Samaveshi Suraksha Health Insurance Policy

Terms & Conditions

I. PREAMBLE

This Policy is a contract of insurance issued by United India Insurance Company Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Policyholder') 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 receipt of the requisite premium.

A. Operative Clause

If during the Policy Period the Insured Person 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 expenses towards the Coverage mentioned in the Policy Schedule.

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

II. 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 other gender and references to any statutory enactment includes subsequent changes to the same.

A. Standard Definitions

1. Accident

   means sudden, unforeseen, and involuntary event caused by external, visible, and violent means.

2. 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.

3. AYUSH Hospital

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

   i. Central or State Government AYUSH Hospital; or
   ii. Teaching hospital attached to AYUSH College recognized 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 recognized 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 all the following criterion:
      a. Having at least 5 in-patient beds;
      b. Having qualified AYUSH Medical Practitioner in charge round the clock;
      c. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      d. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. AYUSH Day Care Centre

means and includes Community Health 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 in charge round the clock;
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.

5. AYUSH Treatment

refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

6. Break in Policy

means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

7. 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.

8. Condition Precedent

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

9. Congenital Anomaly

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

i. **Internal Congenital Anomaly** – Congenital anomaly which is not in the visible and accessible parts of the body.
ii. **External Congenital Anomaly** – Congenital anomaly which is in the visible and accessible parts of the body.

10. Co-Payment

means a cost sharing requirement under a health insurance policy that provides that the Policyholder/ Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

11. 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.

12. Day Care Treatment

means medical treatment, and/or surgical procedure which is:

i. undertaken under general or local anesthesia in a hospital/Day Care Centre in less than twenty-four hours because of technological advancement, and
ii. which would have otherwise required hospitalisation of more than twenty-four hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition

13. Dental Treatment

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

means medical treatment for an Illness/Disease/Injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii. the patient takes treatment at home on account of the non-availability of room in a hospital.

14. 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.

15. Grace Period

means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

16. 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 lakhs 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

17. Hospitalisation

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

18. 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.

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

19. 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.

20. 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.

21. Intensive Care Unit (ICU)

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.

22. Intensive Care Unit (ICU) Charges

means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

23. Medical Advice

means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

24. 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.

25. 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.

26. Medical Practitioner

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

27. Migration

means a facility provided to the Insured Persons to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with Us.

28. 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.

29. Non-Network Provider

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

30. Notification Of Claim

means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

31. Out-Patient (OPD) Treatment

means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

32. Pre-Existing Disease (PED)

means any condition, ailment, injury or disease:

i. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer **or**
ii. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy or its reinstatement.

33. Pre-Hospitalisation Medical Expenses

means medical expenses incurred during a pre-defined number of days preceding the hospitalisation of the Insured Person provided that:

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

34. Portability

means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

35. Post-Hospitalisation Medical Expenses

means relevant medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital provided that:

i. Such Medical expenses are 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.

36. 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.

37. Reasonable And Customary Charges
mean the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/injury involved.

38. Renewal
means the terms on which the contract of insurance can be renewed on mutual consent with a provision of a 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.

39. Room Rent
means the amount charged by a Hospital towards room and boarding expenses and shall include the Associated Medical Expenses.

40. 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.

41. 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.

42. 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.

B. Specific Definitions

1. Age
means completed age in years on the Policy Commencement Date.

2. AIDS
means Acquired Immune Deficiency Syndrome, a condition characterised by a combination of signs and symptoms, caused by Human Immunodeficiency Virus (HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions, as may be specified from time to time.

3. Ambulance
means a motor vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

4. Antiretroviral therapy (ART)
is treatment of people infected with human immunodeficiency virus (HIV) using anti-HIV drugs.

5. 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.

6. Cancellation

defines the terms on which the policy contract can be terminated either by the Insurer or the Insured person by giving sufficient notice to other which is not lower than a period of seven days.

7. CD4 cells

are a type of white blood cells, also called as CD4 T-lymphocytes or 'helper T-cells' which serve as primary receptor for HIV.

8. Continuous Coverage

means uninterrupted coverage of the Insured Person under the Health Insurance Policy from the date of inception of policy for the first time as mentioned in the policy schedule. However for the purpose of applying waiting periods, the break in insurance period for which the premium was not received shall be excluded from it.

