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The Assured named in the First Schedule has contracted with Union Assurance PLC duly incorporated under the Companies Act No 17 of 1982 and assigned with the registration No N (PBS) 137 and re-registered under the Companies Act No 7 of 2007 and now bearing Company No PQ 12 and having its registered office at No 20, St. Michael's Road, Colombo 3 (hereinafter referred to as "the Company") for an Assurance on the terms contained in this Policy and on the basis of the Proposal (and any supplementary proposal or memorandum) by the Assured for the Assurance.

If premiums are paid to the Company in accordance with the First Schedule of the Policy then upon the happening of an event upon which a benefit specified in the First Schedule becomes payable, such benefit shall be paid by the Company.

It is understood that this contract has been entered into in utmost good faith. In the event of Non-disclosure or misrepresentation by the Assured or the Life Assured, the Company shall reserve the right to declare the Policy null and void.

Any notice of assignment or nominations in respect of this Policy must be sent to Life Operations, Union Assurance PLC, Union Assurance Centre, No. 20, St. Michael's Road, Colombo 03.

The Schedules, General Policy Conditions and Privileges, Conditions, Clauses and Endorsements hereinafter contained or attached hereto shall also form part and parcel of the Contract.

Chief Operating Officer

Chief Executive Officer/Principal Officer

IMPORTANT

This is a legally binding document. Please keep it in a safe place. Further, please ensure that the premium is paid when it is due to gain the maximum benefits under this policy.

Union Assurance PLC is licensed by the Insurance Regulatory Commission of Sri Lanka (IRCSL).

Specimen

Schedule No. 2

2. GENERAL POLICY CONDITIONS & PRIVILEGES

2.1 RESIDENCE, TRAVEL AND OCCUPATION

This Policy is free from all restrictions as to travel, residence and occupation, unless otherwise stated therein.

2.2 PROOF OF AGE

The Company reserves the right to require proof of age of the Life Assured before making any payment under this Policy. If age has been inadvertently mis-stated, this alone shall not invalidate the Policy but an equitable adjustment shall be made to the premium and/ or benefits under the Policy.

2.3 LAW & INTERPRETATION

(i) This Policy shall be governed by the laws of Sri Lanka.

(ii) Where the context admits any reference to the Life Assured includes reference to his or her personal representatives and the singular includes the plural, and vice versa.

(iii) Any reference to the masculine gender shall also apply to the feminine gender and vice versa.

(iv) The Additional Rider (Supplementary) Benefit applicable, as stated in the First Schedule to the Policy shall also be subject to the terms and conditions specified in the Schedules of such Supplementary Benefit.

(v) In the event of any inconsistency between this Policy and its English and Tamil texts, the Sinhala text of this Policy shall prevail.

(vi) All premiums and benefits under this Insurance are payable in lawful currency of Sri Lanka.

(vii) To understand your rights and how your collected information is used, please visit our privacy policy on www.unionassurance.com/privacy policy

2.4 PAYMENT OF PREMIUM / GRACE PERIOD

The following conditions apply to the payment of all premium contributions in respect of the benefits provided by this Policy;

(i) All premium payments are payable on or before their relevant due dates.Premium shall be deemed to have been duly paid only when received by the Company's Head Office, any of the Branch Offices or other Institutions, and their Branch Offices, which are duly authorized by the Company to accept payment of premium.

(ii) The official confirmation of receipt of the payment given by the company or any other institution duly authorized by the Company to accept payment of premium, is the only valid evidence of payment of premium.

(iii) A Grace Period of Thirty (30) days from its relevant premium due date shall be allowed for payment of each premium after the first premium. The entire Policy and all coverage under this Policy shall automatically terminate after the Grace Period without the need for prior notification if any premium remains unpaid. During this Grace Period all of the benefits provided by this Policy shall continue.

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2.5 INVESTMENT ACCOUNT

The Company shall maintain an Individual Investment Account in respect of policies issued under this Plan.

(i) The premium paid for the Primary Benefit/ Basic Sum Assured as described in the Part II of the First Schedule shall be credited to the Investment Account on the actual date paid, as per the allocation percentages given below, based on the term of the policy and the Policy year to which the premium belongs to.

