Uni Group Health Insurance Policy

UIN UIIHLGP21251V022021

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Policy Terms and Conditions

I. Preamble & Operating Clause

This is a legal contract between the Policyholder and Us to provide the insurance cover detailed in the Policy to the Insured Persons up to the Sum Insured subject to

i. the receipt of full premium,
ii. disclosure to information norm including the information provided in the Proposal Form or the Request for Quote (RFQ) by the Proposer or by his/ her authorized Intermediary on behalf of him/her-self and all persons to be insured which is incorporated in the policy and is the basis of it; and
iii. the terms, conditions and exclusions of this Policy.

If during the policy period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the medically necessary and Reasonable and Customary expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured opted as specified in the Schedule.

II. Covers under the Policy

In the event of any claim arising as a result of treatment taken for an Injury or Illness during the Policy period which becomes payable under any applicable Base Cover and/or Optional Covers, then We shall indemnify the Reasonable and Customary Medical Expenses incurred or pay for the listed Benefits, in accordance with the terms, conditions and exclusions of the Policy subject to availability of the Sum Insured for the cover/ benefit applicable and subject to the limit, if any, specified in the Policy Schedule/ Certificate of Insurance. All limits mentioned in the Policy Schedule/ Certificate of Insurance are applicable for each Policy period of coverage.

Base Covers

The Policy provides base coverage as described below in this section provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner and are incurred on Medically Necessary Treatment of the Insured Person.

1. In-patient Hospitalisation Expenses Cover

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Treatment taken during Hospitalisation provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy period:

A. Room, Boarding and Nursing expenses as provided by the Hospital/Nursing Home up to the category/limit specified in the Policy Schedule/ Certificate of Insurance or actual expenses incurred, whichever is less, including nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.
B. Charges for accommodation in ICU/CCU/HDU up to the category/limit specified in the Policy Schedule/ Certificate of Insurance or actual expenses incurred, whichever is less,
C. Operation theatre cost,
D. Anaesthestics, Blood, Oxygen, Surgical Appliances and/ or Medical Appliances, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents, and other medical expenses related to the treatment.
E. The fees charged by the Medical Practitioner, Surgeon, Specialists and Anaesthetists treating the Insured Person;
F. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
G. Cost of Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is hospitalized such as but not limited to Radiology, Pathology tests, X-rays, MRI and CT Scans, Physiotherapy.

Note 1:
Proportionate Clause: *In case of admission to a room at rates exceeding the limits mentioned in the Policy Schedule/Certificate of Insurance (for Clause II.1.A), the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent.*
Proportionate Deductions shall not be applied in respect of those hospitals where differential billing is not followed or for those expenses where differential billing is not adopted based on the room category.

Note 2:
Mental Illness Cover Limit:
In case of following mental illnesses the Inpatient Hospitalization benefit will be covered upto the limit as mentioned in the schedule;
1. Schizophrenia (ICD - F20; F21; F25)
2. Bipolar Affective Disorders (ICD - F31; F34)
3. Depression (ICD - F32; F33)
4. Obsessive Compulsive Disorders (ICD - F42; F60.5)
5. Psychosis (ICD - F 22; F23; F28; F29)

All claims under this Benefit can be made as per the process defined under Section V. C and D

2. Day Care Treatment Cover

We will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment (as defined in Section VII.19) during the Policy Period following an Illness or Injury that occurs during the Policy Period provided the Day Care Treatment is for Medically Necessary Treatment and follows the written Medical Advice.

The benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance, whichever is less.

All claims under this Benefit can be made as per the process defined under Section V. C and D

3. Pre – hospitalisation Medical Expenses Cover

We will cover, on a reimbursement basis, the Insured Person's Pre-hospitalization Medical Expenses incurred due to an Illness or Injury that occurs during the Policy Period upto the number of days and upto the amount limit as specified in the Policy Schedule or Certificate of Insurance Or actual expenses incurred, whichever is less, provided that:

(i) We have accepted a claim for In-patient Hospitalization under Section II.1 or II.2 above;
(ii) The Pre-hospitalisation Medical Expenses are related to the same Illness or Injury.
(iii) The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Any One Illness.

All claims under this Benefit can be made as per the process defined under Section V. D

4. Post – hospitalisation Medical Expenses Cover

We will cover, on a reimbursement basis, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period upto the number of days and upto the amount limit as specified in the Policy Schedule or Certificate of Insurance, provided that:

(i) We have accepted a claim for In-patient Hospitalization under Section II.1 or II.2 above;
(ii) The Pre-hospitalisation Medical Expenses are related to the same Illness or Injury.
(iii) The date of discharge from the Hospital for the purpose of this Benefit shall be the date of the Insured Person's last discharge from the Hospital in relation to the same Any One Illness for which We have accepted an In-patient Hospitalization claim under Section II.1 or II.2 above.

All claims under this Benefit can be made as per the process defined under Section V. D

5. Road Ambulance Cover

We will cover the costs incurred up to the limit as specified in the Policy Schedule or Certificate of Insurance on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. It becomes payable if a claim has been admitted under Section II.1 or II.2 and the expenses are related to the same Illness or Injury.

We will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified in the Policy Schedule or Certificate of Insurance:

(i) it is medically required to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
(ii) it is medically required to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of speciality treatment in the existing Hospital.

All claims under this Benefit can be made as per the process defined under Section V. D

6. Domiciliary Hospitalisation Cover

We will cover Medical Expenses, up to the limit specified in the Policy Schedule/ Certificate of Insurance, incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

i. The Domiciliary Hospitalisation continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalisation;
ii. The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically required and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital or the Insured Person satisfies Us that a Hospital bed was unavailable;
iii. We shall not be liable to pay for any claim in connection with:
    a. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
    b. Arthritis, gout and rheumatism;
    c. Chronic nephritis and nephritic syndrome;
    d. Diarrhoea and all type of dysenteries, including gastroenteritis;
    e. Diabetes mellitus and insipidus;
    f. Epilepsy;
    g. Hypertension;
    h. Psychiatric or psychosomatic disorders of all kinds;
    i. Pyrexia of unknown origin.

All claims under this Benefit can be made as per the process defined under Section V. D

7. Donor Expenses Cover

We will cover the In-patient Hospitalization Medical Expenses incurred for an organ donor's treatment during the Policy Period for the harvesting of the organ donated up to the limit as specified in the Policy Schedule or Certificate of Insurance provided that:

i. The donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
ii. We have admitted a claim towards In-patient Hospitalisation under the Base Cover and it is related to the same condition; organ donated is for the use of the Insured Person as certified in writing by a Medical Practitioner;
iii. We will not cover:

a. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor;
b. Screening expenses of the organ donor;
c. Costs associated with the acquisition of the donor's organ;
d. Transplant of any organ/tissue where the transplant is experimental or investigational;
e. Expenses related to organ transportation or preservation;
f. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

All claims under this Benefit can be made as per the process defined under Section V. C and D

8. Modern Treatment Methods & Advancement in Technologies:

In case of an admissible claim under section 4.1, expenses incurred on the following procedures (wherever medically indicated) either as in-patient or as part of day care treatment in a hospital, shall be covered. The claim shall be subject to additional sub-limits indicated against them in the table below:

Sr. No.	Modern Treatment Methods & Advancement in Technology	Limits per Surgery
1	Uterine Artery Embolization & High Intensity Focussed Ultrasound (HIFU)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Uterine Artery Embolization & HIFU
2	Balloon Sinuplasty	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Balloon Sinuplasty
3	Deep Brain Stimulation	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Deep Brain Stimulation
4	Oral Chemotherapy	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Oral Chemotherapy
5	Immunotherapy-Monoclonal Antibody to be given as injection	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period
6	Intra vitreal Injections	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period
7	Robotic Surgeries (Including Robotic Assisted Surgeries)	• up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Robotic Surgeries for (i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies • up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Robotic Surgeries for other diseases
8	Stereotactic Radio Surgeries	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Stereotactic Radio Surgeries
9	Bronchial Thermoplasty	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Bronchial Thermoplasty.
10	Vaporisation of the Prostate (Green laser treatment for holmium laser treatment)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period.
11	Intra Operative Neuro Monitoring (IONM)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Intra Operative Neuro Monitoring
12	Stem Cell Therapy: Hematopoietic Stem Cells for bone marrow transplant for haematological conditions to be covered only	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period.

All claims under this Benefit can be made as per the process defined under Section V. C and D

There are Optional covers available with the Policy. Refer **Section VIII – Optional Covers: Policy Terms and Conditions for Optional Covers** for further details on these.

III. COVER TYPE

The Policy provides cover on an Individual or Family Floater basis. A separate Sum Insured for each Insured Person, as specified in the Policy Schedule/Certificate of Insurance, is provided under Individual basis while under Family Floater basis, the Sum Insured limit is shared by the whole family of the group member as specified in the Policy Schedule/ Certificate of Insurance and Our total liability for the family cannot exceed the Sum Insured in a Policy period. The cover type basis shall be as specified in the Policy Schedule/ Certificate of Insurance. The basis of cover chosen for the Base Cover is applicable for the Optional Covers as well.

Relationships covered under the Policy are as specified in the Policy Schedule/ Certificate of Insurance.

IV. PERMANENT EXCLUSIONS & WAITING PERIODS

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

A. Permanent Exclusions

We shall not be liable to make any payment under this Policy caused by, based on, arising out of, relating to or howsoever attributable to any of the following:

1. All expenses, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.

2. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack.

3. a) Stem cell implantation/Surgery, harvesting, storage or any kind of Treatment using stem cells except as provided for in clause II.8 (12) above; b) growth hormone therapy.

4. External Congenital Anomaly or defects.
5. Sterility and Infertility **(Code-Excl17)**: Expenses related to Sterility and Infertility. This includes:
    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization

6. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.

7. Conditions for which treatment could have been done on an out-patient basis without any Hospitalization.

8. Investigation & Evaluation **(Code-Excl04)**:
   i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;
   ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

9. Any treatment or part of a treatment that is not of a reasonable charge, is not a Medically Necessary Treatment; drugs or treatments which are not supported by a prescription.

10. Costs of donor screening or costs incurred in an organ transplant Surgery involving organs not harvested from a human body.

11. Unproven Treatments **(Code- Excl16)**: Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

12. Any form of Alternative Treatment:
   i. AYUSH Treatment;
   ii. Hydrotherapy, Acupuncture, Reflexology, Chiropractic Treatment or any other form of indigenous system of medicine.

13. Dental Treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalisation. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way.

14. Routine eye examinations, cost of spectacles, multifocal lens, contact lenses.

15. Refractive Error (**Code-Excl15**): Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

16. a) Cost of hearing aids; including optometric therapy; b) cochlear implants unless necessitated by an Accident or required intra-operatively.
17. Vaccinations including inoculation and immunizations except in case of post-bite treatment.

18. Any Treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall Treatment and products,

19. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.

20. Any stay in Hospital without undertaking any Treatment or any other purpose other than for receiving eligible Treatment of a type that normally requires a stay in the Hospital.

21. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure. (**Code-Excl14**)

22. Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state.

23. Rest Cure, Rehabilitation and Respite Care **(Code-Excl05)**: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
    i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
    ii. Any services for people who are terminally ill to address physical, social, emotional, and spiritual needs.

24. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code-Excl13)**

25. Breach of law **(Code-Excl10)**: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

26. Certification / diagnosis / Treatment by a family member, or a person who stays with the Insured Person, save for the proven material costs which are eligible for reimbursement as per the applicable cover, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for.

27. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**

28. Prostheses, corrective devices and and/or Medical Appliances, which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalized.