9. Diagnostic Centre

means a place where diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition are done.

10. HIV

means Human Immunodeficiency Virus.

11. Lending Partner

shall mean an entity engaged in the business of providing credit facilities, such as Non-Banking Financial Companies (NBFCs), to the proposers of insurance, for payment of Premium for availing health insurance cover.

12. Letter to the insurer

means a digitally authenticated or signed declaration by the Proposer or Policyholder at the time of purchasing or renewing the policy, availing the service of *Premium Financing* through the Lending Partner, containing his/her instructions on cancellation of the Policy and refund of premium.

13. Material Fact

means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take an informed decision in the context of underwriting the risk.

14. Mental Illness

means a substantial disorder of thinking, mood, perception, orientation, or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub-normality of intelligence.

15. Nominee

means the person named in the Policy Schedule, Policy certificate and/or endorsement (if any) who is nominated by the Policy Holder/Insured Person, to receive the benefits under this Policy as per the terms of the Policy if the Insured Person deceases.

16. Person with Benchmark Disability/ Disability/ Disabled

means a person with not less than forty percent of a specified disability where specified disability has not been defined in measurable terms and includes a person with disability where specified disability has been defined in measurable terms, as certified by the certifying authority.

17. 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.

18. Policy Period

means the period for which this policy is taken and is in force as specified in the Schedule.

19. Policyholder

means the entity or person named as such in the Schedule.

20. Policy Schedule

means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Person, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

21. Preferred Provider Network (PPN)

means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the Insured Person. The updated list of network providers/PPN is available on our website (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the website of the TPA mentioned in the schedule and is subject to amendment from time to time.

22. Proposal Form

means the form to be filled in by the prospect in written or electronic or any other format as requested by the Company and approved by the IRDAI, for furnishing all material information as required by the Insurer, to:

i. Enable the Insurer to take an informed decision in the context of underwriting the risk
ii. And in the event of acceptance of the risk, to determine the rates, benefits, terms and conditions of the cover to be granted.

23. Psychiatrist

means a Medical Practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist.

24. 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.

25. 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 the Insured Person during the policy period.

26. 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.

27. We/Our/Us/Company/Insurer

means United India Insurance Company Limited

28. You/Your/Insured

means the person who has taken this Policy and is shown as Insured Person or the first Insured Person (if more than one person covered in the policy) in the Schedule.

III. BENEFITS COVERED

A. Base Covers

1. In-patient Care

The Company shall indemnify medical expenses incurred for Hospitalisation of the Insured Person during the Policy period, up to the Base SI as specified in the Policy Schedule for:

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital/ Nursing Home up to 1% of the Sum Insured, subject to maximum of Rs. 5,000.
ii. Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) expenses up to 2% of Sum Insured, subject to maximum of Rs. 10,000.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital.
iv. Anesthesia, Blood, Oxygen, Operation Theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

1.1 Note:

a. 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.
b. PROPORTIONATE PAYMENT CLAUSE: In case of admission to a room at rates exceeding the aforesaid limits in Clause III.A.1, 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.
c. All Day Care Treatments are covered.
d. Mental Illness Cover: The Company shall indemnify the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist or a professional having a post-graduate degree (Ayurveda) in Manovigyan Evum Manas Roga or a Post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a postgraduate degree (Siddha) in Sirappu Maruthuvam

1.2 Sub-Limit

a) Cataract Surgery Limit

Expenses in respect of the Cataract surgeries will be restricted to 10% of Sum Insured subject to maximum of Rs. 40,000/- per eye. This limit is applicable per hospitalisation / surgery.

2. 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.

3. Modern Treatment Methods & Advancement in Technologies:

The following procedures will be covered (wherever medically indicated) either as In-patient or as part of Day Care Treatment in a Hospital up to 50% of Sum Insured during the Policy Period.

a. Uterine Artery Embolization and HIFU (High Intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain Stimulation
d. Oral Chemotherapy
e. Immunotherapy - Monoclonal Antibody to be given as an injection
f. Intra-vitreal injections
g. Robotic Surgeries
h. Stereotactic Radio Surgeries
i. Bronchial Thermoplasty
j. Vaporization of the Prostrate (Green Laser Treatment or Holmium Laser Treatment)
k. IONM - (Intra Operative Neuro Monitoring)
l. Stem Cell Therapy; Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered

4. Emergency Ground Ambulance

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards ambulance charges for transportation of an Insured person, per hospitalisation as per the limit mentioned in Policy Schedule.

