UNITED INDIA INSURANCE COMPANY LIMITED
REGISTERED & HEAD OFFICE: 24, WHITES ROAD, CHENNAI-600014

MAHA BANK SWASTHYA YOJANA (Group Health Insurance Scheme)
UIN No. IRDA/NL-HLT/UII/P-H/V.1/382/13-14

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 hospitalisation/domiciliary hospitalisation 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 through TPA 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 **In the event of any claim becoming admissible under this scheme, the company will pay through TPA 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, Boarding and Nursing expenses as provided by the Hospital/Nursing Home not exceeding 1% of the sum insured per day or the actual amount whichever is less. This also includes nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.**

B. **Intensive Care Unit (ICU) expenses not exceeding 2% of the sum insured per day or actual amount whichever is less.**

C. **Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.**

D. **Anaesthetic, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory/diagnostic tests, X-ray and such similar expenses that are medically necessary.**

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

Note :
1. The amount payable under 1.2 C & D above shall be at the rate applicable to the entitled room category. In case the Insured person opts for a room with rent higher than the entitled category as in 1.2 A above, the charges payable under 1.2 C & D shall be limited to the charges applicable to the entitled category. This will not be applicable in respect of medicines & drugs and implants.
2. No payment shall be made under 1.2 C other than as part of the hospitalisation bill.

1.2.1 **Expenses in respect of the following specified illnesses/surgeries will be restricted as detailed below:**

Hospitalisation Benefits	**LIMITS per surgery RESTRICTED TO**
a. Cataract, Hernia, Hysterectomy	**a. Actual expenses incurred or 25% of the sum insured whichever is less** **b. Actual expenses incurred or 70% of the**

b.	**Major surgeries***	**Sum Insured whichever is less**

*** Major surgeries include Cardiac surgeries, Brain Tumor surgeries, Pacemaker implantation for sick sinus syndrome, Cancer surgeries, Hip, Knee, joint replacement surgery, Organ Transplant.**
*** The above limits specified are applicable per hospitalization/surgery.**

1.3 Pre and Post Hospitalisation expenses payable in respect of each hospitalisation shall be the actual expenses incurred subject to a maximum of 10% of the Sum Insured.

1.4 In addition to the above, the following would apply to claims arising out of persons aged more than 60 years

EXPENSES ON MAJOR ILLNESSES CHARGED AS A TOTAL PACKAGE	**TO BE SETTLED WITH A CO-PAY ON 80:20 BASIS. The co-pay of 20% will be applicable on the admissible claim amount.**

2. DEFINITIONS:

2.1 ACCIDENT:

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

2.2

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 –

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

2.3 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.

2.4 ANY ONE ILLNESS:
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. Occurrence of the same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy.

2.5 CASHLESS FACILITY:
Cashless facility "means a facility extended by the insurer to the insured where the payments, of the cost of treatment undergone by the insured in accordance with the policy terms and conditions, or directly made to the network provider by the insurer to the extent preauthorisation approved.

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

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

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

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

2.8 CONTRIBUTION:

Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured, to share the cost of an indemnity claim on a rateable proportion.

2.9 DAYCARE CENTRE:

A 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 the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under;-

- **has qualified nursing staff under its employment**
- **has all qualified medical practitioner(s) in charge**
- **has a fully equipped operation theatre of its own where surgical procedures are carried out.**
- **maintains daily records of patients and will make these accessible to the insurance companies authorised personnel.**

2.10 DAY CARE TREATMENT:

Day care Treatment refers to 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 DOMICILIARY HOSPITALIZATION:

Domiciliary Hospitalisation 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.

2.12 GRACE PERIOD:

A grace period of 30 days is permissible to effect renewal of policy to protect the benefit of continuity, subject however that no claim shall be admissible for any event arising during the period immediately after the expiry of existing policy and renewal thereof. This grace period is liable for change as and when regulatory changes are effected by IRDA.

2.13 HOSPITAL / NURSING HOME:

A 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 the Clinical establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under

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

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

2.14 HOSPITALIZATION:

Hospitalization means admission in a Hospital/Nursing Home for a minimum period of 24 consecutive hours of inpatient care except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours

2.15 ID CARD:

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

2.16 ILLNESS:

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

2.17 INJURY:

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

2.18 IN PATIENT CARE:

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.

