UNITED INDIA INSURANCE COMPANY LIMITED
REGISTERED & HEAD OFFICE: 24, WHITES ROAD, CHENNAI-600014

UIN: UIIHLIP19116V021819

INDIVIDUAL HEALTH INSURANCE POLICY – (PLATINUM/ GOLD/ SENIOR CITIZEN)

PROSPECTUS

1.1 Product

The policy covers expenses for inpatient treatment (cashless/reimbursement) reasonably and customarily incurred within India for treatment of illness/disease or injury contracted/sustained during the policy period. The policy also covers medical expenses for 30 (Thirty) days of pre-hospitalisation, 60 (Sixty) days of post-hospitalization, 140+ day care procedures/surgeries, Domiciliary hospitalisation, Ayurveda treatment and organ donor's medical expenses.

The policy additionally provides optional covers for hospital daily cash and ambulance charges on payment of additional premium.

WHO CAN TAKE THIS POLICY

1. **Eligibility:**

1.1 This policy is offered on Individual sum insured basis for an individual. The policy is offered on family package basis also, for family comprising of the proposer, spouse, dependent children and parents, with Individual sum insured for each family member.

1.2 Entry Age of Proposer and insured family members for different plans is as under:

A. Platinum: between 18 and 35 years. Children from the age of 91 days can be covered provided either or both of the parents are covered.

B. Gold: between 36 and 60 years.

C. Senior Citizen: between 61 and 65 years.

Persons crossing the maximum age prescribed for a plan will continue to be covered under the same plan provided the policies are renewed with us without break.

Dependent children between the age of 91 days and 18 years shall be covered provided either or both parents are covered concurrently. Children above 18 years will continue to be covered along with parents provided they are unmarried/unemployed and dependent.

1.3 Parents mean proposer's natural parents or parents that have legally adopted him/her, provided they are below the age of 65 years at the time of entry into Individual Health Policy.

1.4 In the event of children becoming independent (either on employment or marriage in the event of girl child), a separate policy can be taken on expiry of the current policy for which continuity benefits will be provided.

1.5 Midterm inclusion of family members is allowed at pro-rata premium only in case of

i) Newly married spouse within 60 (sixty) days of marriage.

ii) New born baby, between the ages of 91 days to 180 days, born to mother insured under the policy.

2. Sum Insured:

2.1 Various options are available under the three plans as under:

A. Platinum: Rs. 2 lacs, 3 lacs, 5 lacs, 8 lacs, 10 lacs, 15 Lacs, 20 Lacs

B. Gold: Rs 2 lacs, 3 lacs, 5 lacs, 8 lacs, 10 lacs.

C. Senior Citizen: Rs 2 lacs, 3 lacs, 5 lacs

(See Premium Chart for available Sum Insured Options and premium)

Sum Insured can be enhanced only at the time of renewal.

2.2 Sum insured may be enhanced only subject to discretion of the company.

2.3 In case of the incremental portions of the Sum Insured, the conditions and waiting periods, as mentioned in exclusion no. 4.1, 4.2, 4.3 and 4.4 of the policy shall apply. Coverage on enhanced sum insured shall be available only after the completion of waiting periods.

3. Term of Policy: One Year. Renewable annually.

4. <u>WHAT POLICY COVERS</u>

Policy covers following Hospitalisation Expenses incurred within India:

4.1 In-patient treatment. This includes:

a. Room, Boarding and Nursing expenses as provided by the Hospital/Nursing Home not exceeding 1% of the sum insured per day or the actual amount whichever is less. This also includes nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.

b. Intensive Care Unit charges, if admitted in the same, not exceeding 2% of the sum insured per day or the actual amount whichever is less.

c. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.

d. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, cost of Artificial Limbs, cost of prosthetic devices implanted internally during a surgical procedure like Pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically necessary.

e. All Hospitalisation Expenses (excluding cost of organ, if any) incurred for donor in respect of Organ transplant to the insured.

Note 1. **PROPORTIONATE PAYMENT CLAUSE**

Reimbursement/payment of Room Rent, boarding and nursing expenses incurred at the Hospital shall not exceed 1% of the Sum Insured per day. In case of admission to Intensive Care Unit or Intensive Cardiac Care Unit, reimbursement or payment of such expenses shall not exceed 2% of the Sum Insured per day. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of expenses under 4.1 C & D incurred at the Hospital, with the exception of cost of medicines, drugs & implants, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

Note 2. No payment shall be made under 4.1 C other than as part of the hospitalisation bill. However, the bills raised by Surgeon, Anaesthetist directly and not forming part of the

hospital bill shall be paid provided a pre-numbered bill/receipt is produced in support thereof, when such payment is made ONLY by cheque/ credit card/debit card or digital/online transfer.

Note 3. Reimbursement of hospitalisation expenses incurred in PPN hospital for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

Company's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured per person as mentioned in the schedule.

4.2 ***(Applicable only for Gold Plan & Senior Citizen Plan):***

Expenses in respect of the following specified illnesses will be restricted as detailed below:

Hospitalisation Benefits			LIMITS per surgery RESTRICTED TO
a.	i.	Cataract	Actual expenses incurred or 25% of the sum insured whichever is less, subject to a maximum of Rs. 40000 per eye.
	ii.	Hernia	Actual expenses incurred or 25% of the sum insured whichever is less, subject to a maximum of Rs. 100000.
	iii.	Hysterectomy	Actual expenses incurred or 25% of the sum insured whichever is less, subject to a maximum of Rs. 100000.
b. Major surgeries*			b. Actual expenses incurred or 70% of the Sum Insured whichever is less

* Major surgeries include cardiac surgeries, brain tumour surgeries, pace maker implantation for sick sinus syndrome, cancer surgeries, hip, knee, joint replacement surgery, Organ Transplant.

Note: *The above limits specified are applicable per hospitalisation / surgery.*

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

4.3.1 However, for Gold Plan & Senior Citizen Plan, these are limited to Actual expenses incurred subject to maximum of 10% of Sum Insured, whichever is less.

4.4 Expenses on Hospitalisation for minimum period of 24 hours are admissible. However, this time limit is not applied to day care procedures as mentioned in ***Annexure-1.***

This condition will also not apply in case of stay in hospital of less than 24 hours provided -

a. The treatment is undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement and

b. Which would have otherwise required a hospitalisation of more than 24 hours.