4.1 Conditions:

The Company will reimburse payments under this Benefit provided that.

a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is suffering from an Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing for management of the current Hospitalisation.
b. Expenses incurred on road Ambulance subject to a maximum of Rs. 2000 per hospitalisation.
c. The ambulance service is offered by a healthcare provider or Registered Ambulance Service Provider.
d. The original Ambulance bills and payment receipt is submitted to the Company.
e. The Company has accepted a claim under *Clauses III.A.1.*
f. Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

5. Lump Sum Benefit for persons with HIV/AIDS

We will pay 100% of the Sum insured or the balance sum insured available under the policy, whichever is lower, as a lump sum amount to the insured, in case the CD4 count of the patient goes below 150 during the policy period.

5.1 Conditions

i. The claim under this clause will trigger after a waiting period of 90 days from the commencement of the policy.

ii. The claim under this benefit shall be payable once in the lifetime of the Insured Person and shall not be necessarily linked to an In-patient Hospitalisation claim made under the policy.
iii. On payment of a claim under this Clause, the policy shall cease and will not be available for renewal.

B. Optional Cover

1. Waiver of Co-Payment

In this optional cover, the applicable Co-Payment as per *Clause V.B.2* will be waived off.

IV. EXCLUSIONS

We shall not be liable to make any payment under this Policy in connection with or in respect of any expenses whatsoever incurred by You in connection with or in respect of:

A. Waiting Periods

The Company is not liable to make any payment under the Policy in connection with or in respect of the following expenses till the expiry of the waiting period and any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or any way attributable to any of the following unless expressly stated to the contrary in this Policy.

1. Pre-Existing Diseases (Code – Excl01)

i. Disease-wise exclusion:
   a. Diseases other than Pre-existing Disability or HIV/AIDS: 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.
   b. HIV/AIDS: Expenses related to the treatment of HIV/AIDS and its direct complications shall be excluded until the expiry of 30 days of continuous coverage after the date of inception of the first policy with Us.
   c. Pre-Existing Disability: Expenses related to the treatment of a pre-existing disability and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with Us.
ii. In case of enhancement of the Sum Insured, the exclusion shall apply afresh to the extent of the 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 the 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.

2. Specified Disease/Procedure Waiting Period (Code – Excl02)

i. Expenses related to the treatment of the listed Conditions in Table A covered under the policy shall be excluded until the expiry of 24 months as (mentioned in Policy Schedule) 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 the sum insured the exclusion shall apply afresh to the extent of the 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 the waiting period for the same would be reduced to the extent of prior coverage.

Table A. Twenty-Four Months waiting period

Adenoidectomy	Hernia of all types
Benign ENT disorders	Hydrocele
Tonsillectomy	Non-Infective Arthritis
Mastoidectomy	Piles, Fissures and Fistula in anus
Tympanoplasty	Pilonidal sinus, Sinusitis and related disorders
Hysterectomy	Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident.
All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps.	Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
Benign prostate hypertrophy	Internal Congenital Anomalies
Cataract	Gout and Rheumatism
Gastric/ Duodenal Ulcer	Varicose Veins and Varicose Ulcers

Note

The waiting period of 24 months for Internal Congenital Anomalies is not applicable on new-born babies.

Table B. Thirty Six Months waiting period

Joint Replacement due to Degenerative condition, unless necessitated due to an accident.
Age-related Osteoarthritis & Osteoporosis
Age-related Macular Degeneration (ARMD)

3. 30-Day 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 a higher sum insured subsequently.

B. Standard Exclusions

1. 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.

2. 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, and moving around either by skilled nurses or assistants or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. 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:
        b.1. Obesity-related cardiomyopathy
        b.2. Coronary heart disease
        b.3. Severe Sleep Apnea
        b.4. Uncontrolled Type2 Diabetes

4. 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. 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 the 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.

6. 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.

7. 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.

