amputation of the penis

110	Plastic reconstruction of the penis
S	Operations on the urinary system
111	Cystoscopical removal of stones
T	Other Operations
112	Lithotripsy
113	Coronary angiography
114	Haemodialysis
115	Radiotherapy for Cancer
116	Cancer Chemotherapy