	Term 10-14	Term 15-19	Term 20-30
1st policy year	45%	35%	25%
2nd policy year	75%	75%	75%
3rd policy year onwards	98%	98%	98%

(ii) At the beginning of each calendar year the Company shall decide on an interim dividend rate which shall be used to accumulate the fund during the year. At the end of the calendar year the Company shall decide on the actual dividend rate for that year. The Company shall guarantee the interim rate decided at the beginning of the year as the minimum dividend rate for a given year.

(iii) The Investment Account shall be debited with the following charges;

(a) A monthly risk premium for the cost of life cover provided under Primary Benefit in the part II of the First Schedule. The risk premium is calculated for the amount at risk, i.e. the difference between the Primary Benefit and the Investment Account and for the current age nearer birthday + 3 years of the Life Assured.

(b) A monthly Fund Management Charge (FMC) of 1% per annum is levied on the Investment Account to cover investment, administration, acquisition and other services provided by the Company.

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Refer to the Annexure II for mortality rates used in cost of life cover calculation

2.6 PRIMARY BENEFIT

2.6.1. DEATH BENEFIT

Upon the death of the Life Assured prior to the Vesting Date of the policy, the Company shall pay the Sum Assured (as specified in the Part II of the First Schedule) to the nominee. The amount remaining in the Investment Account will continue to grow with the regular premium remittances by way of activating the Waiver of Premium Benefit as specified under Schedule No.3.5 hereunder and the accumulation of monthly dividends.

2.6.2. PENSION BENEFIT

The Illustrated Pension Benefits shown in the Part II of the First Schedule are only illustrations of Accumulated Funds at the respective dividend rates and are intended to provide an indication of likely Pension Benefits on the vesting date of the Policy. The Actual Pension Value paid by the Company will depend on the actual dividends declared and the dates of payment of premium. After acquiring the Vesting Date of the policy, the company shall pay the value of the Investment Account to the Life Assured or to the Nominee upon death of the Life Assured subject to the following two (02) options;

(i) Monthly Installment Option – Total fund value will be utilized for the payment of Monthly pension during the term selected as described in the illustrations of Part II of the First Schedule.

Specimen

(ii) Lump Sum Option – Total Fund Value accumulated can be withdrawn as a lump sum at the Vesting Date.

2.7 SURRENDER VALUE

The Policy shall acquire a Surrender Value on completion of Three (03) years from the date of commencement and after Three (03) years premiums have been paid. Any of the Supplementary Benefits stated in the First Schedule of the Policy, shall not acquire a Surrender Value.

The Surrender Value as determined by the Company, less any indebtedness to the Company, in respect of the Policy may be obtained by the person/s entitled to the Policy proceeds subject to the compliance with the Company's requirements. The payment of any premium subsequent to the surrender of the Policy shall not create any liability to the Company.

The Surrender Value will be calculated as follows.

Net Surrender Value = Investment account value at the date of Surrender – Surrender Charge

Surrender Charge is Calculated as follows.

Surrender Charge = Investment account value at the date of Surrender x Surrender Charge %

Refer to the Annexure I for Surrender Charges.

2.8 PARTIAL WITHDRAWAL

On acquiring a Surrender Value as described in section 2.7 of the Second Schedule, the Life Assured may obtain a Partial Withdrawal of Fifteen Percent (15%) of the accumulated funds from the Investment Account once during the policy Term.

2.9 NON PAYMENT OF PREMIUM

If a premium is in default beyond the Grace Period the following conditions shall apply;

(i) **If the Policy has not acquired a Surrender Value** then the Policy shall lapse and no further benefits shall become payable in respect of any claim arising after the date of lapse.

(ii) **If the Policy has acquired a Surrender Value** as detailed in section **2.7** above, the Policy shall be converted to a Paid-up Policy and the Conditions and Privileges detailed in the section **2.10** below shall apply.

2.10 PAID-UP POLICIES AND NON FORFEITURE BENEFIT

The Company on written application by the person/s entitled to the Policy subject to such proof shall convert the Policy to a Paid-up Policy at any time after the Policy has acquired a Surrender Value. The following privileges and conditions shall apply upon conversion whether it is on request or as stated in 2.8 (ii) above automatically.

(i) After acquiring a paid-up value: If regular premiums are defaulted during the period of grace,then, the investment account shall continue to be credited with annual dividends and charges shall continue to be debited. The amount in the investment account shall be paid at maturity.

(ii) The Amount in the Investment Account shall in case of prior death. However, if the date of death is within a period of One Hundred and Eighty (180) days from the due date of the first premium in default, then, the Basic Sum Assured or the Investment Account whichever is higher shall be payable

Specimen

subject to deduction of premium arrears.

