42. *CANCELLATION* defines the terms on which the policy contract can be terminated either by the Insurer or the Insured person by giving sufficient notice to other which is not lower than a period of fifteen days.
43. *CONTINUOUS COVERAGE* means uninterrupted coverage of the Insured person under our Individual Health Insurance Policies or Family Floater Policy from the time the coverage incepted under the policy, provided a break in the insurance period not exceeding thirty days being grace period shall not be reckoned as an interruption in coverage for the purposes of this Clause. In case of change in Sum Insured during such uninterrupted coverage, the lowest Sum Insured would be reckoned for determining Continuous Coverage.
44. *INSURED PERSON* means person(s) named in the schedule of the Policy.
45. *PERIOD OF INSURANCE* means the period for which this policy is taken and is in force as specified in the Schedule.
46. *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.
47. *PSYCHIATRIC DISORDER* means clinically significant Psychological or behavioural syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behaviour or an expected response to a stressful life event) as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the Insured Person in respect of whom a claim is lodged.
48. *PSYCHOSOMATIC DISORDER* means one or more psychological or behavioural problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person's risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after Physical examination of the Insured Person in respect of whom a claim is lodged.
49. *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.
50. *SUM INSURED* means the pre-defined limit specified in the Policy Schedule that represents, the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the policy period.
51. *THIRD PARTY ADMINISTRATOR (TPA)* means a Company registered under the IRDAI (Third Party Administrators – Health Services) Regulations, 2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance Company, for the purpose of providing health services as defined in the regulations. UNPROVEN/EXPERIMENTAL TREATMENT means any treatment including drug experimental therapy which is not based on established medical practice in India.
52. *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.
53. *WE/OUR/US/COMPANY* means UNITED INDIA INSURANCE COMPANY LIMITED
54. *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.

4. 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 Individual Health Insurance Policy whereas Optional Cover is available only upon payment of additional premium.

IMPORTANT: Please note that the coverage mentioned below is applicable for ALL the plans i.e. Platinum/Gold/Senior Citizen under Individual Health Insurance Policy unless explicitly mentioned otherwise.

BASE COVER

The Policy provides base coverage as described below in this section provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner and are incurred on Medically Necessary Treatment of the Insured Person.

4.1 In-Patient Hospitalisation Expenses Cover

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Treatment taken during Hospitalisation provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy Period:

i. Room, Boarding and Nursing expenses (all inclusive) incurred as provided by the Hospital/Nursing Home up to 1% of Sum Insured per day or actual expenses whichever is less. These expenses will include nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.
ii. Charges for accommodation in Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) up to 2% of Sum Insured per day or actual expenses whichever is less.
iii. The fees charged by the Medical Practitioner, Surgeon, Specialists, Consultants and Anaesthetists treating the Insured Person.
iv. Operation theatre charges; Expenses incurred for Anaesthetics, Blood, Oxygen, Surgical Appliances and/or Medical Appliances; Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory/ diagnostic tests, X-Ray and such other similar medical expenses related to the treatment.
v. All hospitalisation expenses (excluding cost of organ) incurred for donor in respect of organ transplant to the Insured Person provided the donation conforms to The Transplantation of Human Organs Act 1994.

Note to 4.1

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 at rates exceeding the aforesaid limits in Clause 4.1.i, 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.

3. No payment shall be made under 4.1 (iii) other than as part of the hospitalisation bill. However, the bills raised by Surgeon, Anaesthetist directly and not forming part of the hospital bill shall be paid provided a pre-numbered bill/receipt is produced in support thereof, when such payment is made ONLY by cheque/ credit card/debit card or digital/online transfer.

4.1.1 Other expenses covered**:**

i. Dental treatment, necessitated due to injury
ii. Plastic surgery necessitated due to disease or injury
iii. All day care treatments as per standard definition no. 3.A.9

4.1.2 Expenses in respect of the following specified illnesses will be restricted as detailed below**:**
(Only Applicable for Gold & Senior Citizen Plans only)

Surgery / Illness / Disease / Procedure	Maximum Limits per Surgery/Hospitalisation restricted to
Cataract	Up to 25% of Sum Insured or Rs. 40,000 per eye, whichever is less
Hernia & Hysterectomy	Up to 25% of Sum Insured or Rs. 1,00,000, whichever is less
Major surgeries which include Cardiac Surgeries; Brain Tumour Surgeries; Pace Maker Implantation for Sick Sinus Syndrome; Cancer Surgeries; Hip, Knee, Joint Replacement Surgery; Organ Transplant	Up to 70% of the Sum Insured

