Bajaj Allianz General Insurance Company Limited
Bajaj Allianz House, Floor, Airport Road, Yerawada, Pune
411006 Reg. no 113. CIN: U66010PN2000PLC015329

MukhyamantriSwasthyaBimaYojana –In the state of Uttarakhand

UIN- 20/IRDAI/HLT/BAGI/MSBY-GOVT-SCHEME/V.I/16-17

Policy Wordings

Whereas, the **State Nodal Agency(SNA)**hereinafter referred to as the I**nsured** 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 Bajaj Allianz General Insurance Company Limited (herein after called the Company) for the insurance hereinafter set forth in respect of **Mukhyamantri Swasthya Bima Yojana (MSBY)**Beneficiary Family Units named in the Policy Schedule and has agreed to pay aggregate annual premium in accordance with Clause 8 of the MSBY Tender Document dated 26th May 2016 released by Government of Uttarakhand as consideration for such insurance, we the Company hereby agrees to indemnify MSBY Beneficiary Family Units named in the Schedule as per these Terms and Conditions.

A. DEFINITIONS:

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Base Cover** in respect of each Beneficiary Family Unit that is enrolled by the Company means the benefits that are set out under Section B. 1. Benefits Under Base Cover- of the policy document
3. **Beneficiaries** mean the members of the Beneficiary Family Unit that are eligible to be enrolled by the Company under MSBY.
4. **Cashless Access Service** means a facility extended by the Company to the Beneficiaries where the payments of the expenses that are covered under each of the Covers are directly made by the Company to the Empanelled Health Care Providers in accordance with the terms and conditions of this Insurance Contract, such that the Beneficiaries are not required to pay any amounts to the Empanelled Health Care Providers in respect of such expenses, either as deposits at the commencement or at the end of care provided by the Empanelled Health Care Providers.
5. **Cashless facility** means a facility extended by the Company 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 Company to the extent pre-authorization approved.
6. **Claim** means a claim that is received by the company from an Empanelled Health Care Provider, either through a MSBY Card transaction or manually, in accordance with the MSBY tender document
7. **Claim Payment** means the payment of a Claim received by an Empanelled Health Care Provider from the Company in respect of benefits under the Covers made available to a Beneficiary.
8. **Condition precedent** means a Policy term or a condition upon which the Company's liability under the Policy is conditional upon
9. **Congenital Anomaly** means a condition(s) present since birth and which is/are abnormal with reference to form, structure or position, but only limited to such condition(s) which is/are present in the visible and accessible parts of the body.
10. **Contribution** is essentially the right of the Company to call upon other Company's liable to the same insured to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.
11. **Cover** means any of the following: (i) the Base Cover; or (ii) the Critical Illness Cover.
12. **Critical Illness** means any of the illnesses, diseases or pathological conditions for which a Beneficiary will be entitled to a Medical Treatment, Surgical Procedure or Day Care Treatment listed in Schedule 4: Critical Illnesses and Related Package Rates attached to the Policy document
13. **Critical Illness Cover** in respect of each Beneficiary Family Unit that is enrolled by the Company means the benefits that are set out under Section B.2 Benefits under Critical Illness in the policy document
14. **Critical Illness Sum Insured** in respect of each Beneficiary Family Unit enrolled under a Policy, means at any time, the Company's maximum liability for any and all Claims made on behalf of such Beneficiary Family Unit during the Policy Cover Period against the Critical Illness Cover
15. **Day Care Centre** means a stand-alone day care centre providing Day Care Treatments, whether public or private, satisfying the minimum criteria for empanelment and that is empanelled by the Company

16. **Day Care Treatment** means any Medical Treatment and/or Surgical Procedure which is undertaken under general anaesthesia or local anaesthesia at an Empanelled Health Care Provider or Day Care Centre in less than 24 hours due to technological advancements, which would otherwise have required Hospitalization.

    The list of eligible Day Care Treatments included within the scope of the Base Cover and Critical Illness cover are:

    1. Haemo Dialysis
    2. Parenteral Chemotherapy
    3. Radiotherapy
    4. Eye Surgery
    5. Lithotripsy (kidney stone removal)
    6. Tonsillectomy
    7. D&C
    8. Dental surgery following an accident
    9. Surgery of Hydrocele
    10. Surgery of Prostrate
    11. Gastrointestinal Surgery
    12. Genital Surgery
    13. Surgery of Nose
    14. Surgery of Throat
    15. Surgery of Ear
    16. Surgery of Urinary System
    17. Treatment of fractures/dislocation (excluding hair line fracture), contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalization.
    18. Laparoscopic therapeutic surgeries.
    19. Identified surgeries under General Anesthesia.
    20. Any other Day Care Treatment that is mutually agreed upon by the Parties or that is listed in Schedule 3: Package Rates for Medical Treatments and Surgical Procedures or Schedule 4 Critical Illnesses and related Package Rates attached to the Policy Document.

17. **Dental treatment** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

18. **Disclosure to information norm**
    In the event of misrepresentation, mis-description or non-disclosure of any material fact by any Beneficiaries and or Head of Family, the Policy shall be void for such Beneficiaries and MSBY Beneficiary Family Unit, and all premium paid hereon as to those Beneficiaries and MSBY Beneficiary Family Unit, shall be forfeited to the Company,
19. **Empanelled Health Care Provider** means a hospital, a nursing home, a CHC, a PHC or any other health care provider, whether public or private, satisfying the minimum criteria for empanelment and that is empanelled by the Company or the TPA in accordance with MSBY Tender document for the provision of health services to the Beneficiaries. For the avoidance of doubt, Empanelled Health Care Provider includes: (i) a Day Care Centre, but only for the purposes of Day Care Treatments that such Day Care Centre is empanelled for; (ii) a Specialty Hospital, but only for the purposes of providing a Medical Treatment or Surgical Procedure or Day Care Treatment or Follow-up Care for a Critical Illness that such Specialty Hospital is empanelled for.
20. **EPIC** means Elector's Photo Identity Card, being a unique identity card issued by the Chief Electoral Office, Government of Uttarakhand to citizens being 18 years or above.
21. **Exclusion** means any of the exclusions that have been listed in the policy document under Section C: Exclusions
22. **Expenses of Hospitalisation** for minimum period of 24 hours are admissible. However this time limit is not applied to specific treatments mentioned in the definition of Day Care Treatment which will be considered under Hospitalisation Benefit. This condition will also not apply in case of stay in Hospital of less than 24 hours provided
    i. The treatment is such that it necessitates hospitalization and the procedure involves specialized infrastructural facilities available in hospitals.
    ii. Due to technological advances hospitalization is required for less than 24 hours only.

