UNITED INDIA INSURANCE COMPANY LIMITED

UIIC, CORPORATE CELL, VULCAN INSURANCE BUILDING,
GROUND FLOOR, 77, V.N. ROAD, CHURCHGATE MUMBAI-400 020.
022-2282 2564-65 Fax: 022-2282 0521

GROUP HEALTH INSURANCE POLICY

UIN No. IRDA/NL-HLT/UII/P.H/V.1/236/13-14

POLICY NO: 5001002818P109892371

PERIOD OF INSURANCE

From 00.00hrs of 01/10/2018

To midnight of 30/09/2019

INSURED

INDIAN BANKS' ASSOCIATION
A/C: BANK OF BARODA
BANK OF BARODA, HEAD OFFICE, BARODA HOUSE, MANDVI, BARODA, GUJARAT - 390006

PART - I
POLICY SCHEDULE

Name of The Insured	INDIAN BANKS' ASSOCIATION A/C BANK OF BARODA
Address of The Insured	BANK OF BARODA, HEAD OFFICE, BARODA HOUSE, MANDVI, BARODA, GUJARAT - 390006
Issue Office Code	LCB Mumbai (500100)
Period of Insurance	From 00.00 hrs of 01/10/2018 To midnight of 30/09/2019
Gross Premium	Net Premium : Rs. 75,89,50,614/- GST : Rs. 1366,11,111/- Total : Rs. 89,55,61,725/-
Co- Insurance Details	United India Insurance Co Ltd. 58.0% National Insurance Co. ltd. 10.0% New India Assurance Co Ltd. 20.0% Oriental Insurance Co. Ltd. 10.0% SBI General Insurance Co. Ltd. 02.0% **Total 100%**
Policy Servicing TPA	MDIndia Healthcare Services (TPA) Pvt. Ltd.
Sum Insured for Critical Illness for Employees only	Rs.1,00,000/- per employee
Sum Insured for Group Health Insurance on Family Floater basis	Officers: INR 4,00,000/- per family Clerical : INR 3,00,000/- per family Sub-staff : INR 3,00,000/- per family

NUMBER OF FAMILIES SUM INSURED, CATEGORY FOR GROUP -Health Insurance

CATEGORY	SUM INSURED	NO OF FAMILES	TOTAL PREMIUM IN RS. (without ST)	PREMIUM PER FAMILY IN RS. (without GST)
Officers	RS. 4,00,000/-	28614	Rs. 4430,30,562 /-	INR 15,483/-
Award Staff	RS. 3,00,000/-	27204	Rs. 3159,20,052/-	INR 11,613/-
TOTAL		55818	Rs. 75,89,50,614 /-	
Room charges as defined in 1.2.1 (A)				Rs. 4,000/- per day
ICU Charges as defined in 1.2.1 (B)				Rs. 7,500/- per day

Corporate Buffer	Corporate Buffer of Rs.100 crores is incorporated in the policy in co-relation to the Initial Premium of Rs. 416 Crores (for first year i.e 2015-16), envisaged to be paid at the commencement of the employees group health insurance policy collectively by the various member Banks, of the Indian Banks' Association.

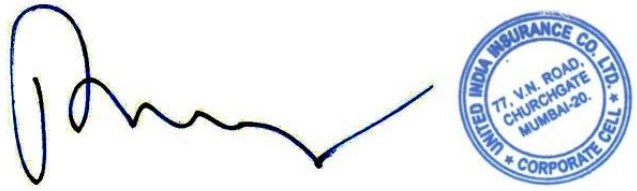
	This Figure of Rs. 100 Crores Corporate Buffer would be in correlation to the total premium received by the Insurance Company this year. ***<u>Corporate Buffer Allotted : Rs. 07,21,90,000/-</u>***
Family Definition	Employee + Spouse + Dependent Children + 2 dependent Parents OR in laws • No age limit for dependent children. Would be considered dependent if their monthly income does not exceed Rs. 10,000/- Widowed daughter and dependent divorced / separated daughters, sisters including unmarried / divorced / abandoned or separated from husband/ widowed sisters and crippled child shall be considered as dependent for the purpose of this policy. Physically challenged Brother / Sister with 40% or more disability. Subject that their individual monthly income does not exceed Rs. 10,000. • No Age Limits for Dependent Parents. Either Dependent Parents or Parents in-law will be covered. A parent would be considered dependent if their monthly income does not exceed Rs. 10,000/-
New Joinees	All New Employees to be covered from the date of joining as per their appointment letter. For additions /deletions during policy period, premium to be charged /refunded on pro rata basis against the Cash Deposit account with UIIC adequately maintained by the Bank. Increase in Sum Insured allowed in case of promotion on charging prorate premium.
Geographical Limits	Treatment taken in India Only.
Continuity Benefits	Continuity benefits coverage to employees on retirement till the end of the policy period provided there is no request for refund of the premium.