4.2 Pre-Hospitalisation and Post-hospitalisation Expenses

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

i. Pre-hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 30 days prior to hospitalisation; and

ii. Post-hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 60 days after the discharge from the hospital,

Subject to a maximum of 10% of Sum Insured, provided that:

i. We have accepted a claim for primary In-patient Hospitalization under Section 4.1 above;
ii. The Pre-hospitalisation & Post-hospitalisation Medical Expenses are related to the same Illness or Injury.
iii. The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Any One Illness.

Note: The maximum limit of 10% of Sum Insured will not be applicable for Platinum Plan.

4.3 Domiciliary Hospitalisation

We will cover, on a reimbursement basis, medical treatment for a period exceeding three days for such an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

However, domiciliary hospitalisation benefits shall not cover:

i. Expenses incurred for treatment for any of the following diseases:
   a. Asthma
   b. Bronchitis
   c. Chronic Nephritis and Nephritic Syndrome
   d. Diarrhoea and all type of Dysenteries including Gastroenteritis
   e. Diabetes Mellitus and Insipidus
   f. Epilepsy
   g. Hypertension
   h. All Psychiatric or Psychosomatic Disorders
   i. Influenza, Cough and Cold
   j. Pyrexia of unknown Origin for less than 10 days
   k. Tonsillitis and Upper Respiratory Tract infection including Laryngitis and pharyngitis
   l. Arthritis, Gout and Rheumatism

Liability of the Company under this clause is restricted as stated in the Schedule as per Annexure – 2.

4.4 Ayurvedic Treatment

We will pay the Reasonable & Customary Charges incurred as in-patient for an Insured Person in case of Medically Necessary Treatment taken during Hospitalisation subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in an AYUSH Hospital as defined in Clause 3.3 above.

4.5 Modern Treatment Methods & Advancement in Technologies

In case of an admissible claim under section 4.1, expenses incurred on the following procedures (wherever medically indicated) either as in-patient or as part of day care treatment in a hospital, shall be covered. The claim shall be subject to additional sub-limits indicated against them in the table below:

Sr. No.	Modern Treatment Methods & Advancement in Technology	Limits per Surgery
1	Uterine Artery Embolization & High Intensity Focussed Ultrasound (HIFU)	Up to 20% of Sum Insured subject to a maximum of Rs.2 Lacs per policy period for claims involving Uterine Artery Embolization & HIFU
2	Balloon Sinuplasty	Up to 10% of Sum Insured subject to a maximum of Rs.1 Lac per policy period for claims involving Balloon Sinuplasty
3	Deep Brain Stimulation	Up to 70% of Sum Insured per policy period for claims involving Deep Brain Stimulation
4	Oral Chemotherapy	Up to 20% of Sum Insured subject to a maximum of Rs.2 Lacs per policy period for claims involving Oral Chemotherapy
5	Immunotherapy-Monoclonal Antibody to be given as injection	Up to 20% of Sum Insured subject to a maximum of Rs.2 Lacs per policy period
6	Intra vitreal Injections	Up to 10% of Sum Insured subject to a maximum of Rs. 1 Lac per policy period

7	Robotic Surgeries (Including Robotic Assisted Surgeries)	• Up to 75% of Sum Insured per policy period for claims involving Robotic Surgeries for (i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies • Up to 50% of Sum Insured per policy period for claims involving Robotic Surgeries for other diseases
8	Stereotactic Radio Surgeries	Up to 50% of Sum Insured per policy period for claims involving Stereotactic Radio Surgeries
9	Bronchial Thermoplasty	Up to 30% of Sum Insured subject to a maximum of Rs.3 Lacs per policy period for claims involving Bronchial Thermoplasty.
10	Vaporisation of the Prostate (Green laser treatment for holmium laser treatment)	Up to 30% of Sum Insured subject to a maximum of Rs.2 Lacs per policy period.
11	Intra Operative Neuro Monitoring (IONM)	Up to 15% of Sum Insured per policy period for claims involving Intra Operative Neuro Monitoring subject to a maximum of Rs. 1 Lac per policy period.
12	Stem Cell Therapy: Hematopoietic Stem Cells for bone marrow transplant for haematological conditions to be covered only	No additional sub-limit

Note: If, for a given admissible claim, limits as listed in the Table above AND limits mentioned in Clause 4.1.2 are applicable simultaneously, then the lower of the two limits shall apply.