8. 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 on 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.

9. (Code – Excl12)

Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

10. (Code – Excl13)

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.

11. (Code – Excl14)

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

12. Refractive Error (Code – Excl15)

    Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

13. 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.

14. 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

15. Maternity (Code- Excl18):

    i Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;

    ii Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

C. Specific Exclusions

1. All expenses caused by or arising from or attributable to foreign invasion, an 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.
2. Any expenses incurred on Out-patient treatment (OPD treatment). Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.
3. All Illnesses/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or any nuclear waste from the combustion of nuclear fuel, nuclear/chemical/biological attack.
4. Any kind of service charge, surcharge levied by the hospital.
5. Any item(s) or treatment specified in 'List of Non-Medical Expenses– Payable/Non-Payable' as per clauses in Annexure – 1 unless specifically covered under the Policy.
6. Any treatment related to sleep disorder or sleep apnoea syndrome.
7. Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state.
8. Change of treatment from one system of medicine to another system unless recommended by the consultant/hospital under whom the treatment is taken.
9. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident.

10. Convalescence, general debility, "Run-down" condition, rest cure, congenital external illness/disease/defect.
11. Cost for any Anti-Retroviral Treatment.
12. Cost of hearing aids; including optometric therapy.
13. Dental treatment or surgery of any kind unless necessitated by disease or accident and requiring hospitalisation.
14. Hospitalisation for donation of any body organs by an Insured including complications arising from the donation of organs.
15. Injury or Disease caused by or contributed to by nuclear weapons/materials.
16. Notwithstanding anything stated under *Clause IV.A.1,* the treatment for specified existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent) shall always be excluded.
17. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to domiciliary hospitalisation shall not be covered. Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.
18. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
19. Stem cell storage.
20. Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.
21. Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, chondrocyte or osteocyte implantation, procedures using platelet-rich plasma, Trans Cutaneous Electric Nerve Stimulation; Use of oral immunomodulatory/ supplemental drugs.
22. Experimental treatment or any other treatment such as acupuncture, acupressure, magnetic, osteopath, chiropractic, reflexology and aromatherapy.
23. Vaccinations or inoculations of any kind, except when required as part of hospitalization or a day care procedure for treatment following an animal bite.

V. GENERAL TERMS AND CLAUSES

A. Standard Terms and Clauses

1. Cancellation

i. The policyholder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall refund a proportionate premium for the unexpired policy period if there is no claim (s) reported during the policy period.

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 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

2. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 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 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 at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim..

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

3. 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.

4. Condition Precedent to Admission of Liability

The Due observance and fulfillment of the terms and conditions of the Policy, by the Insured Person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

5. 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.

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. Free Look Period

The free look period shall be applicable on new Samaveshi Suraksha Health Insurance policies and not on renewals or at the time of porting/migrating the policy. The Insured Person shall be allowed free look period of 30 days from date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy and to return the same if not acceptable.

If the Insured has not made any claim during the free look period, the Insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

8. Migration

The Insured Person will be provided a facility to migrate the policy (including all members) to other health insurance products/plans offered by the company by applying for migration of the policy. 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

9. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

10. 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 can file for claim settlement as per their choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer.
ii. In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, provided a written request for same has been submitted by the Insured Person.

11. 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. ln 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.

12. Portability

The Insured Person will be provided facility to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health Insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability

13. Possibility of Revision of Terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

14. Redressal of Grievance

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

- Website : www.uiic.co.in
- Toll free : 1800 425 333 33
- E-mail : customercare@uiic.co.in
- Courier : Customer Care Department, Head Office,
  United India Insurance Co. Ltd.,
  24, Whites Road, Chennai, Tamil Nadu- 600014

The insured person may also approach the grievance cell at any of the Company's branches with the details of the grievance. If Insured Person is not satisfied with the redressal of the grievance through one of the above methods, The 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 as amended from time to time. The contact details of the Insurance Ombudsman offices have been provided as Annexure 2.
- Grievance may also be lodged at IRDAI Integrated Grievance Management System: https://igms.irda.gov.in/

15. Renewal of Policy

i. The policy shall ordinarily be renewable except on grounds of fraud, non-disclosure or misrepresentation by the Insured Person.
ii. The Company will give notice for renewal.
iii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. 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 except for policies where premium is paid in instalments.
vi. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
vii. No loading shall apply on renewals based on individual claims experience.