2.19 INTENSIVE CARE UNIT:

Intensive Care Unit means an identifies 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.

2.20 MATERNITY EXPENSES:

Maternity expenses/treatment shall include:

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.

2.21 MEDICAL ADVICE:

Any consultation or advice from a medical practitioner/doctor including the issue of any prescription or repeat prescription.

2.22 MEDICAL EXPENSES:

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

2.23 MEDICALLY NECESSARY:

Medically necessary treatment is defined as any treatment, test, medication or stay in hospital or part of a stay in a hospital which

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

2.24 MEDICAL PRACTITIONER:

Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or the homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. The term medical practitioner would include physician, specialist and surgeon.
(The Registered practitioner should not be the insured or close family members such as parents, in-laws, spouse and children.)

2.25 NETWORK PROVIDER:

Network Provider means hospitals 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.

Preferred Provider Network means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. The list is available with the company/TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

2.26 NEW BORN BABY:

A new born baby means baby born during the Policy Period aged between one day and 90 days, both days inclusive.

2.27 NON NETWORK :

Any hospital ,day care centre or other provider that is not part of the network.

2.28 NOTIFICATION OF CLAIM

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

2.29 OPD TREATMENT:

OPD Treatment is one in which the insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of medical a practitioner. The insured is not admitted as a day care or in-patient.

2.30 PRE-EXISTING DISEASE:

Pre Existing Disease is any condition, ailment or injury or related condition(s) for which you ad 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.

2.31 PORTABILITY:

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.

2.32 PRE – HOSPITALISATION MEDICAL EXPENSES:

Medical expenses incurred immediately 30 days before the insured person is hospitalized will be considered as part of a claim as mentioned under Item 1.2 above provided that;

i. such medical expenses are incurred for the same condition for which the insured person's hospitalization was required and

ii. the inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

2.33 POST HOSPITALISATION MEDICAL EXPENSES:

Relevant medical expenses incurred immediately 60 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 the Insurance Company.

2.34 QUALIFIED NURSE:

Qualified Nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India and/or who is employed on recommendation of the attending medical practitioner.

2.35 REASONABLE AND CUSTOMARY CHARGES:

Reasonable 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.

2.36 RENEWAL:

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

2.37 ROOM RENT:

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

2.38 SUBROGATION:

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

2.39 SURGERY:

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.

2.40 THIRD PARTY ADMINISTRATOR

TPA means a Third Party Administrator who holds a valid Licence from Insurance Regulatory and Development Authority to act as a THIRD PARTY ADMINISTRATOR and is engaged by the Company for the provision of health services as specified in the agreement between the Company and TPA.

2.41 UNPROVEN/EXPERIMENTAL TREATMENT:

Unproven/Experimental treatment is treatment, including drug Experimental therapy, which is not based on established medical practice in India.

3. COVERAGES:

3.1 Expenses on Hospitalisation for minimum period of 24 hours are admissible. However, this time limit is not applied to specific treatments, such as

1	**Adenoidectomy**	**19**	**FESS**
2	**Appendectomy**	**20**	**Haemo dialysis**
3	**Ascitic/Pleural tapping**	**21**	**Fissurectomy / Fistulectomy**
4	**Auroplasty**	**22**	**Mastoidectomy**
5	**Coronary angiography**	**23**	**Hydrocele**
6	**Coronary angioplasty**	**24**	**Hysterectomy**
7	**Dental surgery**	**25**	**Inguinal/ventral/ umbilical/femoral hernia**
8	**D&C**	**26**	**Parenteral chemotherapy**
9	**Endoscopies**	**27**	**Polypectomy**
10	**Excision of Cyst/granuloma/lump**	**28**	**Septoplasty**
11	**Eye surgery**	**29**	**Piles/ fistula**
12	**Fracture/dislocation excluding hairline fracture**	**30**	**Prostrate**
13	**Radiotherapy**	**31**	**Sinusitis**
14	**Lithotripsy**	**32**	**Tonsillectomy**
15	**Incision and drainage of abcess**	**33**	**Liver aspiration**
16	**Colonoscopy**	**34**	***Sclerotherapy***
17	**Varicocelectomy**	**35**	***Varicose Vein Ligation***
18	**Wound suturing**		

Or any other surgeries/procedures agreed by the TPA/Company which require less than 24 hours hospitalisation and for which prior approval from TPA/Company is mandatory. This condition will also not apply in case of stay in hospital of less than 24 hours provided -

a) The treatment is such that it necessitates hospitalisation and the procedure involves specialised infrastructural facilities available in hospitals.
b) Due to technological advances hospitalisation is required for less than 24 hours only.
c) They are carried out in Day Care Centre networked by TPAs where requirement of minimum number of beds is overlooked but having (i) fully equipped Operation Theatre, (ii) fully qualified Day Care Staff (c) fully qualified Surgeons/Post-Operative attending Doctors.