Net Premium	Rs. 75,89,50,614/-
GST Stamp Duty	Rs. 1366,11,111/- Rs. 1.00
Total	Rs. 89,55,61,725/-
Collection No.	'10150010018110341329
Collection Date	01/10/2018
GST No.	27AAACU5552C1ZJ
SAC CODE	9971

Date of Proposal and Declaration: 01/10/2018

IN WITNESS WHEREOF, the undersigned being duly authorized has hereunto set His/her hand at MUMBAI-20 on this 01/10/2018.

For and on behalf of
UNITED INDIA INSURANCE CO.LTD.



Duly Constituted Attorney (s)

UNITED INDIA INSURANCE CO LTD.
The Consolidated Stamp Duty has been deposited with
General Stamp Office, Govt Of Maharashtra
Certificate No. CSD/13/2018/2534/18 Dt. 04-07-2018
By Corporate Cell Mumbai No. Separate Stamp is required to
Be affixed on this document .
Office Code: 500100
Corporate Cell : Vulcan Insurance Building , Ground Floor,
77, Veer Nariman Road, Churchgate, Mumbai-400 020

PART - II

1 WHEREAS the insured designated in the Schedule hereto has, by a proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to UNITED INDIA INSURANCE COMPANY LTD. (hereinafter called the COMPANY) for the insurance hereinafter set forth in respect of Employees/Members (including their eligible family members) named in the Schedule hereto (hereinafter called the INSURED PERSON) and has paid premium as consideration for such insurance.

1.1 NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed, or otherwise expressed hereon the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any insured person shall contract any disease or suffer from any illness (hereinafter called DISEASE) or sustain any bodily injury through accident (hereinafter called INJURY) and if such disease or injury shall require any such insured Person, upon the advice of a duly qualified Physician/Medical Specialist/Medical practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called SURGEON) to incur hospitalization/domiciliary hospitalization expenses for medical/surgical treatment at any Nursing Home/Hospital in India as herein defined (hereinafter called HOSPITAL) as an inpatient, the Company will pay to the Hospital / Nursing Home or Insured the amount of such expenses as are reasonably and necessarily incurred in respect thereof by or on behalf of such Insured Person but not exceeding the Sum Insured in aggregate in any one period of insurance stated in the schedule hereto.

1.2 BASIC COVER:

1.2.1 In the event of any claim becoming admissible under this scheme, the company will pay to the Hospital / Nursing Home or insured person the amount of such expenses as would fall under different heads mentioned below and as are reasonably and medically necessary incurred thereof by or on behalf of such insured person but not exceeding the Sum Insured in aggregate mentioned in the schedule hereto.

A) Room and Boarding expenses as provided by the Hospital/Nursing Home not exceeding per day limit as mentioned in the schedule or the actual amount whichever is less.

B) Intensive Care Unit (ICU) expenses not exceeding per day limit as mentioned in the schedule or actual amount whichever is less.

C) Surgeon, team of surgeons, Assistant surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.

D) Nursing Charges , Service Charges, IV Administration Charges, Nebulization Charges, RMO charges ,Anesthetic, Blood, Oxygen, Operation Theatre Charges, surgical appliances, OT consumables, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, Defibrillator Ventilator, orthopedic implants, Cochlear Implant, any other implant, Intra-Ocular Lenses, infra cardiac valve replacements, vascular stents, any other valve replacement, laboratory/diagnostic tests, X-ray CT Scan, MRI, any other scan and such similar expenses that are medically necessary, or incurred during hospitalization as per the advice of the attending doctor,

E) Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured.

1.2.2 **Pre-Hospitalisation and Post-Hospitalisation Expenses -** Medical Expenses relevant to the same condition for which the hospitalization is required incurred during the period upto 30 days prior to

hospitalisation and during the period upto 90 days after the discharge from the hospital. These expenses are admissible only if the primary hospitalisation claim is admissible under the policy.

2. **DEFINITIONS**:

2.1 **ACCIDENT –** An accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.2 **ALTERNATIVE TREATMENTS -** Alternative Treatments are forms of treatment other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian Context.

2.3 **ANY ONE ILLNESS** will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment has been taken.

2.4 **CANCELLATION** defines the terms on which the policy contract can be terminated either by the insurer or the insured person by giving sufficient notice to other which is not lower than a period of fifteen days.

2.5 **CASHLESS FACILITY** means a facility extended by the insurer to the insured where the payment, of **the** costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorisation approved.

2.6 **CONGENITAL ANOMALY** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

1 Internal Congenital Anomaly
Which is not in the visible and accessible parts of the body.

2 External Congenital Anomaly
Which is in the visible and accessible parts of the body.

2.7 **CONDITION PRECEDENT** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional.

2.8 **CONTINUOUS COVERAGE** means uninterrupted coverage of the insured person under our Individual Health Insurance Policies or Family Floater Policy from the time the coverage incepted under the policy, provided a break in the insurance period not exceeding thirty days being grace period shall not be reckoned as an interruption in coverage for the purposes of this Clause. In case of change in Sum Insured during such uninterrupted coverage, the lowest Sum Insured would be reckoned for determining Continuous Coverage.

