Samaveshi Suraksha Health Insurance Policy

Prospectus

I. PRODUCT – KEY FEATURES

This policy is specially designed for Persons with Disability as per The Rights of Persons with Disabilities Act, 2016 Or/ and Individuals with HIV/AIDS as defined under the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017.

COVERAGE AT A GLANCE:

Base Cover
In-Patient Hospitalisation Expenses
Day Care Treatments
Pre-Hospitalisation & Post Hospitalisation Expenses
AYUSH Treatment Expenses
Road Ambulance Expenses
Modern Treatment Methods & Advancement in Technology
Lump Sum Benefit for persons with HIV/AIDS

Optional Cover
Waiver of Co-Payment

II. COVER TYPE

The Policy provides cover on an Individual basis.

III. ELIGIBILITY

1. Eligibility based on age:
   i. Adults: 18 years and 65 years.
   ii. Dependent Children: New-born to 17 years.
2. Eligibility based on Medical Condition:
   i. A person with Benchmark Disability who has at least one of the disabilities as defined under Specified Disability under *The Rights of Persons with Disabilities Act, 2016* and any subsequent additions/ modifications to the list with valid disability certificate. Currently, the following disability/ disabilities are defined under the Act in the Act.

1. Blindness	2. Muscular Dystrophy
3. Low vision	4. Chronic Neurological conditions
5. Leprosy Cured persons	6. Specific Learning Disabilities
7. Hearing Impairment (deaf and hard of hearing)	8. Multiple Sclerosis
9. Locomotor Disability	10. Speech and Language disability
11. Dwarfism	12. Thalassemia
13. Intellectual Disability	14. Haemophilia
15. Mental Illness	16. Sickle Cell disease
17. Autism spectrum disorder	18. Multiple Disabilities including deaf/ blindness
19. Cerebral Palsy	20. Acid Attack victim
21. Parkinson's disease	

Note: Disability for the purpose of this policy means a person with 40% or more of a specified disability as per the Act, where, specified disability has not been defined in measurable terms and includes an Insured Person with disability where specified disability has been defined in measurable terms, as certified by the Certifying Authority.

   ii. A person diagnosed with HIV/AIDS by a duly qualified Medical Practitioner as defined under Human *Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 and* with CD4 count above 350 before the inception of the policy.

Note: **The person must not be having the same/similar policy from any other insurer.**

IV. POLICY TERM

One Year. Renewable annually.

V. CO-PAYMENT

Every admissible claim except Emergency Ground Ambulance or Lump Sum Benefit for persons with HIV/AIDS shall be subject to a Co-payment of 20% on the admissible claim amount.

VI. SUM INSURED

The Sum Insured options available under the policy are Rs. 4,00,000 and Rs. 5,00,000.

VII. COVERAGE

The coverages available under this policy are classified as **Base Cover** and **Optional Cover**. Base Cover refers to the coverage available as default under Samaveshi Suraksha Health Insurance Policy whereas Optional Cover is available only upon payment of additional applicable premium.

A. Base Covers

1. Inpatient Care

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

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

1.1 Note:

a. Expenses of Hospitalisation for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
b. PROPORTIONATE PAYMENT CLAUSE: In case of admission to a room at rates exceeding the aforesaid limits in Clause VII.A.1, the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent. Proportionate Deductions shall not be applied in respect of those hospitals where differential billing is not followed or for those expenses where differential billing is not adopted based on the room category.
c. All Day Care Treatments are covered.
d. Mental Illness Cover: The Company shall indemnify the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist or a professional having a post-graduate degree (Ayurveda) in Manovigyan Evum Manas Roga or a Post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a postgraduate degree (Siddha) in Sirappu Maruthuvam

1.2 Sub-Limit

a) Cataract Surgery Limit

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

2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy period up to 50% of sum insured as specified in the policy schedule in any AYUSH Hospital.

3. Pre-Hospitalisation and Post-Hospitalisation Expenses

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

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

4. Modern Treatment Methods & Advancement in Technologies:

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

i. Uterine Artery Embolization and HIFU (High Intensity focused ultrasound)
ii. Balloon Sinuplasty
iii. Deep Brain Stimulation
iv. Oral Chemotherapy
v. Immunotherapy - Monoclonal Antibody to be given as an injection
vi. Intra-vitreal injections
vii. Robotic Surgeries
viii. Stereotactic Radio Surgeries
ix. Bronchial Thermoplasty
x. Vaporization of the Prostrate (Green Laser Treatment or Holmium Laser Treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem Cell Therapy; Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered

Note: The claims under *Oral Chemotherapy* and *Immunotherapy-Monoclonal Antibody to be given as injection* shall be treated as post-Hospitalisation claim(s). However, the time limits mentioned in *Clause VII.A.3* of the policy shall not be applied.

