AROGYA SANJEEVANI POLICY, UNITED INDIA INSURANCE COMPANY LIMITED TERMS AND CONDITIONS

1. PREAMBLE

This Policy is a contract of insurance issued by UNITED INDIA INSURANCE COMPANY (hereinafter called the COMPANY) to the Proposer mentioned in the Schedule (hereinafter called the 'Policyholder') to cover the person(s) named in the schedule (hereinafter called the 'Insured Person(s)'). 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 the requisite premium.

ii Disclosure to information norm including the information provided in the Proposal Form by the Proposer on behalf of themselves 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.

A. Operative Clause

If during the Policy Period, the Insured Person(s) is required to be hospitalised for treatment of an Illness or Injury at a Hospital /Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner/Mental Health Professional (in case of Mental Illness), 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, exclusions, conditions and definitions contained herein. The maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured opted and the applicable Cumulative Bonus as specified in the Schedule.

B. Cover Type

The Policy provides cover on an Individual Sum Insured basis or Family Floater Sum Insured basis. A separate Sum Insured for each Insured Person is provided on Individual Sum Insured basis while under Family Floater Sum Insured basis, the Sum Insured is shared by the whole family of the Insured as specified in the Policy Schedule and Our total liability for the family cannot exceed the Sum Insured and applicable Cumulative Bonus in a Policy period. The cover type basis shall be as specified in the Policy Schedule.

2. 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 any gender include all genders and references to any statutory enactment includes subsequent changes to the same.

A. STANDARD DEFINITIONS

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Any One Illness** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where the treatment has been taken

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

i. Central or State Government AYUSH Hospital or

ii. Teaching hospital attached to AYUSH College recognised by the Central Government/Central Council of Indian Medicine/ Central Council for Homeopathy; or

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

   i. Having at least 5 in-patient beds;
   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
   iii. Having dedicated AYUSH 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.

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

5. **AYUSH Treatment**
   means hospitalisation treatment given under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy systems.

6. **Break in policy**
   means the period of a 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 person 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** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

9. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   a. Internal Congenital Anomaly
   Congenital Anomaly which is not in the visible and accessible parts of the body.
   b. External Congenital Anomaly
   Congenital Anomaly which is in the visible and accessible parts of the body.

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. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

12. **Day Care Centre** means any institution established for day care treatment of disease/injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
    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 shall make these accessible to the Company's authorized personnel.

13. **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.

14. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, filings (where appropriate), crowns, extractions and surgery.

15. **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.

16. **Emergency Care:** 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.

17. **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 installments during the policy period.

18. **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.

19. **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.

20. **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

21. **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.

22. **In-Patient Care** means treatment for which the insured person has to stay in hospital for more than 24 hours for a covered event.

23. **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.

24. **ICU (Intensive Care Unit) 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.

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

26. **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.

27. **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 the scope and jurisdiction of license.

28. **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 medical practice or the medical community in India.

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

30. **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.

31. **Non-Network Provider** means any hospital that is not part of the network.

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

33. **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.

34. **Pre-Existing Disease (PED):** Pre-existing disease means any condition, ailment or injury or disease:
    a. That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the policy or its reinstatement.

35. **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.

36. **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.

37. **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.

38. **Qualified Nurse** means any person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

39. **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.

40. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

41. **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 and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

B. SPECIFIC DEFINITIONS

1. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

2. **Associated Medical Expenses** means hospitalisation-related expenses on Surgeon, Anesthetist, Medical Practitioner, Consultants and Specialist Fees (whether paid directly to the treating doctor/surgeon or hospital), Anesthetics, Blood, Oxygen, Operation Theatre charges, surgical appliances, and other similar expenses which vary based on the room category occupied by the Insured Person whilst undergoing treatment in a hospital. Associated Medical expenses do not include:

    i. cost of pharmacy and consumables
    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.

3. **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 the other which is not lower than a period of seven days.