Note 1 : Procedures/treatments usually done in out patient department are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours or carried out in Day Care Centres.
Note 2: When treatment such as dialysis, Chemotherapy, Radiotherapy., etc is taken in the hospital / nursing home/Day-care centre and the insured is discharged on the same day the treatment will be considered to be taken under hospitalisation benefit section

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.
subject however that domiciliary hospitalisation benefits shall not cover:
i) Expenses incurred for pre and post hospital treatment and
ii)Expenses incurred for treatment for any of the following diseases:-
a. Asthma
b. Bronchitis
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. Influenza, Cough and Cold
i. All Psychiatric or Psychosomatic Disorders
j. Pyrexia of unknown Origin for less than 10 days
k. Tonsillitis and Upper Respiratory Tract infection including Laryngitis and pharangitis
l. Arthritis, Gout and Rheumatism

Liability of the company under this clause is restricted as stated in the Schedule attached hereto

3.3 For Ayurvedic Treatment, hospitalisation expenses are admissible only when the treatment has been undergone in a Government Hospital or in any Institute recognised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health.

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.

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 Any Pre-existing condition(s) as defined in the policy, until 48 months of continuous coverage of such insured person have elapsed since inception of his/her first policy as mentioned in the schedule attached to the policy

4.2 Any disease other than those stated in clause 4.3 below, contracted by the Insured person during the first 30 days from the commencement date of the policy. This exclusion shall not however, apply in case of the Insured person having been covered for a continuous period of preceding 12 months without any break.

4.3 Unless the Insured has 24 months of continuous coverage, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hyperthrophy, Hysterectomy for Menorrhagia, or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders, Gall Bladder Stone removal, Gout & Rheumatism, Calculus Diseases are not payable. Internal Congenital Disease means anomaly which is not visible and accessible parts of the body.

4.4 Unless the Insured has 48 months of continuous coverage, the expenses related to treatment of Joint Replacement due to Degenerative Condition and age-related Osteoarthritis & Osteoporosis are not payable.

If these diseases mentioned in Exclusion no.4.3 and 4.4 (other than Congenital Internal Diseases) are pre-existing at the time of proposal they will not be covered even during subsequent period of renewal subject to the pre-existing disease exclusion clause. If the Insured is aware of the existence of congenital internal disease before inception of the policy, the same will be treated as pre-existing.

4.5 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).

4.6 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 of any kind unless it is post animal bite.
c. Change of life or cosmetic or aesthetic treatment of any description such as correction of eyesight., etc,
d. Plastic surgery other than as may be necessitated due to an accident or as part of any illness.

4.7 Cost of spectacles and contact lenses, hearing aids.

4.8 Dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalisation.

4.9 Convalescence, general debility; run-down condition or rest cure, Obesity treatment and its complications including morbid obesity, Congenital external disease/defects or anomalies, treatment relating to all psychiatric and psychosomatic disorders, infertility, Sterility, Venereal disease, intentional self injury and use of intoxication drugs / alcohol.

4.10 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.

4.11 **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.**

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

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

4.13 **Treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of these including caesarean section, except abdominal operation for extra uterine pregnancy (Ectopic pregnancy), which is proved by submission of Ultra Sonographic report and Certification by Gynaecologist that it is life threatening one if left untreated.**

4.14 **Naturopathy Treatment, acupressure, acupuncture, magnetic therapies, experimental and unproven treatments/ therapies. Treatment including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.**

4.15 **External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc. Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer, alpha / water bed and similar related items etc., and also any medical equipment, which is subsequently used at home etc.**

4.16 **Genetic disorders and Stem Cell implantation/surgery.**

4.17 **Change of treatment from one system of medicine to another unless recommended by the consultant/hospital under whom the treatment is taken.**