16. 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 expiry of the policy.
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 waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break

B. Specific Terms and Clauses

1. Change of Sum Insured

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

2. Co-Payment

Every admissible claim under *Clause III.A.1-III.A.3* shall be subject to a Co-payment of 20% on the admissible claim amount.

3. Eligibility Criteria

i. A person with Benchmark Disability who has at least one of the disabilities as defined under Specified Disability under *The Rights of Persons With Disabilities Act, 2016* with valid disability certificate is eligible to enroll this product.
ii. A person diagnosed with HIV/AIDS by a duly qualified Medical Practitioner as defined under *Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 and* with CD4 count above 350 before the inception of the policy.
iii. The person is not having the same/similar policy from any other insurer.

4. Limitation of Liability

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

5. Material Change

The Insured Person shall notify the Company in writing of any material change in the risk in relation to the declaration made in the Proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

6. Notice & Communication

i. Any notice, direction or instruction or any other communication related to the Policy should be made in writing.
ii. For issues related to ID card, PPN/network provider, the communication should be made to the TPA at the contact details provided in the Policy Schedule. For any policy related issues or change in address, communication should be made to the policy issuing office at the address mentioned in the schedule.
iii. The Insured shall notify the policy issuing office in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.
iv. 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.
v. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorised official of the Company.

7. Policy cancellation for Premium payment through Lending Partner

If the premium tendered/paid towards the policy has been financed through a Lending Partner, and the policy is cancelled by invocation of the terms stated by the policy holder in the "Letter to the Insurer" or If the refund of premium is due for any reason whatsoever, the refund will be effected to the account which is mentioned by the policy holder in the "Letter to the Insurer" submitted by the policy holder.

8. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

9. 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.

10. Endorsements in the Policy

The Proposal Form, Policy Schedule constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policyholder and the Company. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed, and stamped by Company. All endorsement requests will be made by the Insured Person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except the Company.

11. Revision and Modification of the Policy Product

i. Any revision or modification will be done with the approval of the Authority. We shall notify You about revision/ modification in the Policy including premium payable thereunder. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect.
ii. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next renewal. Credit of continuity/ waiting periods for all the previous policy periods would be extended in the new policy on Renewal with Us.

12. Terms and conditions of the Policy

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

13. Claim Procedure

i. Notification of Claim

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

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

ii. Procedure for Cashless Claims

a. Cashless facility for treatment taken in a hospital is subject to pre-authorization by the TPA.

b. A booklet containing list of network provider/PPN hospitals shall be provided by the TPA. The updated list of network providers/PPNs is available on the website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the TPA mentioned in the schedule.
c. The customer may call the TPA's toll-free phone number provided in the policy copy/on the health ID card for intimation of the claim and related assistance. Please keep the ID number handy for easy reference.
d. On admission to the network provider/PPN hospital, please produce the ID card issued by the TPA at the Hospital Helpdesk. The cashless request form available on the Company's website/with the network provider/PPN and TPA shall be filled and submitted to the TPA for authorisation.
e. The TPA upon getting the cashless request form and related medical information from the Insured Person/ network provider/PPN shall issue a pre-authorization letter to the hospital after verification.
f. At the time of discharge, the Insured Person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
g. The TPA reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.
h. Denial of a Pre-authorization request is in no way to be construed as a denial of treatment or denial of coverage. The Insured Person may get the treatment as per the treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

iii. Procedure for reimbursement of Claims

a. In non-network hospitals payment must be made up-front and for reimbursement of claims the Insured Person may submit the necessary documents to TPA within the prescribed time limit.
b. Claims for Pre- and Post-Hospitalisation will be settled on reimbursement basis on production of relevant claim papers and cash receipts within the prescribed time limit.

iv. Documents

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

a. Duly filled claim form.
b. Photo Identity proof of the patient.
c. Medical practitioner's prescription advising admission.
d. Original bills with itemized break-up
e. Payment receipts
f. Discharge summary including complete medical history of the patient along with other details.
g. Investigation/Diagnostic test reports etc. supported by the prescription from attending medical practitioner
h. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
i. Sticker/ invoices of the Implants, wherever applicable.
j. MLR (Medico Legal Report) copy if carried out and FIR (First information report) if registered, wherever applicable.
k. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
l. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
m. Legal heir/succession certificate, wherever applicable
n. Any other relevant document required by Company/ TPA for assessment of the claim.

