MAHA BANK SWASTHYA YOJANA (GROUP HEALTH INSURANCE SCHEME)

Policy Terms & Conditions

1. PREAMBLE

This Policy is a contract of insurance issued by **UNITED INDIA INSURANCE COMPANY** (hereinafter called the **COMPANY**) to the Proposer mentioned in the Schedule (hereinafter called the '**Insured**') to cover the person(s) named in the schedule (hereinafter called the '**Insured Persons**'). The Policy is based on the statements and declaration provided in the Proposal Form by the Proposer and is subject to the receipt of full premium.

2. OPERATIVE CLAUSE

If during the Policy Period the Insured Person(s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital /Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically Necessary, Reasonable and Customary Medical Expenses towards the Coverage mentioned hereunder.

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

3. DEFINITIONS

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

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.
3. **Any One Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
4. **Associated Medical Expenses** means hospitalisation related expenses on Surgeon, Anaesthetist, Medical Practitioner, Consultants and Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital; Anaesthetics, blood, oxygen, operation theatre charges, surgical appliances and such other similar expenses with the exception of:
   i. Cost of pharmacy and consumables medicines;
   ii. Cost of implants/medical devices;
   iii. Cost of diagnostics.

   The scope of this definition is limited to admissible claims where a proportionate deduction is applicable, as per Point 2 of Note to 4.1.
5. **AYUSH** Treatment refers to hospitalisation treatment given under Ayurvedic system of Medicine (covered under the Policy).
6. An **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner(s)* comprising any of the following:
   i. Central or State Government AYUSH Hospital; or
   ii. Teaching hospital attached to AYUSH College recognised by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

iii. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognised system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with the following criterion:

- Having at least 5 in-patient beds;
- Having qualified AYUSH *Medical Practitioner* in charge round the clock;
- Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are carried out;
- Maintaining daily records of the patients and making them accessible to the insurance company's authorised representative.

7. **AYUSH Day Care Centre** means and includes Community Health Care Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

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

8. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

9. **Cashless Facility** means a facility extended by the Insurer to the Insured, where the payments 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-authorization is approved.

10. **Certificate of Insurance** means the certificate we issue to the Insured Person outlining the Insured Person's cover under the Policy.

11. **Co-morbidity** is the presence of one or more additional conditions co-occurring with a primary condition; in the countable sense of the term, a comorbidity is each additional condition.

12. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

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

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

14. **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:
    i. Has qualified nursing staff under its employment;
    ii. Has qualified Medical Practitioner(s) in charge;
    iii. Has a fully equipped operation theatre of its own where surgical procedures are carried out;
    iv. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

15. **Day Care Treatment** means medical treatment, and/or surgical procedure, which is:
    i. Undertaken under general or local anaesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement; and
    ii. Which would have otherwise required a hospitalisation of more than twenty-four hours.

    Treatment normally taken on an outpatient basis is not included in the scope of this definition.

16. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
17. **Emergency Care** means management for an illness or injury, which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *medical practitioner* to prevent death or serious long-term impairment of the Insured Person's health.
18. **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.
19. **Home Care Treatment** means treatment availed by the Insured Person at home for Covid on positive diagnosis of Covid in a Government authorised diagnostic centre, which in normal course would require care and treatment at a hospital but is actually taken at home provided that:
    i. The Medical Practitioner advises the Insured Person to undergo treatment at home;
    ii. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment;
    iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
20. **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:
    i. Has qualified nursing staff under its employment round the clock;
    ii. Has at least 10 in-patient beds in towns having a population of less than 10 lacs and at least 15 in-patient beds in all other places;
    iii. Has qualified Medical Practitioner(s) in charge round the clock;
    iv. Has a fully equipped Operation Theatre of its own where surgical procedures are carried out;
    v. Maintains daily records of patients and makes these accessible to the insurance Company's authorized personnel.
21. **Hospitalisation** means admission in a Hospital for a minimum period of 24 consecutive *'In-patient care'* hours except for the day-care treatments, where such admission could be for a period of less than 24 consecutive hours.
22. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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:
    i. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests;
    ii. It needs ongoing or long-term control or relief of symptoms;
    iii. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
    iv. It continues indefinitely;
    v. It recurs or is likely to recur.
23. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
24. **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.
25. **Insured Person** means person(s) named in the schedule of the Policy.
26. **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.