5. Emergency Ground Ambulance

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

5.1 Conditions:

The Company will reimburse payments under this Benefit provided that.

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

6. Lump Sum Benefit for persons with HIV/AIDS

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

6.1 Conditions

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

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

B. Optional Cover

1. Waiver of Co-Payment

If this optional cover is opted, then the applicable Co-Payment as per *Clause V* will be waived off.

VIII. WHAT POLICY DOES NOT COVER

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

A. Waiting Periods

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

1. Pre-Existing Diseases (Code – Excl01)

i. Disease-wise exclusion:
   a. Diseases other than Pre-existing Disability or HIV/AIDS: Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with Us.
   b. HIV/AIDS: Expenses related to the treatment of HIV/AIDS and its direct complications shall be excluded until the expiry of 30 days of continuous coverage after the date of inception of the first policy with Us.
   c. Pre-Existing Disability: Expenses related to the treatment of a pre-existing disability and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with Us.
ii. In case of enhancement of the Sum Insured, the exclusion shall apply afresh to the extent of the Sum Insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then the waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

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

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

Table A. Twenty-Four Months waiting period

Adenoidectomy	Hernia of all types
Benign ENT disorders	Hydrocele
Tonsillectomy	Non-Infective Arthritis
Mastoidectomy	Piles, Fissures and Fistula in anus
Tympanoplasty	Pilonidal sinus, Sinusitis and related disorders

Hysterectomy	Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident.
All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps.	Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
Benign prostate hypertrophy	Internal Congenital Anomalies
Cataract	Gout and Rheumatism
Gastric/ Duodenal Ulcer	Varicose Veins and Varicose Ulcers

Note

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

Table B. Forty-Eight Months waiting period

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

3. 30-Day Waiting Period (Code – Excl03)
   i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
   iii. The within-referred waiting period is made applicable to the enhanced sum insured in the event of granting a higher sum insured subsequently.

B. Standard Exclusions

1. Investigation & Evaluation (Code – Excl04)
   i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
2. Rest Cure, Rehabilitation and Respite Care (Code – Excl05)
   Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, and moving around either by skilled nurses or assistants or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
3. Obesity/Weight Control (Code – Excl06)
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   i. Surgery to be conducted is upon the advice of the Doctor
   ii. The surgery/Procedure conducted should be supported by clinical protocols
   iii. The member has to be 18 years of age or older and
   iv. Body Mass Index (BMI):
      a. Greater than or equal to 40 or
      b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         b.1. Obesity-related cardiomyopathy
         b.2. Coronary heart disease
         b.3. Severe Sleep Apnea
         b.4. Uncontrolled Type2 Diabetes
4. Change-of-Gender treatments (Code – Excl07)
   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. Cosmetic or Plastic Surgery (Code – Excl08)
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of the medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
6. Hazardous or Adventure Sports (Code – Excl09)
   Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
7. Breach of Law (Code – Excl10)
   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
8. Excluded Providers (Code – Excl11)
   Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed on its website/notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
9. (Code – Excl12)
   Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
10. (Code – Excl13)
    Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.
11. (Code – Excl14)
    Dietary supplements and substances that can be purchased without a prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of a hospitalisation claim or day care procedure.
12. Refractive Error (Code – Excl15)
    Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.
13. Unproven Treatments (Code – Excl16)
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
14. Sterility and Infertility (Code – Excl17)
    Expenses related to sterility and infertility. This includes:
    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization
15. Maternity (Code- Excl18):
    i Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
    ii Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

C. Specific Exclusions

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

2. All Illnesses/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or any nuclear waste from the combustion of nuclear fuel, nuclear/chemical/biological attack.
3. Any kind of service charge, surcharge levied by the hospital.
4. Any item(s) or treatment specified in 'List of Non-Medical Expenses– Payable/Non-Payable' as per clauses in Annexure – 1 of the policy wordings unless specifically covered under the Policy.
5. Any treatment related to sleep disorder or sleep apnoea syndrome.
6. Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state.
7. Change of treatment from one system of medicine to another system unless recommended by the consultant/hospital under whom the treatment is taken.
8. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident.
9. Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/disease/defect.
10. Cost for any Anti-Retroviral Treatment.
11. Cost of hearing aids; including optometric therapy.
12. Dental treatment or surgery of any kind unless necessitated by disease or accident and requiring hospitalisation.
13. Hospitalisation for donation of any body organs by an Insured including complications arising from the donation of organs.
14. Injury or Disease caused by or contributed to by nuclear weapons/materials.
15. Notwithstanding anything stated under *Clause VIII.A.1,* the treatment for specified ICD codes in respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent) shall always be excluded.
16. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalisation shall not be covered. Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.
17. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
18. Stem cell storage.
19. Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.
20. Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, chondrocyte or osteocyte implantation, procedures using platelet rich plasma, Trans Cutaneous Electric Nerve Stimulation; Use of oral immunomodulatory/ supplemental drugs.
21. Treatment with alternative medicines or Treatment, experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.
22. Vaccination or inoculation except as post bite treatment for animal bite.