4.18 **Treatment for Age related Macular Degeneration (ARMD), treatment such as Rotational Field Quantum magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP), etc.**

4.19 **All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, ayah, private nursing/barber or beauty services, died charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses.**

4.20 **Any kind of Service charges, Surcharges, Admission Fees/Registration Charges, Luxury Tax and similar charges levied by the hospital**

4.21 **All non-Medical expenses. For detailed list of non-medical expenses, please log on to our website www.uiic.co.in.**

5. CONDITIONS:

5.1 **Contract: the proposal form, declaration pre-acceptance health check-up and the policy issued shall constitute the complete contract of insurance.**

5.2 **Every notice or communication regarding hospitalization or claim to be given or made under this Policy shall be delivered in writing at the address of the TPA office as shown in the Schedule. Other matters relating to the policy may be communicated to the policy issuing office.**

5.3 **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 authorised 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.**

5.4 **Notice of Communication: Upon the happening of any event which may give rise to a claim under this Policy notice with full particulars shall be sent to the TPA named in the schedule immediately and in case of emergency hospitalization within 24 hours from the time of Hospitalisation/Domiciliary Hospitalisation**

5.5 **All supporting documents relating to the claim must be filed with TPA within 15 days from the date of discharge from the hospital. In case of post-hospitalisation, treatment (limited to 60 days), all claim documents should be submitted within 7 days after completion of such 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.

5.6 The Insured Person shall obtain and furnish the TPA with all original bills, receipts and other documents upon which a claim is based and shall also give the TPA/ Company such additional information and assistance as the TPA/Company may require in dealing with the claim.

5.7 Any medical practitioner authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

5.8 The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.

5.9 DISCLOSURE TO INFORMATION NORM

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

5.10 If at the time when a claim arises under the policy, there is in existence any other insurance taken by the insured to indemnify the treatment costs, the insured person shall have the right to require a settlement of the claim in terms of any of his policies. If the amount to be claimed exceeds the sum insured under a single policy, after considering deductibles or co-pay, the insured person shall have the right to choose the insurers by whom the claim is to be settled. In such cases, the Company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation costs or expenses.
Note: The insured person must disclose such other insurance at the time of making the claim under this policy.

5.11 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.

5.12 ENHANCEMENT OF SUM INSURED

The insured may seek enhancement of Sum Insured in writing at or before payment of premium for renewal, which may be granted at the discretion of the Company. However, notwithstanding enhancement, for claims arising in respect of ailment, disease or injury contracted or suffered during a preceding policy period, liability of the company shall be only to the extent of the Sum Insured under the policy in force at the time when it was contracted or suffered during the currency of such renewed policy or any subsequent renewal thereof.

Any such request for enhancement must be accompanied by a declaration that the insured or any other insured person in respect of whom such enhancement is sought is not aware of any symptoms or other indications that may give rise to a claim under the policy. The Company may require such insured person/s to undergo a Medical examination to enable the company to take a decision on accepting the request for enhancement in the Sum Insured.

5.13 Cancellation Clause:

The Company may at any time cancel this Policy by sending the Insured 15 days notice by registered letter at the insured's last known address and in such event the Company shall refund to the Insured a pro-rata premium for unexpired Period of Insurance. The Company shall, however, remain liable for any claim, which arose prior to the date of cancellation. The Insured may at any time cancel this Policy and in such event the Company shall allow refund of premium at Company's short period rate only (Table given here below) provided no claim has occurred up to the date of cancellation.

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED
Upto one month	1/4 th of the annual rate
Upto three months	1/2 of the annual rate
Upto six months	3/4th of the annual rate
Exceeding six months	Full annual rate.

5.14 If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision

of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

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

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

5.15 If the TPA, as per terms and conditions of the policy or the Company shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date or receipt of the notice of such disclaimer notify the TPA/ Company in writing that he does not accept such disclaimer and intends to recover his claim from the TPA/Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.16 All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency. Payment of claim shall be made through TPA to the Hospital/Nursing Home or the Insured Person as the case may be.

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

5.17 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

5.18 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:

1. **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.**
2. **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 MATERNITY EXPENSES BENEFIT EXTENSION: (Wherever applicable)

This is an optional cover, which can be obtained on payment of 10% of total basic premium for all the Insured Persons under the Policy.