Procedures/treatments usually done on out-patient basis are not payable under the policy even if converted as an inpatient in the hospital for more than 24 hours or carried out in Day Care Centres.

4.5 Expenses on_Domiciliary Hospitalisation for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

a. The condition of the patient is such that he/she is not in a condition to be removed to a hospital or

b. The patient takes treatment at home on account of non-availability of room in a hospital.

Subject however that domiciliary hospitalisation benefits shall not cover:

1. Treatment of less than three days
2. Expenses incurred for pre and post hospital treatment and
3. 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. Influenza, Cough and Cold
    i. All Psychiatric or Psychosomatic Disorders
    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 3***.

4.6 Expenses on Ayurvedic treatments are covered subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in:

i. A Government Hospital or in any Institute recognised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health.

ii. Teaching hospitals of Ayurvedic colleges recognised by Central Council of Indian Medicine (CCIM)

iii. Ayurvedic Hospitals having registration with a Government authority under appropriate Act in the State/ UT and complies with the following as minimum criteria:

a) Has at least fifteen in-patient beds;
b) Has minimum five qualified and registered Ayurvedic doctors;
c) Has qualified paramedical staff under its employment round the clock;
d) Has dedicated Ayurvedic therapy sections;
e) Maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

Please note that all the above coverages are subject to Limits, Terms and Conditions AND Exclusions contained in this Policy.

Note: Company's Liability for all claims admitted in respect of any/all insured person/s during the period of insurance shall not exceed the Sum Insured stated in the schedule.

5. DEFINITIONS

5.1 **ACCIDENT** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

5.2 **ANY ONE ILLNESS** means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment has been taken.

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

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

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

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

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

5.7 **CONTINOUS COVERAGE** means uninterrupted coverage of the insured person under our Individual Health Policies 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.

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

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

5.9 **DAY CARE TREATMENT** means the medical treatment and/or surgical procedure which is (i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement and

(ii) which would have otherwise required a hospitalisation of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition.

5.10 DEDUCTIBLE

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

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

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

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

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

5.15 **HOSPITAL/NURSING HOME** any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a Hospital with the local authorities under the Clinical establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under

a. Has qualified nursing staff under its employment round the clock.
b. Has at least 10 in-patient beds in towns having a population of less than 10 lacs and at least 15 in-patient beds in all other places;
c. Has qualified medical practitioner(s) in charge round the clock;
d. Has a fully equipped Operation Theatre of its own where surgical procedures are carried out;
e. Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

The term ' Hospital / Nursing Home ' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.

For Ayurvedic Treatment, hospitalisation expenses are admissible only when the treatment has been undergone in a Hospital as defined in clause 4.7 above.

5.16 **HOSPITALISATION** Means admission in a Hospital/Nursing Home for a minimum period of 24 consecutive In-patient care hours except for specified day care procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours. The list of these specified day care procedures/ treatment is provided in Clause 4.5 above.

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

5.18 **ILLNESS** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. It needs ongoing or long-term control or relief of symptoms
3. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. It continues indefinitely
5. It recurs or is likely to recur

5.19 **INJURY -** Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

5.20 **IN-PATIENT CARE**

In-patient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

5.21 **INSURED PERSON** means You and each of the others who are covered under this policy as shown in the Schedule.

5.22 **INTENSIVE CARE UNIT**

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

5.23 **ICU Charges:** ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

5.24 **MEDICAL ADVICE** Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

5.25 **MEDICAL EXPENSES** means those expenses that an Insured person has necessarily and actually incurred for medical treatment on account of illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

5.26 **MEDICALLY NECESARY TREATMENT** is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

A. Is required for the medical management of the illness or injury suffered by the insured;

B. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
C. Must have been prescribed by a Medical Practitioner;
D. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

5.27 MEDICAL PRACTITIONER

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

The term Medical Practitioner would include Physician, Specialist and Surgeon. The Registered Medical Practitioner should not be the insured or any member of his family including parents and in-laws.

5.28 NETWORK PROVIDER

Network Provider means the hospital/nursing home or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured by a cashless facility. The list of Network Hospitals is maintained by and available with the TPA and the same is subject to amendment from time to time.

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

5.29 NON-NETWORK HOSPITALS

Non-Network Hospital means Any hospital, day-care centre or other provider that is not part of the network.

5.30 NOTIFICATION OF CLAIM is the process of notifying a claim to the insurer or TPA within specified timelines through any of the recognised modes of communication.

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

5.32 PORTABILITY

Portability means transfer by an Individual Health Insurance Policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

5.33 PRE-EXISTING DISEASE

Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer. Any complication arising from Pre-existing disease shall be considered as a part of the pre-existing disease.

5.34 PRE– HOSPITALISATION MEDICAL EXPENSES means relevant medical expenses incurred immediately 30 days before the Insured person is hospitalised provided that;

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

5.35 POST HOSPITALISATION MEDICAL EXPENSES means relevant medical expenses incurred immediately **60** days after the Insured person is discharged from the hospital provided

that;

a. Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and

b. The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.

5.36 **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 specialised in the field of Psychiatry after physical examination of the Insured Person in respect of whom a claim is lodged.

5.37 **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.

5.38 **QUALIFIED NURSE** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.

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

5.40 **RENEWAL** defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

5.41 **ROOM RENT** means the amount charged by a hospital for the Occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

5.42 **SUM INSURED** is the maximum amount of coverage under this policy opted for each insured person in individual policy or for all insured persons in a family in case of floater cover as shown in the schedule. Health checkup expenses are payable over and above the Sum Insured whenever applicable.

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

5.44 **THIRD PARTY ADMINISTRATOR (TPA)** means any person who is 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 purposes of providing health services as defined in those.

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

5.46 **WE/OUR/US/COMPANY** means UNITED INDIA INSURANCE COMPANY LIMITED

5.47 **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.

6. ADDITIONAL BENEFIT:

COST OF HEALTH CHECK UP: The insured shall be entitled for a reimbursement of the cost of Medical check-up once at the end of block of every three underwriting years provided

there are no claims reported during the block and subject to the policy being renewed without break. The amount of such reimbursement shall be limited to 1% of the average sum insured for the insured person for the preceding three policy periods subject to a maximum of Rs. 5000.