23. **Final Termination Notice** shall have the same meaning as stated in the policy document under heading Termination Notice as well as in the MSBY Tender Document.
24. **Force Majeure Event** shall mean the occurrence in the State of Uttarakhand of any of the following events after the date of execution of this Insurance Contract, which was not reasonably foreseeable at the time of execution of this Insurance Contract and which is beyond the reasonable control and influence of a Party (the **Affected Party**) and which causes a delay and/or inability for that Party to fulfill its obligations under this Insurance Contract:
    i. fire, flood, atmospheric disturbance, lightning, storm, typhoon, tornado, earthquake, washout or other Acts of God;
    ii. war, riot, blockade, insurrection, acts of public enemies, civil disturbances, terrorism, sabotage or threats of such actions; and
    iii. strikes, lock-out or other disturbances or labour disputes, not involving the employees of such Party or any intermediaries appointed by it,

25. **Hospitalisation** means admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours.

26. **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.
27. **Illness means** a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.
    a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests—it needs ongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.
28. **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 words.
29. **Inpatient care** means treatment for which the Beneficiary has to stay in a hospital for more than 24 hours for a covered event.
30. **Insured** means the State Nodal Agency, which will pay the Premium on behalf of the Beneficiary Family Units enrolled in each district for each Policy Cover Period and in whose name the Policies will be issued or renewed.
31. **Maternity expense** shall include –a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean section incurred during hospitalization). b) Expenses towards lawful medical termination of pregnancy during the Policy period.
32. **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 Homeopathy set up by Government of India or State Government and is thereby entitled to practice medicine within its jurisdiction: and is acting within the scope and jurisdiction of license. Provided that the Medical Practitioner should not be close family members of Beneficiary or MSBY Beneficiary Family Unit.
33. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
34. **Medical expenses** means those expenses that the Beneficiary 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 Beneficiary had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
35. **Medically Necessary** means any Medical Treatment, Surgical Procedure, Day Care Treatment, Follow-up Care or OPD Benefit, which:

i. is required for the medical management of the illness, disease or injury suffered by the Beneficiary;
ii. does not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
iii. has been prescribed by a Medical Practitioner; and
iv. conforms to the professional standards widely accepted in international medical practice or by the medical community in India.

36. **Medical Treatment** means any medical treatment of an illness, disease or injury, including diagnosis and treatment of symptoms thereof, relief of suffering and prolongation of life, provided by a Medical Practitioner, but that is not a Surgical Procedure. Medical Treatments include: treatment for bacterial meningitis, bronchitis-bacterial/viral, chicken pox, dengue fever, diphtheria, dysentery, epilepsy, filariasis, food poisoning, hepatitis, malaria, measles, meningitis, plague, pneumonia, septicaemia, tuberculosis (extra pulmonary, pulmonary etc.), tetanus, typhoid, viral fever, urinary tract infection, lower respiratory tract infection and other such diseases requiring Hospitalization.
37. **Network Provider** means hospitals or health care providers enlisted by the Company or by a TPA and Company together to provide medical services to an insured on payment by a cashless facility.
38. **Non-Network Provider means a**ny hospital, day care centre or other provider that is not part of the network of Company.
39. **New Born Baby** means baby born during the Policy period and is aged between 1 day and 90 Days, both days inclusive
40. **Notification of Claim** means the process of notifying a claim to the Company or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.
41. **OPD treatment** is one in which the Beneficiary visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Beneficiary is not admitted as a day care or in-patient.
42. **Package Rates** means the fixed maximum charge per Medical Treatment or Surgical Procedure or for any Follow-up Care or for any OPD Diagnostic benefit that are covered by the Company.
43. **PHC** means a primary health centre in the state of Uttarakhand.
44. **Policy**, in respect of the Service Area, means the policy issued by the Company to the Insured describing the terms and conditions of providing the Base Cover and the Critical Illness Cover to all the Beneficiary Family Units that are enrolled, including the details of the scope and extent of cover available to the Beneficiaries, the Exclusions from the scope of the Covers available to the Beneficiaries, the Policy Cover Period and the terms and conditions of the issue of the Policy
45. **Premium** means the aggregate sum agreed by the Parties as the annual premium to be paid by the State Nodal Agency to the Company for each Beneficiary Family Unit that is enrolled by the Company, as consideration for providing all the Covers relevant to such Beneficiary Family Unit under this Policy.
46. **Pre-Existing Disease**
    Any condition, ailment or injury or related condition(s) for which Beneficiary had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first Policy issued by the Company.
47. **Pre-hospitalization Medical Expenses means expenses**incurred immediately before the Beneficiary is Hospitalised, provided that:
    i. Such Medical Expenses are incurred for the same condition for which theBeneficiary's Hospitalisation was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.
48. **Post-hospitalization Medical Expenses means** Expenses incurred immediately after the Beneficiary is discharged from hospital , provided that:
    i. Such Medical Expenses are incurred for the same condition for which theBeneficiary'sHospitalisation was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.
49. **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
50. **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.
51. **MSBY** means Mukhyamantri Swasthya Bima Yojana , a scheme Initiated by the State of Uttrakhand for the provision of Health Insurance services by an Company to the MSBY Beneficiary Family Units within defined districts/ blocks of Uttarakhand.

52. **MSBY Beneficiary Family Unit** means a beneficiary family Unit that is eligible to receive the benefit under the MSBY, i.e. those Beneficiary Family Units that are resident in the Service Area shall be eligible to become Beneficiaries, other than: (i) Government employees and pensioners, income taxpayers and their families that are already covered by alternate government sponsored health benefits or health insurance schemes and (ii) income tax payers and their families.
53. **MSBY Card** means identification card issued by the Company in accordance with the specifications set out in Schedule 12 MSBY Card Specifications attached to the Policy Document to each Beneficiary Family Unit that is enrolled, for utilization of the Covers provided under the Policy on a cashless basis.
54. **Preliminary Termination Notice** shall mean upon the occurrence of an Insurer Event of Default, the State Nodal Agency may, without prejudice to any other right it may have under this Insurance Contract, in law or at equity, issue a notice of its intention to terminate this Insurance Contract to the Insurer.
55. **Schedule** means schedules attached to the Policy Documents.
56. **Service Area** means all the 13 districts in the state of Uttarakhand.
57. **Speciality Hospital** means a hospital, whether public or private, that: (i) provides specialized care; (ii) satisfies the minimum criteria for empanelment for the specialty that it caters to; and (iii) is empanelled by the Company for provision of specialist care for Critical Illnesses in accordance with the MSBY Tender Document.
58. **State Nodal Agency m**eans the nodal institution set up by Government of Uttarakhand for the purpose of implementing and monitoring MSBY.
59. **Surgical Procedure** means any manual and/or operative procedure or intervention required for the treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed at the premises of an Empanelled Health Care Provider by a Medical Practitioner.
60. **Subrogation** shall mean the right of the Company to assume the rights of the Beneficiaries to recover expenses paid out under the Policy that may be recovered from any other source.
61. **Third Party Administrators or TPA** means any organization that is licensed by the IRDAI as a third party administrator, meets the criteria set out at Schedule 15: Appointment of Third Party Administrators attached to the Policy Document and that is engaged by the Company, for a fee or remuneration, for providing Policy and Claims facilitation services to the Beneficiaries as well as to the company for an insurable event.
62. **Unproven/experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

The words which are not defined herein, if any, shall have the same meaning as defined by IRDAI under applicable Regulations/guidelines. Provided further if any words that are defined herein are modified/ redefined by IRDAI, then such modified/redefined definitions shall apply.