IX. PROCEDURE FOR TAKING A POLICY

The duly completed and signed Proposal form giving details of the Insured Person along with the following documents should be submitted to the nearest office of the Company.

A. For a person with Disability

i. Valid certificate of Disability as defined under *The Rights of Persons with Disabilities Act, 2016.*
ii. The pre-acceptance health check-up reports, wherever required at Company's discretion.

B. For a Person with HIV/AIDS

i. CD4 absolute count test/ T cell test.
ii. The pre-acceptance health check-up reports, wherever required at Company's discretion.

Notes:

i. The date of medical reports should not exceed 30 (thirty) days prior to the date of proposal.
ii. 50% of the cost of Pre-Acceptance Health check-up shall be reimbursed to the Insured in cases where the proposal is accepted by the Company.
iii. The pre-acceptance health check-up reports, wherever required at Company's discretion must be submitted at Proposer's cost in case You seek the enhancement of Sum Insured.

X. PAYMENT OF PREMIUM

1. Applicable premium must be paid before the commencement of risk for this Policy to come into effect.
2. Premium payable – As per the Premium calculator. The Premium can be paid online for renewals.
3. PAN details must be submitted by the insured. In case PAN is not available, Form 60 or Form 61 must be submitted.

XI. Loadings and Discount

1. Direct Discount

   A discount of 2.5% will be applicable if the fresh policy is purchased directly from United India's office without any agent/intermediary. For renewals, this discount shall be offered, provided the expiring policy does not have any agent/intermediary and the policy is renewed online through UIIC website or directly from United India's office without any agent/intermediary.

2. Underwriting Loading for Pre-existing Conditions

   We may apply a risk loading on the premium payable (excluding statutory levies & taxes) based on your health status if accepted at the time of underwriting. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s).
   The premium, including GST, is subject to a capping of 50% of Sum Insured.

   We shall inform You about the applicable risk loading through a counter offer letter or through an electronic mode, as the case may be and You would need to revert with consent and additional premium (if any), within the duration specified in the counter offer.

   In case, You neither accept the counter offer nor revert to Us within the specified duration, We shall not accept your proposal and will return the amount received, if any. Your Policy will not be issued unless We receive Your consent.

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

XII. CHANGE OF SUM INSURED

1. The Insured can apply for change of Sum Insured at the time of renewal, by submitting a fresh proposal form/written request to the company.
2. 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.
3. The acceptance of enhancement of Sum Insured would be at the discretion of the company, subject to underwriting, based on the health condition of the Insured Persons & claim history of the policy.
4. All waiting periods as defined in the Policy shall apply for the incremental portion of the Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

XIII. CANCELLATION

Cancellation Grid – Refund of Premium (basis Policy period)	
Timing of Cancellation	**Refund (%)**
Up to 30 days	75%
31 – 90 days	50%
3 – 6 months	25%
6 – 12 months	NIL

1. The Insured may cancel this Policy by giving 15days' 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.:

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

2. 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.

XIV. FREE LOOK PERIOD

The free look period shall be applicable at the inception of the first policy and the Insured shall be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

If the Insured has not made any claim during the free look period, he/she shall be entitled to:

i. A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or
ii. Where the risk has already commenced and the option of return of the policy is exercised by the insured, a deduction towards the proportionate risk premium for period on cover or
iii. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

XV. RENEWAL OF POLICY

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

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy periods.
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.

XVI. MIGRATION OF POLICY

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

For Detailed Guidelines on Migration, kindly refer the link: https://irdai.gov.in/document-detail?documentId=393128

XVII. 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:

For Detailed Guidelines on Portability, kindly refer the link – https://irdai.gov.in/document-detail?documentId=393128

XVIII. NOMINATION

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

XIX. TAX BENEFIT

Tax rebate is available as per provision of Income Tax Rules under Section 80-D.

XX. CLAIM PROCEDURE

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 in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:

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

2. Procedure for Cashless Claims

i. 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 our website(https://uiic.co.in/en/tpa-ppn-network-hospitals) and the TPA mentioned in the schedule.
ii. 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.
iii. 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.
iv. 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.
v. At the time of discharge, the Insured Person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
vi. The TPA reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.
vii. 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.

3. Procedure for reimbursement of Claims

i. In non-network hospitals payment must be made up-front and for reimbursement of claims the Insured Person may submit the necessary documents within the prescribed time limit.
ii. 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.