4. **Clinical Psychologist** means a person— (i) having a recognised qualification in Clinical Psychology from an institution approved and recognised, by the Rehabilitation Council of India, constituted under section 3 of the Rehabilitation Council of India Act, 1992 (34 of 1992); or (ii) having a Post-Graduate degree in Psychology or Clinical Psychology or Applied Psychology and a Master of Philosophy in Clinical Psychology or Medical and Social Psychology obtained after completion of a full time course of two years which includes supervised clinical training from any University recognised by the University Grants Commission established under the University Grants Commission Act, 1956 (3 of 1956) and approved and recognised by the Rehabilitation Council of India Act, 1992 (34 of 1992) or such recognised qualifications as may be prescribed.

5. **Continuous Coverage** means uninterrupted coverage of the Insured Person under the Health Insurance Policy from the date of inception of the 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.

6. **Epidemic** means the occurrence of more cases of a disease than would be expected in a community or region spreading rapidly during a given time period; and declared as such by the appropriate Government Authority in India.
7. **Family** means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

a. Legally wedded spouse.
b. Parents and Parents-in-law.
c. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

8. **Insured Person** means person(s) named in the schedule of the Policy.

9. **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.

10. **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 subnormality of intelligence.

11. **Mental Health Professiona**l means— (i) a psychiatrist (ii) a professional registered with the concerned State Authority or (iii) a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam or (iv) clinical psychologist.

12. **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.

13. **Pandemic** means an epidemic of disease that has spread across a large region, for instance multiple continents or worldwide, affecting a substantial number of people; and declared as such by the appropriate Government Authority in India

14. **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

15. **Policy period** means period of one policy year as mentioned in schedule for which the Policy is issued.

16. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy.

17. **Policy Year** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

18. **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 amendments. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

19. **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.

20. **Psychiatrist** means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956 (3 of 1956), or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956 (102 of 1956), or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, 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 for the purposes of this Act.

21. **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.

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

23. **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 as defined in the IRDAI (Third Party Administrators – Health Services) Regulations, 2016, amended from time to time.

24. **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.

25. **We/Our/Us/Company/Insurer** means United India Insurance Company Limited.

26. **You/Your** 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.

3. COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

3.1 Hospitalisation

The company shall indemnify medical expenses incurred for Hospitalisation of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital/Nursing Home up to 2% of the sum insured subject to a maximum of Rs. 5000/- per day.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of the sum insured subject to a maximum of Rs. 10,000/- per day.

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.

3.1.1 Other Expenses

i. Expenses incurred on treatment of cataract subject to the sub limits as mentioned in clause 3.2 below.
ii. Dental treatment, necessitated due to disease or injury
iii. Plastic surgery necessitated due to disease or injury
iv. All the day care treatments
v. Expenses incurred on road Ambulance subject to a maximum of Rs. 2000/- per hospitalisation.

Note

1. 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
2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, implants and cost of diagnostic 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.

3.2 Cataract Treatment

The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs. 40,000/-, whichever is lower, per eye in one policy year.

3.3 Pre Hospitalisation

The company shall indemnify pre-hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalisation covered under the policy. Home Care Treatment also will be deemed as hospitalisation for this cover.

3.4 Post Hospitalisation

The company shall indemnify post hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalisation covered under the policy. Home Care Treatment also will be deemed as hospitalisation for this cover.

3.5 **Modern Treatment Methods & Advancement in Technologies:**

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.

3.6 The expenses that are not covered in this policy are placed under List–I of Annexure–A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List–II, List–III, and List–IV of Annexure–A respectively.

3.7 Home Care Treatment Expenses

We will indemnify the Reasonable and Customary Charges for Home Care Treatment for any epidemic/ pandemic subject to a maximum of 10% of the Sum Insured or Rs. 30,000 per person per policy period, whichever is lower.

Home Care Treatment means Treatment availed by the Insured Person at home for any epidemic/ pandemic on positive diagnosis of the epidemic/ pandemic in a Government authorised diagnostic Centre, which in normal course would require care and treatment at a hospital but is actually taken at home maximum up to 14 days per incident provided that:

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

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

a. Diagnostic tests undergone at home or at diagnostics centre
b. Medicines prescribed in writing
c. Consultation charges of the medical practitioner
d. Nursing charges related to medical staff
e. Medical procedures limited to parenteral administration of medicines
f. Cost of Pulse oximeter, Nebulizer and Rental cost for Oxygen cylinder, oxygen concentrator, if needed

4. WAITING PERIOD

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:

4.1 Pre-Existing Diseases (Code-Excl01)

i. Expenses related to the treatment of a disclosed 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 (Insurance Product) 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.