B. Coverage and Benefits

1. Benefits under Base Cover

The Company hereby agrees, subject to the terms, conditions and Exclusions contained in this Insurance Contract and each Policy, to pay and/or reimburse the following benefits to each enrolled Beneficiary covered by such Policy, for the Policy Cover Period and to the extent of the Base Sum Insured:

(a) Hospitalization Expenses benefit: The Company shall provide cover for payment of Hospitalization expenses that are incurred by the Beneficiary for a Medical Treatment or Surgical Procedure provided by an Empanelled Health Care Provider, subject only to the Exclusions.

The benefit under Hospitalization Expenses Benefit is limited to the available Base Sum Insured.

For the purpose of this, Hospitalization expenses shall include, amongst other things (except transfusion of blood that is payable separately as per package rate decided for per unit of blood or component transfused):

(i) Registration charges;
(ii) Bed charges (General Ward or ICU, as the case may be);
(iii) Nursing and boarding charges;
(iv) Surgeons, anaesthetists, Medical Practitioners, consultants fees, etc;
(v) Anaesthesia, oxygen, operation theatre charges, cost of surgical appliances, etc;
(vi) Medicines and drugs;

(vii) Cost of prosthetic devices, implants, organs, etc;
(viii) Screening, including X-Ray and other diagnostic tests, etc;
(ix) Food to the Beneficiary;
(x) Cost of treating any complications arising during Hospitalization; and
(xi) Any other expenses related to the Medical Treatment or Surgical Procedure provided to the Beneficiary by an Empanelled Health Care Provider.

(b) Day Care Treatment benefit: The Company shall provide cover for payment of expenses that are incurred by the Beneficiary for a Day Care Treatment that is listed at Schedule 2: List of Eligible Day Care Treatments, Schedule 3: Package Rates for Medical Treatments and Surgical Procedures or Schedule 4: Critical Illness and Related Package Rates attached with the policy document and that is provided by an Empanelled Health Care Provider or a Day Care Centre, subject only to the Exclusions.

This benefit is limited to the available Base Sum Insured.

For the purpose of this, Day Care Treatment expenses shall include, amongst other things (except transfusion of blood that is payable separately as per package rate decided for per unit of blood or component transfused):
(i) Registration charges;
(ii) Surgeons, anesthetists, Medical Practitioners, consultants fees, etc;
(iii) Anesthesia, oxygen, operation theatre charges, cost of surgical appliances, etc;
(iv) Medicines and drugs;
(v) Cost of prosthetic devices, implants, organs, etc;
(vi) Screening, including X-Ray and other diagnostic tests, etc.; and
(vii) Any other expenses related to the Day Care Treatment provided to the Beneficiary by an Empanelled Health Care Provider.

(c) Pre-hospitalization and Post-hospitalization Expenses benefit: The Company shall provide cover for payment of expenses that are incurred by the Beneficiary 1 day prior to Hospitalization or Day Care Treatment and for continuous Follow-up Care for up to 5 days after discharge or Day Care Treatment.
This benefit is a part of the benefit available under (a) Hospitalization Expenses Benefit or (b)Day Care Treatment Benefit, as relevant, and is limited to the available Base Sum Insured.

For the purpose of this, pre-hospitalization and post-hospitalization expenses shall include, amongst other things:
(i) Screening, medicines and consultations in the 1 day period prior to Hospitalization or Day Care Treatment;
(ii) Screening and medicines in the 5 days after Hospitalization or Day Care Treatment; and
(iii) Any other expenses related to such pre-hospitalization or post-hospitalization.

(d) Maternity Benefit: The Company shall provide cover for maternity Hospitalization expenses arising out of child-birth, including normal delivery, Caesarean section, miscarriage or abortion induced by an accident or other medical emergency that is undertaken at the premises of an Empanelled Health Care Provider, subject only to the Exclusions.

This maternity benefit shall be available from the date of commencement of the Policy Cover Period, provided that the Hospitalization period for both mother and child is not less than 48 hours post-delivery.

This maternity benefit is limited to the available Base Sum Insured.

(e) New-born Child Benefit: The Company shall provide cover for Hospitalization or Day Care Treatment expenses incurred in respect of a new-born child, subject only to the Exclusions.

This new-born child benefit shall be available from the birth until the expiry of the Term, unless otherwise provided in Terms and Condition of the MSBY Insurance Contract. The new-born child will be deemed a member of the Beneficiary Family Unit for such period, even if the child was born to the family after the enrolment of the family into the scheme.

To avail of this new-born child benefit, any member of the Beneficiary Family Unit enrolled on the MSBY Card will need to verify to the Empanelled Health Care Provider where Hospitalization of the new-born child is sought that the

mother's name is included on the MSBY Card. The New-born Benefit shall be available to the child in the name of the mother.
The new-born child benefit is limited to the available Base Sum Insured.

For the purpose of this, all Hospitalization expenses, Day Care Treatment expenses and pre and post-hospitalization expenses are included.

(f) OPD Diagnostic Benefit: The Company shall provide cover for selected high end diagnostic procedures in out-patient basis only as specified in the section 2 of Schedule 3: Package Rates for Medical Treatment and Surgical Procedures attached to the Policy document. This OPD Diagnostic Benefit is available only in public hospitals.

This is subjected to available Base Sum insured.

(g) Transportation Benefit: The Company shall provide cover for cost of transportation incurred by the Beneficiary in travelling to and from the premises of the Empanelled Health Care Provider for availing of Hospitalization or Day Care Treatment or for Follow-up Care.

This benefit is limited to 100 per occurrence of Hospitalization or Day Care Treatment or visit to an Empanelled Health Care Provider for Follow-up Care. The transportation benefit will be paid to the Beneficiary by the Empanelled Health Care Provider and will then be claimed from the Company as part of the Package Rate.