4.6 Cost of Health Check-Up

We will cover expenses incurred towards cost of health check-up up to 1% of average Sum Insured of preceding 3 years, subject to a maximum of Rs. 5,000 per person per policy period for a block of every three claim-free years provided the health check-up is done at hospitals/diagnostic centre authorised by us within a year from the date when it got due and the policy is in force. Payment under this benefit does not reduce the sum insured.

Note: Payment of expenses towards cost of health check-up will not prejudice the Company's right to deal with a claim in case of non-disclosure of material fact and/or Pre-Existing Diseases in terms of the policy.

OPTIONAL COVERS

4.7 Road Ambulance Cover

We will cover the costs incurred up to Rs. 2500 per person per policy period on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner and becomes payable if a claim has been admitted under Section 4.1 and the expenses are related to the same Illness or Injury.

We will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified above under this cover, if:

i. it is medically required to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
ii. it is medically required to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.

4.8 Daily Cash Allowance on Hospitalisation

We will pay Daily Cash Allowance to the Insured Person for every continuous and completed period of 24 hours of Hospitalisation, subject to the hospitalisation claim being admissible under the policy, as per the table below:

Additional Annual Premium (Excl. GST)	Daily Cash Allowance Limit (in Rs.)
Rs. 150/-	Rs. 250 per day subject to a maximum of Rs. 2500 per policy period
Rs. 300/-	Rs. 500 per day subject to a maximum of Rs. 5000 per policy period

i. The aggregate of Daily Cash Allowance during the policy period shall not exceed 'per policy period limits' as mentioned in the table above.
ii. Daily Cash Allowance will not be payable for Day Care Treatment claims.
iii. Deductible equivalent to Daily Cash Allowance for the first 48 hours Hospitalization will be levied on each Hospitalisation during the Policy Period.

5. PERMANENT EXCLUSIONS & WAITING PERIODS

A. WAITING PERIODS (Only Applicable for Gold & Senior Citizen Plans)

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

1 Pre-Existing Disease (Code- Excl01):

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2 Specific Disease/ Procedure Waiting Period (Code- Excl02):

i. Expenses related to the treatment of the listed Conditions, surgeries/treatments as per Table A and Table B below, shall be excluded until the expiry of 24 months and 48 months respectively 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 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.
vi. List of specific diseases/procedures:

Table A: 24 Months' Waiting Period

Cataract	Piles, Fissures and Fistula-in-Ano
Benign Prostatic Hypertrophy	Sinusitis and related disorders
Treatment for Menorrhagia/ Fibromyoma, Myoma and Prolapse of Uterus	Gout and Rheumatism
Hernia of all types	Calculus diseases
Hydrocele	Congenital Internal diseases

Table B: 48 Months' Waiting Period

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

3 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.

B. STANDARD PERMANENT EXCLUSIONS (Applicable for ALL Plans)

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:

1. Investigation & Evaluation **(Code- Excl04)**:
   a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   b. 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:
   a. 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.
   b. 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:
   A. Surgery to be conducted is upon the advice of the Doctor
   B. The surgery/procedure conducted should be supported by clinical protocols
   C. The member has to be 18 years of age or older and
   D. 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:
         i. Obesity-related cardiomyopathy
         ii. Coronary heart disease
         iii. Severe Sleep Apnoea
         iv. 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 medically necessary treatment. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
6. 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.
7. 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 stabilisation are payable but not the complete claim.
8. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**
9. 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)**
10. 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)**

11. Refractive Error **(Code- Excl15)**: Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.
12. 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.
13. 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
14. Maternity **(Code- Excl18):**
    a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
    b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

