UNITED INDIA INSURANCE COMPANY LIMITED
REGISTERED & HEAD OFFICE: 24, WHITES ROAD, CHENNAI-600014
REGIONAL OFFICE : UNITED INDIA TOWERS, BASHEERBAGH, HYDERABAD- 500 029

AB AROGYADAAN POLICY

PREAMBLE:

1. This Policy is a contract of insurance issued by UNITED INDIA INSURANCE COMPANY (hereinafter called the COMPANY) to the Proposer mentioned in the Certificate of Insurance (hereinafter called the 'Insured') to cover the person(s) named in the Certificate of Insurance (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

i. the receipt of full premium,
ii. disclosure to information norm including the information provided in the Proposal Form by the Insured on behalf of him/her-self and all persons to be insured which is incorporated in the policy and is the basis of it; and
iii. the terms, conditions and exclusions of this Policy.

2. OPERATIVE CLAUSE:

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

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

3. DEFINITIONS:

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

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

3.2 AGE means age of the Insured person on last birthday as on date of commencement of the Policy.

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

3.4 AYUSH Treatment refers to hospitalisation treatments given under Ayurveda, Unani, and Homeopathy systems.

3.5 An **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by Ayurveda, Unani, and Homeopathy Medical Practitioner(s) comprising any of the following:

i. Central or State Government AYUSH Hospital or
ii. Teaching hospital attached to Ayurveda, Unani, and Homeopathy College recognised by the Central Government/Central

Council of Indian Medicine/ Central Council for Homeopathy; or

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

i. Having at least 5 in-patient beds;
ii. Having qualified Ayurveda, Unani, and Homeopathy Medical Practitioner in charge round the clock;
iii. Having dedicated Ayurveda, Unani, and Homeopathy therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

a. Having qualified registered Ayurveda, Unani, and Homeopathy Medical Practitioner (s) in charge;
b. Having dedicated Ayurveda, Unani, and Homeopathy therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
c. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.7 BREAK IN POLICY means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

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

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

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

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

3.11 CONDITION PRECEDENT means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

3.12 CONTINUOUS COVERAGE means uninterrupted coverage of the insured person under our AB AROGYADAAN Policy from the time the coverage incepted under the policy.

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

a. Has qualified nursing staff under its employment

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

3.14 DAY CARE TREATMENT - means medical treatment, and/or surgical procedure which is:

a. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement, and
b. which would have otherwise required a hospitalisation of more than twenty-four hours.

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

3.15 DEDUCTIBLE is a cost sharing requirement under a Health Insurance Policy that provides that the Insurer will not be liable for a specified rupee amount in case of Indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

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

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

3.18 EMERGENCY CARE means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

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

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

3.21 GRACE PERIOD means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Cover age is not available for the period for which no premium is received.

3.22 HOSPITAL means any institution established for in-patient care and day care treatment of disease/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 Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

a. has qualified nursing staff under its employment round the clock;
b. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
c. has qualified medical practitioner(s) in charge round the clock;
d. has a fully equipped operation theatre of its own where surgical procedures are carried out
e. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.23 HOSPITALISATION means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

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

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

3.25 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** means 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** means a disease, illness, or injury that has one or more of the following characteristics

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be special trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

3.26 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.

3.27 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.

3.28 INSURED PERSON means person(s) named in the schedule of the Policy.

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

3.30 INTENSIVE CARE UNIT (ICU) CHARGES means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

3.31 MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

3.32 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.

3.33 MEDICALLY NECESSARY TREATMENT means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

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

3.34 MEDICAL PRACTIONER 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 the scope and jurisdiction of license.

3.35 **NETWORK PROVIDER** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by cashless facility.

3.36 NON NETWORK PROVIDER means any hospital that is not part of the network.

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

3.38 NOTIFICATION OF CLAIM means the process of intimating a claim to the Insurer or TPA through any of the recognised modes of communication.