(iii) The additional benefits provided under the Policy shall automatically terminate, and no further benefit shall be payable in respect of any claims arising after the date of conversion.

(iv) Payment or acceptance of any premium subsequent to the conversion shall not create any further liability, unless the Policy has been subsequently revived.

2.11 REVIVAL / REINSTATEMENT OF A LAPSED POLICY

A Policy which has lapsed or automatically become paid-up due to non-payment of premium may be revived / reinstated during the lifetime of the Life Assured before the final Premium payment due date for the Primary benefit of the Policy on the following terms.

(i) Within six months from the due date of the first unpaid premium, on payment of the full arrears of premium.

(ii) After six months from the due date of the first unpaid premium, on payment of all due premiums with re-instatement charges and upon submission of satisfactory medical evidence of the insurability of the life assured, at no cost to the company.

However, revival / reinstatement of the policy / supplementary benefits shall be considered based on company's underwriting guidelines and the policyholder's insurability at that time.

2.12 POLICY ALTERATIONS

The Company may, at its sole discretion, consider requests of the Policyholder for alterations to the Policy on such terms and conditions that it may deem necessary.

The Privileges and Conditions of this Policy cannot be waived or changed except by a Policy Endorsement duly approved and signed by an Authorized Officer of the Company.

2.13 DIVIDENDS

The Investment Account shall be credited with a dividend on 31st December each year. Dividends shall represent One Hundred percent (100%) of the distributable investment earnings arising from the proportion of the Company's Life fund attributable to the "Investment Account" as determined by the Company's Actuary.

2.14 POLICY LOANS

No policy loans are allowed under this policy.

2.15 ASSIGNMENTS

Any assignment of this Policy shall not be binding upon the Company unless written notice of such assignment is received, recorded and acknowledged by the Company. Upon receipt of any written notice of assignment, the Company shall be entitled to require the production of all original documents for examination to the Company's satisfaction before recording such assignment. In recording assignment, the Company does not accept any responsibility or express any opinion of the contents as to its validity or legal effect.

Specimen

2.16 NOMINATIONS

(i) During the term of the Policy, the Life Assured may, by giving written notice satisfactory to the Company, appoint a nominee/s under this Policy or change any duly appointed nominee/s.

(ii) Subject to the provisions of any law, a change of nominee shall be effective only after receiving a written request from the Assured and it is recorded and acknowledged by the Company.

(iii) When the nominee is changed, the change shall be deemed effective from the date of the written notice. The receipt by the nominee of sums payable by the Company under this Policy shall constitute a valid discharge of the Company's liabilities under the Policy. Any acknowledgment of receipt by the nominee entitled thereto shall be conclusive proof of payment.

(iv) If there is no nominee living at the time of the death of the Life Assured, then the amount payable shall be paid to the estate of the Life Assured.

(v) Any assignment of this Policy shall have the effect of cancelling the current appointment of a nominee. Upon re-assignment of the said Policy, the Policyholder shall be required to give written notice to the Company, to appoint a new nominee or re-appoint the previous nominee.

(vi) The appointment of nominee shall only apply to benefits payable as a result of the death of the Life Assured.

2.17 CLAIM HANDLING PROCEDURE

For immediate assistance with your claim and for any inquiries, please contact us through following channels.

- Call Center General Number: 0112 990 990
- Hotline: 1330 (Operating Hours: 24/7)
- Company Email: info@unionassurance.com

As part of the claim procedure, please ensure that you submit the following standard documents for the assessment of your claim. The standard documentation required is stated based on the claim type.

Please note that each claim is subject to an assessment, and the claim department may request additional documents from the claimant. if necessary, based on the findings of the documents received. Furthermore, kindly note that timely submission of all requested and relevant documents is crucial for the claim evaluation process.

Health Claims

- Claim form
- Diagnosis Ticket
- Original Bills and cash receipts for reimbursement benefits
- Relevant medical reports

Death Claims

- Claim form
- Death certificate

Specimen

- Policy Document/Policy Certificate
- Nominee/s National Identity Card or Birth certificate
- Marriage Certificate if nominee is spouse
- In-quest Report & Postmortem Report (if conducted)

Critical Illness Claims

- Claim Form
- Medical reports / Diagnosis Ticket related to Critical Illness
- Private Medical Attendant's Report (PMAR)

Disability Claims

- Claim Form
- Medical reports / Diagnosis Ticket
- Private Medical Attendant's Report (PMAR)

For specific policy conditions, please refer the applicable conditions of the policy document.