Option for Maternity Benefits has to be exercised at the inception of the Policy period and no refund is allowable in case of Insured's cancellation of this option during currency of the policy.

The hospitalization expenses in respect of the new born child can be covered within the Mother's Maternity expenses. The maximum benefit allowable under this clause will be up to Rs. 50,000/- or the sum insured opted by the group whichever is lower.

Special conditions applicable to Maternity expenses Benefit Extension:
1. **These Benefits are admissible only if the expenses are incurred in Hospital / Nursing Home as in-patients in India**
2. **A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency.**
3. **Claim in respect of delivery for only first two children and / or operations associated therewith will be considered in respect of any one Insured Person covered under the policy or any renewal thereof. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.**
4. **Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.**
5. **Pre-natal and postnatal expenses are not covered unless admitted in Hospital / Nursing Home and treatment is taken there.**

<u>Note:</u> When group policy is extended to include Maternity Expenses Benefit, the exclusion No.4.14 of the policy stands deleted.

7. IRDA REGULATIONS : This policy is subject to IRDA (Health Insurance) Regulations 2013 and IRDA (Protection of Policyholders' Interest) Regulations 2002 as amended from time to time.

8. 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 Grievance cells 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.

9 IMPORTANT NOTICE

The Company may revise any of the terms, conditions and exceptions of this insurance including the premium payable on renewal in accordance with the guidelines/rules framed by the Insurance Regulatory and Development Authority (IRDA) and after obtaining prior approval from the Authority. We shall notify you of such changes at least three months before the revision are to take 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 prior approval from the Authority.

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SPECIAL CONDITIONS FOR MAHA BANK SWASTHYA YOJNA (Group Health Insurance Scheme)

Some of the conditions are relaxed from our normal policy for Bank of Maharashtra accountholders. The special conditions for Maha Bank Swasthya Yojna (Group Health Insurance Scheme) is compared with the normal mediclaim Group policy , and the same is given below:

AGE LIMT: 3 MONTHS TO 65 YEARS & RENEWAL UPTO 80 years

1.2 During Hospitalization payment to Hospital in connection with Room rent, intensive care etc., In the event of any claim becoming admissible under this scheme, the company will pay through TPA to the Hospital/Nursing Home of insured person the amount of such expenses as would fall under different heads mentioned below and as are reasonably and necessarily incurred thereof by or on behalf of such insured person.

- Room, Boarding Expenses as provided by the Hospital/Nursing Home
- Nursing Expenses
- Surgeon, Anaesthetist, Medical Practitioner, Consultants Specialists Fees
- Anesthetist, Blood, Oxygen, Operation Theatre Charges, Surgical appliances, Medicines & Drugs, Diagnostic Materials and X-Ray.
- Dialysis, Chemotherapy, Radiotherapy Cost of Pacemaker, Artificial Limbs.

    - (N.B. Company's Liability in respect of all claims admitted during the period of Insurance shall not exceed the Sum Insured per Family as mentioned in the Schedule).

    - ***(This means that there is no separate cap in*** **Maha Bank Swasthya Yojna (Group Health Insurance Scheme)** ***for room Rent/ICU charges)***

1.2.1 **Claim payable under Hospitalization:**

The restrictions imposed under 1.2.1 is not applicable for this policy.

1.3 **Pre & Post Hospitaliztion**

There is no cap for expenses under Pre & Post Hospitalization.

1.4 **claims arising out of persons aged more than 60 years**

The condition of Co-pay does not apply to this policy.

2.11 **DOMICILIARY HOSPITALIZATION:**

There is no Domiciliary Hospitalization cover available under this policy.

2.29 **OPD TREATMENT:**

There is no OPD treatment cover available under this policy.

2.30 PRE-EXISTING DISEASE:

Under 2.30 clause instead of 48 months in Maha Bank Swasthya Yojna (Group Health Insurance Scheme) this stands corrected as 36 months

EXCLUSIONS

4.1 In this clause referring to pre-existing condition(s) , the period of 48 months shall stand corrected as 36 months in Maha Bank Swasthya Yojna (Group Health Insurance Scheme)

4.2 In this clause the waiting period of two years shall be read as one year in Maha Bank Swasthya YOJNA (Group Health Insurance Scheme)

4.3 This clause is not applicable for this policy.

4.13 This clause does not apply for this policy.

4.15 This clause does not apply for this policy.

4.17 This clause does not apply for this policy.

5.12 ENHANCEMENT OF SUM INSURED :

Subject to this clause, in Maha Bank Swasthya Yojna (Group Health Insurance Scheme), during renewal, the client may increase the sum insured to the immediate next slabs only.