3.39 OUT-PATIENT (OPD) TREATMENT means treatment 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.

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

3.41 PERIOD OF INSURANCE means the period for which this policy is taken and is in force as specified in the Certificate of Insurance.

3.42 PRE-EXISTING DISEASE : Pre-existing disease means any condition, ailment or injury or disease:

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or
b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

3.43 PRE-HOSPITALISATION MEDICAL EXPENSES means medical expenses incurred during the period of 30 days preceding the hospitalisation of the Insured Person, provided that:

a. Such medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
b. The In-Patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

3.44 POST HOSPITALISATION MEDICAL EXPENSES means medical expenses incurred during the period of 60 days immediately after insured person is discharged from the hospital, provided that:

a. Such medical expenses are for the same condition for which the insured person's hospitalisation was required, and

b. The in-patient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

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

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

3.47 **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.

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

3.49 RENEWAL : Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

3.50 ROOM RENT means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

3.51 Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

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

3.53 THIRD PARTY ADMINISTRATOR (TPA) means a company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

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

4. BASIC COVER:

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

a. Room, Boarding and Nursing expenses as provided by the Hospital/Nursing Home upto 1% of SI per day or the actual amount whichever is less. This also includes nursing

care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.

b. Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) expenses upto 2% of the SI per day or actual amount whichever is less.
c. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees
d. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory/ diagnostic tests, X Ray and such similar expenses related to the treatment.
e. All hospitalisation expenses (excluding cost of organ) incurred for donor in respect of organ transplant to the insured.

NOTE:

1. PROPORTIONATE PAYMENT CLAUSE: Reimbursement/payment of Room Rent, boarding and nursing expenses incurred at the Hospital shall not exceed the limit as specified in clause 3.1.A above. In case of admission to Intensive Care Unit or Intensive Cardiac Care Unit, reimbursement or payment of such
   expenses shall not exceed the limit as specified in clause 3.1.B above. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of expenses under 3.1 C & D incurred at the Hospital, with the exception of cost of medicines, drugs & implants, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.
2. No payment shall be made under 3.1 C other than as part of the hospitalisation bill. However, the bills raised by Surgeon, Anaesthetist directly and not forming part of the hospital bill shall be paid provided a pre-numbered bill/receipt is produced in support thereof, when such payment is made ONLY by cheque/ credit card/debit card or digital/online transfer.

b. Hospitalisation expenses limited to :

Hospitalisation Benefits	LIMITS per surgery RESTRICTED TO
Cataract	Actual expenses incurred or 10% of Sum Insured whichever is less, subject to a maximum of Rs. 25000
Hernia	Actual expenses incurred or 15% of Sum Insured whichever is less, subject to a maximum of Rs. 30000
Hysterectomy	Actual expenses incurred or 20% of Sum Insured whichever is less, subject to a maximum of Rs. 50000
b. Major surgeries (Cardiac/ Cancer/ Brain Tumour/ Pace maker implantation for Sick Sinus syndrome/Hip replacement/Knee joint replacement)	Actual expenses incurred or 80% of the Sum Insured whichever is less under basic cover. Hip replacement/Knee joint Replacement will be covered after 36 months for fresh policy holders

Pre and post hospitalisation expenses : Actual subject to a maximum of 10% of the sum Insured paid policy wise. 30 days in case of pre hospitalisation and 60 days in case of post hospitalization.

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

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

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

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

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

4.3 Ayurvedic / Unani / Homeopathic treatment - Subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in a hospital/ Day Care Centre as defined in Clause 3.5 and 3.6 above.

4.4 Pre-Hospitalisation and Post-Hospitalisation Expenses - Medical Expenses relevant to the same condition for which the hospitalization is required incurred during the period upto 30 days prior to hospitalisation and during the period upto 60 days after the discharge from the hospital. These expenses are admissible only if the primary hospitalisation claim is admissible under the policy.