7. <u>WHAT POLICY DOES NOT COVER:</u> -

7.1 Any pre-existing condition(s) as defined in the policy, until 48 months of continuous coverage of such insured person have elapsed, from the date of inception of his/her first policy as mentioned in the Schedule. ***However, this exclusion will not be applicable for 'Platinum' Plan.***

Any complication arising from pre-existing disease shall be considered as a part of the pre-existing disease.

7.2 Any disease contracted by the Insured person during the first 30 days from the commencement date of the policy. This condition 4.2 shall not however, apply in case of the Insured person having been covered for a continuous period of preceding 12 months without any break***. However, this exclusion will not be applicable for 'Platinum' Plan.***

7.3 Unless the Insured has 24 months of continuous coverage, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hypertrophy, Treatment for Menorrhagia/ Fibromyoma/ Myoma and prolapse of uterus, Hernia, Hydrocele, Fistula in anus, piles, Sinusitis and related disorders, Gout & Rheumatism, Calculus Diseases are not payable.
Note: Even after twenty-four months of continuous coverage, the above mentioned diseases will not be covered if they arise from a pre-existing condition, until 48 months of continuous coverage have elapsed, since inception of the first policy with the Company.
However, this exclusion will not be applicable for 'Platinum' Plan.

7.4 Unless the Insured has 48 months of continuous coverage, the expenses related to treatment of Joint Replacement due to Degenerative Condition and age-related Osteoarthritis & Osteoporosis are not payable.
If these diseases mentioned in Exclusion no.4.3 and 4.4 are pre-existing at the time of proposal they will not be covered even during subsequent period of renewal subject to the pre-existing disease exclusion clause.
However, this exclusion will not be applicable for 'Platinum' Plan.

7.5

a. Congenital Internal Diseases or Defects or anomalies. However, if not known to the insured as pre-existing at the time of inception of first policy with Us, these diseases will be covered after 24 months of continuous coverage. If the insured is aware of the existence of congenital internal disease before inception of the policy, the same will be covered after 48 months.
b. Congenital External Diseases or Defects or anomalies.

7.6 Injury / disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign enemy, War like operations (whether war be declared or not).

7.7 a. Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.
b. vaccination or inoculation of any kind unless it is post animal bite,
c. change of life or cosmetic or aesthetic treatment of any description.
d. such as correction of eyesight due to refractive error
e. plastic surgery other than as may be necessitated due to disease/injury.

7.8 Cost of spectacles, contact lenses and hearing aids, cochlear implants.

7.9 Dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalisation.

7.10 a. Convalescence, general debility; run-down condition or rest cure,
b. Treatment for obesity or condition arising therefrom (including morbid obesity) and any other weight control and management programme/ services/ supplies or treatment
c. Infertility/sub fertility, sterility, assisted conception procedures.
d. Venereal disease, Sexually Transmitted Diseases.
f. Treatment of illness or injury arising out of misuse or abuse of drugs / alcohol or use of intoxicating substances.
g. Bodily Injury due to wilful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury, attempted suicide.
h. Treatment of any Injury or Illness sustained whilst or as a result of committing or attempting to commit breach of law with criminal intent

7.11 Charges incurred at Hospital or Nursing Home primarily for diagnosis, x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home.

7.12 Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified by the attending physician.

7.13 Injury or Disease directly or indirectly caused by or contributed to by nuclear weapon / materials.

7.14 Treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of these including caesarean section, except abdominal operation for extra uterine pregnancy (Ectopic Pregnancy) which is proved by submission of Ultra Sonographic report and Certificate of Gynaecologist that it is life threatening one if left untreated.

7.15 Naturopathy Treatment, acupressure, acupuncture, magnetic therapies, experimental and unproven treatments/therapies. Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

7.16 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 CPAP, CAPD, Infusion pump, Oxygen concentrator etc., Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer/Thermometer, alpha/water bed and similar related items etc. and also any medical equipment, which are subsequently used at home. This is indicative and please refer to ***Annexure-2*** for the complete list of non-payable items.

7.17 Stem cell implantation/surgery.

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

7.19 Use of Intra vitreal injections for the treatment of all diseases including Age Related Macular Degeneration (ARMD) and Retinal vein occlusion; treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy and CPAD (Continuous Peritoneal Ambulatory Dialysis).

7.20 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, ayah, private nursing/barber or beauty services, diet charges, baby food, cosmetic, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses. The detailed list of non-payable expenses is as per ***Annexure-2.***

7.21 Any kind of Service charges, Surcharges, Admission Fees/Registration Charges, Luxury tax and similar charges levied by the hospital. Please refer to ***Annexure-2*** for detailed list***.***

8. WHAT IS THE PROCEDURE FOR TAKING A POLICY

8.1 The duly completed and signed Proposal form giving details of all Insured persons and a signed copy of the Prospectus along with Pre-Acceptance Health Check-up reports, if any, should be submitted to the Company.

Pre–acceptance medical check–up is required for all the members entering after the age of 60 years. A person also needs to undergo this pre–acceptance medical check–up if he has an adverse medical history as revealed from the proposal form. The cost of this check–up will be borne by the proposer. But if the proposal is accepted, then 50% of the cost of this check–up will be reimbursed to the proposer.

Pre–acceptance medical check–up shall be conducted at designated centres authorized by Us.

Note: Adverse Medical History for a person means:

1. more than two Hospitalisation occurred in previous two years,
2. person suffering from Critical Illness, Recurring Illness or Chronic Illness.
3. is Suffering from Hypertension / Diabetes/ Chest Pain or Coronary Insufficiency or Myocardial Infarction.
4. is not in good health and is not free from Physical and mental diseases or infirmity or medical complaints.

The pre-acceptance health check-up reports as detailed below have to be submitted at proposer's cost in the following cases–

i. Persons upto 60 years of age with adverse medical history (fresh entrants)
ii. Persons above 60 years of age (fresh entrants)
iii. Persons above 60 years of age (Break in insurance)
iv. Persons above 60 years of age (Seeking enhancement of Sum Insured by more than Rs. One Lac)
v. Persons upto 60 years seeking enhancement of Sum Insured:
A. Current Sum Insured upto Rs. 10 lacs - by more than Rs. Three Lacs of Sum Insured.