C. SPECIFIC PERMANENT EXCLUSIONS

15. All expenses caused by or arising from or attributable to foreign invasion, 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.
16. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack.
17. a) Stem cell implantation/Surgery/therapy, harvesting, storage or any kind of Treatment using stem cells except as provided for in Clause 4.5.12 above; b) growth hormone therapy.
18. Congenital External Diseases, Defects or anomalies.
19. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
20. Cost of routine medical examination and preventive health check-up unless as provided for in Base Cover 4.6.
21. Vaccination or inoculation of any kind unless it is post animal bite.
22. i. Routine eye-examination expenses, cost of spectacles, contact lenses;
    ii. Cost of hearing aids; including optometric therapy;
    iii. Cochlear implants unless necessitated by an Accident or required intra-operatively.
23. Treatments other than Allopathy and Ayurvedic branches of medicine.
24. Intentional self-inflicted Injury, attempted suicide.
25. Unless used intra-operatively, any expenses incurred on prosthesis, corrective devices; External and/or durable Medical /Non-medical equipment of any kind used for diagnosis and/or treatment and/or monitoring and/or maintenance and/or support including instruments used in treatment of sleep apnoea syndrome; Infusion pump, Oxygen concentrator, Ambulatory devices, sub cutaneous insulin pump and also any medical equipment, which are subsequently used at home. This is indicative and please refer to Annexure – 1 for the complete list of non-payable items.
26. Change of treatment from one system of medicine to another system unless recommended by the consultant/hospital under whom the treatment is taken.
27. 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.
28. 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.
29. Any item(s) or treatment specified in 'List of Non-Medical Expenses– Payable/Non-Payable' as per Annexure – 1 and available on Company web site also, unless specifically covered under the Policy.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/ any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance policy:

i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
iii. any other act fitted to deceive; and
iv. any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the claim and/ or forfeit the policy benefits on the ground of fraud, if the Insured Person/Beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

6.7 Cancellation Clause

i. The Policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired Policy Period as detailed in the table below:

Cancellation after Period on Risk	Rate of Premium to be refunded
Up to One Month	75% of Annual Premium
> 1 Month and Up to 3 Months	50% of Annual Premium
> 3 Month and Up to 6 Months	25% of Annual Premium
Exceeding 6 Months	No Refund

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.

ii. The Company may cancel the policy at any time on grounds of misrepresentation, 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 misrepresentation, non-disclosure of material facts or fraud

6.8 Migration

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://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

6. 9 Portability

The Insured Person will have the option to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health Insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

6.10 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation, non-disclosure of material facts 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 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.
v. No loading shall apply on renewals based on individual claims experience.

6.11 Withdrawal of Policy

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

6.12 Moratorium Period

After completion of eight continuous years under the policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

6.13 Possibility of Revision of Terms of the Policy including the Premium Rates

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

6.14 Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The Insured Person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, the Insured shall be entitled to:

i. A refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person 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 Person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

6.15 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.

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

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

6.17 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 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 to the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the company shall be liable to pay interest to the Policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

B. SPECIFIC TERMS & CLAUSES

6.18 Change of Sum Insured

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

6.19 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

6.20 Limitation

If a claim is declined and within 12 calendar months from such disclaimer any suit or proceeding is not filed then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

6.21 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 for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

6.22 Territorial Limit

The geographical scope of this Policy applies to events limited to India. All medical treatment for the purpose of this insurance will have to be taken in India only and all admitted or payable claims shall be settled in India in Indian rupees.

6.23 Claims Procedure

A. 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:

i. Within 24 hours from the date of emergency hospitalization 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 Hospitalization.

B. Procedure for Cashless Claims

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

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

iii. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference
iv. On admission in the network provider/PPN hospital, produce the ID card issued by the TPA at the Hospital Helpdesk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.
v. The TPA upon getting cashless request form and related medical information from the Insured Person/Network Provider/PPN shall issue pre-authorization letter to the hospital after verification.
vi. At the time of discharge, the Insured Person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
vii. The TPA reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.
viii. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

C. 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 to TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) within the prescribed time limit.
ii. Claims for Pre and Post-Hospitalization will be settled on reimbursement basis on production of relevant claim papers and cash receipts within the prescribed time limit.
iii. Claims for Cost of Health Check-up will be settled on reimbursement basis on production of test reports and cash receipts within the prescribed time limit.

D. Supporting Documents

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

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

Note

In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other Insurer, the Company may accept the duly certified documents listed under condition VII.6.d and claim settlement advice duly certified by the other Insurer subject to satisfaction of the Company.

E. Time Limit for Submission of Documents

Type of Claim	Time Limit for Submission of Documents to Company / TPA
Reimbursement of hospitalisation and pre-hospitalisation expenses (limited to 30 days)	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of Post-hospitalisation expenses (limited to 60 days)	Within 15 (fifteen) days from completion of Post-hospitalisation treatment
Reimbursement of Cost of Health Check-up	Within 15 (fifteen) days from Health Check-up

Note

i. Waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
ii. The Company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
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.