Further, this benefit is limited to a maximum of 10 instances of Hospitalization or Day Care Treatment or Follow-up Care during each Policy Cover Period.

2. Benefits under Critical Illness Cover

The Company hereby agrees, subject to the terms, conditions and Exclusions contained in this Insurance Contract and each Policy, to pay and/or reimburse the following benefits to each enrolled Beneficiary covered by such Policy, for the Policy Cover Period and to the extent of the Critical Illness Sum Insured:

a) Hospitalization Expenses Benefit: The Company Shall provide cover for payment of Hospitalization expenses that are incurred by the Beneficiary for a Medical Treatment or Surgical Procedure for a Critical Illness that is provided by a Specialty Hospital, subject only to the Exclusions.

The benefit under this is limited to: (1) the available Critical Illness Sum Insured; and (2) the eligible Medical Treatments or Surgical Procedures that are listed at Section 1 of Schedule 4: Critical Illnesses and related Package Rates attached to the policy document..

For the purpose of this, Hospitalization expenses shall have the meaning given to it in Clause 1(a)Hospitalization Expenses benefit.

(b) Day Care Treatment Benefit: The Company shall provide cover for payment of expenses that are incurred by the Beneficiary for a Day Care Treatment that is listed at Schedule 4Critical Illnesses and related Package Rates attached to the policy document and that is provided by a Specialty Hospital, subject only to the Exclusions.
The benefit under this is limited to: (1) the available Critical Illness Sum Insured; and (2) the eligible Day Care Treatments that are listed at Section 1 of Schedule 4:Critical Illnesses and related Package Rates attached to the Policy document. For the purpose of this, Day Care Treatment expenses shall have the meaning given to it inClause1(b)Day Care Treatment benefit.

(c) Pre-hospitalization and Post-hospitalization Expenses Benefit: The Company shall provide cover for payment of expenses that are incurred by the Beneficiary 15 days prior to Hospitalization or Day Care Treatment for a Critical Illness and for continuous and follow-up treatment for up to 30 days after discharge.

This benefit is a part of the benefit available under Clause 2(a) or clause 2(b) and is limited to the available Critical Illness Sum Insured.
For the purpose of this, pre-hospitalization and post-hospitalization expenses shall have the meaning given to it in Clause1 (c).

(d) Follow-up Care Benefit: The Company shall provide cover for payment of expenses that are incurred by the Beneficiary for Follow-up Care provided by an Empanelled Health Care Provider consequent to Hospitalization or Day Care Treatment of the Beneficiary for a Critical Illness.

The Follow-up Care benefit is in addition to the post-hospitalization expenses benefit set out in Pre-hospitalization and Post-hospitalization Expenses benefit, i.e., it will only be available in respect of expenses incurred by the Beneficiary once the 30 day period post-discharge has been completed.

This benefit will only be available in relation to Follow-up Care provided consequent to a Medical Treatment or Surgical Procedure for a Critical Illness for which the Beneficiary has been Hospitalized or obtained Day Care Treatment under the Critical Illness Cover, and not otherwise.

This benefit is limited to the package rates and number of instances for Follow-up care specified in section 2 of Schedule 4:Critical Illnesses and related Package Rates attached to the Policy Document.
(e) Transportation Benefit: The Company shall provide cover for cost of transportation incurred by the Beneficiary in travelling to and from the premises of the Specialty Hospital for availing of Medical Treatment or Surgical Procedure from the Specialty Hospital.

This benefit is limited to 1000 per occurrence of Hospitalization or Day Care Treatment or visit to an Empanelled Health Care Provider for the first instance of Follow-up Care (but not for subsequent visits for Follow-up Care) required for treatment of a Critical Illness. The transportation benefit will be paid to the Beneficiary by the Empanelled Health Care Provider and will then be claimed from the Company as part of the Package Rate.

Further, this benefit is limited to a maximum of 5 instances of Hospitalization or Day Care Treatment or Follow-up Care required for treatment of a Critical Illness.

Each of the benefits specified above shall be available for all pre-existing diseases, illnesses or conditions for which Medical Treatments, Surgical Procedures or Day Care Treatments are listed in Section 1 of Schedule 4:Critical Illnesses and related Package Rates attached to the policy document and that affect the Beneficiaries on the date of commencement of each Policy Cover Period, subject only to the Exclusions.

Sum Insured

1. Base Sum Insured

For each Policy Cover Period, the Sum Insured in respect of the Base Cover for each Beneficiary Family Unit:
(a) As on the date of commencement of risk cover for such Beneficiary Family Unit as applicable, shall be 50,000; and
(b) as on the date of a Claim Payment by the Company, shall stand reduced by all Claim Payments made as on that date in respect of the Base Cover, for the remainder of such Policy Cover Period.

2. Critical Illness Sum Insured

For each Policy Cover Period, the Critical Illness Sum Insured in respect of the Critical Illness Cover for each Beneficiary Family Unit:
(a) as on the date of commencement of risk cover for such Beneficiary Family Unit as applicable, shall be 1,25,000; and
(b) as on the date of a Claim Payment by the Company under the Critical Illness Cover, shall stand reduced by all Claim Payments made as on that date, for the remainder of such Policy Cover Period.

Note: Sum Insured on Family Floater Basis
(a) The Covers shall be provided to each Beneficiary Family Unit on a family floater basis covering the members of the Beneficiary Family Unit, i.e., the Sum Insured will be available to any or all members of such Beneficiary Family Unit for one or more Claims during each Policy Cover Period.

Cashless Access Service

Benefit with or without a MSBY Card

(a) The Company agrees that all Empanelled Healthcare Providers shall be informed sufficiently to honor all patients coming to them with or without a MSBY card yet claiming the benefits under the scheme. For such conditions, situations and checks as stated below should come into force. Thus even if a Beneficiary Family Unit is not found to

be enrolled into the Beneficiary Database the Company shall require the hospital to intimate the company and subsequent to that family can be enrolled into the scheme upon the intimation from the hospital by the Company with prior permission from the State Nodal Agency.

The issuance of a MSBY Card to each Beneficiary Family Unit shall be the proof of eligibility of the Beneficiary Family Unit for the purpose of availing benefits under this Insurance Contract and a Policy issued pursuant to this Insurance Contract. In case of card not yet issued to him/her the situation and respective checks suggested is as in table.