B. Current Sum Insured above Rs. 10 Lacs for Platinum Plan - By more than one slab.

1	Physical examination (report to be signed by the Doctor with minimum MD/MS qualification
2	CBC
3	Urine Routine & Microscopic
4	HbA1c (Glycosylated Haemoglobin)
5	Lipid Profile
6	Serum Creatinine
7	SGOT & SGPT
8	ECG
9	Stress Test if necessitated.
10	Any other investigation required by the company ***The date of medical reports should not exceed 30 (thirty) days prior to the date of proposal***.

NOTE: 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.

8.2 PAYMENT OF PREMIUM:

i. Full premium must be paid before commencement of risk for this Policy to have effect.

ii. Premium payable – As per ***Premium Table*** attached.

iii. Premium can be paid online for both, new policy and renewals.

iv. PAN details must be submitted by the insured. In case PAN is not available, Form 60 or Form 61 must be submitted

8.3 FAMILY DISCOUNT

A family discount of 5% of the total premium will be allowed comprising the insured and any one or more of the following:

a. Spouse,

b. Dependent children

c. Parent(s).

8.4 RENEWAL

i. The policy can be renewed annually throughout the lifetime of the insured person.

ii. The policy may be renewed by mutual consent before the expiry of the policy.

iii. The company is not bound to send renewal notice.

iv. We shall renew this policy if the insured shall remit the requisite premium to the Company prior to expiry of the period of insurance stated in the schedule.

v. We shall be entitled to decline renewal if;

a. Any non-cooperation, fraud, misrepresentation or suppression by the insured or on his behalf is found either in obtaining insurance or subsequently in relation thereto or,

b. The Company has discontinued issue of the policy after due approval from IRDAI, in which event the insured shall however have the option for renewal under any similar policy being issued by the company, provided however benefits payable shall be subject to the terms contained in such other policy.

vi. If You fail to remit premium for renewal before expiry of the period of insurance, but remit within 30 days thereafter, admissibility of any claim during the period of subsequent policy shall be considered in the same manner as under a Policy renewed without break. The Company however shall not be liable for any claim arising out of ailment suffered or hospitalisation commencing in the interim period after expiry of the earlier policy and prior to date of commencement of subsequent policy.

9. ENHANCEMENT OF SUM INSUREDS

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a fresh proposal form/ written request to the company. Any such request for enhancement must be accompanied by a declaration that the insured or any other insured person in respect of whom such enhancement is sought is not aware of any symptoms or other indications that may give rise to a claim under the policy. The Company may require such insured person/s to undergo a Medical examination to enable the company to take a decision on accepting the request for enhancement in the Sum Insured.

ii. The acceptance of enhancement of Sum Insured would be at the discretion of the company, based on the health condition of the insured members & claim history of the policy.

iii. Enhancement of Sum Insured is subject to the limits mentioned below:

Age <= 60 years	For current SI upto Rs. 10 Lacs- Upto Rs. Three Lacs without Medical Examination.
Age <= 60 years	For current SI upto Rs. 10 Lacs- More than Rs. Three Lacs with Medical Examination.
Age <= 60 years	For current SI above Rs. 10 Lacs for Platinum Plan - Upto one slab without Medical Examination.
Age <= 60 years	For current SI above Rs. 10 Lacs for Platinum Plan- More than one slab with Medical Examination.
Age 61–65 Years	Upto Rs. One Lac without Medical Examination
Age 61–65 Years	More than Rs. One Lac with Medical Examination

iv. Enhancement of Sum Insured will not be considered for:

1. Any Insured Person who had undergone more than three Hospitalisation in the preceding two years.
2. Any Insured Person suffering from one or more of the following Illnesses / Conditions:
   a) Any chronic Illness
   b) Any recurring Illness

c) Any Critical Illness

v. 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.

10. WHAT IS THE CONDITION FOR PORTING

In the event of insured porting to another insurer, the insured person must apply with details of policy and claims at least 45 days before the date of expiry of policy.
Portability shall be allowed in the following cases:

a. All Individual Health Insurance Policies issued by non-life insurance companies including family floater policies.
b. Individual members, including the family members covered under any Group Health insurance policy of our company shall have the right to migrate from such a group policy to this policy. One year thereafter, the insured person shall be accorded the right to port to another non-life insurance company.

11. IS NOMINATION REQUIRED

The insured is mandatorily 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 insured.
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 case of any insured person other than the proposer under the policy, for the purpose of payment of claims in the event of death, the default nominee would be the proposer.
No assignment of the policy or the benefits there under shall be permitted.

12. WHAT IS THE TAX BENEFIT

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

13. WHAT IS FREE LOOK PERIOD

The new policy has a free look period which shall be applicable at the inception of the first policy and;

i. The insured will be allowed a period of at least 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 nor acceptable.
ii. If the insured has not made any claim during the free look period, the insured shall be entitled to –
    a. 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
    b. Where the risk has already commenced and the opinion of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;

c. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period

14. WHAT IS THE PROCEDURE FOR CLAIMS

14.1.1 Notification of claim

Upon the happening of any event which may give rise to a claim under this Policy, the insured person/insured person's representative shall notify the TPA (if claim is processed by TPA)/company (if claim is processed by the company) in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Notification of claim in case of Cashless facility	**TPA must be informed:**
In the event of planned hospitalisation	At least 72 (seventy two) hours prior to the insured person's admission to network provider/PPN
In the event of emergency hospitalisation	Within 24 (twenty four) hours of the insured person's admission to network provider/PPN

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

14.1.2 Procedure for Cashless claims

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

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

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

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

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

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

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

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

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

14.1.3 Procedure for reimbursement of claims

In non-network hospitals payment must be made up-front and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/company (if claim is processed by the company) within the prescribed time limit.

14.1.4 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, investigation test reports etc. supported by the prescription from attending medical practitioner.

iii. Medical history of the patient recorded, bills and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.

iv. Discharge certificate/ summary from the hospital.

iv. Cash-memo from the Diagnostic Centre (s)/ hospital (s)/chemist (s) supported by proper prescription

v. Payment receipts from doctors, surgeons, anaesthetist.

vi. Any other document required by company/TPA

Note

In the event of a claim lodged as per Settlement under multiple policies clause of the policy and the original documents having been submitted to the other insurer, the company may accept the documents listed under clause 14.1.4 above and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

14.1.5.