F. Services Offered by TPA

Servicing of claims i.e. claim admissions and assessments, under this Policy by way of pre-authorization 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 into with the Company.

G. Payment of Claim

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

6.24 Premium

i. Unless full premium is paid before commencement of risk, this Policy shall have no effect.
ii. Premium can be paid online for both, new policy, and renewals.
iii. PAN details must be submitted by the Insured. In case PAN is not available, Form 60 or Form 61 must be submitted
iv. Tax rebate available as per provision of Income Tax rules under Section 80-D.

6.25 Discount

i. Family Discount

A Discount of 5% is offered on the total premium if the policy covers the Policyholder and any one or more of the following:

a. Spouse
b. Dependent Children
c. Parent(s)

ii. Online Discount

A discount of 10%, subject to a maximum of Rs. 2000 per policy, will be applicable for fresh policies purchased online through the Company's website.

6 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.

Individual Health Insurance Policy – Platinum / Gold / Senior Citizen

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	Platinum Plan	Gold Plan	Senior Citizen Plan
Age of Entry	18-35 years (Children above 91 days of age can be covered provided one or both the parents are covered)	36-60 years	61-65 years
Sum Insured Options	2 Lakh, 3 Lakh, 4 Lakh, 5 Lakh, 8 Lakh, 10 Lakh, 15 Lakh and 20 Lakh	2 Lakh, 3 Lakh, 4 Lakh, 5 Lakh, 8 Lakh and 10 Lakh	2 Lakh, 3 Lakh, 4 Lakh and 5 Lakh
Policy Period	1 Year		
Base Cover			
Room Rent	1% of SI	1% of SI	1% of SI
ICU/ICCU	2% of SI	2% of SI	2% of SI
Proportionate Deduction	Applicable	Applicable	Applicable
Organ Donor Medical Expenses	Covered	Covered	Covered
Day Care Treatments	All as per Definition	All as per Definition	All as per Definition
Cataract	Actuals	Up to 25% of SI or Rs. 40,000 per eye, whichever is less	Up to 25% of SI or Rs. 40,000 per eye, whichever is less
Hernia & Hysterectomy	Actuals	Up to 25% of SI or Rs. 1,00,000, whichever is less	Up to 25% of SI or Rs. 1,00,000, whichever is less
Major Surgeries#	Actuals	Up to 70% of SI	Up to 70% of SI
Pre-Hospitalisation	30 Days	30 Days subject to max of 10% of SI	30 Days subject to max of 10% of SI
Post-hospitalisation	60 Days	60 Days subject to max of 10% of SI	60 Days subject to max of 10% of SI
Domiciliary Hospitalisation	Covered	Covered	Covered
Ayurvedic Treatment	Covered	Covered	Covered
Modern Treatment Methods#	Covered	Covered	Covered
Cost of Health Check Up	Every three claim free years up to 1% of average SI per Insured Person subject to a maximum of Rs. 5000.	Every three claim free years up to 1% of average SI per Insured Person subject to a maximum of Rs. 5000.	Every three claim free years up to 1% of average SI per Insured Person subject to a maximum of Rs. 5000.
Optional Cover			
Road Ambulance	Up to a maximum of Rs.2500/- per person per policy period.	Up to a maximum of Rs.2500/- per person per policy period.	Up to a maximum of Rs.2500/- per person per policy period.
Daily Cash Allowance on Hospitalisation	Up to Rs. 2500/5000 per person per policy period	Up to Rs. 2500/5000 per person per policy period	Up to Rs. 2500/5000 per person per policy period

Please refer to Policy Wordings for details on what constitutes Major Surgeries and Modern Treatment Methods

Individual Health Insurance Policy – Platinum / Gold / Senior Citizen

Domiciliary Hospitalisation Limits

Sum Insured (in Rs.)	Annual Limit (in Rs.)
50,000	10,000
75,000	15,000
100,000	20,000
125,000	23,750
150,000	27,250
175,000	31,250
200,000	35,000
225,000	37,500
250,000	40,000
275,000	42,500
300,000	45,000
325,000	47,500
350,000 – 1,000,000	50,000
1,500,000	75,000
2,000,000	100,000