4.5 Cost of Health Check-Up:
The insured shall be entitled for a reimbursement of the cost of Medical check-up once at the end of block of every three underwriting years provided there are no claims reported during the block and subject to the policy being renewed without break. The amount of such reimbursement shall be limited to 1% of the average sum insured for the insured person for the preceding three policy periods subject to a maximum of Rs. 5000. This is applicable only for basic section and not for Super Top Up section.

4.6 The following procedures will be covered (wherever medically indicated) either as inpatient care or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization & HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy- Monoclonal Antibody to be given as injection
F. Intra vitreal Injections
G. Robotic Surgeries
H. Stereotactic radio surgeries
I. Bronchial Thermoplasty
J. Vaporisation of the Prostate (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 haematological conditions to be covered.

NOTE: For all the above, the Company's Liability for all claims admitted in respect of any/all insured person/s during the period of insurance shall not exceed the Sum Insured stated in the Certificate of Insurance.

5. EXCLUSIONS:

5.1 The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

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

Pre-Existing Diseases (Code-Excl01)

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

First Thirty Days Waiting Period (Code-Excl03)

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

Specific Waiting Period (Code-Excl02)

i. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

12 Months Waiting Period

1. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps	10. Piles, Fissures and Fistula-in-ano; Pilonidal sinus
2. Benign ENT disorders	11. Prolapse intervertebral Disc and Spinal Diseases unless arising from Accident
3. Benign prostatic hypertrophy	12. Benign Skin Disorders

4. Cataract	13. Calculus diseases
5. Acid Peptic diseases	14. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapse of uterus
6. Gout and Rheumatism; Age-related Osteoarthritis & Osteoporosis	15. Any treatment for varicose veins and ulcers including surgical intervention
7. Hernia of all types	16. Renal Failure
8. Hydrocele	17. Polycystic ovarian disease
9. Non infective Arthritis	18. Congenital internal diseases

36 Months Waiting Period

- Treatment for joint replacement unless arising from accident
- Age-related Osteoarthritis & Osteoporosis

A. PERMANENT EXCLUSIONS

5.2 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

5.3 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

5.4 a. Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.

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

5.5 Investigation & Evaluation (Code-Excl04)

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

5.6 Rest Cure, rehabilitation and respite care (Code-Excl05)

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

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

5.7 Obesity/Weight Control (Code-Excl06)

Expenses related to the surgical treatment of obesity that does not fulfill 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:
        1. Obesity-related cardiomyopathy
        2. Coronary heart disease
        3. Severe Sleep Apnoea
        4. Uncontrolled Type2 Diabetes

5.8 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.

5.9 Cosmetic or Plastic Surgery: (Code-Excl08)

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

5.10 Hazardous or Adventure sports: (Code-Excl09)

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

5.11 Breach of law: (Code-Excl10)

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

5.12 Excluded Providers: (Code-Excl11)

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

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

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

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

5.16 Refractive Error: (Code-Excl15)

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

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

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

i. Any type of 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

5.19 Maternity Expenses (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.

5.20 Cost of spectacles and contact lenses, hearing aids.

5.21 Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity~~,~~ unless arising from disease or injury and which requires hospitalization for treatment; root canal treatment including wear and tear.

5.22 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and/or treatment and/or monitoring and/or maintenance and/or support, Infusion pump, Oxygen concentrator, Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer/Thermometer, alpha/water bed and similar related items and also any medical equipment, which are subsequently used at home. This is only indicative.

5.23 Yoga/Naturopathy Treatment, acupressure, acupuncture, magnetic therapies~~,~~

5.24 a) Stem cell implantation/Surgery/therapy, harvesting, storage or any kind of Treatment using stem cells except as provided for in Clause 4.6 L above; b) growth hormone therapy.

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

5.26 Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy and CPAD (Continuous Peritoneal Ambulatory Dialysis).