6. MATERNITY EXPENSES BENEFIT EXTENSION:

Under Maha Bank Swasthya Yojna (Group Health Insurance Scheme), there is no additional premium for Maternity cover and may be read in place of the clauses 6 as given below:

i) Maternity Expenses Benefits: Means treatment taken in hospital/nursing home arising from or traceable to pregnancy childbirth including normal caesarean section. Waiting period is 9 months and the reimbursement / cashless facility is available for first two children. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.

ii) Pre-natal and postnatal expenses are not covered unless admitted in Hospital / Nursing Home and treatment is taken there.

iii) Baby care means, expenses relating to treatment given to the new born child in the hospital as an inpatient for a maximum period of 90 days from the date of its birth. The reimbursement of Maternity and baby care will be limited to the actual expenses subject to a maximum of 5% of sum insured opted in the mediclaim section. After 90 days from the date of birth, the baby will have to be covered under policy on payment of additional premium.

In addition to the above, the following additional benefits are also available for Maha bank Swasthya Yojna (Group Health Insurance Scheme) which are to be added as part of the special conditions forming part of the policy:

a) Reasonable ambulance charges:

Reasonable ambulance charges include the charges incurred for emergency transport of the patient from the residence/place :>f accident/illness to the hospital where treatment is taken. It also includes ambulance charges for transport of the patient by the hospital . where treatment is being taken to another hospital for treatment/diagnostic tests etc. but subject to a maximum of RS.1 000/- per policy period. The relevant bills for such ambulance charges will have to be submitted by the insured. The ambulance charge is part of the total sum

insured under the Mediclaim policy.

b) Hospital cash up to Rs.1,000/- to parents in case of hospitalization of children up to 12 years of age:

A Cash allowance of RS.100/- per day subject to a maximum of RS.1000/- will be given to the parents/guardians of children up to the age of 12 who are hospitalized and there is a valid claim under the policy. Hospital cash forms a part of the total sum insured under the policy.

C) Cost of health check up :

The insured shall be entitled for reimbursement of the cost of medical check up once at the end of every three underwriting years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 1 % of the amount of average sum insured during the block of three claim free underwriting years of the policy issued by United India Insurance co ltd..

IMPORTANT: The health check up provision is applicable only in respect of continuous insurance without break.

d) Funeral expenses: RS.1000/- :

In case the insured or his family members have died following hospitalization due to an illness/accident and their eyes have been donated to a recognized institution. funeral expenses of RS.1 000/- will be paid under the policy on production of the original certificate from the said institution. This is subject to there being a valid claim under the mediclaim policy. This amount will be reimbursed over and above the sum insured opted.

f) Reimbursement of expenses - NEPAL & BHUTAN:

Reimbursement in Indian rupees of emergency hospitalisation expenses for treatment at Nepal or Bhutan while the insured is away at these places either on holiday or business purposes. Cashless facility is not offered under this extension.

SAILENT FEATURES OF PERSONAL ACCIDENT (DEATH) INSURANCE:

- The Policy provides that, if at any time during the currency of this policy the insured and his/her family members shall sustain any bodily injury resulting sole and directly from accident caused by external violent and visible means resulting in death, then the company shall pay to the insured of his legal personal representative (s) as the case may be, a sum of 100% of Mediclaim Sum Insured in case of death of Account Holder and the family members as mentioned in the policy.

- Account Holder-100% of mediclaim Sum Insured, Spouse –50% of mediclaim S.I., Children above 12 yrs & below 21 yrs- 20% of mediclaim S.I., Children below 12 yrs – 10% of mediclaim S.I., Nomination facility is available

The Policy excludes death due to :

1 Intentional Self Injury / Suicide / Attempted Suicide
2. Whilst under influence of intoxicating liquor or drugs
3.Whilst engaged in Aviation or Ballooning
4 Due to Venereal diseases or Insanity
5Due to Insured committing any breach of law with Criminal intent
6 From Service in the armed forces
7 Directly or indirectly from child-birth or pregnancy.