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

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

14.1.6 The Insured Person shall obtain and furnish to the TPA with all original bills, receipts and other documents upon which a claim is based and shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with

the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.

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

14.1.8 Any medical practitioner or Authorised Person authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required at the time of admission.

14.2 Claim Settlement

i. On receipt of the final document(s), the company shall within a period of 30 (thirty) days offer a settlement of the claim to the insured person.

ii. In the cases of delay in the payment, the company shall pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate that is 2% (two percent) above the bank rate prevalent at the beginning of the financial year in which the claim is paid.

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, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid, from the date of receipt of last necessary document to the date of payment of claim.

v. The payment of the amount due shall be made by the company, upon acceptance of an offer of settlement as stated above by the insured person, within 7 (seven) days from the date of acceptance of the offer.

vi. A claim, which is not covered under the policy cover and conditions, can be rejected.

vi. If the company, for any reasons, decides to reject a claim under the policy, we shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be.

14.3 Settlement under Multiple Policies:

If two or more policies are taken by the insured during a period from us or other insurer(s) to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies
3. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

Further, the insured, if having multiple policies, shall also have the right to prefer claims from this policy for the amounts disallowed under the earlier chosen policy/ policies, even if the Sum Insured in the earlier chosen policy is not exhausted. Then we shall settle the claim subject to the terms & conditions of the other policy/ policies so chosen.

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

15. WHEN POLICY MAY BE CANCELLED

The Company may at any time cancel the Policy on grounds of fraud, misrepresentation, non-disclosure of material fact by sending fifteen days' notice in writing by Registered A/D to the Insured at the address mentioned in the schedule in which case the policy shall become void and all premium paid hereon shall be forfeited. In case of non-cooperation by the Insured person/s, the policy shall be cancelled and we shall refund the ratable proportion of the premium paid corresponding to the unexpired period of insurance if no claim has been reported/paid under the policy.

The Insured person may at any time cancel this policy and in such event, the Company shall allow refund of premium after charging premium at company's short period rate mentioned below provided no claim is reported up to the date of cancellation

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED.
Upto one month	1/4 of the annual rate
Upto three months	1/2 of the annual rate
Upto six months	3/4 of the annual rate
Exceeding six months	Full annual rate.

16. OPTIONAL COVERS OFFERED

16.1 Ambulance Charges

IN CONSIDERATION OF PAYMENT of additional premium of Rs.100/-, the Company through the TPA will pay to the insured person/Hospital the road ambulance charges incurred to shift the insured person from Residence/accident site to Hospitals in emergency cases and from one Hospital/Nursing Home to another Hospital/Nursing Home/Diagnostic centre for better care/diagnosis, upto a maximum of Rs.2500/- per policy period. This benefit shall be subject to the terms and conditions stipulated in the Policy and will be payable only if the claim is otherwise admitted under the Policy.

16.2. Hospital Daily Cash Allowance

IN CONSIDERATION OF payment of following additional premium, the Company through the TPA will pay to the insured person a Daily Cash Allowance as given below from the third day onwards for the period of hospitalisation subject to a maximum stated below

Additional Premium	Allowance per day	Subject to maximum of
Rs.150/-	Rs.250/-	Rs. 2,500/- per policy period
Rs.300/-	Rs.500/-	Rs. 5,000/- per policy period

This benefit shall be subject to the terms and conditions stipulated in the Policy and will be payable only if the claim is otherwise admitted under the Policy.

17. WHERE TO APPROACH IN CASE OF GRIEVANCE

17.1 GRIEVANCE REDRESSAL: In the event of the policyholder having any grievance relating to the insurance, the insured person may submit in writing to the Policy Issuing Office or Grievance cells at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact the Officer, Uni-Customer Care Department, Head Office. For more information on grievance mechanism, and to download grievance form, visit our website www.uiic.co.in

17.2. OMBUDSMAN: The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The updated list of Office of Insurance Ombudsman are available on IRDA website www.irdai.gov.in and on the website of General Insurance Council www.gicouncil.in

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

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

The prospectus contains salient features of the policy. For details, reference is to be made to the Policy.

This Prospectus shall form part of the proposal form. Please sign in token of having noted the contents of Prospectus.

Signature

Name
Place
Date

Annexure-1

ATTACHED TO AND FORMING PART OF INDIVIDUAL HEALTH POLICY (Platinum/ Gold/ Senior Citizen)

List of Day Care Procedures:

Operations on the ears	
	Microsurgical operations on the middle ear
1	Stapedotomy
2	Stapedectomy
3	Revision of a stapedectomy
4	Other operations on the auditory ossicles
5	Myringoplasty (Type I tympanoplasty)
6	Tympanoplasty (closure of an eardrum perforation and reconstruction of the auditory ossicles)
7	Revision of a tympanoplasty
8	Other microsurgical operations on the middle ear
	Other operations on the middle and internal ear
9	Paracentesis (myringotomy)
10	Removal of a tympanic drain
11	Incision of the mastoid process and middle ear
12	Mastoidectomy
13	Reconstruction of the middle ear
14	Other excisions of the middle and inner ear
15	Fenestration of the inner ear
16	Revision of a fenestration of the inner ear
17	Incision (opening) and destruction (elimination) of the inner ear
18	Other operations on the middle and inner ear
Operations on the nose and the nasal sinuses	
19	Excision and destruction of diseased tissue of the nose
20	Operations on the turbinates (nasal concha)
21	Other operations on the nose
22	Nasal sinus aspiration
Operations on the eyes	
23	Incision of tear glands
24	Other operations on the tear ducts
25	Incision of diseased eyelids
26	Excision and destruction of diseased tissue of the eyelid
27	Operations on the canthus and epicanthus
28	Corrective surgery for entropion and ectropion
29	Corrective surgery for blepharoptosis
30	Removal of a foreign body from the conjunctiva
31	Removal of a foreign body from the cornea
32	Incision of the cornea
33	Operations for pterygium
34	Other operations on the cornea
35	Removal of a foreign body from the lens of the eye
36	Removal of a foreign body from the posterior chamber of the eye