27. **ICU (Intensive Care Unit) 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.

28. **Maternity Expenses** mean
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    ii. Expenses towards lawful medical termination of pregnancy during the policy period.

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

30. **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.

31. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i. Is required for the medical management of the illness or injury suffered by the Insured;
    ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
    iii. Must have been prescribed by a Medical Practitioner;
    iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

32. **Medical Practitioner** means 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 its 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.

33. **Migration** means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

34. **Network Provider** means hospitals or health care providers enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a cashless facility.

    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.

35. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.

36. **Notification of Claim** means the process of notifying a claim to the Insurer or TPA through any of the recognised modes of communication.

37. **OPD (Out-Patient) 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.

38. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured Person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured Person.
39. **Policy Period** means period of one policy year as mentioned in schedule for which the Policy is issued.
40. **Policy Schedule** means the Policy Schedule attaching to and forming part of the Policy.
41. **Pre-Existing Disease** means any condition, ailment, injury or disease:
    i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement; or
    ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement.
42. **Pre-Hospitalisation Medical Expenses** means relevant medical expenses incurred immediately 30 days before the Insured Person is hospitalised provided that:
    i. Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
    ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.
43. **Post-Hospitalisation Medical Expenses** means relevant medical expenses incurred immediately 60 days after the Insured Person is discharged from the hospital provided that:
    i. Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
    ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.
44. **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.
45. **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.
46. **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.
47. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/injury involved.
48. **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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
49. **Room Rent** shall mean the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses.
50. **Single Occupancy Standard Air-Conditioned Room** means an individual air-conditioned room for accommodating a single patient with attached wash room. This room may have a television, telephone and a couch. Such room must be the most economical of all such air-conditioned accommodations available in that hospital as single occupancy. This does not include deluxe room / suite or room with additional facilities other than those stated herein.
51. **Sub-Limit** means a cost-sharing requirement under a health insurance policy in which an Insurer would not be liable to pay any amount in excess of the pre-defined limit.
52. **Sum Insured (SI)** means the pre-defined limit specified in the Policy Schedule that represents, the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual Sum Insured basis) or all Insured Persons (on Floater basis) during the policy period.

53. **Surgery or Surgical Procedure** means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.
54. **Third Party Administrator (TPA)** means a company 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 purpose of providing health services as defined in the regulations.
55. **Unproven/Experimental Treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
56. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
57. **We/Our/Us/Company** means the United India Insurance Company Limited.
58. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

4. COVERAGE

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

IMPORTANT: Please note that the coverage mentioned below is applicable for ALL the plans

4.1 In-patient Hospitalisation Expenses Cover

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

i. Room, Boarding and Nursing expenses (all inclusive) incurred as provided by the Hospital/Nursing Home upto the limits provided below:

Sum Insured	Limit (Rs.) per day
Upto Rs. 5 Lacs	1% of Sum Insured
Above Rs. 5 Lacs	1% of Sum Insured or Single Occupancy Standard Air-Conditioned Room Charges whichever is higher

These expenses will include nursing care, RMO charges, Patient's diet Charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.

ii. Charges for accommodation in Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) upto the limits provided below:

Sum Insured	Limit (Rs.) per day
Upto Rs. 5 Lacs	2% of Sum Insured
Above Rs. 5 Lacs	Actuals

iii. The fees charged by the Medical Practitioner, Surgeon, Anaesthetists, Consultants and Specialists treating the Insured Person;

iv. Anaesthetics, Blood, Oxygen, Operation Theatre charges, Surgical Appliances, Cost of Artificial Limbs, cost of Prosthetic devices implanted during surgical procedure like pacemaker, Implants, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, costs towards Diagnostics, Diagnostic Imaging Modalities and such similar other expenses related to the treatment;

v. All hospitalisation expenses (excluding cost of organ, if any) incurred for donor in respect of organ transplant to the Insured Person provided the donation conforms to The Transplantation of Human Organs Act 1994.