5.27 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, ayah, private nursing/barber or beauty services, diet charges, baby food, cosmetic, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses. This is only indicative. For detailed list of non-medical expenses, the details can be found **in Annexure I**

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

5.29 Domiciliary hospitalization expenses.

6. CONDITIONS:

6.1 Basis of Insurance: This policy is issued on the basis of the truth and accuracy of statements in the Proposal. This policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of fraud, misrepresentation or misdescription or non-disclosure of any material fact. The Proposal Form, Prospectus, Pre-acceptance Health check-up report (if carried out) and the Policy issued shall constitute complete contract of insurance.

6.2 Contract - The proposal form, declaration, pre-acceptance health check-up (if carried out) and the Certificate of Insurance issued shall constitute the complete contract of insurance.

6.3 Condition Precedent to Admission of Liability
The due observance of and fulfilment 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.

6.4 PREMIUM: The premium payable under this Policy shall be paid in advance. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy. Unless full premium is paid before commencement of risk, this Policy shall have no effect.

6.5 Place of treatment and Payment:

6.5.1 This Policy covers only medical/surgical treatment taken in India.

6.5.2 Admissible claims shall be payable only in Indian Rupees.

6.5.3 Payment shall be made directly to Network Hospital if cashless facility is applied for before treatment and accepted by TPA. If TPA does not accept the request for Cashless facility, bills shall be submitted after payment under Reimbursement. However, submission of claim papers does not mean admission of claim.

6.6 CLAIM PROCEDURE:

6.6.1 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 (if claim is processed by TPA)/company (if claim is processed by the company) in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number within the prescribed time limit.

Notification of claim in case of Cashless facility	**TPA must be informed:**

In the event of planned hospitalization	At least 72 (seventy two) hours prior to the insured person's admission to network provider/PPN hospital
In the event of emergency hospitalization	Within 24 (twenty four) hours of the insured person's admission to network provider/PPN hospital

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

6.6.2 Procedure for Cashless claims

i. Cashless facility for treatment in network hospitals only shall be available to insured if opted for claim processing by TPA.

ii. Treatment may be taken in a network provider/PPN hospital and is subject to pre authorization by the TPA. Booklet containing list of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the TPA mentioned in the schedule.

iii. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference

iv. On admission in the network provider/PPN hospital, produce the ID card issued by the TPA at the Hospital Helpdesk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.

v. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.

vi. At the time of discharge, the insured person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.

vii. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.

viii. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

Claims for Pre and Post-Hospitalization will be settled on a reimbursement basis on production of cash receipts.

6.6.3 Procedure for reimbursement of claims

In non-network hospitals payment must be made up-front and for reimbursement of claims the insured

person may submit the necessary documents to TPA (if claim is processed by TPA)/company (if claim is processed by the company) within the prescribed time limit.

6.6.4 Documents
The claim is to be supported with the following original documents and submitted within 15 days from the date of discharge from Hospital.

Note: Waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

i. Duly completed claim form
ii. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed, along with date of diagnosis, investigation test reports supported by the prescription from attending medical practitioner.
iii. Medical history of the patient recorded, bills and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.
iv. Discharge certificate/ summary from the hospital.
v. Cash-memo from the Diagnostic Centre (s)/ hospital (s)/chemist (s) supported by proper prescription
vi. Payment receipts from doctors, surgeons, anaesthetist.
vii. Any other document required by company/TPA

Note In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under condition 5.6.4 and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

6.6.5 The Insured Person shall obtain and furnish to the TPA with all original bills, receipts and other documents upon which a claim is based and shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab.

6.6.6 All the documents submitted to TPA shall be electronically collected by Insurance Company for settlement and denial of the claims by the appropriate authority.

6.6.7 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 at the time of admission.

6.7 Claim Settlement

i. On receipt of the final document(s), the company shall within a period of 30 (thirty) days offer a settlement of the claim to the insured person.
ii. A claim, which is not covered under the policy cover and conditions, can be rejected.
iii. If the company, for any reasons, decides to reject a claim under the policy, the Company shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be.

6.8 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 shall be forfeited. Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, 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 specifically declares to be fraudulent

The company shall not repudiate the policy 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 mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

6.9 Multiple Policies

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

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

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

Note: The insured person must disclose such other insurance at the time of making the claim under this policy.