37	Removal of a foreign body from the orbit and eyeball
38	Operation of cataract
Operations on the skin and subcutaneous tissues	
39	Incision of a pilonidal sinus
40	Other incisions of the skin and subcutaneous tissues
41	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin
	and subcutaneous tissues
42	Local excision of diseased tissue of the skin and subcutaneous tissues
43	Other excisions of the skin and subcutaneous tissues
44	Simple restoration of surface continuity of the skin and subcutaneous tissues
45	Free skin transplantation, donor site
46	Free skin transplantation, recipient site
47	Revision of skin plasty
48	Other restoration and reconstruction of the skin and subcutaneous tissues
49	Chemosurgery to the skin
50	Destruction of diseased tissue in the skin and subcutaneous tissues
Operations on the mouth and face	
	Operations on the tongue
51	Incision, excision and destruction of diseased tissue of the tongue
52	Partial glossectomy
53	Glossectomy
54	Reconstruction of the tongue
55	Other operations on the tongue
	Operations on the salivary glands and salivary ducts
56	Incision and lancing of a salivary gland and a salivary duct
57	Excision of diseased tissue of a salivary gland and a salivary duct
58	Resection of a salivary gland
59	Reconstruction of a salivary gland and a salivary duct
60	Other operations on the salivary glands and salivary ducts
	Other operations on the mouth and face
61	External incision and drainage in the region of the mouth, jaw and face
62	Incision of the hard and soft palate
63	Excision and destruction of diseased hard and soft palate
64	Incision, excision and destruction in the mouth
65	Plastic surgery to the floor of the mouth
66	Palatoplasty
67	Other operations in the mouth
	Operations on the tonsils and adenoids
68	Transoral incision and drainage of a pharyngeal abscess
69	Tonsillectomy without adenoidectomy
70	Tonsillectomy with adenoidectomy
71	Excision and destruction of a lingual tonsil
72	Other operations on the tonsils and adenoids
Traumatological surgery and orthopaedics	

73	Incision on bone, septic and aseptic
74	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis*
75	Suture and other operations on tendons and tendon sheath
76	Reduction of dislocation under GA
77	Arthroscopic knee aspiration
Operations on the breast	
78	Incision of the breast
79	Operations on the nipple
Operations on the digestive tract	
80	Incision and excision of tissue in the perianal region
81	Surgical treatment of anal fistulas
82	Surgical treatment of haemorrhoids
83	Division of the anal sphincter (sphincterotomy)
84	Other operations on the anus
85	Ultrasound guided aspirations
86	Sclerotherapy etc.
Operations on the female sexual organs	
87	Incision of the ovary
88	Insufflation of the Fallopian tubes
89	Other operations on the Fallopian tube
90	Dilatation of the cervical canal
91	Conisation of the uterine cervix
92	Other operations on the uterine cervix
93	Incision of the uterus (hysterotomy)
94	Therapeutic curettage
95	Culdotomy
96	Incision of the vagina
97	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
98	Incision of the vulva
99	Operations on Bartholin's glands (cyst)
Operations on the male sexual organs	
	Operations on the prostate and seminal vesicles
100	Incision of the prostate
101	Transurethral excision and destruction of prostate tissue
102	Transurethral and percutaneous destruction of prostate tissue
103	Open surgical excision and destruction of prostate tissue
104	Radical prostatovesiculectomy
105	Other excision and destruction of prostate tissue
106	Operations on the seminal vesicles
107	Incision and excision of periprostatic tissue
108	Other operations on the prostate
	Operations on the scrotum and tunica vaginalis testis
109	Incision of the scrotum and tunica vaginalis testis
110	Operation on a testicular hydrocele

111	Excision and destruction of diseased scrotal tissue
112	Plastic reconstruction of the scrotum and tunica vaginalis testis
113	Other operations on the scrotum and tunica vaginalis testis
	Operations on the testes
114	Incision of the testes
115	Excision and destruction of diseased tissue of the testes
116	Unilateral orchidectomy
117	Bilateral orchidectomy
118	Orchidopexy
119	Abdominal exploration in cryptorchidism
120	Surgical repositioning of an abdominal testis
121	Reconstruction of the testis
122	Implantation, exchange and removal of a testicular prosthesis
123	Other operations on the testis
	Operations on the spermatic cord, epididymis und ductus deferens
124	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
125	Excision in the area of the epididymis
126	Epididymectomy
127	Reconstruction of the spermatic cord
128	Reconstruction of the ductus deferens and epididymis
129	Other operations on the spermatic cord, epididymis and ductus deferens
	Operations on the penis
130	Operations on the foreskin
131	Local excision and destruction of diseased tissue of the penis
132	Amputation of the penis
133	Plastic reconstruction of the penis
134	Other operations on the penis
Operations on the urinary system	
135	Cystoscopical removal of stones
Other Operations	
136	Lithotripsy
137	Coronary angiography
138	Haemodialysis
139	Radiotherapy for Cancer
140	Cancer Chemotherapy

ANNEXURE-2

UNITED INDIA INSURANCE CO. LTD.

INDIVIDUAL HEALTH POLICY

SNO	LIST OF EXPENSES EXCLUDED ("NON-MEDICAL")	SUGGESTIONS
	TOILETRIES/COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS	
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	M01STUR1SER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Not Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable

31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by In surer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Not Payable
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Not Payable
61	HOME VISIT CHARGES	Not Payable
62	DONOR SCREENING CHARGES	Not Payable
63	ADMISSION/REGISTRATION CHARGES	Not Payable
64	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Not Payable

65	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable
	ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
66	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not separately
67	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the Hospital payable. Purchase of Instruments Not Payable.
68	MICROSCOPE COVER	Payable under OT Charges, not separately
69	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER	Payable under OT Charges, not separately
70	SURGICAL DRILL	Payable under OT Charges, not separately
71	EYE KIT	Payable under OT Charges, not separately
72	EYE DRAPE	Payable under OT Charges, not separately
73	X-RAY FILM	Payable under Radiology Charges, not as consumable
74	SPUTUM CUP	Payable under Investigation Charges, not as consumable
75	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
76	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
77	Antiseptic or disinfectant lotions	Not Payable - Part of Dressing Charges
78	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
79	COTTON	Not Payable -Part of Dressing Charges
80	COTTON BANDAGE	Not Payable- Part of Dressing Charges
81	MICROPORE/ SURGICAL TAPE	Not Payable – Part of Dressing Charges
82	BLADE	Not Payable
83	APRON	Not Payable
84	TORNIQUET	Not Payable
85	ORTHOBUNDLE, GYNAEC BUNDLE	Not Payable, Part of Dressing Charges
86	URINE CONTAINER	Not Payable
	ELEMENTS OF ROOM CHARGE	