4.1.1 Expenses in respect of the following specified illnesses will be restricted to as detailed below:

Surgery/Illness/Disease/Procedure	Maximum Limits restricted to
Cataract	10% of SI subject to maximum of Rs.40,000 per eye per surgery/ hospitalisation
Hernia	15% of SI subject to maximum of Rs.75,000/- per surgery/ hospitalisation
Hysterectomy	20% of SI subject to maximum of Rs.1,00,000/- per surgery/ hospitalisation
Mental Illness: In case of following mental illnesses the actual In-patient Hospitalization expenses will be covered upto 20% of Sum Insured per policy year; 1. Schizophrenia (ICD - F20; F21; F25) 2. Bipolar Affective Disorders (ICD - F31; F34) 3. Depression (ICD - F32; F33) 4. Obsessive Compulsive Disorders (ICD - F42; F60.5) 5. Psychosis (ICD - F 22; F23; F28; F29)	20% of Sum Insured per policy year

Note to 4.1

i. No payment shall be made under 4.1 (iii) other than as part of the hospitalisation bill. However, the bills raised by Surgeon, Anaesthetist directly and not forming part of the hospital bill shall be paid provided a pre-numbered bill/receipt is produced in support thereof, when such payment is made ONLY by cheque/ credit card/debit card or digital/online transfer.

ii. In case of admission to a room at rates exceeding the aforesaid limits in Clause 4.1.i, the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent.

Proportionate Deductions shall not be applied in respect of those hospitals where differential billing is not followed or for those expenses where differential billing is not adopted based on the room category.

iii. Mental Disorders Treatment coverage is subject to fulfilment of following conditions:

a. Mental Disorders Treatment is only covered where patient is diagnosed by a qualified psychiatrist and / or referred to a clinical psychologist for further treatment.

b. The Hospitalization is for Medically Necessary Treatment and prescribed in writing by a registered mental health specialist, psychiatrist or clinical psychologist.

c. The treatment should be taken in Hospitals that complies with the following additional minimum criteria:

- Has qualified psychiatric doctor who is registered with respective medical council;
- Has dedicated mental therapy sections

4.2 Day Care Treatment

We shall indemnify the Reasonable and Customary Charges incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

i. The Medical Expenses are incurred in case of Day Care Treatment or Surgery undertaken for the Illness/ condition covered under Base Cover that requires less than 24 hours Hospitalisation due to advancement in technology, including for any procedure which requires a period of specialized observation or care after completion of the procedure undertaken by an Insured Person as Day Care Treatment. ***All Day Care Treatments as defined under 3.15 are covered;***

ii. The Day Care Treatment is for Medically Necessary Treatment and follows the written Medical Advice;

iii. Procedures/treatments usually done on out-patient (OPD) basis are not payable under the policy even if converted as an inpatient in the hospital for more than 24 hours or carried out in Day Care Centres. Diagnostic Services are also not covered under this benefit.

Note to 4.2

i. Expenses of Hospitalisation for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
ii. When treatment such as Dialysis, Chemotherapy, Radiotherapy 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 in-patient hospitalisation benefit section.

4.3 Pre-Hospitalisation and Post-hospitalisation Expenses

We will cover, on a reimbursement basis, the Insured Person's

i. Pre-hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 30 days prior to hospitalisation; and
ii. Post-hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 60 days after the discharge from the hospital,

Subject to a maximum of 10% of Sum Insured put together for both i and ii above, provided that:

i. We have accepted a claim for primary In-patient Hospitalization under Section 4.1 or Section 4.2 above;
ii. The Pre-hospitalisation & Post-hospitalisation Medical Expenses are related to the same Illness or Injury.

4.4 Ayurvedic treatment

We shall indemnify the Reasonable & Customary Charges incurred as in-patient for an Insured Person in case of Medically Necessary Treatment taken during Hospitalisation subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in an AYUSH Hospital/AYUSH Day Care Centre as defined in Clause 3.6 and 3.7 above respectively.