29. Cosmetic or Plastic Surgery **(Code-Excl08)**: Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the Insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

30. Change-of-Gender treatments **(Code-Excl07)**: Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

31. Obesity/ Weight Control **(Code-Excl06)**: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
    i. Surgery to be conducted is upon the advice of the Doctor
    ii. The surgery/Procedure conducted should be supported by clinical protocols
    iii. The member has to be 18 years of age or older and
    iv. Body Mass Index (BMI)
        A. greater than or equal to 40 or
        B. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
            a. Obesity-related cardiomyopathy
            b. Coronary heart disease
            c. Severe Sleep Apnoea
            d. Uncontrolled Type2 Diabetes

32. Treatment received outside India.

33. **a)** Instrument used in Treatment of Sleep Apnea Syndrome (C.P.A.P.); **b)** Oxygen Concentrator for Bronchial Asthmatic condition; **c)** Infusion pump or any other external devices used during or after Treatment.

34. Hazardous or Adventure sports **(Code- Excl09)**: Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

35. Injury caused whilst flying or taking part in aerial activities (including cabin) except as a fare-paying passenger in a regular scheduled airline or air charter company.

36. Maternity **(Code-Excl18)**:
    i. Medical treatment expenses traceable to child birth (Including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

37. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and Treatment of the Illness/Injury for which the Insured Person was Hospitalised, such as, ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses. For complete list of non-medical expenses, please refer to the ***Annexure I*** “Non-Medical Expenses” and also on Our website.

38. Any opted Deductible (Per claim/ Aggregate/ Corporate) amount or percentage of admissible claim under Co-Payment, Sub Limit if applicable and as specified in the Policy Schedule/ Certificate of Insurance to this Policy.

39. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing, including MRD charges (medical records department charges).

40. Any physical, medical or mental condition or Treatment or service that is specifically excluded in the Policy Schedule/ Certificate of Insurance under Special Conditions.

B. Pre-Existing Disease Waiting Period (Code-Excl01)

i. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, of continuous coverage after the date of inception of the first policy with us.
ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

C. Initial Waiting Period for Hospitalization (Code-Excl03)

i. Expenses related to the treatment of any illness within the number of days, as mentioned in the Policy schedule or Certificate of Insurance, from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

D. Specific Waiting Period (Code-Excl02)

i. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, of continuous coverage, as may be the case after the date of inception of the first policy with the Insurer. This exclusion shall not be applicable for claims arising due to an accident.
ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
iii. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
vi. List of specific diseases/procedures:

a) Cataract
b) Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids
c) Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal Diseases
d) Varicose Veins and Varicose Ulcers
e) Stones in the urinary, uro-genital and biliary systems including calculus diseases
f) Benign Prostate Hypertrophy, all types of Hydrocele
g) Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Hemorrhoids and any abscess related to the anal region
h) Chronic Supportive Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery
i) Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/skin tumors, and any type of Breast lumps (unless malignant), Polycystic Ovarian Diseases
j) Any Surgery of the genito-urinary system unless necessitated by malignancy
k) Age-related Macular Degeneration (ARMD)
l) All Neurodegenerative disorders
m) Waiting Period for Named Mental Illnesses

S. No.	Organ / Organ Systems	Illness / Surgeries
1.	**Mental Disorders**	1. Schizophrenia (ICD - F20; F21; F25) 2. Bipolar Affective Disorders (ICD - F31; F34) 3. Depression (ICD - F32; F33) 4. Obsessive Compulsive Disorders (ICD - F42; F60.5) 5. Psychosis (ICD - F 22; F23; F28; F29)

V. Claims Procedure

A. Claims Administration & Process

It shall be the condition precedent to admission of Our liability under this Policy that the terms and conditions of making the payment of premium in full and on time, insofar as they relate to anything to be done or complied with by You or any Insured Person, are fulfilled including complying with the following in relation to claims:

1. On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.
2. The treatment should be taken as per the directions, advice and guidance of the treating Medical Practitioner. Any failure to follow such directions, Medical advice or guidance will prejudice the claim.
3. The Insured Person must submit to medical examination by Our Medical Practitioner or our authorized representative in case requested by Us and at Our cost, as often as We consider reasonable and necessary and We/Our representatives must be permitted to

inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

4. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

B. Notification of claim

Upon the happening of any event which may give rise to a claim under this Policy, the insured person/insured person's representative shall notify the TPA (if claim is processed by TPA)/company (if claim is processed by the company) in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

C. Procedure for Cashless claims

1. Cashless facility for treatment in network hospitals only shall be available to insured if opted for claim processing by TPA.
2. Treatment may be taken in a network provider/PPN hospital and is subject to pre-authorization by the TPA. Booklet containing list of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the TPA mentioned in the schedule.
3. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.
4. On admission in the network provider/PPN hospital, produce the ID card issued by the TPA at the Hospital Insurance-desk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for pre- authorization.
5. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorisation letter to the hospital after verification.
6. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorisation date at a Network Provider and pre-authorisation shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre-authorised by Us or the associated TPA, We will make the payment of the amounts assessed directly to the Network Provider.
7. In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalization to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under V.4 above.
8. At the time of discharge, the insured person shall verify and sign the discharge papers and final bill and pay for non-medical and inadmissible expenses.

Note: (Applicable to V.C): Cashless facility for Hospitalization expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider/ PPN hospital for Illness or Injury / Accident/ Critical Illness as the case may be

which are covered under the Policy. For all cashless authorisations, the Insured Person will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and / or opted Deductible (Per claim/ Aggregate/ Corporate) (if applicable), directly with the Hospital.

9. The TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medical details. Denial of a Pre-authorisation request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.
10. In case of admission in PPN hospitals, duly filled and signed PPN declaration format available with the hospital must be submitted.
11. Claims for Pre and Post-Hospitalisation will be settled on a reimbursement basis on production of cash receipts alongwith supporting documents.

D. Procedure for reimbursement of claims

In non-network hospitals payment must be made up-front and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/company (if claim is processed by the company) within the prescribed time limit.

E. Documents

1. The claim is to be supported with the following original documents and submitted within the prescribed time limit.

i. Duly completed claim form;
ii. Photo ID and Age proof;
iii. Health Card, policy copy, photo ID, KYC documents;
iv. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed, along with date of diagnosis, investigation test reports etc. supported by the prescription from attending medical practitioner.
v. Original discharge card / day care summary / transfer summary;
vi. Original final Hospital bill with detailed break-up with all original deposit and final payment receipt;
vii. Original invoice with payment receipt and implant stickers for all implants used during Surgeries i.e. lens sticker and Invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery;
viii. All previous consultation papers indicating history and treatment details for current ailment;
ix. All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center;
x. All original medicine / pharmacy bills along with the Medical Practitioner's prescription;
xi. MLC / FIR copy – in Accidental cases only;
xii. Copy of death summary and copy of death certificate (in death claims only);
xiii. Pre and post-operative imaging reports;

xiv. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress;
xv. KYC documents
xvi. Cheque copy with name of proposer printed on the cheque leaf or copy of the first page of the bank passbook or the bank statement not later than 3 months.

Note
In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under condition 5.6.4 and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

2. Time limit for submission of documents

Type of claim	**Time limit for submission of documents to company/TPA**
Where Cashless Facility has been authorised	Immediately after discharge.
Reimbursement of hospitalisation and pre hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post hospitalisation treatment

Note: Waiver of this 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.

3. The Insured Person shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
4. All the documents submitted to TPA shall be electronically collected by Us for settlement and denial of the claims by the appropriate authority.

F. Scrutiny of Claim Documents

a. TPA/ We shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/ Network Provider as the case may be.
   If the deficiency in the necessary claim documents is not met or is partially met in 10 working days of the first intimation. We will send a maximum of 3 (three) reminders. We may, at Our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.
b. In case a reimbursement claim is received when a pre-authorisation letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorisation has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.

c. The Pre-Hospitalisation Medical Expenses Cover claim and Post- Hospitalization Medical Expenses Cover claim shall be processed only after decision of the main Hospitalization claim.

G. Claim Assessment

We will pay the fixed or indemnity amount as specified in the applicable Base or Optional cover in accordance with the terms of this Policy.

We will assess all admissible claims under the Policy in the following progressive order:

1. Application Proportionate clause as per Note 1.clause II.1.
2. Co-pay as applicable.
3. Limit/ Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/ Certificate of Insurance
4. Opted Deductible (Per claim/ Aggregate)

<u>Claim Assessment for Benefit Plans:</u>

We will pay fixed benefit amounts as specified in the Policy Schedule/ Certificate of Insurance in accordance with the terms of this Policy. We are not liable to make any reimbursements of Medical Expenses or pay any other amounts not specified in the Policy.

H. Claim Settlement (provision for Penal Interest)

1. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
2. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Insured Person from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
3. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
4. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Insured Person at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).

I. Claim Rejection/ Repudiation

If the company, for any reasons, decides to reject a claim under the policy, we shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be. Where a rejection is communicated by Us, the Insured Person may, if so desired, within 15 days from the date of receipt of the claims decision represent to Us for reconsideration of the decision.

J. Claim Payment Terms

i. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.
All claims will be payable in India and in Indian rupees.

ii. We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice or guidance provided by a Medical Practitioner.

iii. The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.

iv. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.

v. **For Cashless claims**, the payment shall be made to the Network Provider whose discharge would be complete and final.

vi. **For Reimbursement claims**, the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, we will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

K. Services offered by TPA (To be stated where TPA is involved)

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorisation of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.
The services offered by a TPA shall not include:

i. Claim settlement and rejection;
ii. Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

L. Payment of Claim

All claims under the policy shall be payable in Indian currency only.

VI. Terms and conditions

1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

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

2. **Condition Precedent to Admission of Liability**
   The terms and conditions of the policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the policy.

3. **Parties to the Policy**
   The only parties to this Policy are the Policyholder and Us.

4. **No Constructive Notice**
   Any knowledge or information of any circumstance or condition in relation to You/Insured Person in Our possession or in the possession of any of Our officials shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve You/Insured Person from your/her duty of disclosure, notwithstanding subsequent acceptance of any premium.

5. **Eligibility**
   To be eligible for coverage under the Policy, the Insured Person must be -
   a. Either an employee of the policyholder where there is an employer/employee relationship OR a member of the group as defined in extant IRDAI guidelines on Group Health Insurance in case of Non-Employer-Employee policies
   b. The relationships which may be covered under the Policy are-
      i. Self
      ii. Employee/member's legal Spouse, Life Partner (including live-in partner)

         For the purpose of this section, Life Partner (including live-in partner) shall be taken as declared at the time of inception of Policy and no change would be accepted during the Policy Period. However, the Insured may request for change at the time of Renewal of the cover.
      iii. The Employee/member's children between the age of 91 days and 18 years shall be covered provided either or both parents are covered concurrently. Children above 18 years will continue to be covered along with parents up to the age of 26 years, provided they are unmarried/unemployed and dependent.
      iv. Parents/Parents-in-law
      v. The Employee/member's siblings shall be covered up to the age of 26 years, provided they are unmarried/unemployed and dependent.
      vi. Any other relationship as specified in the Policy Schedule/Certificate of Insurance
   c. Minimum Group size: The Policyholder shall ensure that the minimum number of Employees/members who will form a group to avail the Benefits under this Policy shall be 7 (Seven).
   d. New Born Babies will be accepted for cover (subject to the limitations of the New Born Baby Benefit Cover) from birth if mother is covered and maternity cover is opted. Acceptance of New Born Babies as Insured Persons is subject to written notification on or before the last day of the month following the birth of the child and receipt of the agreed premium.

6. Reasonable Care

The Insured Person understands and agrees to take all reasonable steps in order to safeguard against any Illnesses, Accident or Injury that may give rise to any claim under this Policy.