87	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
88	HVAC	Part of room charge, Not Payable separately
89	HOUSE KEEPING CHARGES	Part of room charge, Not Payable separately
90	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge, Not Payable separately
91	TELEVISION & AIR CONDITIONER CHARGES	Part of room charge, Not Payable separately
92	SURCHARGES	Part of room charge, Not Payable separately
93	ATTENDANT CHARGES	Part of room charge, Not Payable separately
94	IM IV INJECTION CHARGES	Part of nursing charge, Not Payable separately
95	CLEAN SHEET	Part of Laundry/ Housekeeping, Not Payable separately
96	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by Hospital is payable
97	BLANKET/WARMER BLANKET	Part of room charge, Not Payable separately
	ADMINISTRATIVE OR NON - MEDICAL CHARGES	
98	ADMISSION KIT	Not Payable
99	BIRTH CERTIFICATE	Not Payable
100	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
101	CERTIFICATE CHARGES	Not Payable
102	COURIER CHARGES	Not Payable
103	CONVENYANCE CHARGES	Not Payable
104	DIABETIC CHART CHARGES	Not Payable
105	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
106	DISCHARGE PROCEDURE CHARGES	Not Payable
107	DAILY CHART CHARGES	Not Payable
108	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
109	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	Payable under Post- Hospitalisation where admissible
110	FILE OPENING CHARGES	Not Payable
111	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
112	MEDICAL CERTIFICATE	Not Payable
113	MAINTENANCE CHARGES	Not Payable
114	MEDICAL RECORDS	Not Payable

115	PREPARATION CHARGES	Not Payable
116	PHOTOCOPIES CHARGES	Not Payable
117	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
118	WASHING CHARGES	Not Payable
119	MEDICINE BOX	Not Payable
120	MORTUARY CHARGES	Payable up to 24 hrs, shifting charges not payable
121	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
	EXTERNAL DURABLE DEVICES	
122	WALKING AIDS CHARGES	Not Payable
123	BIPAP MACHINE	Not Payable
124	COMMODE	Not Payable
125	CPAP/ CAPD EQUIPMENTS	Device not payable
126	INFUSION PUMP – COST	Device not payable
127	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
128	PULSEOXYMETER CHARGES	Device not payable
129	SPACER	Not Payable
130	SPIROMETRE	Device not payable
131	SP02 PROBE	Not Payable
132	NEBULIZER KIT	Not Payable
133	STEAM INHALER	Not Payable
134	ARMSLING	Not Payable
135	THERMOMETER	Not Payable
136	CERVICAL COLLAR	Not Payable
137	SPLINT	Not Payable
138	DIABETIC FOOT WEAR	Not Payable
139	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
140	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
141	LUMBOSACRAL BELT	Payable for surgery of lumbar spine.
142	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia /quadriplegia for any reason and at reasonable cost of approximately Rs 200/day
143	AMBULANCE COLLAR	Not Payable
144	AMBULANCE EQUIPMENT	Not Payable
145	MICROSHEILD	Not Payable
146	ABDOMINAL BINDER	Essential and should be paid in post-surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.

	ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
147	BETADINE / HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC	Not Payable
148	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES Post hospitalization nursing charges	Not Payable
149	NUTRITION PLANNING CHARGES - DIETICIAN CHARGESDIET CHARGES	Patient Diet provided by hospital is payable
150	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
151	CREAMS POWDERS LOTIONS	Payable when prescribed (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
152	Digestion gels	Payable when prescribed
153	ECG ELECTRODES	One set every second day is Payable.
154	GLOVES Sterilized	Gloves payable / unsterilized gloves not payable
155	HIV KIT	payable Pre-operative screening
156	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
157	LOZENGES	Payable when prescribed
158	MOUTH PAINT	Payable when prescribed
159	NEBULISATION KIT	If used during Hospitalisation is Payable reasonably
160	NOVARAPID	Payable when prescribed
161	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
162	ZYTEE GEL	Payable when prescribed
163	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
	PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
164	AHD	Not Payable - Part of Hospital's internal Cost
165	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
166	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
	OTHERS	
167	VACCINE CHARGES FOR BABY	Not Payable
168	TPA CHARGES	Not Payable
169	VISCO BELT CHARGES	Not Payable
170	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
171	EXAMINATION GLOVES	Not payable
172	KIDNEY TRAY	Not Payable

173	MASK	Not Payable
174	OUNCE GLASS	Not Payable
175	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable
176	OXYGEN MASK	Not Payable
177	PAPER GLOVES	Not Payable
178	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction
179	REFERAL DOCTOR'S FEES	Not Payable
180	ACCU CHECK (Glucometery/ Strips)	Not payable pre Hospitalisation or post Hospitalisation / Reports and Charts required / Device not payable
181	PAN CAN	Not Payable
182	SOFNET	Not Payable
183	TROLLY COVER	Not Payable
184	UROMETER, URINE JUG	Not Payable
185	AMBULANCE	Payable
186	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
187	URINE BAG	Payable where Medically Necessary - maximum 1 per 24 hrs
188	SOFTOVAC	Not Payable
189	STOCKINGS	Payable for case like CABG etc.