4.2 First Thirty Days Waiting Period (Code-Excl03)

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

4.3 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 24/36 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.

24 Months Waiting Period

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

- Varicose Veins and Varicose Ulcers

36 Months Waiting Period

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

5. EXCLUSIONS

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

5.1 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.

5.2 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, 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.

5.3 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

5.4 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.

5.5 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 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.

5.6 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.

5.7 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.

5.8 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 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.

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

5.10 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)**

5.11 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)**

5.12 Refractive Error: (Code-Excl15)

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

5.13 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.

5.14 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

5.15 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.

5.16 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.

5.17 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:

i. 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.

ii. 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.

iii. 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.

5.18 Any expenses incurred on Domiciliary Hospitalisation and OPD Treatment

5.19 Treatment taken outside the geographical limits of India

5.20 In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD Codes.

6 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.

7 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 (if claim is processed by TPA)/company (if claim is processed by the company) in writing providing all relevant information relating to claim including 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 prior to 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. 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.
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 claim and related assistance. Please keep the ID number handy for easy reference.
d. On admission in the network provider/PPN hospital, please 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 filled and submitted to the TPA for authorization.
e. 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.
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 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.

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 claim is to be supported with the following original documents and submitted within the prescribed time limit:

a. Duly completed claim form
b. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed, along with date of diagnosis, advise for admission, investigation test reports etc. supported by the prescription from attending medical practitioner.
c. Medical history of the patient as recorded, bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.
d. Discharge certificate/ summary from the hospital.
e. Cash-memos from the Diagnostic Centre(s)/ hospital(s)/ chemist(s) supported by proper prescription.
f. Payment receipts from doctors, surgeons and anesthetists.
g. Bills, receipts, Stickers of the Implants.
h. 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 *Clause 7.iv* and claim settlement advice duly certified by the other Insurer subject to satisfaction of the company.

v. *Time Limit for submission of documents*

Type of Claim	Time Limit for submission of documents to company/TPA
Reimbursement of hospitalisation, daycare 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 7.v* 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 into with the Company.

8. Co-payment:

Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to a claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

9. 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 last 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 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.

10. Payment of Claim

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

11 GENERAL TERMS AND CONDITIONS

11.1 Disclosure of Information

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

11.2 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.

11.3 Material Change

The Insured 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.

11.4 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 Policyholder or 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.

11.5 Complete Discharge

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

11.6 Notice & Communication

i. Any notice, direction or instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the Schedule.

11.7 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

11.8 Multiple Policies

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 his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer.

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.

11.9 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.

11.10 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 proportionate premium for 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.

11.11 Automatic change in Coverage under the policy

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

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

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

account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

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

11.12 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.

11.13 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 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.

11.14 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 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.

11.15 Renewal of Policy

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

i. The Company will give renewal notice.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period except in case of installment premium.
v. 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.
vi. No loading shall apply on renewals based on individual claims experience.

11.16 Premium Payment in Installment

If the insured person has opted for payment of premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (not withstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days would be given to pay the installment premium due for the Policy if the premium is paid as monthly installments. For other installment basis, the grace period will be 30 days.
ii. During such grace period, coverage will be available.
iii. The Benefits provided under – "Waiting Periods", "Specific Waiting Periods" clause shall continue in the event of payment of premium within the stipulated grace period.
iv. No interest will be charged if the installment premium is not paid on due date.
v. In case of installment premium due not received within the grace period, the Policy will get cancelled.
vi. In the event of a claim, all subsequent premium installment shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

11.17 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.

11.18 Free Look Period

i. The free look period shall be applicable on new Arogya Sanjeevani 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.
ii. 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.

11.19 Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

11.20 Change of Sum Insured

Sum Insured can be changed (increased/decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

11.21 Terms and Conditions of the Policy

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

11.22 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.

12 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

13 No Claim Rewards

The Insured Person(s) shall be eligible for a No Claim Reward if no claim is reported under the expiring policy and the policy is renewed with Us without any break in policy. The No Claim Reward may either be a No Claim Discount (NCD), calculated as a percentage of the renewal premium, or a Cumulative Bonus (CB), calculated as a percentage of the expiring policy's Sum Insured. There are a maximum of 10 slabs of NCR, with each slab representing one claim-free year.