7. Premium

The premium for each Policy will be determined based on the available data of each group, coverage sought by the insured and applicable discounts and loadings. Payment of premiums will be available in Single mode. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Policyholder in so far as they relate to anything to be done or complied with by the Policyholder shall be a Condition Precedent to Our liability to make any payment under this Policy.
Premium will be subject to revision at the time of renewal of the Policy. Further, premium shall be paid in Indian Rupees and in favour of United India Insurance Company Ltd.

NOTE: Where Instalment facility is granted by Us for the payment of premium, it is to be in accordance with the schedule of payments agreed between the Policyholder and Us in writing.
Where premium is payable on an instalment basis, the revival period shall be 15 days. Wherever premiums are not received within the revival period, the Policy will be terminated effective from instalment due date and all claims that fall beyond such instalment due date shall not be paid. However, we will be liable to pay in respect of all claims where the Treatment/Admission/Accident has commenced/ occurred before the date of termination of such Policy.
For installment premium, in the event of cancellation of policy, we will refund premium on pro rata basis after deducting Our expenses.

Premium shall be refunded for all lives which have not registered a claim with Us under the Policy up to the date of cancellation.

8. Role of Group Administrator/Policyholder

i. The Policyholder should provide all the written information that is reasonably required to work out the premium and pay any claim/ Benefit provided under the Policy including the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.
ii. Material information to be disclosed includes every matter that the Insured Person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the RFQ/ proposal form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. The Insured Person/ Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, or endorsement of the Policy.

iii. The Policy holder i.e. the Employer may issue confirmation of insurance protection to the individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.
iv. The claims of the individual employees may be processed through the employer.

9. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us. All endorsement requests will be made by the Policyholder only.

10. Material Information for administration

The Insured Person and/ or the Policyholder must give Us all the written information that is reasonably required to work out the premium and pay any claim/ Benefit provided under the Policy. You must give Us written notification specifying the details of the Insured Persons to be deleted and the details of the eligible persons proposed to be added to the Policy as Insured Persons.

Material information to be disclosed includes every matter that the Insured Person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the proposal form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. The Insured Person/ Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation or endorsement of the Policy.

11. Material Change

It is Condition Precedent to Our liability under the Policy that You shall at Your own expense immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business of any Insured Person. We may, in Our discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

12. Fraud

If any claim made by the Insured Person is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/ Policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/ any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance policy:

i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

iii. any other act fitted to deceive; and
iv. any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and/ or forfeit the policy benefits on the ground of fraud, if the Insured Person/beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

13. Geographical Area

The geographical scope of this Policy applies to events limited to India unless specified under this Policy in a particular Benefit or definition. However, all admitted or payable claims shall be settled in India in Indian rupees.

14. Addition and Deletion of a Member

We shall include/exclude a group member/Employee of the Policyholder and/or his/her Dependent(s) as an Insured Person under the Policy in accordance with the following procedure:

A. **Additions**

a. Employer – Employee Group:

i) Newly appointed employee and his/her dependents
ii) Newly wedded spouse of the employee,
iii) New born child of the employee

may be added to the Policy as an Insured Person during the Policy period provided that the application for cover has been accepted by Us, additional premium on pro-rata basis applied on the risk coverage duration for the Insured Person has been received by Us and We have issued an endorsement confirming the addition of such person as an Insured Person

b. Non-Employer – Employee Group: As specified in the Policy Schedule

B. **Deletions:**

a. Employer – Employee Group

i) Employee leaving the company/organization on account of resignation/retirement/termination and his/her dependents shall be deleted from the policy effective from the date of resignation/retirement/termination or till the last day of the month of resignation/retirement/termination at the option of the insured
ii) In the event of death of an employee, his/her dependents may continue to be covered until the expiry of the policy period at the option of the insured

b. Non-Employer – Employee Group: As specified in the Policy Schedule

Refund of premium shall be made on a pro-rata basis, provided that no claim is paid/outstanding in respect of that Insured Person or his/her Dependents.

Throughout the Policy period, the Policyholder will notify Us of all and any changes in the membership of the Policy occurring in a month on or before the last day of the succeeding month.

15. Nomination

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

16. Endorsements

The Policy will allow the following endorsements during the Policy period. Any request for endorsement must be made only in writing by the Policyholder. Any endorsement would be effective from the date of the request received from You, or the date of receipt of premium, whichever is later.

- Rectification in name of the proposer / Insured Person.
- Rectification in gender of the proposer/ Insured Person.
- Rectification in relationship of the Insured Person with the proposer.
- Rectification of age/ date of birth of the Insured Person
- Change in the correspondence address of the proposer.
- Change/updating in the contact details viz., phone number, E-mail ID, etc.
- Updating of alternate contact address of the proposer.
- Change in Nominee details.
- Deletion of Insured Person on death or upon leaving the group provided no claims are paid / outstanding.
- Addition of member (New Born Baby or newly wedded Spouse).

All endorsement requests shall be assessed by the underwriter and where required additional information/documents/ premium may be requested.

17. Multiple Policies

i. In case of multiple policies taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person 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. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies, even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and condition of this policy.

iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

18. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation, non-disclosure of material facts by the Insured Person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

19. Renewal Terms

Alterations like increase/ decrease in Sum Insured or change in optional covers can be requested at the time of Renewal of the Policy. We reserve Our right to carry out assessment of the group and provide the Renewal quote in respect of the revised Policy.

We may in Our sole discretion, revise the premiums payable under the Policy or the terms of the cover, provided that all such changes are in accordance with the IRDAI rules and regulations as applicable from time to time.

20. Cancellation

i. The policyholder may request for cancellation of the policy at any time by giving 15 days' notice in writing. In such case We shall refund the percentage of premium for the unexpired Policy Period on short period scale as per the table below:
The grid is applicable for single premium Policy

Cancellation Grid	
Period* for which risk is retained	Refund
Upto 1 Month	75%
>1 Month- less than 3 Month	50%
>3 Months – less than 6 months	25%
>6 Months – less than 9 months	15%
>9 Months	Nil

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the policy.

ii. The Company may cancel the policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

21. Our Right of Termination

A. Termination of Policy:

Prior to the expiry of the Policy as shown in the Policy Schedule/ Certificate of Insurance, cover will end immediately for all Insured Persons, if:

i. there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person without any refund of premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

ii. there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis for all lives which have not registered a claim with Us, after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

iii. the Policyholder does not pay the premiums owed under the Policy within the Grace Period.

Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If Treatment has been authorized or an approval for Cashless facility has been issued, we will not be held responsible for any Treatment costs if the Policy ends. However, we will be liable to pay in respect of all claims where the Treatment/admission has commenced before the date of termination of such Policy.

B. Termination for Insured Person's cover

Cover will end for a Member or dependent:

i. If the Policyholder stops paying premiums for the Insured Person(s) and their Dependents (if any);

ii. When this Policy terminates at the expiry of the period shown in the Policy Schedule/ Certificate of Insurance.

iii. If he or she dies;

iv. When a dependent insured person ceases to be a Dependent; unless otherwise agreed specifically for continuation till end of policy period;

v. If the Insured Person ceases to be a member of the group.

22. Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

23. Migration

The Insured Person will have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy at least 30

days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on Migration, kindly refer the link:
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

24. Operation of Policy & Certificate of Insurance

The Policy shall be issued for the duration as specified in the Policy Schedule/ Certificate of Insurance. The Policy takes effect on the Inception Date stated in the Policy Schedule and/or the Certificate of Insurance and ends on the date of expiry of the Policy. For specific groups, upon request, all additions thereto by way of Certificate/s of Insurance shall be valid up to the Policy Period commencing from the actual date of addition to the Policy, it being agreed and understood that We shall continue to extend the benefit of coverage of insurance to the Insured Person(s) in the same manner on Renewal of the Policy or until expiry of the Certificate of Insurance, whichever is later.

25. Electronic Transactions

The Policyholder/ Insured Person agrees to comply with all the terms and conditions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy, or Our other services, shall constitute legally binding when done in compliance with Our terms for such facilities.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder/ Insured Person. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by the Policyholder/ Insured Person.

26. Communications & Notices

iii. Any notice, direction or instruction or any other communication related to the Policy should be made in writing.
iv. Such communication shall be sent to the address of the Company or through any other electronic modes at contact address as specified in the Policy Schedule.
v. No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us.
vi. The Company shall communicate to The Policyholder/ Insured Person in writing, at the address as specified in the Policy Schedule/ Certificate of Insurance or through any other electronic mode at the contact address as specified in the policy schedule

27. Complete Discharge

Any payment to the Policyholder, Insured Person or his/her nominees or his/her legal representative or Assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

28. Withdrawal of Policy

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

29. Moratorium Period

After completion of eight continuous years under the policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

30. Redressal of Grievances

In case of any grievance the Insured Person may contact the Company through:
Website: www.uiic.co.in
Toll free: 1800 425 333 33
E-mail: customercare@uiic.co.in
Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd., 19, IV Lane, Nungambakkam High Road, Chennai, Tamil Nadu- 600034

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance. If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at customercare@uiic.co.in
For updated details of grievance officer, kindly refer the link https://uiic.co.in/en/customercare/grievance

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Insurance Ombudsman offices have been provided as ***Annexure – C***

Grievance may also be lodged at IRDAI Integrated Grievance Management System: https://igms.irda.gov.in/

31. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the policy shall be determined by the Indian court and according to Indian law.

VII. Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age or Aged** means age of the Insured Person on last birthday as on date of commencement of the Policy.
3. **Alternative Treatments** are forms of Treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.
4. **Annexure** means a document attached and marked as Annexure to this Policy.
5. **Ambulance** means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical Treatment of the person requiring medical attention.
6. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
7. **Associated Medical Expenses** means hospitalisation related expenses on Surgeon, Anesthetist, Medical Practitioner, Consultants and Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital; Anesthesia, blood, oxygen, operation theatre charges, surgical appliances and such other similar expenses with the exception of:
    a. cost of pharmacy and consumables medicines
    b. cost of implants/medical devices
    c. cost of diagnostics

    The scope of this definition is limited to admissible claims where a proportionate deduction is applicable, as per Note 1 of Clause II.1.

8. **AYUSH Treatment** refers to the medical and /or Hospitalization Treatments given under Ayurveda, Unani, Siddha and Homeopathy Systems.
9. **Benefit** means any benefit shown in the Policy Schedule and/or Certificate of Insurance.
10. **Base Sum Insured** means the Sum Insured for the Base Cover as specified in the Policy Schedule and/or Certificate of Insurance.
11. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
12. **Cashless facility** means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured Person in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorisation is approved.

13. **Certificate of Insurance** means the certificate We issue to the Insured Person outlining the Insured Person's cover under the Policy.
14. **Co-Morbidity** is the presence of one or more additional conditions co-occurring with a primary condition; in the countable sense of the term, a comorbidity is each additional condition
15. **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.
16. **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** – Congenital anomaly which is not in the visible and accessible parts of the body.
    b) **External Congenital Anomaly** – Congenital anomaly which is in the visible and accessible parts of the body.
16. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
17. **Cosmetic Surgery** means Surgery or medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.
18. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
19. **Day Care Treatment** means medical treatment, and/or *surgical procedure* which is:
    i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
    ii. which would have otherwise required a hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
20. **Day Care Centre** means any institution established for day care treatment of illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-
    i) has qualified nursing staff under its employment;
    ii) has qualified medical practitioner/s in charge;
    iii) has fully equipped operation theatre of its own where surgical procedures are carried out;
    iv) Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
21. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
22. **Dentist** means a dentist, dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided.
23. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
24. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    a. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

b. the patient takes treatment at home on account of non-availability of room in a hospital.