Sum Insured (Rs.)	Limit per Policy Period (Rs.)
Upto Rs. 5 Lacs	15,000
Above Rs. 5 Lacs	25,000

4.5 Modern Treatment Methods & Advancement in Technologies:

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

Sr. No.	Modern Treatment Methods & Advancement in Technology	Additional Limit
1	Uterine Artery Embolization & High Intensity Focussed Ultrasound (HIFU)	Up to 20% of Sum Insured subject to a maximum of Rs.2 Lacs per policy period for claims involving Uterine Artery Embolization & HIFU
2	Balloon Sinuplasty	Up to 10% of Sum Insured subject to a maximum of Rs.1 Lac per policy period for claims involving Balloon Sinuplasty
3	Deep Brain Stimulation	Up to 70% of Sum Insured per policy period for claims involving Deep Brain Stimulation
4	Oral Chemotherapy	Up to 20% of Sum Insured subject to a maximum of Rs.2 Lacs per policy period for claims involving Oral Chemotherapy
5	Immunotherapy-Monoclonal Antibody to be given as injection	Up to 20% of Sum Insured subject to a maximum of Rs.2 Lacs per policy period
6	Intra vitreal Injections	Up to 10% of Sum Insured subject to a maximum of Rs. 1 Lac per policy period
7	Robotic Surgeries (Including Robotic Assisted Surgeries)	▪ Up to 75% of Sum Insured per policy period for claims involving Robotic Surgeries for (i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies ▪ Up to 50% of Sum Insured per policy period for claims involving Robotic Surgeries for other diseases
8	Stereotactic Radio Surgeries	Up to 50% of Sum Insured per policy period for claims involving Stereotactic Radio Surgeries
9	Bronchial Thermoplasty	Up to 30% of Sum Insured subject to a maximum of Rs.3 Lacs per policy period for claims involving Bronchial Thermoplasty.
10	Vaporisation of the Prostate (Green laser treatment for holmium laser treatment)	Up to 30% of Sum Insured subject to a maximum of Rs.2 Lacs per policy period.

11	Intra Operative Neuro Monitoring (IONM)	Up to 15% of Sum Insured per policy period for claims involving Intra Operative Neuro Monitoring subject to a maximum of Rs. 1 Lac per policy period.
12	Stem Cell Therapy: Hematopoietic Stem Cells for bone marrow transplant for haematological conditions to be covered only	No additional sub-limit

4.6 Home Care Treatment Expenses Cover:

Home Care Treatment means Treatment availed by the Insured Person at home for Covid on positive diagnosis of Covid in a Government authorised diagnostic Centre, which in normal course would require care and treatment at a hospital but is actually taken at home maximum up to 14 days and also subject to a maximum of Rs. 15000 per incident and further subject to an overall limit of Rs. 30000 per policy during the policy period provided that:

i. The Medical Practitioner advises the Insured Person to undergo treatment at home
ii. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment
iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
iv. Insured shall be permitted to avail the services as prescribed by the Medical Practitioner. Cashless or reimbursement facility shall be offered under home care expenses subject to claim settlement policy disclosed in the website.
v. In case the insured intends to avail the services of non-network provider claim shall be subject to reimbursement, a prior approval from the Insurer needs to be taken before availing such services.

In this benefit, the following shall be covered if prescribed by the treating Medical Practitioner and is related to treatment of COVID,

i. Diagnostic tests undergone at home or at diagnostics centre;
ii. Medicines prescribed in writing;
iii. Consultation charges of the medical practitioner;
iv. Nursing charges related to medical staff;
v. Medical procedures limited to parenteral administration of medicines;
vi. Cost of Pulse oximeter, Oxygen cylinder and Nebulizer.

4.7 Maternity Expenses Cover:

We shall indemnify the medical expenses incurred as an in-patient during the Policy Period in respect of a female Insured Person (The Proposer or Proposer's spouse only) above 18 years for treatment arising from or traceable to Pregnancy or childbirth or for medically required and lawful medical termination of pregnancy.
The hospitalization expenses in respect of treatment given to the new born baby in the Hospital as an in-patient for a maximum period of 90 days from the date of its birth shall be covered within the Mother's Maternity expenses.