Claims will be settled within 14 days once all documentation are fulfilled, including the establishment of the quantum of the claim, receipt of the discharge documents, and verification of the claimant's identity.

2.18 SUICIDE

If the Life Assured commits suicide whether sane or insane within Twelve (12) calendar months from the Date of Commencement or the Date of Revival/Reinstatement of the Policy whichever shall be the later, the Policy shall become void except to the extent of the interest of third parties acquired by bona fide assignment for valuable consideration and written notice of such interest has been received and acknowledged by the Company prior to the date of death.

2.19 TOTAL EXCLUSION OF LIABILITY

The Company shall not be liable to make any payment under this Policy;

(i) Where the death or accident was caused by or resulted from the active participation of the Life Assured whether directly or indirectly in, any wars and circumstances comparable with a state of war, act of terrorism, invasion, act by a foreign enemy, hostilities and war like events (with or without declaration of war), civil war, riot, mutiny, revolution, confiscation or nationalization by order of any public or local government or authority; any act of a person acting in the name of or in connection with any organization whose activities aim to overturn a de jure or de facto government violently; and/or

(ii) Where the death or accident caused as a result of any action taken by any member of the armed or police forces whilst attempting to quell such war, rebellion, insurrection, mutiny or terrorist activity or whilst attempting to arrest or apprehend the Life Assured in connection with his/her direct or indirect participation or involvement in any such war, rebellion, riot, insurrection, mutiny or terrorist activity; and/or

(iii) Where the Life Assured has failed to make a full and frank disclosure of all material facts in the proposal, declaration and/or in any other documents/applications related to and/or required under this Policy; and/or

Specimen

(iv) Where the claim has been made fraudulently or dishonestly; and/or

(v) Where the Life Assured has breached any Law; and/or in act of breach by the Life Assured of any Law; and/or

(vi) Where the Life Assured has breached any Law; and/or injuries resulting in an assault provoked by the Life Assured or resisting an arrest while being a party to a criminal act.

Whenever the Company disclaims liability under this clause the burden of proving that the death or accident complained of was not occasioned or did not result from any of the acts or events stipulated above shall be on the person/s claiming any benefit under this Policy.

2.20 FORFEITURE OF PREMIUM

If the liability under this Policy is repudiated on the grounds of non-disclouser and/or any untrue or incorrect averment is contained in the proposal and declaration or in any other subsequent documentation, which is provided in terms of this contract, this Policy shall be void and all premiums that have been paid under and in terms of this Policy shall be forfeited.

2.21 MISSING PERSONS

Where the death of the Life Assured is sought to be established on the basis of a presumption generated in circumstances where he/she had not been heard of for a period of One (01) year by those who would have naturally heard of him/her if he/she had been alive, no money shall become due under the Policy until the expiry of a period of Seven (07) years computed from the time when the Life Assured had ceased to be heard of.

2.22 RIGHT OF CANCELLATION

This Policy may be cancelled by the Life Assured or the Assured by returning the Policy document to the Company within Twenty One (21) days (known as Cooling-off period/free-look period) from the Date of receipt of the policy.

In the event of such cancellation, the Company shall refund all premium paid after recovering the cost incurred for medical examinations and/or laboratory investigations. However, if a policy is cancelled after Twenty One (21) days from the Date of receipt of the policy, there shall be no payment made, other than the Surrender Value if acquired.

2.23 INCONTESTABILITY

After the Policy has been in force for a period of two (02) years from the date of its commencement, last revival or reinstatement whichever is later, the Company will not contest the validity of this policy unless their is proof to the effect that the Assured or the Life Assured made fraudulent statements of a material nature to induce the Company into forming a contract under this Policy with the Assured or the Life Assured.

2.24 TAXATION

The Company is entitled to make such deductions which, in its option, are necessary and appropriate, from the fund and from any of the benefits recievable under the Insurance on account of any tax or other payment which may be imposed by any legislation, order or regulation or otherwise upon the Company, Policy Owner, Nominee or Claimant.

Specimen

2.25 GRIEVANCES/COMPLAINTS HANDLING AND DISPUTE RESOLUTION PROCEDURE

The Complaint Handling Policy outlines the procedures for addressing any grievances related to the services or policies offered by the company. The policy ensures a structured approach to resolving complaints promptly and efficiently.