25. **Effective Date** means the date shown on the Certificate of Insurance on which the Insured Person was first included under the Policy.
26. **Eligibility** means the provisions of the Policy that state the requirements to be complied with.
27. **Employee** means any member of Your staff who is proposed and sponsored by You and who becomes an Insured Person under this Policy.
28. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.
29. **Emergency** shall mean a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an emergency anymore.
30. **Exclusions** mean specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under a particular health insurance contract.
31. **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.
32. **Home nursing** is arranged by the Hospital for a Qualified Nurse to visit the patient's home to give expert nursing services immediately after Hospital Treatment for as long as is required by medical necessity, visits for as long as is required by medical necessity for Treatment which would normally be provided in a Hospital.
    In either case, the Specialist who treated the patient must have recommended these services.
33. **Hospital** means any institution established for in- patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act or complies with all minimum criteria as under:
    i) has qualified nursing staff under its employment round the clock;
    ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii) has qualified medical practitioner(s) in charge round the clock;
    iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v) Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.
34. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive '*In-patient Care*' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
35. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    1. **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

2. **Chronic condition -** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
   - i. it needs on going or long-term monitoring through consultations, examinations, check-ups, and/ or tests
   - ii. it needs on going or long-term control or relief of symptoms
   - iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
   - iv. it continues indefinitely
   - v. it recurs or is likely to recur

36. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
37. **Inception Date** means the inception date of this Policy as specified in the Policy Schedule or Certificate of Insurance when the coverage under the Policy commences.
38. **Inpatient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.
39. **In-patient** means an Employee/ Member or Dependent who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving Treatment.
40. **Insured Person** means the Employee/ Member and/or Dependents named in the Policy Schedule/ Certificate of Insurance, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium is paid.
41. **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.
42. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
43. **IRDAI** means the Insurance Regulatory and Development Authority of India.
44. **Maternity expenses** means:
    a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b) expenses towards lawful medical termination of pregnancy during the Policy period.
45. **Medical Assistance Service** is a service which provides Medical Advice, evacuation, assistance and repatriation. This service can be multi-lingual and is available 24 hours a day.
46. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
47. **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.
48. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up

by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

49. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which:
    i. is required for the medical management of the illness or injury suffered by the insured;
    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. must have been prescribed by a medical practitioner;
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
50. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same Insurer.
51. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a cashless facility.
52. **Nominee** means the person named in the Policy Schedule or Certificate of Insurance (as applicable) who is nominated to receive the Benefits in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.
53. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.
54. **New Born Baby** means baby born during the Policy period and is aged upto 90 days.
55. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
56. **Out-Patient** means a patient who undergoes OPD treatment.
57. **OPD treatment** means the 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.
58. **Policy** is sent to You comprising of Policy wordings, Certificates of Insurance issued to the Insured Persons, group proposal form/RFQ and Policy Schedule/ Certificate Of Insurance which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.
59. **Policy Period** means the period between the Inception Date and the expiry date of the Policy as specified in the Policy Schedule/ Certificate of Insurance or the date of cancellation of this Policy, whichever is earlier.
60. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
61. **Pre-Existing Disease (PED)** means any condition, ailment, injury, or disease:
    i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement or
    ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement.
62. **Pre-hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person, provided that:

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

63. **Post-hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the insurance company.

64. **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.

65. **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.

66. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

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

68. **Spouse** means the Employee's legal husband or wife proposed to be covered under the Policy.

69. **Specialist** is a Medical Practitioner who:
-- Has received advanced specialist training;
-- Practices a particular branch of medicine or Surgery;
-- Is or has been appointed as a consultant in a Hospital or is or has been appointed to a position in a Hospital Which We accept as being of equivalent status.
It is clarified that a physiotherapist who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided is only a Specialist for the purpose of physiotherapy as described in the list of Benefits.

70. **Sum Insured** means, subject to the terms, conditions and exclusions of this Policy, the amount representing Our maximum, total liability for any or all claims arising under this Policy for the respective Benefit(s) in respect of an Insured Person and is as specified in the Policy Schedule and/or Certificate of Insurance against the particular Benefit(s).

71. **Surgical Appliance and/or Medical Appliance** means:
-- An artificial limb, prosthesis or device which is required for the purpose of or in connection with a Surgery;
-- An artificial device or prosthesis which is a necessary part of the Treatment immediately following Surgery for as long as such device or prosthesis is required by medical necessity.
-- A prosthesis or appliance which is medically necessary and is part of the recuperation process on a Short-Term basis.

72. **Service Partner** is an assistance company utilized by Us to support You for facilitation of access to Network Providers and for providing Medical Assistance Services. In India such services will be provided by a TPA.

73. **Sub Limit** defines limitation on the amount of coverage available to cover a specific type of claim. A sublimit is part of, rather than in addition to, the limit that would otherwise apply to the admissible claim amount.

74. **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 from suffering and prolongation of life, performed in a hospital or day care centre by a *medical practitioner*.
75. **Third Party Administrator (TPA)** means a Company who is licensed under the IRDAI (Third Party Administrators – Health Services) Regulations 2016, as amended from time to time, by the IRDAI and is engaged for a fee or remuneration by Us for the purposes of providing health services.
76. **Treatment** means any relevant treatment controlled or administered by a Medical Practitioner to cure or substantially relieve Illness within the scope of the Policy.
77. **Unproven/Experimental Treatment** means the treatment, including drug experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.
78. **Waiting Period** means a time bound exclusion period related to condition(s) specified in the Policy Schedule or Certificate of Insurance or Policy which shall be served before a claim related to such condition(s) becomes admissible.
79. **We/Our/Us** means the United India Insurance Company Limited.
80. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

VIII. Optional Covers: Policy Terms and Conditions for Optional Covers

(In conjunction with Policy Terms and Conditions)

This Policy may also provide Options to the Base Covers if these are specified to be applicable in the Policy Schedule and/or the Certificate of Insurance subject to (I) the terms, conditions, exclusions and limitations of the Options set out herein along with Optional Benefits (if any), (II) receipt of premium, statements in the proposal and information disclosed to Us by You or on Your behalf and on behalf of all persons to be insured which is incorporated into the Policy and is the basis of it.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base Cover (Section II of the Policy) shall apply.

1. Disease Category Sub Limit

We will limit the claim for a distinct Disease Category in a Policy period up to the amount specified in the Policy Schedule/ Certificate of Insurance per Insured Person in case the Policy provides for cover on an Individual basis and per family if the Policy provides for cover on a Family Floater basis.

Any number of claims can be made within any Disease Category up to the limit specified in the Policy Schedule/ Certificate of Insurance by any or all Insured Persons.

For the purpose of this Section, “Disease Category” means an Illness / Injury (including its complications) for which a claim has been paid during the Policy period under the Base Cover.

2. Maternity Expenses Cover

We will cover Medical Expenses incurred in respect of a female Insured Person above 18 years for the delivery of a child in a Hospital during the Policy Period (including but not limited to caesarean section, vacuum birthing, water birthing, hypnobirthing, midwife birthing) or for medically required and lawful medical termination of pregnancy.

This Benefit will be available subject to the following:

(i) Up to the limits as specified in the Policy Schedule or Certificate of Insurance;
(ii) After the waiting period as specified in the Policy Schedule or Certificate of Insurance from the Start Date;
(iii) Up to a maximum number of deliveries/ terminations as specified in the Policy Schedule or Certificate of Insurance,
(iv) Those insured persons who are already having number of living children as specified in the schedule will not be eligible for this benefit.
(v) Pre and post-natal Medical Expenses incurred only under hospitalisation shall be covered within the Maternity Expenses Cover limit. In such a case, We will pay the Pre and post-natal Medical expenses incurred from the date of conception up to a period of 6 weeks from delivery.
(vi) Payment under this cover will be limited to per event and will be a part of the Base Sum Insured specified in the Policy Schedule and/or Certificate of Insurance.

2.1 Option for including Pre and post-natal Medical Expenses incurred on Out-patient basis: Pre and post-natal Medical Expenses incurred on Out-patient basis, if specifically opted for, shall be covered within the Maternity Expenses Cover limit upto the sub-limit specified in the Policy Schedule or Certificate of Insurance. These expenses (including expenses incurred on pre-natal check-ups, doctor's consultations for monitoring of the pregnancy and any complications arising therefrom) shall be covered from the date of conception up to a period of 6 weeks from the delivery.

We will not be liable to make any payment in respect of the following:

a. Medical Expenses incurred in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses.
b. Medical Expenses for ectopic pregnancy, which will be covered under Section II.1 of the Base Cover Terms and Conditions.
c. Complications arising as a result of infertility Treatment (assisted conception).

Pre or post-natal Care Expenses shall not be considered for payment under any Pre-hospitalisation Medical Expenses or Post–hospitalisation Medical Expenses paid under the Base Cover.

If Maternity Expenses Cover is in force in respect of the Insured Person, then the part of Exclusion IV.A.36 pertaining to the Optional cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

All claims under this Benefit can be made as per the process defined under Section V of the Base Cover Terms and Conditions.

3. New Born Baby Cover

A. Medical Expenses

We will cover the Medical Expenses incurred towards In-patient Hospitalization of the New Born Baby within the Basic Sum Insured for any Illness or Injury from the date of birth till the expiry of this Policy. Congenital External Anomaly of the New Born Baby is not covered under the Policy.

Any expense incurred towards pre-term or pre-mature care or any expense incurred in connection with delivery of such New Born Baby is not covered under this cover.

No coverage for the New Born Baby would be available during subsequent renewals unless the child is declared for Insurance and covered as an Insured Person.

The cover is subject to the following:

i. Up to the sub-limit as specified in the Policy Schedule or Certificate of Insurance;
ii. The mother is covered as an Insured Person under the Policy with maternity expenses cover option and is hospitalized as an In-patient for delivery;
iii. The cover shall be subject to the maximum number of children allowed under the family definition. In case of multiple birth, all the new born babies are covered provided that before the birth the number of children were below the limit allowed under family definition.

B. Wellness Cover

We will pay the Reasonable and Customary Charges incurred during the Policy period in relation to vaccination expenses as per the WHO recommendations for Routine Immunisation of the New Born Baby, provided that:

i. The mother is covered as an Insured Person under the Policy with maternity expenses cover option and is hospitalized as an In-patient for delivery;
ii. This cover is offered only if Medical Expenses optional cover under 4.A is opted.
iii. The Benefit will be limited to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance and would be a part of the Base Sum Insured.
iv. If this Option is in force in respect of the Insured Person, then the part of Exclusion IV.A. 17, will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person up to the limit specified for this Benefit.

All claims under this Benefit can be made as per the process defined under Section V of the Base Cover Terms and Conditions.

4. Mother Care Cover

If an Insured Person who is less than 3 years of Age is Hospitalized in an ICU or a Neo-natal ICU or a Cardiac Care Unit of a Hospital, then we will cover room rent and other boarding expenses incurred upto limits as specified in the Policy Schedule of the Insured Person's mother to stay with the Insured Person in the same Hospital.

5. Out- Patient Treatment Cover

A) Out- Patient Treatment Cover (over and above the basic Sum Insured)

We will cover the Reasonable and Customary Charges incurred for medically required consultations, visit(s) to a doctor, diagnostic tests and pharmacy expenses which are incurred on an out-patient basis up to the limits as specified in the Policy Schedule or Certificate of Insurance.
Alternative Treatments shall also be covered under this Benefit.
The Benefit payable will be over and above the Base Sum Insured subject to any applicable Co-Payment as specified in the Policy Schedule/ Certificate of Insurance.
For the purpose of this Cover, Outpatient means an Insured person who is not hospitalized but who visits a hospital, clinic or associated facility for diagnosis or treatment.
The following exclusions will be applicable in addition to the exclusions under the Base Cover Terms and Conditions:

a. Naturopathy and Yoga
b. Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation, etc.
c. Cost of spectacles, etc. as Medical Aids.