Situations	Validations/ Check
1. A valid MSBY card with beneficiary and the details are found in the database after search.	No need of any further documentary proof for identification.
2. A valid MSBY card with beneficiary but the details are not found in the database after search.	• Details to be searched with EPIC. If found in database then treatment to be authorized. • If search with EPIC fails then the patient to be enrolled after due diligence. verification of documents supporting the eligibility
3. A valid MSBY card with the beneficiary‘s family but name of the patient undergoing treatment is not shown in database upon search	• If patient is above 18 year of age then as identity proof EPIC or any other valid photo ID card, and • A document showing relation with the HoF such as copy of ration card, family register. • For patient below the age of 18 years only a proof of relation as stated above shall be required.
4.No MSBY card with the beneficiary but having a valid EPIC.	• Details to be searched with EPIC. If found in database then treatment to be authorised. • If search with EPIC fails then the patient to be enrolled after due diligence. (Verification of documents supporting the eligibility
5. No MSBY card neither a valid EPIC card	• Facilitate for issuance of EPIC • Fresh Enrolment

(b) The State Nodal Agency from time to time may issue the Scheme Guidelines in this direction which shall govern the situations in this matter.

Benefit included in Package List or Not

(a) If a condition requires hospitalization for a certain Medical Treatment, Surgical Procedure or Day care Treatment that is not included in Schedule 3: Package Rates for Medical Treatments and Surgical Procedures or Schedule 4: Critical Illnesses and related Package Rates attached to the Policy document then the Company shall require the Empanelled Healthcare Provider to intimate the details of procedure required, estimated price of that procedure and other relevant details. Following this the Company may agree to the price of the procedure provided that the procedure thus requested is not costing more than Rs 50,000 for a Base Cover and Rs. 1, 25,000 for a Critical Cover.

(b) The package thus identified and agreed shall be included into the Schedule 3: : Package Rates for Medical Treatments and Surgical Procedures or Schedule 4: Critical Illnesses and related Package Rates attached to the Policy Document as per the package rate agreed. Additional packages shall be negotiated and added in the package list with mutual consent of SNA and company at the time of monthly review meetings.

Intimation of Claim

(a) The Company shall require the Empanelled Health Care provider to intimate all instances of hospitalization of all individuals claiming to be MSBY Beneficiaries irrespective of their enrollment status or type of benefit required.
(b)Intimation of all cases requiring hospitalization, Day Care Treatment, OPD Diagnostic Benefit, Follow Up care shall be mandatory as soon as patient arrives. Hospitalization or procedure should be commenced only once intimation has been sent. Only in case of certain conditions presenting as emergency intimation may be sent later to commencement of the treatment or procedure.

(c) Within a stipulated time of intimation by an Empanelled Health Care provider (3 hour for a hill district and 2 hours for a plain district) the Company shall require to acknowledge the hospital suitably using the IT infrastructure (Online intimation) or otherwise (Offline Intimation).
(d) The Company shall require a prescribed set of documents to be provided mandatorily by all Empanelled Healthcare Providers in all instances of intimation whether intimated offline or online as per described in details in Schedule 5: Process for Cashless Access Services attached to the Policy document. Failure to provide these documents shall be deemed as non-intimation. The Company shall not require additional documents than those prescribed in the set at the time of intimation.
(e) The Company shall also require the healthcare provider to intimate any change in procedure or Beneficiary detail or plan, duration or cost of treatment to Company using Online or Offline channels.

Registering of Claims, Post processing and Validity of Claims-
(a) An intimation done in accordance, shall be responded as per the details provided in MSBY Tender Document. The intimation after proper response from the Company shall be registered as claim.
(b) Qualification of intimation to become a claim is subjected to the completion of formalities associated with hospitals. The Company acknowledges that intimation may be subjected to field verification before or after it has been converted into a claim.
(c) The Company shall require the healthcare providers to submit a prescribed set of documents related to the treatment or procedure performed during the hospitalization or Day Care Treatment to be made available to the Company on or before date of discharge. Failure to provide these documents shall result in pendency of the claims. The details of the set of documents to be provided as per MSBY Tender Document.
(d) A claim is considered valid or payable if (1) the intimation was made in proper order, (2) the set of documents as mentioned are available. The various reasons for which a claim can be rejected along with the proposed line of rejection are outlined in Schedule 5: Process for Cashless Access Services attached to the Policy document.

Process for Cashless Access Service

The Beneficiaries shall be provided treatment by Empanelled Health Care Providers free of cost for all such diseases, illnesses suffered or accidents that require Hospitalization, Day Care Treatments or specified OPD Diagnostic Benefits within the limits or sub-limits and subject to the available Sum Insured, subject only to the Exclusions.
The Services Agreement between the Company and the Empanelled Health Care Provider shall include the Package Rates determined in accordance with the MSBY Tender Document for the Medical Treatments, Surgical Procedures, Day Care Treatments, Follow-up Care and OPD Diagnostic benefits for which such Empanelled Health Care Provider is empanelled.
The Empanelled Health Care Provider shall be reimbursed for the expenses of Hospitalization or Day Care Treatment for a Medical Treatment or Surgical Procedure, Follow-up Care or OPD benefit as per the Package Rates specified in the Services Agreement that it executes with the Company. If no Package Rate is specified, then the reimbursement for the eligible expenses shall be determined in accordance with the pre-authorization process specified as per
Schedule 5: Process for Cashless Access Services attached to the Policy document.

The Empanelled Health Care Provider shall, at the time of discharge, debit the amount as per the agreed Package Rate or the Pre-authorized Amount.
The given below procedures shall be followed for providing the health care facility:
a) Establishing the identification of the beneficiary as per the MSBY card and other identification document.

b) Establishing that the beneficiary family has sufficient balance left for the procedure.

c) The disease under treatment is covered by MSBY as specified or unspecified. In case the disease for which treatment is needed is not available then process to be followed has been described below.

d) Additionally hospital shall also fill up an online pre-auth (PA) form and supporting documents to intimate the Company. The set of documents required with the intimation are-

i. Properly filled up, signed and sealed PA form,
ii. Hospital OPD ticket or Emergency Ticket or Prescription note of the physician

iii. Copy of MSBY card/EPIC and or ration card if data was not found in database upon search

e) Pre-authorisation is not necessary for emergency cases such as all labor cases, Road Traffic Accidents, Burn, Shock, accidental poisonings. This list is indicative and more conditions can be added as directed by SNA

f) Within 2 hrs of receipt of a PA in case of plain terrain and within 1 hrs of receipt of a PA in a hilly terrain, The Company is required to either approve the PA or raise a query. Further, if a suitable response to PA (approval or query) is not provided by the company within stipulated time then the claim is admissible by default and full amount claimed is payable by the company. Also, a penalty is to be incurred by the company for delay in responding to PA.

g) In case of a query being raised by the company for a PA, it will be the responsibility of the Company to inform the concerned hospital person by phone/text/mail/fax that a query has been generated that need to be responded. The details of information sought under query shall be available in hospital log in. The hospital has to respond to the query online through specified log in only.

h) After a query has been responded the decision on approval or rejection of the PA should be taken within a maximum of 1 hr. of receiving clarification from hospital. Failing which the claim is admissible for payment and a penalty is levied on the company.

i) Public hospitals are only required to raise a pre-authorisation and can proceed with the treatment plan even before the pre-auth is approved or a query is sent.

j) However, private hospital should proceed for a treatment only after the pre-authorisation is approved directly or after a PA has been approved either directly or after a resolved query.