However, the benefit of Continuous Coverage getting carried over from other policies will not be available for HIV/AIDS coverage.

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

a. Has qualified nursing staff under its employment
b. Has qualified Medical Practitioner(s) in charge
c. Has a fully equipped operation theatre of its own where surgical procedures are carried out-
d. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

2.10 DAY CARE TREATMENT - Day Care treatment means the medical treatment and/or surgical procedure which is – (i) Undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement and (ii) which would have otherwise required a hospitalisation of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition.

2.11 DEDUCTIBLE is 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.

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

2.13 DISCLOSURE TO INFORMATION NORM: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.14 EMERGENCY CARE means management for a severe 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.

2.15 EMERGENCY DENTAL TREATMENT means the services or supplies provided by a Licensed dentist, Hospital or other provider that are medically and immediately necessary to treat dental problems resulting from injury. However, this definition shall not include any treatment taken for a pre-existing condition.

2.16 EMERGENCY MEDICAL TREATMENT means the services or supplies provided by a Physician, Hospital or Licensed provider that are Medically Necessary to treat any illness or other covered condition that is acute (onset is sudden and unexpected), considered life threatening, and one which, if left untreated, could deteriorate resulting in serious and irreparable harm.

2.17 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.

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

a. Has qualified nursing staff under its employment round the clock.
b. Has at least 10 in-patient beds in towns having a population of less than 10 lacs and at least 15 in-patient beds in all other places;
c. Has qualified Medical Practitioner(s) in charge round the clock;
d. Has a fully equipped Operation Theatre of its own where surgical procedures are carried out;
e. Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

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

For Ayurveda, Unani, Siddha and Homeopathy treatment, hospitalisation expenses are admissible only when the treatment has been undergone in a hospital as defined in clause 3.3 below.

2.19 HOSPITALISATION

Means admission in a Hospital/Nursing Home for a minimum period of 24 In-patient care consecutive hours except for the specified day care procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

For list of these specified day care procedures/treatments, please see Annexure-1.

Note: Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.

2.18 **ID CARD** means the identity card issued to the insured person by the TPA to avail cashless facility in network hospitals.

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

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

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

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

2.21 **IN-PATIENT CARE** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

2.22 **INSURED PERSON** means the employee of the bank and each of the other family members who are covered under this policy as shown in the Schedule.

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

2.24 **INTENSIVE CARE UNIT (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.

2.25 **MEDICAL ADVICE** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

2.26 **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.

2.27 **MEDICALLY NECESSARY TREATMENT** is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

1 Is required for the medical management of the illness or injury suffered by the insured;
2 Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
3 Must have been prescribed by a Medical Practitioner;
4 Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

The term Medical Practitioner would include Physician, Specialist and Surgeon. The Registered Medical Practitioner should not be the insured or any member of his family including parents and in-laws.

2.29 **NETWORK PROVIDER** means the hospital/nursing home or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility. The list of Network Hospitals is maintained by and available with the TPA and the same is subject to amendment from time to time.

PPN-Preferred Provider Network means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and website of the TPA mentioned in the schedule and is subject to amendment from time to time.

2.30 **NEW BORN BABY:** A new born baby means a baby born during the Policy Period aged between one day and 90 days, both days inclusive.

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

2.32 **NOTIFICATION OF CLAIM** is the process of notifying a claim to the insurer or TPA within specified timelines through any of the recognised modes of communication.

2.33 **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.

2.34 **PERIOD OF INSURANCE** means the period for which this policy is taken and is in force as specified in the Schedule.

2.35 **PORTABILITY** means transfer by an Individual Health Insurance Policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

2.36 **PRE-EXISTING DISEASE** means Any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer. Any complication arising from pre-existing disease shall be considered as a part of the pre-existing disease.

2.37 **PRE – HOSPITALISATION MEDICAL EXPENSES**

Relevant medical expenses incurred immediately 30 days before the Insured person is hospitalised provided that;

a. Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
b. The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.

2.38 **POST HOSPITALISATION MEDICAL EXPENSES**

Relevant medical expenses incurred immediately 90 days after the Insured person is discharged from the hospital provided that;

a. Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
b. The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.

2.39 **PSYCHIATRIC DISORDER** means clinically significant Psychological or behavioural syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behaviour or an expected response to a stressful life event) as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the Insured person in respect of whom a claim is lodged.

2.40 **PSYCHOSOMATIC DISORDER** means one or more psychological or behavioural problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person's risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after Physical examination of the Insured person in respect of whom a claim is lodged.

2.41 **QUALIFIED NURSE** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.

2.42 **REASONABLE AND CUSTOMARY CHARGES**

Reasonable and Customary charges mean 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 illness/injury involved.

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

2.44 **ROOM RENT** shall mean the amount charged by a hospital for the Occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

2.45 **SUM INSURED** is the maximum amount of coverage under this policy opted for all insured persons shown in the schedule.

2.46 **SURGERY OR SURGICAL PROCEDURE**

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

2.47 **THIRD PARTY ADMINISTRATOR (TPA)** means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those.