(i) Methods of Lodging Complaints

- Customer Service Hotline: Contact the Customer Service Hotline on 0112990990 or short Code 1330
- Written Complaint: Submit a written complaint to the Head Office of the company.
- In-Person Visit: Visit the Head Office of the company or any branch of the company.
- Corporate WhatsApp: Send a written complaint via corporate WhatsApp on 0771330000.
- Corporate Email: Send a written complaint via email to info@unionassurance.com.

Upon lodging a complaint, the policyholder will receive the acknowledgment within 3 working days with a system-generated complaint reference number. This reference number allows the policyolder to track the status of their complaint throughout the resolution process. Please visit www.unionassurance.com for further information pertaining to the company Complaint handling procedure.

(ii) Resolution Timeline:

Complaints, will be resolved within 14 working days from the date of complaint is received. In cases where additional time is required, the policyholder will be duly notified with reasons for the extension with an indicative period within which a resolution can be expected.

(iii) Dispute Resolution:

If the policyholder is not satisfied with the initial resolution, an appeal can be raised to the nominated officer as an Alternative Dispute Resolution (ADR) mechanism within 4 weeks from the date of receipt of the resolution or response from the company. All matters relating to complaints and appeals pending for a response from the policyholder will be closed in the absence of a reply after 4weeks from the date of receipt of the resolution/response from the company.

In the event of disagreement with the resolution provided by the company, the policyholder retains the right to escalate the complaint to the insurance ombudsman or the Insurance Regulatory Commission of Sri Lanka or to commence litigation through the courts within Sri Lanka. This ensures impartial resolution and adherence to regulatory standards.

Details of Insurance Regulatory Commission of Sri Lanka (IRCSL).
Director Investigations
Insurance Regulatory Commission of Sri Lanka
Level 11 East Tower, World Trade Center Colombo 01
Tel: 0112396184-9 / 0112335167
Email: investigation@ircsl.gov.lk / info@ircsl.gov.lk

Details of Insurance Ombudsman.
The Sri Lanka Insurance Ombudsman
No 01, Bethesda Place, Milagiriya, Bambalapitiya.
Tel : 0114528671, 0112505542
Email : info@insuranceombudsman.lk
Web : www.insuranceombudsman.lk

Specimen

2.26 LIMITS UNDER PRIMARY BENEFIT

The following limits apply to eligibility for the primary benefit:

Category	Minimum (Years)	Maximum (Years)
Age	25	55
Policy Term	10	30

Specimen

Schedule No. 3

3. SCHEDULES FOR ADDITIONAL RIDER (SUPPLEMENTARY) BENEFITS

Schedule No. 3.1

3.1 LEVEL TERM BENEFIT (LTB)

3.1.1 KEY PURPOSE AND COVERAGE

Level Term Benefit (LTB) shall be applicable if included in this policy and shown in the Part II of the First Schedule to this Policy.

Sum Assured indicated under Level Term Benefit in the Part II of the First Schedule, shall become payable upon the death of the Life Assured prior to the expiry date of this rider, subject to the general terms and conditions of the Policy and the specific terms and conditions set out below.

3.1.2 CONDITIONS

(i) For the consideration of benefits, the death of the Life Assured should occur;

  (a) Before the expiry date of this Level Term Benefit as stipulated in the Part II of the First Schedule; or
  (b) Before the Policy Anniversary following the 75th birthday of the Life Assured; whichever happens earlier.

(ii) Level Term Benefit shall lapse on expiry of the Thirty (30) days grace period if the premium remains unpaid. The Company reserves the right to decline the reinstatement or revival of this Benefit.

(iii) This rider Benefit shall terminate if the main policy is terminated.

(iv) Level Term Benefit shall not;

  (a) Participate in profits or
  (b) Acquire a surrender value, paid up value or a maturity value.

3.1.3 EXCLUSIONS APPLICABLE FOR THIS BENEFIT – N/A

Specimen

Schedule No. 3.2

3.2 UNION SUWAMAGA BENEFIT (SMB)

3.2.1 KEY PURPOSE AND COVERAGE

The Suwamaga Benefit shall be applicable if included in this policy and shown in the Part II of the First Schedule to this Policy.