In case a particular medical treatment/surgical procedure/day care treatment is not included in Schedule 3: : Package Rates for Medical Treatments and Surgical Procedures or schedule 4: Critical Illnesses and related Package Rates attached to the Policy document then the hospital shall negotiate the cost of treatment with Company at the time of intimation. The Company shall approve the case after due-diligence and shall update the schedule 3: : Package Rates for Medical Treatments and Surgical Procedures or schedule 4: Critical Illnesses and related Package Rates attached to the Policy document as may be the case after intimation and approval from the SNA. This arrangement is applicable only in those cases which are not included in schedule 3: : Package Rates for Medical Treatments and Surgical Procedures and schedule 4:Critical Illnesses and related Package Rates attached to the Policy Document and are not under Exclusion and yet cost of such treatment is less than Rs 50,000 or Rs 1,25,000.00 as the case may be.

Note: In cases where the Beneficiary is admitted in a healthcare provider during the current Policy period but is discharged after the end of the Policy period, the claim has to be paid by the company which is operating during the period in which Beneficiary was admitted.

C. EXCLUSIONS:

The Company shall not be liable to make any payment under any of the Covers in respect of any expenses whatsoever incurred by any Beneficiary in connection with or in respect of:

a. IN-PATIENT CARE & DAY CARE TREATMENTS

1. Conditions that do not require Hospitalization

a. Conditions that do not require Hospitalization and can be treated under Out Patient Care, i.e., Screening or OPD medical and surgical procedures, other than: (i) the Day Care Treatments identified in Schedule2: List of Eligible Day Care Treatments and schedule 3: Package Rates for Medical Treatments and Surgical Procedures attached to the Policy Document; and (ii) the OPD consultations and Screening covered under the OPD Benefits.

b. Expenses incurred at an Empanelled Health Care Provider primarily for Screening, i.e., evaluation or diagnostic purposes only during the Hospitalization and expenses on vitamins and tonics etc., other than such expenses that are required as a part of the expenses for: (i) Hospitalization expenses for a Medical Treatment or Surgical Procedure, as certified by the attending physician; (ii) Follow-up Care; or (iii) the OPD consultations and Screening covered under the OPD Benefits.

c. Any dental treatment or Surgical Procedure which is corrective, cosmetic or of aesthetic nature, filling of cavity, root canal including wear and tear etc., is excluded, unless arising from the disease, illness or injury and which requires Hospitalization for treatment, other than: the OPD consultations or dental treatment provided as part of the child care benefits under Clause 3.1(h).

2. **Congenital Anomalies and Convalescence**
   a. Treatment or procedures for external Congenital Anomalies, other than the Congenital Anomalies listed in Schedule 3: Package Rates for Medical Treatments and Surgical Procedures or Schedule 4 Critical Illnesses and related Package Rates attached to the Policy Document. .
   b. Convalescence or treatment for general debility, "run down" condition or rest cure.
   c. Any treatment received in a convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments or as mutually agreed between the Insured and the Company.

3. **Sterilization, Fertility and Sex Change procedures**
   a. Sterilization
   b. Any fertility, sub-fertility or assisted conception procedure
   c. Hormone replacement therapies, sex change or treatments which result from or are in any way related to sex change.

4. **Vaccinations and Cosmetic Treatments**
   a. Vaccination or inoculation, other than such expenses that are required as a part of the expenses for the OPD Benefits.
   b. Change of life or cosmetic or aesthetic treatments of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
   c. Circumcision, unless necessary for treatment of a disease or illness not excluded hereunder or as may be necessitated by any accident.

5. **War, Nuclear invasion**
   Disease, illness or injury directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not) or by nuclear weapons/materials.

6. **Suicide**
   Intentional self-injury/suicide.

b. EXCLUSIONS: MATERNITY BENEFITS

1. **Termination of Pregnancy**
   Voluntary medical termination of pregnancy is not covered, except in the case of a lawful termination or induced by accident or other medical emergency to save the life of mother.

2. **Minimum Hospitalization period**
   Normal Hospitalization period is less than 24 hours from the time of delivery or operations associated therewith for this benefit.

3. **Pre-Natal Expenses**
   Pre-natal expenses incurred prior to delivery, other than: (i) the ante-natal and post-natal benefits covered under the OPD Benefits; and (ii) any complications in the pregnancy for which a Medical Treatment or Surgical Procedure is provided in respect of the mother and/or unborn child and which requires Hospitalization prior to delivery, provided that such Medical Treatment or Surgical Procedure is listed in Schedule 3 Package Rates for Medical Treatments and Surgical Procedures attached to the Policy document.

D. <u>GENERAL CONDITIONS:</u>

1. Every notice of communication to be given or made under this Policy shall be delivered in writing at the address of the Company and/or TPA office as shown in the Schedule.

2. **Payment of Claims and Claim Turnaround Time**
   The claim settlement process will be as stated below:

a) The Company shall require the Empanelled Health Care Providers to submit their final documents regarding Medical Treatment, Surgical Procedure, Day care treatment, or Follow up care or provision of OPD benefits electronically within 7 days of discharge or Follow-up Care to the Beneficiary in a format to be prescribed byUs. However, if the Empanelled Health Care Provider is: (i) unable to do so due to a lack of internet connectivity; or (ii) making a Claim for utilization of the Critical Illness Cover benefits, then such Empanelled Health Care Provider shall be required to submit its Claims electronically or manually within a maximum of 10 days.
b) The Company may reject any Claim that is received after 30 days of discharge or visit of the Beneficiary.
c) Along with the claim rejection information, the company will also inform the hospital that it can appeal to the District Grievance Redressal Committee if required. The contact details of the District Grievance Redressal Committee will be provided along with each claim rejection letter.
d) In case a claim is rejected, the company shall issue a written letter of rejection to the Empanelled Health Care Provider stating details of the Claim summary; reasons for rejection; and details of the District Grievance Nodal Officer. The letter of rejection shall be issued to the State Nodal Agency and the Empanelled Health Care Provider within 15 days of receipt of the Claim. The Company will also inform the Empanelled Health Care Provider of its right to seek redress for any Claim related grievance before the District Grievance Redressal Committee in its letter of rejection.
e) in case the Claim is rejected because the Empanelled Health Care Provider making the Claim is not empanelled for providing the health care services in respect of which the Claim is made, then the Company shall while rejecting the Claim inform the Beneficiary of an alternate Empanelled Health Care Provider where the benefit can be availed.
f) If a Claim is not rejected within 15 days, the Company shall have to make the Claim Payment (based on the Package Rate or the Pre-Authorized Amount) to Empanelled Health Care Provider.
g) If a Claim event falls within two Policy Cover Periods, the Claim shall be paid taking into consideration the available Sum Insured in the two Policy Cover Periods. The eligible Claim Payment shall be made by the Company in full, whether or not the renewal Premium for the subsequent Policy Cover Period has been received by the Company.
h) Where a claim is being investigated by the company, the process shall be completed within 15 days of receipt of the claim.
i) The company may collect at their own cost complete claim papers from the provider, if required for audit purposes. This will not have any bearing on the claim settlement to the provider.