2.48 **UNPROVEN/EXPERIMENTAL TREATMENT** means any treatment including drug experimental therapy which is not based on established medical practice in India.

2.49 **WE/OUR/US/COMPANY** means UNITED INDIA INSURANCE COMPANY LIMITED

3. ADDITIONAL COVERAGES:

3.1 DOMICILIARY TREATMENT:

Medical expenses incurred in case of the following diseases which need domiciliary treatment as may be certified by the attending medical practitioner and / or bank's 'medical officer shall be deemed as hospitalization expenses and reimbursed to the extent of 100% subject to the overall limit of Sum Insured under the policy:

a. Cancer	b. Leukemia	c. Thalassemia	d. Tuberculosis
e. Paralysis	f. Cardiac Ailments	g. Pleurisy	h. Leprosy
i. Kidney Ailment	j. All Seizure disorders	k. Parkinson's diseases	l. Psychiatric disorder including schizophrenia and psychotherapy
m. Diabetes and its complications	n. hypertension	o. Hepatitis –B , Hepatitis - C	p. Hemophilia
q. Myasthenia gravis	r. Wilson's disease	s. Ulcerative Colitis	t. Epidermolysis bullosa
u. Venous Thrombosis(not caused by smoking)	v. Aplastic Anaemia	w. Psoriasis	x. Third Degree burns
y. Arthritis	z. Hypothyroidism , Hyperthyroidism expenses incurred on radiotherapy and chemotherapy in the treatment of cancer and leukemia	aa. Glaucoma	bb. Tumor
cc. Diphtheria	dd. Malaria	ee. Non-Alcoholic Cirrhosis of Liver	ff. Purpura

gg. Typhoid	hh. Accidents of Serious Nature	ii. Cerebral Palsy	jj. Polio
kk. All Strokes Leading to Paralysis	ll. Haemorrhages caused by accidents	mm. All animal/reptile/insect bite or sting	nn. chronic pancreatitis
oo. multiple sclerosis / motor neuron disease	pp. status asthamaticus, sequalea of meningitis	qq. osteoporosis	rr. muscular dystrophies
ss. sleep apnea syndrome(not related to obesity)	tt. any organ related (chronic) condition	uu. sickle cell disease, systemic lupus erythematous (SLE)	vv. varicose veins
ww. thrombo embolism venous thrombosis/venous thrombo embolism (VTE)	xx. growth disorders	yy. Graves' disease	zz. Chronic obstructive Pulmonary Disease, Chronic Bronchitis, Asthma
aaa. Physiotherapy	bbb. swine flu	ccc. Connective tissue disorder	

The cost of Medicines, Investigations, and consultations etc. in respect of domiciliary treatment shall be reimbursed for the period stated by the specialist and / or the attending doctor and / or the bank's medical officer, in Prescription duly supported by relevant investigation reports where ever necessary. If no period stated, the prescription for the purpose of reimbursement shall be valid for a period not exceeding 90 days.

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

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.

3.3 **Alternate treatment** - Subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in:

i. a Government Hospital or in any Institute recognised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health.

ii. Teaching hospitals of Ayurveda, Unani, Siddha and Homeopathy colleges recognised by Central Council of Indian Medicine (CCIM)

iii. Ayurveda, Unani, Siddha and Homeopathy Hospitals having registration with a Government authority under appropriate Act in the State/ UT and complies with the following as minimum criteria:

a) has at least fifteen in-patient beds;

b) has minimum five qualified and registered Ayurveda, Unani, Siddha and Homeopathy doctors;
c) has qualified paramedical staff under its employment round the clock;
d) has dedicated Ayurveda, Unani, Siddha and Homeopathy therapy sections;
e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Company's Liability for all claims admitted in respect of any/all insured person/s during the period of insurance shall not exceed the Sum Insured stated in the schedule.

3.4 Expenses on Hospitalization for minimum period of a day are admissible. However, this time limit is not applied to specific treatments, such as

1	Adenoidectomy	20	Haemo dialysis
2	Appendectomy	21	Fissurectomy / Fistulectomy
3	Ascitic / Plueral tapping	22	Mastoidectomy
4	Auroplasty not Cosmetic in nature	23	Hydrocele Surgeries
5	Coronary/ Renal Angiography	24	Hysterectomy
6	Coronary angioplasty	25	Inguinal/ ventral/ umbilical/ femoral hernia surgeries
7	Dental surgery	26	Parenteral chemotherapy
8	D&C	27	Polypectomy
9	Excision of cyst/ granuloma/lump/tumor	28	Septoplasty
10	Eye surgery	29	Piles/-fistula surgeries
11	Fracture including hairline fracture /dislocation	30	Prostate surgeries
12	Radiotherapy	31	Sinusitis surgeries
13	Chemotherapy including parental chemotherapy	32	Tonsillectomy
14	Lithotripsy	33	Liver aspiration
15	Incision and drainage of abscess	34	Sclerotherapy
16	Varicocelectomy	35	Varicose Vein Ligation
17	Wound suturing	36	All scopies along with biopsies
18	FESS	37	Lumbar puncture
19	Operations/Micro surgical operations on the nose, middle ear/internal ear, tongue, mouth, face, tonsils & adenoids, salivary glands & salivary ducts, breast, skin & subcutaneous tissues, digestive tract, female/male sexual organs.		