If You have opted for the Dental Expenses and Vision Expenses Optional Covers separately, then the expenses paid under the said covers will not be payable under the Out-Patient Treatment Cover.
Exclusion 7 under Section IV A will stand deleted for this Option.
All claims under this Benefit can be made as per the process defined under Section V. of the Base Cover Terms and Conditions and Section III of the Optional Cover Terms and Conditions, as applicable.

B) Out- Patient Treatment Cover (within the basic Sum Insured)

We will cover the Reasonable and Customary Charges incurred for medically required consultations, visit(s) to a doctor, diagnostic tests and pharmacy expenses which are incurred on an out-patient basis up to the limits as specified in the Policy Schedule or Certificate of Insurance.
Alternative Treatments shall also be covered under this Benefit.
The Benefit payable will be within the Base Sum Insured subject to any applicable Co-Payment as specified in the Policy Schedule/ Certificate of Insurance.
For the purpose of this Cover, Outpatient means an Insured person who is not hospitalized but who visits a hospital, clinic or associated facility for diagnosis or treatment.
The following exclusions will be applicable in addition to the exclusions under the Base Cover Terms and Conditions:

a. Naturopathy and Yoga
b. Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation, etc.
c. Cost of spectacles, etc. as Medical Aids.

If You have opted for the Dental Expenses and Vision Expenses Optional Covers separately, then the expenses paid under the said covers will not be payable under the Out-Patient Treatment Cover.
Exclusion 7 under Section IV will stand deleted for this Option.
All claims under this Benefit can be made as per the process defined under Section V of the Base Cover Terms and Conditions and Section III of the Optional Cover Terms and Conditions, as applicable.

6. Sub Limit on Treatment/ Illness Surgery/Medical Condition

We will pay the Medical Expenses incurred towards claim for a specified Treatment(s) of an Illness /procedure(s) up to the amount of Sub Limit applicable per claim during the Policy period as specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. For the balance amount, if any, subject to the applicability of Sub Limits on Medical Expenses incurred on specified Treatment of an Illness / procedure, our liability to make any payment shall be limited to such extent as applicable.

ii. The amount of Sub Limit for the specified Treatment(s) of an Illness /procedure(s) shall be as opted by the Policyholder from the table below:

Medical Procedure/ Treatment	Minimum Limit	Maximum Limit
Appendicectomy - laparoscopic	30000	100000
Appendicectomy – open	25000	75000
Arthroscopy	23000	85000
Cataract (including Lens)	20000	75000
Cholecystectomy – laparoscopic	40000	100000
Cholecystectomy – open	37000	65000
Coronary Angiogram (including dye)	10000	45000
Dialysis (for Multiple use dialyzer)	1000	3000
Exploratory Laparotomy	50000	100000
Fissurectomy	20000	70000
Haemorrhoidectomy (Excluding staples & tackers)	22000	50000
Hernia repair – laparoscopic (unilateral)	40000	150000
Hernia repair – Open (including mesh) (unilateral)	25000	60000
Hydrocelectomy – Bilateral	20000	50000
Hydrocelectomy – Unilateral	15000	35000
Hysterectomy – laparoscopic	45000	100000
Hysterectomy – vaginal /open	45000	85000
Mastectomy (Radical)	35000	100000
PID-Discectomy (For single level including Implants)	45000	80000
Septoplasty	25000	90000
Thyroidectomy - HEMI	30000	80000
Thyroidectomy - TOTAL	40000	100000
Tonsillectomy	20000	50000
Total Knee Replacement - Both (excluding Implant)	80000	250000
Total Knee Replacement - Single (excluding Implant)	60000	150000
TURP	40000	100000
Tympanoplasty	25000	60000
Ureterorenoscopic Lithotripsy	30000	100000

All claims under this Benefit can be made as per the process defined under Section V of the Base Cover Terms and Conditions and Section III of the Optional Cover Terms and Conditions, as applicable.

7. Voluntary Co-Payment for In-patient Hospitalization

The Insured Person will pay the percentage specified in the Policy Schedule/ Certificate of Insurance as Voluntary Co-Payment over and above the amount specified in the Policy Schedule. We will pay the remaining part of the admissible amount in respect of the claim made by an Insured Person under the Policy.

The Voluntary Co-Payment percentage will be applicable on all claims under the Base Cover and on all In-patient Hospitalization claims under indemnity based Optional covers on the admissible claim amount.

8. Annual Aggregate Deductible

The Deductible amount specified in the Policy Schedule/ Certificate of Insurance shall be applicable on the aggregate of all claims made by an Insured Person if covered under the Policy on an Individual basis or by the family if covered under the Policy on a Family Floater basis during the Policy period, provided that:

a. The Annual Aggregate Deductible will be applied on all claims under the Base Cover and all In-patient Hospitalization claims under indemnity based Options on the admissible claim amount.
b. For the purpose of calculating the Annual Aggregate Deductible and assessment of admissibility, all claims must be submitted in accordance with Sections V of the claims process under Base Cover and Section III of the Optional Cover Terms and Conditions, as applicable.
c. The consumption of the Deductible amount will be on the basis of the admissible claim amount after applying the Sub Limits of the Policy.

9. Per-Claim Deductible

The Deductible amount specified in the Policy Schedule/ Certificate of Insurance as the Per Claim Deductible shall be applicable on each and every claim made by an Insured Person during the Policy period, provided that:

a. The Per Claim Deductible will be applied on all claims under the Base Cover and all In-patient Hospitalization claims under indemnity based Options on the admissible claim amount.
b. For the purpose of calculating the Deductible and assessment of admissibility, all claims must be submitted in accordance with Sections V of the claims process under the Base Cover and Section III of the Optional Cover Terms and Conditions, as applicable.
c. The consumption of the Deductible amount will be on the basis of the admissible claim amount after applying the Sub Limits of the Policy.

10. Hospital Daily Cash Benefit (HDCB) Cover

We will pay the Daily Cash Amount specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation/Hospitalisation in an ICU during the Policy Period provided that:

a. We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
b. Deductible as specified in the Policy Schedule/ Certificate of Insurance is applicable to this Benefit
c. This benefit is applicable on an individual basis irrespective of type of policy (Individual Sum Insured/ Floater Sum Insured)
d. We shall not be liable to make payment for more than the maximum number of days per policy period specified in the Policy Schedule/Certificate of Insurance for this Cover.

The payment under this benefit is within the Basic Sum Insured subject to the limits specified, if any.

If hospitalization occurs in an ICU as well as a normal room, then the deductible will be applied on the cumulative amount.

All claims under this Benefit can be made as per the process defined under Section V. 5 under the Base Cover Terms and Conditions and Sections III and IV under Optional Cover Terms and Conditions, as applicable.

11. Critical Illness Benefit Cover

For the purpose of this Section, “Critical Illness” means any Illness, medical event or Surgical Procedure as specifically defined whose signs or symptoms first commence after the period specified under the Critical Illness Waiting Period section in the Policy Schedule/ Certificate of Insurance since the commencement of the Policy period. The Benefits under this cover (as set out below) will be over and above the Base Sum Insured.

The cover is applicable provided that the Critical Illness, which the Insured Person is suffering from, occurs during the Policy period as a first incidence.

If an Insured Person is diagnosed to be suffering from any of the Critical Illnesses of the nature specified below during the Policy period, then We will pay a Critical Illness Sum Insured specified in the Policy Schedule/ Certificate of Insurance provided that:

a. The payment of the Benefit shall be subject to survival of the Insured Person for the period specified as Survival Period for Critical Illness in the Policy Schedule/ Certificate of Insurance from the date of diagnosis of the Critical Illness.
b. Upon Our admission of the first claim under this Benefit in respect of an Insured Person in any Policy period, the cover under this Benefit shall automatically terminate in respect of that Insured Person.
c. Our total and cumulative liability in respect of an Insured Person under this Benefit will be limited to the Critical Illness Sum Insured opted.
d. This Benefit is paid as a lump sum amount and is over and above the Base Sum Insured.
e. One or more critical illnesses out of the following list of critical illnesses can be opted under this benefit.

A. List of Critical Illnesses cover under this Benefit:

1. CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded –

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All 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
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumours in the presence of HIV infection.

2. MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris
   iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

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

II. The following are excluded:
  i. Angioplasty and/or any other intra-arterial procedures

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
  i. no response to external stimuli continuously for at least 96 hours;
  ii. life support measures are necessary to sustain life; and
  iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:
  i. Transient ischemic attacks (TIA)
  ii. Traumatic injury of the brain
  iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN /BONE MARROW TRANSPLANT

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

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

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only Islets of Langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

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 PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

12. ANGIOPLASTY

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

13. BENIGN BRAIN TUMOR

I. Benign brain tumour is defined as a life threatening, non-cancerous tumour in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumour must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
ii. Undergone surgical resection or radiation therapy to treat the brain tumour.

III. The following conditions are **excluded:**

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumours, tumours of skull bones and tumours of the spinal cord.

14. BLINDNESS

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:
   i. corrected visual acuity being 3/60 or less in both eyes or ;
   ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

15. DEAFNESS

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

16. END STAGE LUNG FAILURE

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
   i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
   ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
   iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
   iv. Dyspnoea at rest.

17. END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   i. Permanent jaundice; and
   ii. Ascites; and
   iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is **excluded.**

18. LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose and Throat (ENT) specialist.

II. All psychiatric related causes are excluded.

19. LOSS OF LIMBS

The physical separation of **two** or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting from self-inflicted injury, alcohol or drug abuse is excluded.

20. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
- iv. Mobility: the ability to move indoors from room to room on level surfaces;
- v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- vi. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. Spinal cord injury is excluded.

21. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

- i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

22. THIRD DEGREE BURNS

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

B. Specific Exclusions under Critical Illness Cover in addition to exclusions under Base Cover:

We shall not be liable to make any payment under this cover caused by, based on, arising out of, relating to or howsoever attributable to any of the following:

i. Any Illness other than those specified as Critical Illness under this Policy.
ii. Any claim with respect to any Critical Illness diagnosed prior to the Inception Date.
iii. Any Pre-Existing Disease or any complication arising therefrom.
iv. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner;
v. Working in underground mines, tunneling or involving electrical installations with high tension supply, or as jockeys or circus personnel.
vi. Any loss resulting from, contributed or aggravated or prolonged by childbirth or from pregnancy.
vii. Death of the Insured Person within the stipulated survival period as specified in the Optional Cover.
viii. Failure to seek or follow Medical Advice.
ix. Any Treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including Caesarian section), abortion or complications arising therefrom. This exclusion will not apply to ectopic pregnancy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base cover (Section II) shall apply.

All claims under this Benefit can be made as per the process defined under Sections V. C and D under the Base Cover Terms and Conditions and Section III under Optional Cover Terms and Conditions, as applicable.

<u>Terms & Conditions: Survival Period for Critical Illness</u>

The Benefit payment shall be subject to survival of the Insured Person for the period specified in the Policy Schedule/ Certificate of Insurance, following the first diagnosis of the Critical Illness or undergoing the Surgical Procedure for the first time, whichever is earlier, unless it has been specially waived on payment of additional premium.

12. 'Loss of Pay' Cover

If an Insured Person is hospitalised due to any illness/disease/ Injury due to an accident while the Policy is in force then We will pay a fixed benefit amount per week as specified in the Policy Schedule/ Certificate of Insurance for the period, subject to a maximum of 50 weeks per Policy Period. The benefit shall commence from the day when "Loss of Pay" starts after exhausting all leaves to the Employees Credit.