6.12 Grace Period and Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

6.13 NOMINATION :

The policyholder 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. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

6.14 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 affected.

6.15 Cancellation Clause:

6.15.1 Cancellation by You

i. The Insured may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Refund %	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	**1 Year**
Up to 30 Days	75.00%
31 to 90 Days	50.00%
3 to 6 months	25.00%
6 to 12 months	0.00%

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

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

6.15.2 Our Right of Termination

A. Termination of Policy:

Prior to the termination of the Policy, at the expiry of the period shown in the Policy Schedule/ Certificate of Insurance, cover will end immediately for all Insured Persons, if:

i. there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person without any refund of premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
ii. there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
iii. the Policyholder does not pay the premiums owed under the Policy within the Grace Period.

Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If Treatment has been authorized or an approval for Cashless facility has been issued, we will not be held responsible for any Treatment costs if the Policy ends or an Employee or member or Dependent leaves the Policy before Treatment has taken place. However, we will be liable to pay in respect of all claims where the Treatment/admission has commenced before the date of termination of such Policy.

B. Termination for Insured Person's cover

Cover will end for a Member or dependent:

i. When this Policy terminates at the expiry of the period shown in the Policy Schedule/ Certificate of Insurance.
ii. If he or she dies;
iii. When a dependent insured person ceases to be a Dependent; unless otherwise agreed specifically for continuation till end of policy period;
iv. If the Insured Person ceases to be a member of the group.

6.16 ENHANCEMENT OF SUM INSURED

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a fresh proposal form/ written request to the company. Any such request for enhancement must be accompanied by a declaration that the insured or any other insured person in respect of whom such enhancement is sought is not aware of any symptoms or other indications that may give rise to a claim under the policy. The Company may require such insured person/s to undergo a Medical examination to enable the company to take a decision on accepting the request for enhancement in the Sum Insured.
ii. The acceptance of enhancement of Sum Insured would be at the discretion of the company, based on the health condition of the insured members & claim history of the policy.
iii. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit

from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

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

6.18 Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link:
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

6.19 Portability The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section VI shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For detailed Guidelines on Portability, kindly refer the link:
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

6.20 ARBITRATION:

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the Policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

7. OPTIONAL COVER - SUPER TOP UP COVER :

Super Top Up cover is on family floater basis that covers health risks beyond a threshold limit of the Sum Insured under the basic cover. Only basic covers with Sum Insured not less than Rs.10 lacs are eligible for this optional cover.

Waiting period of 36 months is applicable for pre-existing ailments.
This cover would be operational only after exhausting Sum Insured of the basic cover.

Pre and post hospitalisation expenses are paid policy wise (Basic and Super Top Up) upto a maximum of 10% of Sum Insured.

For specified major surgeries, a limit of 80% of the Sum Insured under Super Top up Section would be applicable.

All the other terms and conditions are as per basic cover.

8. REDRESSAL OF GRIEVANCE

Grievance – In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the policy issuing office or Uni-Customer Care Department at Regional Office of the company for redressal. If the grievance remains unaddressed, the insured person may contact the Officer, Uni-Customer Care Department, Head Office in person or through post/email to customercare@uiic.co.in

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

IRDAI Integrated Grievance Management System – https://igms.irda.gov.in/

Insurance Ombudsman – The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure – B

9. IRDAI REGULATIONS

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

10. IMPORTANT NOTICE

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

The Company may also withdraw the insurance as offered hereunder after following the due process as laid down by the IRDA and we shall offer to cover under such revised/new terms, conditions, exceptions and premium for which the Company shall have obtained prior approval from the Authority.

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IN CASE REQUIREMENT OF ANY FURTHER INFORMATION, PLEASE FEEL FREE TO CONTACT YOUR BANK BRANCH OR UNITED INDIA INSURANCE COMPANY LIMITED ON 040-23230537/23230537