Note:

a. The company shall only accept bills/ invoices/ medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
b. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.
c. 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.
d. **In case of lumpsum payment for HIV/AIDS**, the Insured will need to submit the below mentioned documents for the processing of the Claim:
   i. Identity proof of the claimant /patient.
   ii. Duly filled Claim form
   iii. Copy of Hospital summary/ Discharge card/ treatment advise / medical reference
   iv. Copy of Medical reports/ records
   v. Copy of Investigation reports
   vi. Doctor's certificate
   vii. Any other relevant document required by Company/TPA for assessment of the claim..

   On receipt of claim documents from Insured, We will assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, We will make the payment of benefit as per the contract. In case if the claim is repudiated We will inform You about the same in writing with reason for repudiation.

v. *Time Limit for submission of documents*

Type of Claim	Time Limit
Reimbursement of hospitalisation, day care and pre-hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital.
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post-hospitalisation treatment.

Notes:

a. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
b. Waiver of *clause V.B.13.i* may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
c. The Insured Person shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
d. All the documents submitted to TPA shall be electronically collected by us for settlement/denial of the claims by the appropriate authority.
e. 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.

vi. *Services offered by TPA*

Servicing of claims i.e., claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims, as per the terms and conditions of the policy.

The services offered by a TPA shall not include:

a. Claim settlement and claim rejection;
b. 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 with the Company.

vii. Payment of Claim

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

14. 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

VI. OTHER TERMS AND CONDITIONS

1. Loadings & Discount

i. Direct Discount

A discount will be applicable if the fresh policy is purchased directly from United India's office without any agent/intermediary. For renewals, this discount shall be offered, provided the expiring policy does not have any agent/intermediary and the policy is renewed online through UIIC website or directly from United India's office without any agent/intermediary.

ii. Underwriting Loading for Pre-existing Conditions

We may apply a risk loading on the premium payable (excluding statutory levies & taxes) based on your health status if accepted at the time of underwriting. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s).

Note: The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in *Clause IV.A.1* above shall be applied on illness/condition, as applicable.

2. IRDAI Regulations

This policy is subject to Provisions of Insurance Act, 1938, IRDAI (Insurance Products) Regulations 2024 and IRDAI (Protection of Policyholders' Interest) Regulations 2024 as amended from time to time.

ANNEXURE – 1

List of Non-Medical Expenses under this Policy:

- List I – Optional Items - Indicated whether payable or not under the Policy
- List II – Items that are to be subsumed into Room Charges
- List III – Items that are to be subsumed into Procedure Charges
- List IV – Items that are to be subsumed into costs of treatment

List 1		
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 hours, shifting charges not payable
34	Walking Aids Charges	Not Payable
35	Oxygen Cylinder (For Usage Outside the Hospital)	Not Payable
36	Spacer	Not Payable
37	Spirometer	Device not payable
38	Nebulizer Kit	Not Payable
39	Steam Inhaler	Not Payable
40	Arm-sling	Not Payable
41	Thermometer	Not Payable
42	Cervical Collar	Not Payable
43	Splint	Not Payable

List 1		
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 a reasonable cost of approximately Rs 200/- day
49	Ambulance Collar	Not Payable
50	Ambulance Equipment	Not Payable
51	Abdominal Binder	Payable for cases who have undergone surgery of lumbar spine.
52	Private Nurses Charges- Special Nursing Charges	Payable in post-hospitalisation
53	Sugar Free Tablets	Payable -Sugar free variants of admissible medicines are not excluded
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)	Payable when prescribed
55	ECG Electrodes	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day is payable.
56	Gloves	Sterilized Gloves payable / unsterilized gloves not payable
57	Nebulization Kit	Payable reasonably if used during hospitalisation
58	Any Kit With No Details Mentioned [Delivery Kit, Ortho-kit, Recovery Kit, Etc.]	Not Payable
59	Kidney Tray	Not Payable
60	Mask	Not Payable
61	Ounce Glass	Not Payable
62	Oxygen Mask	Not Payable
63	Pelvic Traction Belt	Payable in case of PIVD requiring traction
64	Pan Can	Not Payable
65	Trolley Cover	Not Payable
66	Urometer, Urine Jug	Not Payable
67	Ambulance	Payable
68	Vasofix Safety	Payable - maximum of 3 in 48 hours and then 1 in 24 hours