The cover can be opted as anyone or combination of:

a. Illnesses / Disease
b. Injury due to an Accident

Provided that:

i. The Benefit is payable only for one of the Illness/ disease or injury due to an accident on Hospitalisation for an Insured Person during a particular week.
ii. This Benefit is paid as a lump sum amount at the end of every month and is over and above the Base Sum Insured subject to a maximum of 50 weeks per Policy period.
For the purpose of this Section, "week" in respect of this Benefit will be calculated from the date of commencement of 'Loss of Pay' of the Employee from work for the covered condition (as applicable). The number of days for payment shall be on the basis of a certificate from the employer confirming the absence & 'Loss of Pay status' of the Insured Person.
iii. A certificate, issued by the treating Medical Practitioner at the hospital at which treatment is undertaken, shall be submitted to confirm the inability from engaging in current employment or occupation due to the covered condition.
iv. The cover ceases from the date on which the Hospital / Nursing Home / Treating Doctor Certifies that the Employee is fit for resumption of duty or the date on which the Employee resumes duty, whichever is earlier.
v. For a claim to be admissible under this clause a claim must be admissible under the hospitalization claim.
vi. The cover is not applicable to the Employee's family members.

13. Dental Expenses Cover

We will pay the medical expenses incurred towards dental treatment including any emergency treatment by a Dentist following an accident where the Insured Person suffers injuries or damage to his natural teeth and/or gums. The payment under this benefit is within the Basic Sum Insured, subject to limits specified in the schedule.

This benefit also provides cover for:

a. The fees for a dental practitioner and associated costs for carrying out routine dental procedures like clinical oral examinations, tooth scaling, normal fillings, minor procedures and non-surgical extractions.
b. Root canal treatment and surgical extraction of tooth.

This Benefit will exclude

i. Any instructions for plaque control, oral hygiene and diet
ii. Any treatment which is cosmetic in nature.

Permanent Exclusion 13 under Section IV of the Policy Wordings stands deleted for this cover.

All claims under this Benefit can be made as per the process defined under Section V. 5 under the Base Cover Terms and Conditions and Section III under Optional Cover Terms and Conditions, as applicable.

14. Vision Expenses Cover

We will pay the Reasonable and Customary Charges incurred during the Policy period by the Insured Person up to the limit specified in the Policy Schedule/ Certificate of Insurance and will be within the Base Sum Insured in relation to the following:

i. Eye examination by an optometrist or ophthalmologist
ii. Cost of lenses to correct refractory errors

We will not be liable to make any payment in respect of the following:

i. Cost of frames for the prescribed lenses.
ii. Sunglasses, unless medically prescribed by a Medical Practitioner.
iii. Medical or surgical Treatment of the eye.
iv. Lenses which are not medically necessary and are not prescribed by an optometrist or ophthalmologist.

If this Option is in force in respect of the Insured Person, then the relevant part of Exclusion IV.A.14 will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person up to the Sum Insured specified for this Benefit.

All claims under this Benefit can be made as per the process defined under Section V 5 under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

15. Refractive Error Correction (Less than 7.5 dioptres) Expenses Cover

We will pay the Reasonable and Customary Charges incurred during the Policy period, by the Insured Person for Laser-Assisted *in situ* Keratomileusis (LASIK) Surgery, including refractive keratotomy (RK) and photorefractive keratectomy (PRK) or any other advanced Surgical Procedures conducted to correct the refractive errors (Less than 7.5 dioptres) beyond the limit specified in the schedule, to change the refraction of one or both eyes, provided that:

i. If this Option is in force in respect of the Insured Person, then the relevant part of Exclusion IV.A.15 will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person up to the Sum Insured specified for this Benefit.
ii. The Benefit will be limited to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance and would be a part of the Base Sum Insured

We will not be liable to make any payment in respect of any other non-Surgical Procedures.
All claims under this Benefit can be made as per the process defined under Sections V.C and D under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

16. OPD Physiotherapy Charges Cover

We will pay the Reasonable and Customary Charges incurred during the Policy period by the Insured Person for a prescribed physiotherapy Treatment which is a Medically Necessary Treatment undertaken as an Out-Patient in a Hospital or at home by a qualified physiotherapist

up to the sublimit specified in the Policy Schedule/ Certificate of Insurance and would be within the Base Sum Insured.

All claims under this Benefit can be made as per the process defined under Section V. 5 under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

17. Home Nursing Charges Cover

We will pay for the expenses incurred for medical care services of a qualified nurse at the residence of the Insured Person following discharge from hospital after treatment for Illness/ Injury provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;

(b) Such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to Illness/ Injury for which the Insured Person has undertaken treatment during the hospitalisation

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons).

For the purpose of this Section, “activities of daily living” means:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene.
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other Surgical Appliances.
iii. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.
iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
vi. Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence.

The cover is applicable irrespective of the number of occurrences during the Policy period subject to the overall Basic Sum Insured and for a maximum number of days as specified in the Policy Schedule/Certificate of Insurance.

This Benefit is not related to any Domiciliary Hospitalisation.

The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any.

If this Option is in force in respect of the Insured Person, then the part of Exclusion IV.A.23.i pertaining to the Optional Cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person up to the limit specified for this Benefit.

All claims under this Benefit can be made as per the process defined under Section V.5 under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base Cover (Section II) shall apply.

18. Air Ambulance Cover

We will pay the Reasonable and Customary Charges incurred during the Policy period towards emergency transportation of the Insured Person to a Hospital by an air ambulance or to move the Insured Person from one healthcare facility to another healthcare facility within India only up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. The Illness/Injury is covered under the base Cover.
ii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment's vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers.
iii. The total number of emergency transportations by Air Ambulance during the Policy Period does not exceed the number specified in the Policy Schedule/ Certificate of Insurance.

All claims under this Benefit can be made as per the process defined under Section V. 5. under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

19. Emergency Evacuation Cover

In case of an Emergency during the Policy period. in respect of an Insured Person, if adequate medical facilities are not available locally, we will pay the amount up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance for this Benefit towards the arrangement of an Emergency evacuation of the Insured Person to the nearest facility capable of providing adequate care, provided that:

i. The medical evacuations must be determined by Our medical team to be medically necessary to prevent the immediate and significant effects of Illness/Injury which if left untreated could result in a significant deterioration of health and it has been determined that the Treatment is not available locally.
ii. The Emergency medical evacuation is pre-authorised by Our medical team. If it is not possible for pre-authorisation to be sought before the evacuation takes place, authorization must be sought as soon as possible thereafter, but not later than 7 days after evacuation. We will only authorize medical evacuations after the evacuation has occurred where it was not reasonably possible for authorization to be sought before the evacuation took place.
iii. In making Our determinations, we will consider the nature of the Emergency, the Insured Person's medical condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered.
iv. The Insured Person's medical condition must require the accompaniment of a qualified Medical Practitioner during the entire course of the evacuation to be considered an Emergency and requiring Emergency evacuation.

v. Transportation must be undertaken by medically equipped specialty aircraft, commercial airline, train or Ambulance depending upon the medical needs and available transportation specific to each case. This Benefit is available in India only.

All claims under this Benefit can be made as per the process defined under Sections V.C and D under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

20. Medical Equipment Cover

We will pay the Reasonable and Customary Charges up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance for prescription medical equipment that are medically necessary and which are otherwise classified as non-payable items under the Base Cover, provided that:

i. The Benefit covers expenses incurred on Medical equipment such as hearing aids, instrument used in the Treatment of Sleep Apnoea Syndrome, Oxygen Concentrator for Bronchial Asthmatic condition, infusion pump or any other external devices, Prostheses, corrective devices and Medical Appliances, which are not required intra-operatively.

ii. The Benefit payable will be a part of the Base Sum Insured and becomes payable only if we have admitted an In-patient Hospitalization Expenses claim during the Policy period.

iii. If this Option is in force in respect of the Insured Person, then the part of Exclusion IV.A.16.a, IV.A.33 and IV.A.28 pertaining to the Optional cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person

All claims under this Benefit can be made as per the process defined under Section V. 5 under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

21. Ultra-Modern Treatment Cover

We will pay the Reasonable and Customary Charges, within the base sum insured, up to sublimit specified in the Policy Schedule or Certificate of Insurance incurred on the Insured Person's In-patient Hospitalization or Day Care Treatment during the Policy Period for ultra-modern medicine provided that:

i. The Hospitalization is for Medically Necessary Treatment and the In-patient Hospitalization or Day Care Treatment is in accordance with the conditions set out in Sections 1 and 2 of the base covers

ii. Coverage under this Benefit will include the following treatment/combination of treatments:
   - Stem Cell Therapy (does not include the cost of harvesting and storage) other than as provided for in clause II.8 (12) above
   - Milk teeth banking (does not include the cost of harvesting and storage)
   - Laser tonsillectomy

Permanent Exclusion No. IV.A.3.a as applicable in view of the treatment/combination of treatments chosen, shall be inoperative in respect of this Benefit.

All claims under this Benefit can be made as per the process defined under Sections V. under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

22. Adventure Sports Cover

We will pay the Reasonable and Customary Charges incurred during the Policy period, up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance and which would be a part of the Base Sum Insured, incurred in relation to an Injury sustained while the Insured Person is engaged in an adventure sport carried out in accordance with the guidelines, codes of good practice and recommendations for safe practices as laid down by a governing body or authority. Permanent Exclusion No. IV.A.34 as applicable shall be inoperative in respect of this Benefit.

All claims under this Benefit can be made as per the process defined under Sections V.C and D under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

23. Waiver of Proportionate Clause

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Note 1 (Proportionate Clause) under Clause II.1 (Base Covers) stands deleted for the members covered in the Policy as stated in the Schedule.

You/Insured Person shall continue to bear the differential between actual and eligible Room Rent.

24. Birth Control Procedure Cover

We will pay the Reasonable and Customary Charges for the Medical Expenses incurred during the Policy period, of an Insured Person up to the Sub Limit specified in the Policy Schedule/ Certificate Of Insurance and which would be a part of the Base Sum Insured, provided that:

i. The Medical Expenses (including OPD) are incurred towards implanted/ injected contraceptives, post appropriate counselling, surgical therapies which are medically necessary including but not limited to Tubal Ligation, Vasectomies including any associated Medical Expenses.
ii. If this Option is in force in respect of the Insured Person, then the relevant part of Exclusion IV.A.5.i pertaining to the Optional cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

All claims under this Benefit can be made as per the process defined under Sections V under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

25. Infertility Treatment Cover

A. We will pay the Medical Expenses incurred during the Policy period, for diagnostic infertility services to determine the cause of infertility, Treatment and procedures, provided that:

i. Our maximum liability for each Policy period is subject to the limits specified in the Policy Schedule/ Certificate of Insurance for Treatment of infertility as In-patient Hospitalization, Day Care Treatment or OPD treatment once a Policy period.
ii. The Benefit payable will be a part of the Base Sum Insured.
iii. We will be liable to pay for the Medical Expenses incurred in relation to the following:
    a. Fertility hormones
    b. Artificial insemination

c. Surgery
d. Assisted reproductive technology (ART)

iv. The Benefit under this cover will have a maximum limit for procedures and OPD treatment as specified in the Policy Schedule/ Certificate of Insurance.
v. If this Option is in force in respect of the Insured Person, then the part of Exclusion IV.A.5 pertaining to the Optional cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

B. We will not be liable to make any payment in respect of the following:

i. Infertility services beyond 8 weeks of pregnancy;
ii. Infertility services for persons who have undergone voluntary sterilisation procedures; and
iii. Infertility services for women with natural menopause at the age 40 years and older.