4. Documents

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

i. Duly filled claim form.
ii. Photo Identity proof of the patient.
iii. Medical practitioner's prescription advising admission.
iv. Original bills with itemized break-up

v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/ invoices of the Implants, wherever applicable.
x. MLR (Medico Legal Report) copy if carried out and FIR (First information report) if registered, wherever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate, wherever applicable
xiv. Any other relevant document required by Company/ TPA for assessment of the claim.

Note:

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

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

5. Time Limit for submission of documents

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

Notes:

i. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
ii. Waiver of *clause XX.1* 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.
iii. 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.
iv. All the documents submitted to TPA shall be electronically collected by us for settlement/denial of the claims by the appropriate authority.
v. Any medical practitioner or Authorised Person authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

6. 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:

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

7. Payment of Claim

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

XXI. POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUM RATES

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

XXII. WITHDRAWAL OF POLICY

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

XXIII. REDRESSAL OF GRIEVANCE

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

Website: www.uiic.co.in
Toll-free: 1800 425 333 33
E-mail: customercare@uiic.co.in
Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd., 19, IV Lane, Nungambakkam High Road, Chennai, Tamil Nadu- 600034

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

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

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the **office of Insurance Ombudsman** of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Insurance Ombudsman offices have been provided as Annexure – 3 of the Policy Wordings.

The grievance may also be lodged at IRDAI Integrated Grievance Management System: https://igms.irda.gov.in/

XXIV. REGULATIONS

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

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Insurance is the subject matter of Solicitation.

Samaveshi Suraksha Health Insurance Policy

Table of Benefits

The following table of Benefits is intended as a brief indicative list for quick and easy reference. For details of what your coverage is, please refer to your Policy Schedule along with the Policy Wordings.

Features	
Age of Entry	Dependent Children - New-born to 17 years Adults – 18 years to 65 years
SI Options	4 lakhs and 5 lakhs
Policy Period	1 Year
Base Cover	
Room Rent	Room, Boarding and Nursing expenses (all-inclusive) incurred as provided by the Hospital/Nursing Home - up to 1% of the Sum Insured, subject to maximum of Rs. 5,000.
ICU/ICCU	up to 2% of Sum Insured, subject to maximum of Rs. 10,000.
Day Care Treatments	All covered.
Pre-Hospitalisation	For 30 days prior to hospitalisation.
Post-Hospitalisation	Upto 60 days from the date of discharge from the hospitalisation.
AYUSH Treatment	Covered upto 50% of Sum Insured.
Road Ambulance	Covered up to Actuals subject to a maximum of Rs. 2000 per event.
Modern Treatment MATs	Covered upto 50% of Sum Insured.
Lump Sum Benefit for HIV/AIDS	100% of Sum Insured or Balance Sum Insured, whichever is lower.
Optional Cover	
Waiver of Co-Payment	If this optional cover is opted, then the applicable Co-Payment will be waived off.

Samaveshi Suraksha Health Insurance Policy

Premium Rate Tables

IMPORTANT INFORMATION

- All premium rates shown in this document are Annual Premium Rates in INR (₹) and are exclusive of Goods & Service Tax (GST) & Cess (if any). GST as applicable will be charged extra.
- Premium will be based on the completed age of the individual insured member.
- Premium at renewal may change due to a change in age or changes in the applicable tax rate.
- A 20% co-payment is applicable on all admissible claims unless the Insured Person opts for waiving this co-payment. For rates with 20% co-payment, refer to '**Table A**' and for rates without 20% co-payment, refer to '**Table B**'.

I. PREMIUM RATES (EXCL. OF GST)

Table A: With 20% co-payment

Sum Insured	0-17	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	75+
4 Lakhs	2,435	4,110	4,566	5,480	6,659	8,602	10,397	12,476	17,915	23,888	29,183	32,949	38,008
5 Lakhs	2,591	4,372	4,858	5,830	7,085	10,121	12,232	14,678	21,076	28,104	34,333	38,763	44,716

Table B: Premium including "Waiver of Co-Payment" add-on

Sum Insured	0-17	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	75+
4 Lakhs	2,988	5,043	5,603	6,724	8,171	10,555	12,757	15,308	21,981	29,310	35,807	40,428	46,636
5 Lakhs	3,179	5,365	5,961	7,153	8,693	12,418	15,008	18,010	25,860	34,483	42,126	47,562	54,866

Note for Table A & B: Premium for 66 years and above age are applicable only for Renewals.

II. DIGITAL/DIRECT DISCOUNT

A discount of 2.5% will be applicable if a fresh policy is purchased directly from United India's office without any agent/intermediary. For renewals, this discount shall be offered, provided the policy is renewed online through UIIC website or directly from United India's office without any agent/intermediary.

III. LOADINGS

We may apply a risk loading on the premium payable (excluding statutory levies & taxes) based upon information declared in the proposal form and the health status of the persons proposed for insurance. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s).

Note: The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Policy Terms and Conditions shall be applied on illness/condition, as applicable.