Annexure 3

UNITED INDIA INSURANCE CO. LTD.
INDIVIDUAL HEALTH INSURANCE POLICY
(PLATINUM/ GOLD/SENIOR CITIZEN)

Sum Insured	Domiciliary Hospitalization Limit
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

Individual Health Policy Prospectus

Table of Benefits (brief indicative features only)

Features/Plan	Platinum	Gold	Senior Citizen
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	**INR 2 Lacs, 3 Lacs, 5 Lacs, 8 Lacs, 10 Lacs, 15 Lacs, 20 Lacs**	**INR 2 Lacs, 3 Lacs, 5 Lacs, 8 Lacs, 10 Lacs**	**INR 2 Lacs, 3 Lacs, 5 Lacs**
Hospitalisation, Pre (30days) and Post (60 days) Hospitalisation, Daycare procedures	Hospitalisation, Pre (30 days) and Post (60 days) Hospitalisation, Daycare procedures (140+) covered	Hospitalisation, Pre (30days) and Post (60 days) Hospitalisation, Daycare procedures (140+) covered	Hospitalisation, Pre (30days) and Post (60 days) Hospitalisation, Daycare procedures (140+) covered
Pre-existing disease	Pre-existing disease exclusion does not apply	Covered after 48 months of continuous coverage	Covered after 48 months of continuous coverage
Room / ICU charges	1% / 2% of SI	1% / 2% of SI	1% / 2% of SI
Limit for Cataract Surgery	Actuals	Actual expenses incurred or 25% of the sum insured whichever is less, subject to a maximum of INR 40000 only.	Actual expenses incurred or 25% of the sum insured whichever is less, subject to a maximum of INR 40000 only.
Limit for Hernia Surgery	Actuals	Actual expenses incurred or 25% of the sum insured whichever is less, subject to a maximum of INR 100000 only.	Actual expenses incurred or 25% of the sum insured whichever is less, subject to a maximum of INR 100000 only.
Limit for Hysterectomy surgery	Actuals	Actual expenses incurred or 25% of the sum insured whichever is less, subject to a maximum of INR 100000 only.	Actual expenses incurred or 25% of the sum insured whichever is less, subject to a maximum of INR 100000 only.
Limit for major surgery (include cardiac surgeries, brain tumour surgeries, pace maker implantation for sick sinus syndrome, cancer surgeries, hip, knee, joint replacement surgery, Organ Transplant)	Actuals	Actual expenses incurred or 70% of the Sum Insured whichever is less.	Actual expenses incurred or 70% of the Sum Insured whichever is less.
Ayurvedic Treatment	Up to sum insured	Up to sum insured	Up to sum insured
Domiciliary Treatment	Yes, subject to limits as shown in Annexure 3	Yes, subject to limits as shown in Annexure 3	Yes, subject to limits as shown in Annexure 3
Organ donor's medical expenses	Covered	Covered	Covered
Organ Transplant	Hospitalisation Expenses (excluding cost of organ) incurred for/by a Donor within the Sum Insured of the Insured Person	Hospitalisation Expenses (excluding cost of organ) incurred for/by a Donor within the Sum Insured of the Insured Person	Hospitalisation Expenses (excluding cost of organ) incurred for/by a Donor within the Sum Insured of the Insured Person

Good Health Incentives			
Health checkup	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 covers on payment of extra premium			
Ambulance Charges	upto a maximum of Rs.2500/- per person per policy period.	upto a maximum of Rs.2500/- per person per policy period.	upto a maximum of Rs.2500/- per person per policy period.
Hospital Daily Cash Allowance	Rs.250/500 per day, Maximum Rs. 2500/5000 per person per policy period	250/500 per day, Maximum Rs. 2500/5000 per person per policy period	250/500 per day, Maximum Rs. 2500/5000 per person per policy period

Individual Health Insurance Policy Prospectus
Premium Tables for Fresh Proposals

Platinum

SI / AGE	0-25	26-30	31-35
200000	2,891	3,455	3,811
300000	3,399	4,061	4,479
500000	4,167	4,979	5,492
800000	5,112	6,109	6,737
1000000	5,627	6,723	7,415
1500000	6,687	7,991	8,813
2000000	7,551	9,023	9,951

Gold

SI / AGE	36-40	41-45	46-50	51-55	56-60
200000	4,305	4,699	5,858	6,929	9,592
300000	5,060	6,029	7,516	9,106	12,607
500000	6,204	8,253	10,289	12,849	17,789
800000	7,611	11,217	14,823	19,071	26,403
1000000	8,377	12,769	17,162	22,386	30,992

Senior Citizen

SI / AGE	61-65
200000	12,032
300000	16,353
500000	24,071

Note:

1. GST as applicable will be charged extra
2. For Pre Existing Disease of diabetes and hypertension, premium will be loaded by 10% each
3. In case the policy covers more than one member of the family, a discount of 5% is offered on the premium of each and every member of the family
4. Discount of 10% (subject to a maximum of Rs. 2000 per policy) will be applicable for policies purchased online through UIIC website; this is applicable for new policies only

Individual Health Insurance Policy Prospectus
Premium Tables for Renewals

Platinum

SI / AGE	0-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60
200000	2,891	3,455	3,811	4,305	4,699	5,858	6,929	9,592
300000	3,399	4,061	4,479	5,060	6,029	7,516	9,106	12,607
500000	4,167	4,979	5,492	6,204	8,253	10,289	12,849	17,789
800000	5,112	6,109	6,737	7,611	11,217	14,823	19,071	26,403
1000000	5,627	6,723	7,415	8,377	12,769	17,162	22,386	30,992
1500000	6,687	7,991	8,813	9,956	16,142	22,327	29,848	41,322
2000000	7,551	9,023	9,951	11,242	19,049	26,857	36,524	50,565

Gold

SI / AGE	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	>75
200000	4,305	4,699	5,858	6,929	9,592	12,032	14,760	17,038	20,048
300000	5,060	6,029	7,516	9,106	12,607	16,353	20,061	23,158	27,249
500000	6,204	8,253	10,289	12,849	17,789	24,071	29,528	34,087	40,109
800000	7,611	11,217	14,823	19,071	26,403	35,383	43,404	50,105	58,957
1000000	8,377	12,769	17,162	22,386	30,992	42,335	51,932	59,950	70,541

Senior Citizen

SI / AGE	61-65	66-70	71-75	>75
200000	12,032	14,760	17,038	20,048
300000	16,353	20,061	23,158	27,249
500000	24,071	29,528	34,087	40,109

Note:

1. GST as applicable will be charged extra
2. For Pre Existing Disease of diabetes and hypertension at the time of entry, premium will be loaded by 10% each
3. In case the policy covers more than one member of the family, a discount of 5% is offered on the premium of each and every member of the family