3. Penalty linked to delay in Claim payment

If the Company does not settle the claim within 15 days for a reason other than a delay by the State Nodal Agency in making payment of the Premium that is due and payable, then the Company shall be liable to pay a penal interest to the Empanelled Health Care Provider as follows:

1. For 1st 15 day delay- 0.5% of the payable amount
2. For next 15 days delay- 0.75 % of the payable amount
3. For next one month delay- 1 % of the payable amount.

4. Fraudulent Claims

The Company shall not be liable to make any payment under this Policy in respect of any claim:

i. If the Policy has been obtained by misrepresentation of material facts,
ii. If such claim be in any manner be fraudulent or supported by any fraudulent means or device whether by the Beneficiaries or by any other person acting on his behalf.

5. Repudiation of Claims

If the Company rejects a claim, then the company shall issue a written letter of rejection to the Empanelled Health Care Provider stating: details of the Claim summary; reasons for rejection; and details of the District Grievance Nodal Officer. The letter of rejection shall be issued to the State Nodal Agency and the Empanelled Health Care Provider within 15 days of receipt of the Claim. The Company should inform the Empanelled Health Care Provider of its right to seek redress for any Claim related grievance before the District Grievance Redressal Committee in its letter of rejection.

6. AVAILABILITY OF BENEFITS UNDER COVERS
Benefits Available only through Network Hospitals

a. **T**he Base Cover benefits shall only be available to a Beneficiary through an Empanelled Health Care Provider against presentation of the MSBY Card or other valid documents for identification in case MSBY card is not available as per Clause2(c) of the MSBY Tender Document.

b. The Critical Illness Cover benefits shall only be available to a Beneficiary through an Empanelled Specialty Hospital, against presentation of the MSBY Card or other valid documents for identification in case MSBY card is not available as per Clause 2(c) of the MSBY Tender Document.

c. The benefits under each Cover shall, subject to the available Sum Insured, be available to the Beneficiary on a cashless basis in accordance with MSBY Tender Document. .

7. No Contributions

a. The Company agrees that any Beneficiary Family Unit or any of the Beneficiaries or any other third party shall be entitled to obtain additional health insurance or any other insurance cover or to obtain funding from the State Illness Fund or other healthcare funding of any nature whatsoever, including in relation to the benefits provided under this Policy, either individually or on a family floater cover basis.

b. Notwithstanding that such Beneficiary Family Unit or any of the Beneficiaries or any third party acting on their behalf effect additional health insurance or any other insurance cover or any other funding of any nature whatsoever, the Company agrees that:

I. its liability to make a Claim Payment shall not be waived or discharged in part or in full based on a ratable or any other proportion of the expenses incurred and that are covered by the benefits under the Covers;

II. it shall be required to make the full Claim Payment in respect of the benefits provided under this Policy; and

III. if the total expenses incurred by the Beneficiary exceeds the available Sum Insured under the Covers (after taking into account the deductibles and co-payment obligations), then the Company shall make payment to the extent of the available Sum Insured in respect of the benefits provided under this Policy and the other insurers or health fund managers shall pay for any excess expenses not covered.

8. **Arbitration**-

a. Any Disputes between SNA and Company shall be referred to the respective Nodal Officer of SNA or CMD of Company for resolution. In the event that the SNO or CMD are unable to resolve the dispute within 30 days of it being referred to them, then either party may refer the dispute for resolution to a sole arbitrator who shall be jointly appointed by both parties. In the event that the parties are unable to agree on the person to act as the sole arbitrator within 30 days after any party has claimed for an arbitration in written form, three arbitrators shall be appointed, one to be appointed by each party with the power to the two arbitrators appointed so, to appoint a third arbitrator. Arbitration process shall take place as per the Arbitration or Reconciliation Act, 1996 as amended or re-entered from time to time. The proceedings of arbitration shall be conducted in the English language. The Arbitration shall be held in Dehradun, India.

b. If any dispute or difference shall arise between the Company and Beneficiary as to the quantum to be paid under this Policy (liability being otherwise admitted by the Company) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the Company and Beneficiary , or if they cannot agree upon a single arbitrator within 30 days of either the Company and Beneficiary 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 Company and Beneficiary to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.The law of the arbitration will be Indian law, and the seat of arbitration and venue for all hearings shall be within India.

It is clearly agreed and understood that no difference or dispute between the Company and Beneficiary shall be referable to arbitration, as hereinbefore provided, if the Company has disputed/Rejected 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 the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

Subject to above arbitration provisions, if no court action or suit is commenced by the Beneficiary within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits to the Beneficiary under this Policy shall be forfeited and the rights of the Beneficiary insured shall stand extinguished and the liability of the company shall also stand discharged.
In the event that these arbitration provisions shall be held to be invalid then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts.

9. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law. Each party agrees to submit such dispute to a Court of competent jurisdiction and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court

10. Payment Of Premium

The Company hereby agrees to collect the premium, on behalf of the Beneficiary Family Units that are enrolled and issued MSBY Cards for the first Policy Cover Period as provided in the Insurance as per Clause 8 Premium payment of the MSBY tender document dated 26th May 2016.

11. Penalty for Delay in Premium Payment

If the premium is not paid to the Company within eight months of the commencement of the Policy, interest of 0.5% of the amount for every 15 days delay if the premium payment is delayed beyond 8 months of the start of the Policy shall be paid by the State Nodal Agency to the Insurance Company

12. Refund of Surplus Premium

The premium refund shall be as per the formula below:

1) Administrative cost 20 % of the total premium due during 1st year of policy period and 15 % of the total premium due for the successive renewal policy period.
2)After providing for the administrative cost as above and outstanding claims if any, if there is any surplus at the end of the policy period, then 80 % of this leftover surplus will be refunded to the SNA within 30 days after the expiry of the policy period.
3) If there is no surplus leftover or the claims exceed 80 % of the total premium paid then there shall be no additional premium (no loading of the premium) paid by the government.