<u>Special conditions applicable to Maternity Expenses Benefit Extension:</u>

i. Expenses under this section shall be limited to a maximum of 5% of Sum Insured per Policy Period.
ii. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency.
iii. 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.
iv. Pre-natal and post-natal expenses are not covered unless admitted in Hospital / Nursing Home and treatment is taken there
v. After 90 days from the date of birth, the Insured must submit a request to include the baby under the policy for necessary endorsement on payment of additional premium.

4.8 Road Ambulance Charges

We shall indemnify the Reasonable and Customary Charges incurred for transportation of the Insured Person by road ambulance from the Residence/Place of Accident/Illness to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner and becomes payable if a claim has been admitted under Section 4.1 or 4.2 and the expenses are related to the same Illness or Injury. Expenses under this cover are limited to a maximum of Rs. 1000 per policy period.

We will also cover the costs incurred on transportation of the Insured Person by road Ambulance up to the limits specified above under this cover, if It is medically required to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.

4.9 Hospital Cash

We will pay a Daily Cash Allowance of Rs. 250/- per day, subject to a maximum of Rs. 2,500/- per policy period, to Parents/Guardians of Insured Children up to the age of 12, for each continuous and completed period of 24 hours of hospitalisation.

Note to 4.9

i. Payment under this section is subject to the hospitalisation claim being admissible under the policy;
ii. Daily Cash Allowance will not be payable for Day Care Treatment claims;
iii. This benefit is covered within the Sum Insured.

4.10 Cost of Health Check-Up

We will reimburse expenses incurred towards cost of health check-up up to 1% of average Sum Insured of preceding three claim-free years, for a block of every three claim-free years, within a year from the date when it got due and the policy is in force. Payment under this benefit does not reduce the sum insured.

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

4.11 Reimbursement of Expenses – Nepal & Bhutan

We shall reimburse, in Indian Rupees, expenses in respect of Emergency Hospitalisation 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.

4.12 Personal Accident (Death) Insurance

If at any time during the Policy Period, the Insured or his/her family members sustain any bodily injury resulting solely and directly from an accident caused by external, violent and visible means resulting in Death of the Insured, then the Company shall pay to the Insured or his/her legal representative(s), as the case may be, the benefit amount as stated below for such Insured Person.

Benefit amount payable under Personal Accident (Death) Cover:

- Account Holder (Self) – 100% of Sum Insured under Health Insurance Section
- Spouse – 50% of Sum Insured under Health Insurance Section
- Children– Children aged above 12 years and below 21 years – 20% of Sum Insured under Health Insurance Section for each child
- Children upto 12 years – 10% of Sum Insured under Health Insurance Section for each child

The total claim settlement shall not exceed the Sum Insured under Health Insurance Section.

Nomination facility is available.

The Policy excludes death due to:

i. Intentional Self Injury / Suicide / Attempted Suicide;
ii. Whilst under influence of intoxicating liquor or drugs;
iii. Whilst engaged in Aviation or Ballooning;
iv. Due to Insanity;
v. Due to Insured committing any breach of law with Criminal intent;
vi. From service in the Armed Forces;
vii. Directly or indirectly from childbirth or pregnancy.

5. STANDARD EXCLUSIONS & WAITING PERIODS

A. WAITING PERIODS

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

5.1 Pre-Existing Disease Waiting Period (Code- Excl01):

i. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

5.2 First Thirty Days Waiting Period (Code-Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered;
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months;
iii. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

5.3 Specific Waiting Period (Code-Excl02)

i. Expenses related to the treatment of the listed Conditions, surgeries/treatments as per Table A and Table B below, shall be excluded until the expiry of 12 months and 36 months respectively of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident;
ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase;
iii. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply;
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion;
v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage;
vi. List of specific diseases/procedures:

Table A: 12 Months' Waiting Period

1.	Benign prostatic hypertrophy	6.	Piles, Fissures and Fistula-in-ano; Pilonidal sinus
2.	Cataract	7.	Sinusitis and Benign ENT disorders
3.	Gout and Rheumatism	8.	Calculus diseases

4. Hernia of all types	9. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapse of uterus
5. Hydrocele	10. Internal Congenital Anomaly

Table B: 36 Months' Waiting Period

1. Treatment for joint replacement unless arising from accident	2. Age-related Osteoarthritis & Osteoporosis
3. Age-related Macular Degeneration (ARMD)	4. All Neurodegenerative disorders

B. STANDARD PERMANENT EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

5.4 **Investigation & Evaluation** (**Code-Excl04**):

i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;
ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5.5 **Rest Cure, Rehabilitation and Respite Care** (**Code-Excl05**): Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional, and spiritual needs.

5.6 **Obesity/ Weight Control** (**Code-Excl06**): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

i. Surgery to be conducted is upon the advice of the Doctor
ii. The surgery/Procedure conducted should be supported by clinical protocols
iii. The member has to be 18 years of age or older and
iv. Body Mass Index (BMI)
    a. greater than or equal to 40 or
    b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        i. Obesity-related cardiomyopathy
        ii. Coronary heart disease
        iii. Severe Sleep Apnoea
        iv. Uncontrolled Type2 Diabetes

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

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

5.9 Hazardous or Adventure sports: (Code-Excl09)

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

5.10 **Breach of law: (Code-Excl10)**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

5.11 **Excluded Providers: (Code-Excl11)**

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

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

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

5.17 Sterility and Infertility (**Code-Excl17**): Expenses related to Sterility and infertility. This includes:

i. Any type of contraception, sterilization;
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI;
iii. Gestational Surrogacy;
iv. Reversal of sterilization.

C. SPECIFIC PERMANENT EXCLUSIONS

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

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

5.20 Stem cell implantation/Surgery, harvesting, storage or any kind of Treatment using stem cells except as provided for in clause 4.5 (12) above.

5.21 Congenital External Diseases or Defects or anomalies.

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

5.23 Vaccination or inoculation of any kind unless it is post animal bite.

5.24 i. Cost of spectacles, contact lenses;
ii. Cost of hearing aids

5.25 Intentional self-inflicted Injury, attempted suicide.

5.26 Naturopathy Treatment, acupressure, acupuncture, magnetic therapies, treatment including drug experimental therapy which is not based on established medical practice in India.

5.27 External and/or durable Medical /Non-medical equipment of any kind used for diagnosis and/or treatment 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 also any medical equipment, which are subsequently used at home. This is indicative and please refer to *Annexure – 1* for the complete list of non-payable items.

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

5.29 Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP).

5.30 Dental treatment or surgery of any kind unless necessitated by disease or injury and requiring hospitalisation.

5.31 Any item(s) or treatment specified in 'List of Non-Medical Expenses– Payable/Non-Payable' as per *Annexure – 1* and available on Company web site also, unless specifically covered under the Policy.

5.32 Any expenses incurred on OPD (Out-Patient) Treatment.

5.33 Any expenses incurred on domiciliary treatment.

6. CLAIM PROCEDURE

6.1 Procedure for Cashless Claims:

i. Treatment may be taken in a network provider and is subject to pre-authorization by the Company or its authorized TPA;
ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization;
iii. The Company/TPA upon getting cashless request form and related medical information from the Insured Person/network provider will issue pre-authorization letter to the hospital after verification;
iv. At the time of discharge, the Insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses;
v. The Company/TPA reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details;
vi. In case of denial of cashless access, the Insured Person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/TPA for treatment.