This condition will also not apply in case of stay in hospital of less than a day provided –

A) The treatment is undertaken under General or Local Anesthesia in a hospital / day care Centre in less than a day because of technological advancement and
B) Which would have otherwise required hospitalization of more than a day.

3.5 MATERNITY EXPENSES BENEFIT EXTENSION

We will pay the Maternity Expenses for the delivery of a child and/or Maternity Expenses related to a Medically Necessary Treatment and lawful medical termination of pregnancy, during the Policy Year. The maximum benefit allowable under this clause will be up to Rs. 50,000/- for Normal Delivery and Rs. 75,000/- for Caesarean Section. The hospitalization expenses in respect of the new born child will be covered within the Mother's Maternity expenses.

Special conditions applicable to Maternity Expenses Benefit Extension:

I. No waiting period for 9 months under maternity benefit.
II. Pre-natal & post-natal charges in respect of maternity benefit are covered under the policy up to 30 days and 60 days only, unless the same requires hospitalization.
III. Missed Abortions, Miscarriage, Medical Termination of Pregnancy or abortions induced by accidents are covered under the limit of Maternity Expenses.
IV. Complications in Maternity including operations for extra uterine pregnancy/ ectopic pregnancy would be covered up to the Sum Insured + Corporate Buffer
V. Maternity Expenses Benefit Extension is allowable irrespective of the number of living children.

3.6 BABY DAY ONE COVER

New born baby is covered from day one. All expenses incurred on the new born baby during maternity will be covered up to Rs. 20000/- Per child, in addition to the maternity limit
However, if the baby contacts any illness the same shall be considered in the Sum Insured + Corporate buffer. Baby to be taken as an additional member within the normal family floater.

3.7 AMBULANCE CHARGES

Ambulance charges are payable up to Rs 2500/- per trip to hospital and / or transfer to another hospital or transfer from hospital to home if medically advised. Taxi and Auto expenses in actual maximum up to Rs. 750/- per Hospitalisation.
Ambulance charges actually incurred on transfer from one center to another center due to Non availability of medical services/ medical complication shall be payable in full.

3.8 PRE-EXISTING DISEASES / AILMENTS

Pre-existing diseases are covered under the scheme from day one.

3.9 CONGENITAL ANOMALIES

Expenses for Treatment of Congenital Internal / External diseases, defects anomalies are covered under the policy

3.11 PSYCHIATRIC DISEASES

Expenses for treatment of psychiatric and psychosomatic diseases will be payable with or without hospitalization upto the Sum Insured.

3.12 ADVANCED MEDICAL TREATMENT

New advanced medical procedures approved by the appropriate authority e.g. laser surgery, stem cell therapy for treatment of a disease is payable on hospitalization /day care surgery.

3.13 Treatment taken for Accidents can be payable even on OPD basis in a Hospital up to Sum Insured

3.14 TAXES AND OTHER CHARGES

All Taxes, Surcharges, Service Charges, Registration charges, Admission Charges, Nursing, and Administration charges to be payable.

Charges for diapers and sanitary pads are payable if necessary as part of the treatment. Charges for Hiring a nurse / attendant during hospitalization will be payable only in case of recommendation from the treating doctor in case ICU / CCU, Neo natal nursing care or any other case where the patient is critical and requiring special care.

3.15 Treatment for Genetic Disorder and stem cell therapy is covered under the scheme.

3.16 Treatment for Age related Macular Degeneration (ARMD), treatment such as Rotational Field Quantum magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP), etc. are covered under the scheme. Treatment for all neurological/ macular degenerative disorders shall be covered under the scheme.

3.17 Rental Charges for External and or durable Medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Bi-PAP, Infusion pump etc. will be covered under the scheme. However, purchase of the above equipment to be subsequently used at home in exceptional cases on medical advice shall be covered.

3.18 Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, elastocrepe bandages, external orthopedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer (including Glucose Test Strips)/ Nebulizer/ prosthetic devise/ Thermometer, alpha / water bed and such similar items, will be covered under the scheme.

3.19 PHYSIOTHERAPY CHARGES: Physiotherapy charges shall be covered for the period specified by the Medical Practitioner even if taken at home.

All claims admitted in respect of any/all insured person/s during the period of insurance shall not exceed the Sum Insured stated in the schedule and Corporate Buffer if allocated.

4. EXCLUSIONS:

The company shall not be liable to make any payment under this policy in respect of any expenses

whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 Injury / disease directly or indirectly caused by or arising from or attributable to War, invasion, Act of Foreign enemy, War like operations (whether war be declared or not); Nuclear radiation.