If no claim is reported, the Policyholder must choose one of the following options at the time of renewal. If no choice is explicitly made as per clause 11.6, the option selected in the expiring policy will be deemed chosen. If the option to choose an NCR is not exercised at the first renewal, the policyholder will automatically be entitled to the Cumulative Bonus.

a. No Claim Discount (NCD):

The Insured Person(s) shall receive a 2.5% discount on the renewal premium for each slab, up to a maximum of 25%.

b. Cumulative Bonus (CB):

The Cumulative Bonus shall increase by 5% for each slab, up to a maximum of 50% of the Sum Insured under the current policy year.

Notes on Cumulative Bonus (CB):

i. If the Insured Person(s) were covered under the expiring policy on an Individual Sum Insured Basis and had accumulated a CB, but renewed on a Floater Sum Insured Basis, only the lowest CB slab among the insured persons will be carried forward in the renewed policy.
ii. If the Insured Person(s) covered under a floater policy with an accumulated CB choose to split the policy into two or more floater or individual policies upon renewal, the CB from the expiring policy will be apportioned among the renewed policies in proportion to their respective Sum Insured.
iii. If the Sum Insured is enhanced at the time of renewal, the CB will be calculated on the Sum Insured from the last completed policy year.
iv. If the Sum Insured is reduced at the time of renewal, the CB will be reduced in the same proportion as the decrease in the Sum Insured in the current policy.

Notes on No Claim Rewards (NCR):

i. If a claim is reported in any particular year, the NCR accrued shall be reduced at the same rate at which it has accrued.
ii. Where the policy is on individual sum insured basis, the NCR shall be available to each insured person separately. If a claim is reported, the NCR will reduce by one slab as it was accrued for that person only.
iii. Where the policy is on floater sum insured basis, the NCR shall be available for the entire family. If a claim is reported from any insured person, the NCR will reduce by one slab as it was accrued for the entire family.
iv. If the policyholder opts to switch from the No Claim Discount (NCD) to the Cumulative Bonus (CB) or vice versa at the time of renewal, the premium and sum insured shall be suitably adjusted to ensure that the policyholder gets the benefit of either of the options only.
v. If a claim is reported in the expiring policy and notified to us after acceptance of the renewal premium, applicable No Claim Rewards will be adjusted accordingly.

14 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.

List I – Items for which coverage is not available in the Policy

Sr. No	Item	Sr. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE Tablets
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	Television Charges	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLEY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY

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

Sr. No	Item	Sr. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	20	LUXURY TAX
2	HAND WASH	21	HVAC
3	SHOE COVER	22	HOUSE KEEPING CHARGES
4	CAPS	23	AIR CONDITIONER CHARGES
5	CRADLE CHARGES	24	IM IV INJECTION CHARGES
6	COMB	25	CLEAN SHEET
7	EAU DE-COLOGNE / ROOM FRESHNERS	26	BLANKET/WARMER BLANKET
8	FOOT COVER	27	ADMISSION KIT
9	GOWN	28	DIABETIC CHART CHARGES
10	SLIPPERS	29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
11	TISSUE PAPER	30	DISCHARGE PROCEDURE CHARGES
12	TOOTH PASTE	31	DAILY CHART CHARGES
13	TOOTH BRUSH	32	ENTRANCE PASS / VISTOR'S PASS CHARGES
14	BED PAN	33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
15	FACE MASK	34	FILE OPENING CHARGES
16	FLEXI MASK	35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
17	HAND HOLDER	36	PATIENT IDENTIFICATION BAND / NAME TAG
18	SPUTUM CUP	37	PULSE OXIMETER CHARGES
19	DISINFECTANT LOTIONS		

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

Sr. No	Item	Sr. No	Item
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	TORNIQUET
11	MICROSCOPE COVER	23	ORTHOBUNDLE, GYNAEC BUNDLE
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER		

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

Sr. No	Item	Sr. No	Item
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

DETAILS OF INSURANCE OMBUDSMEN

ANNEXURE - B

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

Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman & Diu	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	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	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	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	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)	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	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	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	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	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	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	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)	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	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	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)	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