6.2 Procedure for reimbursement of claims:

For reimbursement of claims the Insured Person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder:

Sr. No.	Type of Claim	Prescribed Time Limit
1.	Reimbursement of hospitalisation, day care and pre-hospitalisation expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post-hospitalisation expenses	Within fifteen days from completion of post-hospitalisation treatment

6.3 Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

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

6.4 Documents to be submitted:

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

i. Duly completed claim form;
ii. Self-attested copy of Photo Identity proof of the patient;
iii. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed or Operation Theatre (OT) Notes, along with date of diagnosis, advise for admission, investigation test reports etc. supported by the prescription from attending medical practitioner;
iv. Medical history of the patient recorded, bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital;
v. Discharge certificate/ summary from the hospital;
vi. Cash-memo/ bills/ invoices from the Diagnostic Centre(s)/ hospital(s)/ chemist(s) supported by proper prescription;
vii. Payment receipts from Doctors, Surgeons and Anaesthetist;
viii. Bills, receipt, Sticker of the Implants;
ix. MLR (Medico Legal Report copy if carried out and FIR (First Information Report) if registered, wherever applicable);
x. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled Cheque;
xi. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs. 1 Lakh as per AML Guidelines;
xii. Any other document required by Company/TPA.

Note

i. 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 6.4 and claim settlement advice duly certified by the other Insurer subject to satisfaction of the Company.
ii. The documents are required in original. However, the Company may waive off this requirement for any of these documents, on case to case basis, at its discretion.
iii. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person
iv. Any medical practitioner or Authorised Person 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.

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

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorisation of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

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

6.6 Payment of Claim

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

7. GENERAL TERMS AND CONDITIONS

A. Standard Terms & Conditions

7.1 Disclosure of Information

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

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

7.2 Condition Precedent to Admission of Liability

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

7.3 Claim Settlement (provision for Penal Interest)

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

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

7.4 Complete Discharge

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

7.5 Multiple Policies

i. In case of multiple policies taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies, even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and condition of this policy.
iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.
iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

7.6 Fraud

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

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

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

i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
iii. any other act fitted to deceive; and
iv. any such act or omission as the law specially declares to be fraudulent

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

7.7 Cancellation

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

Cancellation Grid	
Period for which risk is retained	**Refund**
Up to 1 Month	75%
>1 Month- less than 3 Month	50%
>3 Months – less than 6 months	25%
>6 Months	NIL

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

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

7.8 Migration

The Insured Person will have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer the link:

https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

7.9 Renewal of Policy

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

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

7.10 Withdrawal of Policy

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

7.11 Moratorium Period

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

7.12 Redressal of Grievance

In case of any grievance the Insured Person may contact the company through:

Level 1

Phone: 020/25534038, 25535621
Mobile: 7738897314/ 9789989385
E-mail: mahaswasthya@uiic.co.in, support.portal@uiic.co.in
Address *: United India Insurance Co. Ltd., DO (163000), Veer Sawarkar Bhavan, J.M. Road,(Near Balgandharva Rang Mandir, Shivajinagar, Pune, Maharashtra - 411005*

Level 2

Phone: 020/25590000, 25590001
E-mail: customercare@uiic.co.in
Address*: United India Insurance Co. Ltd Regional Office, Kakade Bizz Icon, Unit No. 202, floor no.2, Ganesh Khind Road, Bhamburda, Pune- 411016*

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at customercare@uiic.co.in
Website: www.uiic.co.in
Toll free: 1800 425 333 33
Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd., 19, IV Lane, Nungambakkam High Road, Chennai, Tamil Nadu- 600034

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance. If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at customercare@uiic.co.in

For updated details of grievance officer, kindly refer the link https://uiic.co.in/en/customercare/grievance

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the **office of Insurance Ombudsman** of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Insurance Ombudsman offices have been provided as *Annex. - 2*.
Grievance may also be lodged at IRDAI Integrated Grievance Management System: https://igms.irda.gov.in/

7.13 Nomination

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

B. Specific Terms & Conditions

7.14 Eligibility

This Policy is specially designed for the group of accountholders of Bank of Maharashtra under an arrangement with the Bank through an MoU and the policy terms and conditions and premium are subject to revision of the arrangement between Bank of Maharashtra and the Company. In the event of such revision or discontinuation of the arrangement, the Company, after following the laid down process as per IRDAI guidelines, may revise the terms of the policy including the premium rates or withdraw the product.