All claims under this Benefit can be made as per the process defined under Sections V under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

26. In-patient Hospitalization Cover for AYUSH (Ayurvedic/Unani/ Siddha/ Homeopathic Treatment)

A. We will pay the Medical Expenses incurred during the Policy period, up to the sub-limits specified in the Policy Schedule/ Certificate of Insurance of an Insured Person in case of Medically Necessary Treatment taken during In-patient Hospitalization for Ayurvedic/Unani/ Siddha/ Homeopathic Treatment for an Illness or Injury that occurs during the Policy period, provided that:

The Insured Person has undergone Ayurvedic/Unani/ Siddha/ Homeopathic Treatment in an AYUSH Hospital/ AYUSH Day Care Centre as defined hereunder:

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

a. Central or State Government AYUSH Hospital or
b. Teaching hospital attached to AYUSH College recognised by the Central Government/Central Council of Indian Medicine/ Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognised system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with the following criterion:
   i. Having at least 5 in-patient beds;
   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iv. Maintaining daily records of the patients and making them accessible to the insurance Company's authorized representative.

AYUSH Day Care Centre means and includes Community Health Care Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment

procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

a. Having qualified registered AYUSH Medical Practitioner (s) in charge;
b. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
c. Maintaining daily records of the patients and making them accessible to the insurance Company's authorized representative.

B. The amount payable under this Benefit will be a part of the Base Sum Insured.

C.

a. If this Option is in force in respect of the Insured Person, then Exclusion IV.A.12.i will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.
b. The following exclusion will be applicable in addition to the exclusions under Section IV of the Base Cover:
   Facilities and services availed for pleasure or rejuvenation or as a preventive aid, including but not limited to beauty treatments, Panchakarma, purification, detoxification and rejuvenation.

All claims under this Benefit can be made as per the process defined under Sections V under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

27. Enhanced Accidental Hospitalization Cover

We will pay the costs incurred on Medical Expenses up to the limit specified in the Policy Schedule/ Certificate of Insurance for Hospitalization of the Insured Person during the Policy period due to an Accident in the Policy period, provided that:

a. The Hospitalization is for Medically Necessary Treatment and is on the written advice of a Medical Practitioner.
b. The Insured Person is admitted to Hospital within 7 days of the occurrence of the Accident.

Further, if this Option is in force in respect of the Insured Person:

i. The Sum Insured will be over and above the Base Sum Insured.
ii. The Sum Insured cannot be utilised for any Hospitalization other than Hospitalization of the Insured Person due to an Accident.
iii. The Base Sum Insured will also be payable in case of Hospitalization of the Insured Person due to an Accident along with the Sum Insured as specified in this Benefit.
iv. In case of an inpatient hospitalization due to an accident, where the claim is admissible both under this section and section II.1 of Base Cover, the admissible claim shall be paid utilizing the limit as specified in the Policy Schedule or Certificate of Insurance under this section (Enhanced Accidental Hospitalization) first and balance if any from available sum Insured under Section II.1 thereafter up to the limits as specified in the Policy Schedule or Certificate of Insurance.

All claims under this Benefit can be made as per the process defined under Section V under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

28. Corporate Buffer

We will provide for a Corporate Buffer as per limits specified in the Policy Schedule/Certificate of Insurance during the Policy period, provided that:

i. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.
ii. This Benefit will be available for those Insured Persons who have already exhausted their Sum Insured limit subject to per Insured Person/ family limit as mentioned in the Policy Schedule.
iii. This Benefit will be restricted to Individual/ family/amount specified in the Policy Schedule in respect of each and every Insured Person/ family.
iv. If the Policy is issued on a Family Floater basis, the enhanced Sum Insured on account of the Corporate Buffer applicable will also be available on a Family Floater basis.
v. Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy period.

The Benefit payable will be over and above the Base Sum Insured.
All claims under this Benefit can be made as per the process defined under Sections V. under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

29. Corporate Buffer for Critical/Named Illness only

We will provide for a Corporate Buffer as per limits specified in the Policy Schedule/Certificate of Insurance during the Policy period for Critical/Named illnesses specified under this section, provided that:

i. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.
ii. This Benefit will be available for those Insured Persons who have already exhausted their Sum
iii. Insured limit subject to per Insured Person/ family limit as mentioned in the Policy Schedule.
iv. This Benefit will be restricted to Individual/ family/amount specified in the Policy Schedule in respect of each and every Insured Person/ family.

All claims under this Benefit can be made as per the process defined under Sections V under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

30. Domiciliary Hospitalisation Exclusion Cover

We will exclude Domiciliary Hospitalisation from the Base Cover and the below mentioned Exclusion will be applicable to You.
Exclusion: Any expenses arising out of Domiciliary Hospitalization will be excluded.

31. Remote Medical Second Opinion Cover

We will facilitate the Insured person for availing a Remote Second Opinion on his/her medical condition occurring during the Policy Period as per the frequency provided in the Policy Schedule/ Certificate of Insurance, provided that:
(a) We shall only provide access to an E-opinion and this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner;

(b) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.
(c) The Insured person is free to choose whether or not to obtain the expert opinion and if obtained whether or not to act on it

32. External Congenital Disease Cover

We will pay the Reasonable and Customary charges for the Medical Expenses of the Insured person in respect of External Congenital Diseases which are present at birth and which may or may not be inherited provided that the Benefit will not pay for any OPD treatment.
The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any. Permanent Exclusion 4 of section IV of the Policy Wordings stands deleted to the extent of this Benefit only.

33. Coverage Continuity in case of Loss of Employment

We will provide continuity of coverage under this Policy for an Insured Person until the end of the Policy period in case of loss of employment of such Insured Person provided the loss of employment shall arise as a result of an Illness/injury contracted during the period of employment.

34. Wellness Management Services Program

We will provide the various wellness benefits/services under this Benefit. Any one or a combination of the following programs specified in the Policy Schedule/ Certificate of Insurance can be offered under this program:

Wellness Management Services:
1) Track your Health
2) Medical Concierge services
3) Health check up
4) Medical Practitioner’s consultations
5) Health tips or newsletters
6) Any other, as specified in the Policy Schedule/ Certificate of Insurance

We will inform you/Insured Person regarding the wellness services proposed to be provided as specified in the Policy Schedule/ Certificate of Insurance at the time of Policy issuance or any other notification/ communication required to be sent hereunder on Your/ Insured Person’s registered email ID or address specified in the Policy Schedule/ Certificate of Insurance.

Claim Process for Optional Covers

1. **Claim Intimation:**

In addition to the claim intimation process set out in the Base Cover, the following conditions apply in relation to the respective Options. Upon the discovery or occurrence of an Accident/ Critical Illness or any other contingency that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person or the Nominee, as the case may be, must notify Us/ Our TPA either at the call centre or in writing and shall undertake the following:

- In the case of Accidental Death Benefit/ PTD/ PPD/ Critical Illness (if applicable) -The Insured Person or the Nominee, as the case may be, shall notify Us either at the call centre or in writing, within 10 days from the date of occurrence of such Accident/diagnosis of a Critical Illness.

2. Reimbursement Process

In addition to the documents mentioned in the Base Cover claim reimbursement process, the following additional documents will be required for reimbursement claim for the respective Options.

Optional Cover	Additional Documents Required
Critical Illness – Benefit Cover	The Insured Person may submit the following documents for reimbursement of the claim to our policy issuing office at his/her own expense ninety (90) days from the date of first diagnosis of the Illness/ date of Surgical Procedure or date of occurrence of the medical event, as the case may be Medical certificate confirming the diagnosis of Critical Illness. Discharge certificate/ card from the Hospital, if any. Investigation test reports confirming the diagnosis. First consultation letter and subsequent prescriptions. Indoor case papers, if applicable. Specific documents listed under the respective Critical Illness. Any other documents as may be required by Us. In those cases, where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted.
Out- Patient Cover	The Insured Person shall avail these benefits as defined in Policy T&C if opted for. **Submission of claim** Invoices, treating Medical Practitioner's prescription, reports, duly signed by Insured Person as the case may be, to the TPA Head Office **Assessment of claim documents** We shall assess the claim documents and ascertain the admissibility of claim. **Settlement & Repudiation of a claim** We shall settle claims, including its rejection, within 30 days of the receipt of the last 'necessary' document.
Dental Expenses Cover & Vision Expenses Cover	The Insured Person shall avail these Benefits as defined below, if opted for. **Submission of claim** Insured Person can send the claim form provided along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by the Insured Person as the case may be, to Our branch office or head office. **Assessment of claim documents** We shall assess the claim documents and ascertain the admissibility of claim. **Settlement & Repudiation of a claim** We shall settle claims, including its rejection, within 30 days of the receipt of the last 'necessary' document. In respect of Orthodontic Treatment claims for Dependent Children below 18 years, pre-authorisation is a must. For claims in respect of Orthodontic Treatment towards Dependent Children below 18 years, the Employee/ Member or Dependent must send the following information prepared by the Dentist who is to carry out the proposed Treatment to Us before Treatment starts, so that We can confirm the Benefit that will be payable: • Full description of the proposed Treatment; • X-rays and study models; • An estimate of the cost of the Treatment.

	Any Benefit will be payable only if We have authorised the cover before Treatment starts.
Refractive Error Correction Expenses Cover	Prescription from Specialist Medical Practitioner specifying the refractive error and medical necessity of the Treatment.
Home Nursing Charges Cover	Bills from registered nursing service provider.
Air Ambulance Cover	Air ambulance ticket for registered service provider.
Emergency Evacuation Cover	In the event of an Insured Person requiring Emergency evacuation and repatriation, the Insured Person must notify Us immediately either at Our call centre or in writing. Emergency medical evacuations shall be pre-authorised by Us. Our team of Specialists in association with the Emergency assistance service provider shall determine the medical necessity of such Emergency evacuation or repatriation post which the same will be approved.
Medical Equipment Cover	Prescriptions of treating Specialist for support items and original invoice of actual Medical Expenses incurred.
Ultra-modern Treatment Cover	Certificate by qualified medical surgeons indicating the medical necessity of the procedure.
Birth Control Procedure Cover	All medical records and treating Medical Practitioner's certificate on the indication.
Infertility Treatment Cover	Certificate from Specialist Medical Practitioner detailing the cause of infertility, Treatment, procedure.
Deductible (Aggregate/ Per-Claim)	Any claim towards Hospitalisation during the Policy period must be submitted to Us for assessment in accordance with the claim process laid down under Section V of the Policy towards Cashless facility or reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the Deductible, We will assess and pay such claim in accordance with Section V.F and G of the Policy. Wherever such Hospitalisation claims as stated under Section V above is being covered under another policy held by the Insured Person, We will assess the claim on available photocopies duly attested by the Insured Person's insurer / TPA as the case may be.

We may call for any additional document/information as required based on the circumstances of the claim wherever the claim is under further investigation or available documents do not provide clarity.

POLICY SCHEDULE

<Company Logo>

<Policy issuing office address, contact no., email id>

<Product name>

<UIN No.>

<Policy No.>

<Period of Insurance>

<Insured name & address>

<Agent/Intermediary Name>

<Agent/Intermediary Code>

<Agent/Intermediary contact no., email id>

For any Information, Service Requests and Grievances please write to <grievance email id of policy issuing office>

For ID Cards & Claim Intimations Please contact the TPA mentioned in the Policy document.

Attached to and forming part of Policy No.: <>
UIN No.: <>

POLICY SCHEDULE CUM TAX INVOICE

Policy No.:
Previous Policy No.:
Insured Name:
Insured Address:
Insured contact no. & email id:
Period of Insurance:
Coinsurance:

Premium:
IGST (18%) / CGST (9%) & SGST (9%):
Stamp Duty:
Total Premium:
Total Premium (in words):
Receipt Number:
Receipt Date:
Development Officer Code / Intermediary Code:

Customer GST No.:
Office GST No.:
SAC Code:
Invoice No. & Date:
Amount Subject to Reverse Charges:

Anti-Money Laundering Clause: - In the event of a claim under the policy exceeding 1 lakh or a claim for refund of premium exceeding 1 lakh, the insured will comply with the provisions of AML policy of the company. The AML policy is available in all our operating offices as well as Company's web site.