4) If any surplus leftover has been refunded by the Company then the same shall be used for compensating the Company in case the claims exceed 100 % of the premium paid in subsequent years, maximum to the limit of the refunded amount.

13. Termination of Policy

The Policy shall not be terminated by the company except on grounds of mis-representation, fraud, non-disclosure of material facts or non-co-operation of the insured. However the termination of cover shall be only in respect of the MSBY beneficiary family unit whose claim has been repudiated on grounds of mis-representation, fraud, non-disclosure of material facts or non-co-operation and shall not be applicable to the other family units covered under the policy. In case of termination of cover to any beneficiary family unit due to mis-representation, fraud, non-disclosure of material facts or non-co-operation of the insured, the premium pertaining to that beneficiary family unit shall be forfeited.

The State Nodal Agency may, without prejudice to any other right it may have under this policy, in law or at equity, issue a preliminary terminate on notice of its intention to terminate this policy to the Company.
If the Company fails to remedy or rectify the stated in the Notice within 30 days of receipt of the Notice, the State Nodal Agency will be entitled to terminate this Policy by issuing a final termination notice.
However, in the event of termination the conditions will be as per the MSBY Tender Document,

The Company shall be entitled to terminate this policy upon the occurrence of a material breach of this policy by the State Nodal Agency that remains uncured despite receipt of a 60 day cure notice from the Company provided that such event is not attributable to a Force Majeure Event.

The Company may, without prejudice to any other right it may have under this Policy, in law or at equity, issue a Preliminary Termination Notice to the State Nodal Agency. If the State Nodal Agency fails to remedy or rectify the State Nodal Agency Event of Default stated in the Preliminary Termination Notice issued by the company within 60 days of receipt of the Preliminary Termination Notice, the Company will be entitled to terminate this Policy by issuing a Final Termination Notice.

14. Grievance Redressal

The Greivance Redressal process will be as laid down in the MSBY tender document dated 26th May 2016. If the Beneficiary or MSBY Beneficiary Unit has a grievance on issues relating to enrolment or hospitalisation against the company, he/she will approach the District Grievance Redressal Commitee {DGRC.] The DGRC should take a decision within 30 days of receiving the complaint. If either of the parties is not satisfied with the decision, they can appeal to State Grievance Redressal Commitee(SGRC) within 30 days of the decision of the DGRC. The SGRC shall decide the appeal within 30 days of receiving the appeal .The decision of the SGRC on such issues will be final.

In case of a rejection of claim, the Hospital will have to be informed within one month of receiving the claim. Along with the claim rejection information, the company will inform the Hospital that it can appeal to the DGRC/SGRC if required and the address of the DGRC/SGRC will be provided in the rejection letter.

The Hospital shall have the right of appeal to approach the company if they feel that the claim is payable .If the Company's decision is not agreeable in this regard, it can appeal to the DGRC/SGRC

In witness where of the undersigned being duly authorized by the company on behalf of the company has hereunto set his hand at ……on ……..day of……..200……

For The Bajaj Allianz General Insurance Company Limited

Authorized Signatory

15. Grievance Redressal Procedure

Bajaj Allianz General Insurance has always been known as a forward looking customer centric organization. We take immense pride in the spirit of service and the culture of keeping customer first in our scheme of things. In order to provide you with top-notch service on all fronts, we have provided you with multiple platforms via which you can always reach one of our representatives.

Level 1

In case you have any concern, you may please reach out to our Customer Experience Team through any of the following options:

- Our Website @ https://general.bajajallianz.com/Corp/aboutus/general-insurance-customer-service.jsp
- Call us on our Toll free no 1800 209 5858
- Mail us on bagichelp@bajajallianz.co.in
- Write to Bajaj Allianz General Insurance Co. Ltd.
  Bajaj Allianz House, Airport Road, Yerwada Pune- 411006

Level 2

In case you are not satisfied with the response given to you by our team, you may write to our Grievance Redressal Officer **Mr. Jerome Vincent** at ggro@bajajallianz. co.in

Level 3

If in case, your grievance is not resolved and you wish to talk to our care specialist, please Give a missed on +91 80809 45060 OR SMS <WORRY> To 575758 and our care specialist will call you back

If you are still not satisfied with the solutions provided, write to Mr. Ankit Goenka, Head of Customer experience directly at head. customerservice@ bajajallianz.co.in.

Grievance Redressal Cell for Senior Citizens

Bajaj Allianz introduces a dedicated team for all the senior citizens, so no more wait time, no more standing in long queue.

Senior citizens can now contact us on 1800-103-2529 or write to us at seniorcitizen@bajajallianz.co.in

In case your complaint is not fully addressed by the insurer, You may use the Integrated Greivance Management System (IGMS) for escalating the complaint to IRDAI or call 155255 . Through IGMS you can register your complain online and track its status. For registration please visit IRDAI website www.irda.gov.in.
If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah 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@cioins.co.in	Karnataka
BHOPAL - Shri Guru Saran Shrivastava 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@cioins.co.in	Madhya Pradesh Chattisgarh
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa

Office Details	Jurisdiction of Office Union Territory,District)
CHANDIGARH - Dr. Dinesh Kumar Verma 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@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Tey-nampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - Shri Kiriti .B. Saha 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@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD - Shri I. Suresh Babu 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 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.

Office Details	Jurisdiction of Office Union Territory,District)
ERNAKULAM - Ms. Poonam Bodra 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@cioins.co.in	Kerala, Lakshadweep, MaKerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry. he-a part of Pondicherry
KOLKATA - Shri P. K. Rath 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@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW -Shri Justice Anil Kumar Srivastava 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@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhab-dra,Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao,Sita-pur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi,Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar,Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI - Shri Milind A. Kharat 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@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri,Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad,Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Sham-li, Rampur,Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur

Office Details	Jurisdiction of Office Union Territory,District)
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
PUNE - Shri Vinay Sah 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@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

Note: Address and contact number of Governing Body of Insurance Council

Secretary General - Governing Body of Insurance Council
Jeevan Seva Annexe, 3rd Floor, S.V. Road, Santacruz (W), Mumbai - 400 054
Tel No: 022-2610 6889, 26106245, Fax No. : 022-26106949, 2610 6052, E-mail ID: inscoun@vsnl.net