To be eligible for coverage under the Policy, the Insured Person must be –

A. An account-holder of Bank of Maharashtra or his/ her family member with relationship as specified in 7.14.C below.
   Age of Entry: Minimum: 18 Years; Maximum: 65 years for Proposer/ Insured Persons except in case of children as mentioned in 7.14.C (c) below. Renewal is available under this product till the agreement with the bank continues or under other retail health products of the Insurer subject to underwriting .
B. The relationships which may be covered under the Policy are:
   a. Accountholder as Self
   b. Account-holder's legally Wedded Spouse
   c. Account-holder's dependent children between the age of 91 days and 18 years shall be covered provided either or both parents are covered concurrently. Coverage for Dependent Children is defined as follows:
      A child shall be covered up to the age of 25 years or till he/she gets employed/married, whichever occurs earlier.
   d. Parents of : Accountholder

7.14.1 Plans: The relationships as mentioned above shall be covered under different plans under the Policy as per table below:

Plan A	Self + Spouse + Two dependent children (1+3), Eldest Insured Person aged up to 65 years.
Plan B	Self + Spouse + Two dependent children + Parents (1+5), Eldest Insured Person aged up to 65 years

7.14.2 Midterm inclusion of following family members is allowed on paying requisite premium:
   A. Newly married spouse

B. New born baby, after the age of 91 days born to mother, insured under the policy.
The newly married spouse/ the new born baby can be covered subject to the conditions of the existing plan (A/B) including the waiting periods applicable from the date of inclusion.
Acceptance of Newly married spouse and New Born Babies as Insured Persons is subject to written notification.

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

7.15 Premium

The premium payable under this Policy shall be paid in advance. No receipt for premium shall be valid except on the Company's official form signed by the Company's duly authorized official. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Policyholder in so far as they relate to anything to be done or complied with by the Policyholder shall be a Condition Precedent to Our liability to make any payment under this Policy.

Premium will be subject to revision at the time of renewal of the Policy.

7.16 Notice & Communication

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

7.17 Territorial Limit

The geographical scope of this Policy applies to events limited to India. All medical treatment for the purpose of this insurance will have to be taken in India only and all admitted or payable claims shall be settled in India in Indian rupees.

However, the territorial limit is extended for Reimbursement of emergency hospitalisation expenses in Indian rupees for treatment at Nepal or Bhutan while the Insured is away at these places either on holiday or business purposes.

7.18 Enhancement of Sum Insured

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a fresh proposal form/ written request to the company. 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.
ii. The acceptance of enhancement of Sum Insured would be at the discretion of the company, based on the health condition of the insured members & claim history of the policy.
iii. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

7.19 Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

i. In the case of his/her (Insured Person) demise:

However, the cover shall continue for the remaining Insured Persons till the end of the Policy Period. The other Insured Persons may also apply to renew the policy. In case, the other Insured Person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the Insured Person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the policy will be effective.

ii. Upon exhaustion of sum insured for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

7.20 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.

7.21 Territorial Jurisdiction

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

7.22 Renewal Terms

Renewal of the Policy is subject to the agreement between the Company and Bank of Maharashtra. We may revise Premium Rates for renewals based on the past claim experience of the group of accountholders of Bank of Maharashtra.

7.23 Endorsements (Changes in Policy)

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the Company. Any change made by the Company shall be evidenced by a written endorsement signed and stamped.

7.24 Terms and Conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

8. IRDAI 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.

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ANNEXURE – 1

Maha Bank Swasthya Yojana (Group Health Insurance Scheme)

List of Non-Medical Expenses under this Policy – Payable/Not Payable

List I – Optional Items

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

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

List II – Items that are to be subsumed into Room Charges

Sr. No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)

2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISTOR'S PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSE OXIMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

Sr. No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHIELD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUZE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER

13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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

ANNEXURE -2

Details of Insurance Ombudsmen

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

Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar	
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960. Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kasganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253. Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952. Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555. Email: bimalokpal.pune@ecoi.co.in

The updated details of Insurance Ombudsman are also available at:

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