4.2

a. Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.
b. Vaccination or inoculation.
c. Change of life or cosmetic or aesthetic treatment of any description is not covered.
d. Plastic surgery other than as may be necessitated due to an accident or as part of any illness.

4.3 Cost of spectacles and contact lenses, hearing aids, other than Intra-Ocular Lenses and Cochlear Implant.

4.4 Dental treatment or surgery of any kind which are done in a dental clinic and those that are cosmetic in nature.

4.5 Convalescence, rest cure, Obesity treatment and its complications including morbid obesity, Venereal disease, intentional self-injury and use of intoxication drugs / alcohol.

4.6 All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

4.7 Charges incurred at Hospital or Nursing Home primarily for diagnosis x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home, unless recommended by the attending doctor.

4.8 Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified by the attending physician

4.9 Injury or Disease directly or indirectly caused by or contributed to by nuclear weapon / materials.

4.10 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, /barber or beauty services, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses, unless and otherwise they are necessitated during the course of treatment.

4.11 Attempted suicide, critical illness before the commencement of the policy, are not covered.

4.12 Expenses on purchase of medicine not supported by bills/ receipts/ cash-memos with valid GST No. of the issuer of such bills/ receipts/ cash-memos.

5. 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 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 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 in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Notification of claim in case of Cashless facility	**TPA must be informed:**
In the event of planned hospitalisation	At least 72 (seventy two) hours prior to the insured person's admission to network provider/PPN hospital
In the event of emergency hospitalisation	Within 24 (twenty four) hours of the insured person's admission to network provider/PPN hospital

Notification of claim in case of Reimbursement	**TPA must be informed:**
In the event of planned hospitalisation	At least 72 (seventy two hours prior to the insured person's admission to hospital
In the event of emergency hospitalisation	Within 24 (twenty four) hours of the insured person's admission to hospital

C. Procedure for Cashless claims

1. Cashless facility for treatment shall be available to insured in network hospitals only.
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 Helpdesk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization Each request for pre-authorisation must be through duly completed standard pre-authorisation format including the following details:
    i. The health card which We or the associated TPA has issued to the Insured Person supported with the Insured Person's KYC documents.
    ii. The Policy number;
    iii. Name of the Policyholder/Employer;
    iv. Name and address of Insured Person/Employee/member in respect of whom the request is being made;
    v. Nature of the Illness/Injury and the treatment/Surgery required;
    vi. Name and address of the attending Medical Practitioner;
    vii. Hospital where treatment/Surgery is proposed to be taken;
    viii. Proposed date of admission.
5. If these details are not provided in full or are insufficient for the associated TPA to consider the request, the associated TPA will request additional information or documentation in respect of that request.
6. When the associated TPA have obtained sufficient details to assess the request, the associated TPA will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles and non-payable items, if applicable, or We may reject the request for pre-authorisation specifying reasons for the rejection.
7. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
8. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization 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 the associated TPA, the associated TPA will make the payment of the amounts assessed to be due directly to the Network Provider.
9. In the event that the cost of Hospitalization exceeds the authorized limit as mentioned in the authorization letter:
    a. The Network Provider shall request Us for an enhancement of authorization limit as described under Section 5.C.4 including details of the specific circumstances which have led to the need for increase in the previously authorized limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.
    b. We shall accept or decline such request for enhancement of pre-authorized limit for enhancement.

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 5.4 (a) above.

10. At the time of discharge, the insured person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
11. At the time of discharge:
    a. The Network Provider may forward a final request for authorization for any residual amount to the TPA along with the discharge summary and the detailed bill break up in accordance with the process described at 5.C.4 above.
    b. Upon receipt of the final authorization letter from the TPA, the Insured Person may be discharged by the Network Provider.

Note: (Applicable to 5 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 authorizations, 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.

12. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details. Denial of a Pre-authorization 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.
13. Claims for Pre and Post-Hospitalization will be settled on a reimbursement basis on production of cash receipts.

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)/ the Bank's office authorised to deal with Health Claims within the prescribed time limit.

For all claims for which Cashless Facilities have not been pre-authorised or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within the timelines as mentioned for reimbursement claims in B above:

(1) The Policy number;
(2) Name of the Policyholder/Employer;
(3) Name and address of the Insured Person/Employee/member in respect of whom the request is being made;
(4) Health Card, photo ID, KYC documents;
(5) Nature of Illness or Injury and the treatment/Surgery taken;

(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment/Surgery was taken;
(8) Date of admission and date of discharge;
(9) Any other information that may be relevant to the Illness/ Injury/ Hospitalization;
(10) Duly completed claim form.

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 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 – in Accidental cases only;
   xiv. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress;

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 (limited to 30 days)	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses (limited to 90 days)	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. The TPA 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 are partially met in 10 working days of the first intimation, The TPA 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-authorization letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorization 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-Hospitalization 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:

i. If any Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/ Certificate of Insurance, our liability to make payment shall be limited to the extent of the applicable Sub Limit for that Medical Expense.
ii. Opted Deductible (Per claim/ Aggregate/ Corporate), if any, shall be applicable on the amount payable by Us after applying (I), and (ii) above.
iii. Co-Payments if any, shall be applicable on the amount payable by Us after applying (I), and (ii).