Risk Coverage Details

No. of Employees/Members covered	
No. of Dependents Covered	
Total No. of Persons covered	
Sum Insured Slab/s	
Total Sum Insured	
Total Sum Insured (in words)	
Cover type basis	
Family Definition (with age limit)	

Details of Insured Persons: As per Annexure attached.

Attached to and forming part of Policy No.: <>
UIN No.: <>

Base Covers:

Coverage	Sum Insured (In Rs.) & Limits
In-patient Hospitalisation Expenses Cover	
Day Care Treatment Cover	
Pre – hospitalisation Medical Expenses Cover	
Post – hospitalisation Medical Expenses Cover	
Road Ambulance Cover	
Domiciliary Hospitalisation Cover	
Donor Expenses Cover	
Modern Treatment Methods & Advancement in Technologies	

Optional Covers:

1. Disease Category Sub Limit: <disease name> <limit>
2. Maternity Expenses Cover: <waiting period> <limit> <maximum no. of deliveries> < Pre or post-natal Medical Expenses on Outpatient basis limit>
3. New Born Baby Cover: < Medical Expenses limit> < Wellness Cover limit>
4. Mother Care Cover: <limit>
5. Out- Patient Treatment Cover: <over and above the basic Sum Insured limit> < within the basic Sum Insured limit>
6. Sub Limit on Treatment/ Illness Surgery/Medical Condition: < specified Treatment(s) of an Illness /procedure(s)> <limit>
7. Voluntary Co-Payment for In-patient Hospitalization: <limit %>
8. Annual Aggregate Deductible: <limit>
9. Per-Claim Deductible: <limit>
10. Hospital Daily Cash Benefit (HDCB) Cover: < Daily Cash Amount> <maximum number of days per policy period> < Deductible>
11. Critical Illness Benefit Cover: <No. of Critical Illness selected> <Critical Illness Waiting Period> < Critical Illness Sum Insured> < Survival Period for Critical Illness>
12. 'Loss of Pay' Cover: < Illnesses / Disease> <Injury due to an Accident> < benefit amount per week>
13. Dental Expenses Cover: <limit>
14. Vision Expenses Cover: <limit>
15. Refractive Error Correction Expenses Cover: <refractive error limit> <Amount limit>
16. OPD Physiotherapy Charges Cover: <limit>
17. Home Nursing Charges Cover: <limit> <maximum number of days>
18. Air Ambulance Cover: <Per event limit> < total number of emergency transportations during the Policy Period>
19. Emergency Evacuation Cover: <limit>
20. Medical Equipment Cover: <limit>
21. Ultra-Modern Treatment Cover: <treatment name> <limit>
22. Adventure Sports Cover: <limit>
23. Waiver of Proportionate Clause:
24. Birth Control Procedure Cover: <limit>
25. Infertility Treatment Cover: <limit> <maximum limit for procedures> < maximum limit for OPD treatment>
26. In-patient Hospitalization Cover for AYUSH (Ayurvedic/Unani/ Siddha/ Homeopathic Treatment): <limit>
27. Enhanced Accidental Hospitalization Cover: <limit>
28. Corporate Buffer: <limit>
29. Corporate Buffer for Critical/Named Illness only: <limit>
30. Domiciliary Hospitalisation Exclusion Cover:
31. Remote Medical Second Opinion Cover: < frequency limit>
32. External Congenital Disease Cover:

Attached to and forming part of Policy No.: <>
UIN No.: <>

33. Coverage Continuity in case of Loss of Employment:
34. Wellness Management Services Program: < Wellness Management Service Name>

Waiting Periods:

Pre-Existing Disease Waiting Period:
Initial Waiting Period for Hospitalization:
Specific Illness Waiting Period: <Illness Name> <Waiting Period>

Other conditions:

- All Other Terms & Conditions Subject to printed Policy (Uni Group Health Insurance Policy) Clauses attached.
- Addition / Deletion of Employees & Dependents:
    - Insured will be allowed a window period of 30 days from the policy Inception date to review the employee list covered under the policy. All Addition / deletion / Correction of the persons to be done subject to additional premium, if there is a change in the group size.
    - We agree for providing cover for additions from the date of joining of the new employee by charging pro rata premium from the date of joining till the expiry of the policy, subject to maintenance of free and adequate balance under Cash Deposit maintained by the Insured with us or the coverage will be effective from the date of payment of premium.

This Schedule and the attached policy shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this Policy or of the Schedule shall bear the same meaning wherever it may appear.

Date of Proposal and Declaration:
IN WITNESS WHEREOF, this policy has been signed at <> on this <> day of <Month> <Year>

For and On behalf of
United India Insurance Co. Ltd.

Authorized Signatory
Underwritten By
Affix Policy Stamp here

Attached to and forming part of Policy No.: <>
UIN No.: <>

Details of TPA

Please contact the following TPA for Issue of Identity Cards, Cashless Approvals & Claims Settlement.

Name of TPA:
Address:
Toll Free number:
Telephone Numbers:
Email IDs:

Annexure-I

Attached to and forming part of Policy No.: <>

Uni Group Health Insurance Policy

List I – Optional Items

Sr. No.	Item	Payable / Not Payable
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERVICES	Not Payable
4	BELTS/ BRACES	Payable for cases who have undergone surgery of thoracic or lumbar spine.
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7	CARRY BAGS	Not Payable
8	EMAIL / INTERNET CHARGES	Not Payable
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
10	LEGGINGS	Payable in case of varicose vein surgery
11	LAUNDRY CHARGES	Not Payable
12	MINERAL WATER	Not Payable
13	SANITARY PAD	Not Payable
14	TELEPHONE CHARGES	Not Payable
15	GUEST SERVICES	Not Payable
16	CREPE BANDAGE	Not Payable
17	DIAPER OF ANY TYPE	Not Payable
18	EYELET COLLAR	Not Payable
19	SLINGS	Reasonable costs for one sling in case of upper arm fractures is payable
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
22	Television Charges	Payable under room charges not if separately levied
23	SURCHARGES	Part of Room Charge, Not payable separately
24	ATTENDANT CHARGES	Not Payable - Part of Room Charges
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
26	BIRTH CERTIFICATE	Not Payable
27	CERTIFICATE CHARGES	Not Payable
28	COURIER CHARGES	Not Payable
29	CONVEYANCE CHARGES	Not Payable
30	MEDICAL CERTIFICATE	Not Payable
31	MEDICAL RECORDS	Not Payable
32	PHOTOCOPIES CHARGES	Not Payable
33	MORTUARY CHARGES	Payable up to 24 hrs, shifting charges not payable
34	WALKING AIDS CHARGES	Not Payable
35	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSPITAL)	Not Payable
36	SPACER	Not Payable
37	SPIROMETRE	Device not payable
38	NEBULIZER KIT	Not Payable
39	STEAM INHALER	Not Payable
40	ARMSLING	Not Payable
41	THERMOMETER	Not Payable
42	CERVICAL COLLAR	Not Payable
43	SPLINT	Not Payable
44	DIABETIC FOOT WEAR	Not Payable
45	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
47	LUMBO SACRAL BELT	Payable for cases who have undergone surgery of lumbar spine.

48	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
49	AMBULANCE COLLAR	Not Payable
50	AMBULANCE EQUIPMENT	Not Payable
51	ABDOMINAL BINDER	Payable for cases who have undergone surgery of lumbar spine.
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Payable in Post-hospitalisation
53	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
55	ECG ELECTRODES	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day is payable.
56	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
57	NEBULISATION KIT	Payable reasonably if used during hospitalisation
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
59	KIDNEY TRAY	Not Payable
60	MASK	Not Payable
61	OUNCE GLASS	Not Payable
62	OXYGEN MASK	Not Payable
63	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction
64	PAN CAN	Not Payable
65	TROLLEY COVER	Not Payable
66	UROMETER, URINE JUG	Not Payable
67	AMBULANCE	Payable
68	VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs

<u>List II – Items that are to be subsumed into Room Charges</u>

Sr. No	Item	Sr. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	20	LUXURY TAX
2	HAND WASH	21	HVAC
3	SHOE COVER	22	HOUSE KEEPING CHARGES
4	CAPS	23	AIR CONDITIONER CHARGES
5	CRADLE CHARGES	24	IM IV INJECTION CHARGES
6	COMB	25	CLEAN SHEET
7	EAU DE-COLOGNE / ROOM FRESHNERS	26	BLANKET/WARMER BLANKET
8	FOOT COVER	27	ADMISSION KIT
9	GOWN	28	DIABETIC CHART CHARGES
10	SLIPPERS	29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
11	TISSUE PAPER	30	DISCHARGE PROCEDURE CHARGES
12	TOOTH PASTE	31	DAILY CHART CHARGES
13	TOOTH BRUSH	32	ENTRANCE PASS / VISTOR'S PASS CHARGES
14	BED PAN	33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
15	FACE MASK	34	FILE OPENING CHARGES
16	FLEXI MASK	35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
17	HAND HOLDER	36	PATIENT IDENTIFICATION BAND / NAME TAG
18	SPUTUM CUP	37	PULSE OXIMETER CHARGES
19	DISINFECTANT LOTIONS		

<u>List III – Items that are to be subsumed into Procedure Charges</u>

Sr. No	Item	Sr. No	Item
1	HAIR REMOVAL CREAM	13	SURGICAL DRILL
2	DISPOSABLES RAZORS CHARGES (for site preparations)	14	EYE KIT
3	EYE PAD	15	EYE DRAPE
4	EYE SHIELD	16	X-RAY FILM
5	CAMERA COVER	17	BOYLES APPARATUS CHARGES
6	DVD, CD CHARGES	18	COTTON
7	GAUZE SOFT	19	COTTON BANDAGE

8	GAUZE	20	SURGICAL
9	WARD AND THEATRE BOOKING CHARGES	21	APRON
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	22	TORNIQUET
11	MICROSCOPE COVER	23	ORTHOBUNDLE, GYNAEC BUNDLE
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER		

List IV – Items that are to be subsumed into costs of treatment

Sr. No	Item	Sr. No	Item
1	ADMISSION/REGISTRATION CHARGES	10	HIV KIT
2	HOSPITALISATION FOR EVALUATION/DIAGNOSTIC PURPOSE	11	ANTISEPTIC MOUTHWASH
3	URINE CONTAINER	12	LOZENGES
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	13	MOUTH PAINT
5	BIPAP MACHINE	14	VACCINATION CHARGES
6	CPAP/ CAPD EQUIPMENTS	15	ALCOHOL SWABS
7	INFUSION PUMP-COST	16	SCRUB SOLUTIONS / STERILLIUM
8	HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC	17	GLUCOMETER & STRIPS
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES, DIET CHARGES	18	URINE BAG

Annexure-II
Attached to and forming part of Policy No.: <>
UIN No.: <>

Details of Insurance Ombudsmen

Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel No: 079 - 25501201/02/05/06. Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049. Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh, Chhattisgarh	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202. Fax: 0755 – 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Orissa	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455. Fax: 0674 – 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468. Fax: 0172 – 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24335284. Fax: 044 – 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/2321350 4. Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (ASSAM). Tel.: 0361 - 2632204 / 2602205. Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana, and Yanam - part of Territory of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122. Fax: 040 – 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363. Email: Bimalokpal.jaipur@ecoi.co.in
Kerala, Lakshadweep, Mahe- a part of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338. Fax: 0484 – 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340. Fax: 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331. Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.

	Tel.: 022 - 26106552 / 26106960. Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kasganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253. Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952. Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555. Email: bimalokpal.pune@ecoi.co.in

The updated details of Insurance Ombudsman are also available at:

- IRDAI website: https://www.irdai.gov.in/
- General Insurance Council website: https://www.gicouncil.in/
- Our Company Website: https://uiic.co.in/
- From any of the offices of our Company