List II			
1	Baby Charges (Unless Specified/Indicated)	8	Foot Cover
2	Hand Wash	9	Gown
3	Shoe Cover	10	Slippers
4	Caps	11	Tissue Paper
5	Cradle Charges	12	Toothpaste
6	Comb	13	Toothbrush
7	Eau De-Cologne / Room Fresheners	14	Bed Pan
15	Face Mask	27	Admission Kit
16	Flexi Mask	28	Diabetic Chart Charges
17	Hand Holder	29	Documentation Charges / Administrative Expenses
18	Sputum Cup	30	Discharge Procedure Charges
19	Disinfectant Lotions	31	Daily Chart Charges
20	Luxury Tax	32	Entrance Pass / Visitor's Pass Charges
21	Hvac	33	Expenses Related To Prescription On Discharge
22	Housekeeping Charges	34	File Opening Charges
23	Air Conditioner Charges	35	Incidental Expenses / Misc. Charges (Not Explained)
24	Im Iv Injection Charges	36	Patient Identification Band / Name Tag
25	Clean Sheet	37	Pulse Oximeter Charges
26	Blanket/Warmer Blanket		

List III			
1	Hair Removal Cream	13	Surgical Drill
2	Disposables Razors Charges (For Site Preparations)	14	Eye Kit
3	Eye Pad	15	Eye Drape
4	Eye Shield	16	X-Ray Film
5	Camera Cover	17	Boyles Apparatus Charges
6	DVD, CD Charges	18	Cotton
7	Gauze Soft	19	Cotton Bandage
8	Gauze	20	Surgical
9	Ward And Theatre Booking Charges	21	Apron
10	Arthroscopy And Endoscopy Instruments	22	Tourniquet
11	Microscope Cover	23	Orthobundle, Gynaec Bundle
12	Surgical Blades, Harmonic Scalpel, Shaver		

List IV			
1	Admission / Registration Charges	10	HIV Kit
2	Hospitalisation For Evaluation/Diagnostic Purpose	11	Antiseptic Mouthwash
3	Urine Container	12	Lozenges
4	Blood Reservation Charges And Ante Natal Booking Charges	13	Mouth Paint
5	Bipap Machine	14	Vaccination Charges
6	Cpap / Capd Equipments	15	Alcohol Swabs
7	Infusion Pump-Cost	16	Scrub Solutions / Sterillium
8	Hydrogen Peroxide / Spirit / Disinfectants, Etc.	17	Glucometer & Strips
9	Nutrition Planning Charges – Dietician Charges, Diet Charges	18	Urine Bag

ANNEXURE – 2

The contact details of the **Insurance Ombudsman** offices are as below:

Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman & Diu	**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
Karnataka	**Mr. Vipin Anand** Office of the Insurance Ombudsman, Jeevan Soudha Building No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh, Chhattisgarh	**Shri R. M. Singh** 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 Email: bimalokpal.bhopal@cioins.co.in
Odisha	**Shri Suresh Chandra Panda** Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh	**Mr. Atul Jerath** 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 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)	**Shri Segar Sampath Kumar** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh	**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
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	**Shri Somnath Ghosh** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Pan bazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry	**Shri N. Sankaran** 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 Email: bimalokpal.hyderabad@cioins.co.in
Rajasthan	**Shri Rajiv Dutt Sharma** 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

Jurisdiction	Office of the Insurance Ombudsman
Kerala, Lakshadweep, Mahe- a part of Union Territory of Puducherry	**Shri G. Radhakrishnan** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands	**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 Email: bimalokpal.kolkata@cioins.co.in
Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, 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, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)	**Shri Bharatkumar S. Pandya** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.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 Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	**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
Bihar, Jharkhand	**Shri N. K. Singh** Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)	**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

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