The claim amount assessed under Section 5.J (i), (ii) and (iii) will be deducted from the following amounts in the following progressive order after applying Sub Limit

a. Sum Insured
b. Corporate Buffer

H. Claim Settlement

1. On receipt of the final document(s), the company shall within a period of 30 (thirty) days offer a settlement of the claim to the insured person.
2. In the cases of delay in the payment, the company shall pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate that is 2% (two percent) above the bank rate prevalent at the beginning of the financial year in which the claim is paid.
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, Insurer shall settle 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 at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid, from the date of receipt of last necessary document to the date of payment of claim.
5. The payment of the amount due shall be made by the company, upon acceptance of an offer of settlement as stated above by the insured person, within 7 (seven) days from the date of acceptance of the offer.
6. A claim, which is not covered under the policy cover and conditions, can be rejected.

I. Rejection/ Repudiation of Claim

a. If the company, for any reasons, decides to reject/ repudiate 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.

b. In case of rejection of claims, it would go through a Committee set up of the Bank, Third Party Administrator and United India Insurance Co Ltd. unless rejected by the committee in real time the claim should not be rejected.

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.

~~ii.~~ All claims will be payable in India and in Indian rupees.

~~iii.~~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.

~~iv.~~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.

~~v.~~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.

~~vi.~~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. Claims will be managed through the same Office of the Bank from where it is managed at present. The Third Party Administrator will be setting up a help desk at that office and supporting the bank in clearing all the claims on real time basis.

6. TERMS AND CONDITIONS

6.1 CONTRACT: the proposal form, declaration, and the policy issued shall constitute the complete contract of insurance.

6.2 The premium payable under this Policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy. No waiver of any terms,

provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorised official of the Company.

6.3 COMMUNICATION & NOTICE: Every notice or notice or instruction under this Policy shall be in writing and will be sent to:

a. The Policyholder/Insured Person, at the address as specified in the Policy Schedule/Certificate of Insurance
b. To Us, at the address specified in the Policy Schedule/ Certificate of Insurance.

6.4 Fraudulent Claims

If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent devices are used by You or the Insured Person or anyone acting on their behalf to obtain any Benefit under this Policy then this Policy shall be void in respect of such Insured Person and all claims being processed shall be forfeited for all Insured Persons within the family. All sums paid under this Policy shall be repaid to Us by You on behalf of all Insured Persons who shall be jointly liable for such repayment.

6.5 DISCLOSURE TO INFORMATION NORM

The claim shall be rejected in the event of misrepresentation, mis-description or non-disclosure of any material fact.

6.6 **Geographical Area**

The geographical scope of this Policy applies to events limited to India and all admitted or payable claims shall be settled in India in Indian rupees.

6.7 The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof. The Company shall not be bound to give notice that such renewal premium is due, provided however that if the insured shall apply for renewal and remit the requisite premium before the expiry of this policy, renewal shall not normally be refused, unless the Company has reasonable justification to do so.

6.8 **ENHANCEMENT OF SUM INSURED**

Change in sum insured after commencement of policy to be considered in case of promotion of the employee or vice versa.

6.9 **CANCELLATION CLAUSE:**

The Company may at any time cancel this Policy on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the insured giving fifteen days' notice in writing by Registered A/D to the insured at his last known address in which case the company shall return to the insured a proportion of the last premium corresponding to the unexpired period of insurance if no claim has been paid under the policy.

The Insured may at any time cancel this Policy and in such event the Company shall allow refund of premium at Company's short period rate table given below provided no claim has occurred upto the date of cancellation.

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%
Beyond 6 Months	Nil

6.10 LOW CLAIM RATIO DISCOUNT (BONUS)

Low Claim Ratio Discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claim ratio for the entire group insured under the Group Mediclaim Insurance Policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal where the Group Mediclaim Insurance Policy has not been in force for 3 completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken in to account

Incurred Claim ratio under the group policy	**Discount %**
Not exceeding 60%	5
Not exceeding 50%	15
Not exceeding 40%	25
Not exceeding 30%	35
Not exceeding 25%	40

6.11 **HIGH CLAIMS RATIO LOADING (MALUS)**

The total premium payable at renewal of the Group Policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Insurance Policy for the preceding year (immediately preceding the date of renewal).

Incurred claims ratio under this group policy	Loading
Between 70% and 100%	25 %
Between 101% and 125 %	55 %
Between 126 % and 150 %	90 %
Between 151 % and 175 %	120 %
Between 176 and 200	150%
Over 200 %	Cover to be reviewed

Note:

Low Claim Ratio Discount (Bonus) or High Claim Ratio loading (Malus) will be applicable to the Premium at renewal of the Policy depending on the incurred claims Ratio for the entire Group Insured.

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

The insured shall throughout the period of insurance keep and maintain a proper record of register containing the names of all the insured persons and other relevant details as are normally kept in any institution/ Organisation. The insured shall declare to the company any additions in the number of insured persons as and when arising during the period of insurance and shall pay the additional premium as agreed.

It is hereby agreed and understood that, that this insurance being a Group Policy availed by the Insured covering Members, the benefit thereof would not be available to Members who cease to be part of the group for any reason whatsoever.

Such members may obtain further individual insurance directly from the Company and any claims shall be governed by the terms thereof.

6.12 **ARBITRATION:**

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

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

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

6.13 **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.

6.14 **IRDA REGULATIONS**

This policy is subject to Provisions of Insurance Act, 1938, IRDAI (Health Insurance) Regulations 2016 and IRDAI (Protection of Policyholders' Interest) Regulations 2017 as amended from time to time.

6.15 GRIEVANCE REDRESSAL:

In the event of the policyholder having any grievance relating to the insurance, the insured person may submit in writing to the Policy Issuing Office or Uni-Customer Care Department at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact the Officer, Uni-Customer Care Department, Head Office in person or through post/email to customercare@uiic.co.in

The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The list of Insurance Ombudsman is attached with the policy. The updated list of Office of Insurance Ombudsman are available on IRDA website www.irda.gov.in and on the website of General Insurance Council www.gicouncil.in

6.16 REVISION/ MODIFICATION OF THE POLICY:

There is a possibility of revision/ modification of terms, conditions, coverages and/or premiums of this product at any time in future, with appropriate approval from IRDAI. In such an event of revision/modification of the product, intimation shall be set out to all the existing insured members at least 3 months prior to the date of such revision/modification comes into the effect The Company may also withdraw the insurance as offered hereunder after following the due process as laid down by the IRDA and after obtaining prior approval of the Authority and we shall offer to cover you under such revised/new terms, conditions, exceptions and premium for which we shall have obtained from the Authority.

6.17 WITHDRAWAL OF POLICY:

There is possibility of withdrawal of this product at any time in future with appropriate approval from IRDAI, as We reserve Our right to do so with an intimation of 3 months to all the existing insured members. In such an event of withdrawal of this product, at the time of the insured seeking renewal of

this Policy, he/she can choose, from among the Company's available similar and closely similar Health insurance products. Upon the Insured so choosing the Company's new product, he/she will be charged the Premium as per the premium chart for such chosen new product, as approved by IRDAI.

Provided however, if the Insured does not respond to the Company's intimation regarding the withdrawal of the product under which this Policy is issued, then this Policy shall be withdrawn and shall not be available to the Insured for renewal on the renewal date and accordingly upon his/ her seeking renewal of this Policy, he/she shall have to take a Policy under available new products of the Company subject to the insured paying the Premium as per the premium chart for such available new product chosen by the Insured and also subject to Portability condition.

PART - III

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 since the commencement of the Policy Year. 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 or first manifests itself during the Policy Year as a first incidence.

Critical Illness is to be provided to the employee subject to a sum insured of Rs. 1,00,000/- . The Cover starts on inception of the policy. In case an employee contracts a Critical Illness as listed below, the total sum insured of Rs.1,00,000/- is paid, as a benefit. This benefit is provided on first detection/diagnosis of the Critical Illness.

A. List of Critical Illnesses cover under this Benefit:

I. **CANCER OF SPECIFIED SEVERITY (INCLUDING LEUKEMIA)**

A malignant tumor 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 leukemia, lymphoma and sarcoma.
The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, 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;
   a. Malignant melanoma that has not caused invasion beyond the epidermis;
   All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
   b. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
   c. Chronic lymphocytic leukemia less than RAI stage 3.
   d. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
   e. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
   f. All tumors in the presence of HIV infection.

II. **STROKE RESULTING IN PERMANENT SYMPTOMS**

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

The following are excluded:

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

III. **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.

IV. **OPEN CHEST CABG**

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.

The following are excluded:

Angioplasty and/or any other intra-arterial procedures

V. **MYOCARDIAL INFARCTION (First Heart Attack of specific severity)**

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

VI. **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.

VII. **MAJOR ORGAN /BONE MARROW TRANSPLANT**

i. The actual undergoing of a transplant of:
   a. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   b. Human bone marrow using hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

ii. The following are excluded:
   a. Other stem-cell transplants.

b. Where only islets of Langerhans are transplanted.

VIII. **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 (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

IX. **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.**

B. Cover

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

a. Under this policy there would be no waiting period for the payment of the claim on the inception of the policy, nor any survival period for the payment of the claim on the individual contracting any of the above mentioned Critical Illness.
b. Upon Our admission of the first claim under this Benefit in respect of an Insured Person in any Policy Year, 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 of **Rs. One Lac only**.
d. This Benefit is paid as a lump sum amount and is over and above the Base Sum Insured.

Hospitalization is not required to claim this benefit. Further the Employee can claim the cost of hospitalization on the same from the Group Mediclaim Policy as cashless / reimbursement of expenses for the treatment taken by him.

****