Sum Assured indicated under Suwamaga Benefit in the First Schedule shall become payable if the Life Assured, and/or the Spouse of the Life Assured is/are or the first time in his/her life has been diagnosed or has undergone surgery for a Critical Illness listed below (except ANGIOPLASTY) subject to the general terms and conditions of the Policy and the specific terms and conditions set out below.

In the case of ANGIOPLASTY, Fifty percent (50%) of the Suwamaga Benefit Sum Assured shall be paid subject to a maximum amount of Rupees One Million (Rs. 1,000,000) per individual, from all insurances taken to cover Critical Illness/Dread Disease.

3.2.2.WAITING PERIOD

The cover except for ANGIOPLASTY shall commence Ninety (90) after the;

(i) Date of Commencement of the Benefit; or
(ii) Date of Policy; or
(iii) Date of Revival/Reinstatement of Policy; or
(iv) Hundred and Eighty (180) days from the date of inclusion if the Benefit is included subsequently whichever is later.

The cover on ANGIOPLASTY shall commence Hundred and Eighty (180) days after the

(i) Date of Commencement of the Benefit; or
(ii) Date of Policy; or
(iii) Date of Revival/Reinstatement of the Policy
whichever is later.

3.2.3 DEFINITIONS OF CRITICAL ILLNESSES

(I) CANCER

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The diagnosis must be confirmed by a Specialist.

Unless not specifically excluded, leukaemia, malignant lymphoma and myelodysplastic syndrome are covered under this definition.

For the above definition, the following are not covered:

- Any tumour histologically classified as pre-malignant, non-invasive or carcinoma in situ (including ductal and lobular carcinoma in situ of the breast and cervical dysplasia CIN-1, CIN-2 and CIN-3).
- Any prostate cancer unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.

Specimen

- Chronic lymphocytic leukaemia unless having progressed to at least Binet Stage B
- Basal cell carcinoma and squamous cell carcinoma of the skin and malignant melanoma stage IA (T1aN0M0) unless there is evidence for metastases
- Papillary thyroid cancer less than 1 cm in diameter and histologically described as T1N0M0
- Papillary micro-carcinoma of the bladder histologically described as Ta
- Polycythemia rubra vera and essential thrombocythemia
- Monoclonal gammopathy of undetermined significance
- Gastric MALT Lymphoma if the condition can be treated with Helicobacter- eradication
- Gastrointestinal stromal tumour (GIST) stage I and II according to the AJCC Cancer Staging Manual, Seventh Edition (2010)
- Cutaneous lymphoma unless the condition requires treatment with chemotherapy or radiation
- Microinvasive carcinoma of the breast (histologically classified as T1mic) unless the condition requires mastectomy, chemotherapy or radiation
- Microinvasive carcinoma of the cervix uteri (histologically classified as stage IA1) unless the condition requires hysterectomy, chemotherapy or radiation.

(II) HEART ATTACK (MYOCARDIAL INFARCTION)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- Other acute Coronary Syndromes
- Any type of angina pectoris
- A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

(III) STROKE

Death of brain tissue due to an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage (including subarachnoid haemorrhage), or embolism from an extracranial source with

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination.

The neurological deficit must persist for more than 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist and supported by imaging findings.
For the above definition, the following are not covered:

- Transient Ischaemic Attack (TIA) and Prolonged Reversible Ischaemic Neurological Deficit (PRIND);
- Traumatic injury to brain tissue or blood vessels
- Neurological deficits due to general hypoxia, infection, inflammatory disease, migraine or medical intervention
- Incidental imaging findings (CT- or MRI-scan) without clearly related clinical symptoms (silent stroke)

Specimen

(IV) CORONARY ARTERY (BYPASS) SURGERY

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

- Angioplasty and/or any other intra-arterial procedures

(V) KIDNEY FAILURE (END STAGE RENAL DISEASE)

Chronic and irreversible failure of both kidneys, as a result of which either regular haemodialysis or peritoneal dialysis is instituted or renal transplantation is carried out. The dialysis must be medically necessary and confirmed by a Consultant Nephrologist.

For the above definition, the following are not covered:

- Acute reversible kidney failure with temporary renal dialysis

(VI) MAJOR ORGAN TRANSPLANTATION

The undergoing as a recipient of an allograft or isograft transplant of one or more of the following:

- Heart
- Kidney
- Liver (including split liver and living donor liver transplantation)
- Lung (including living donor lobe transplantation or single-lung transplantation)
- Bone marrow (allogeneic hematopoietic stem cell transplantation preceded by total bone marrow ablation)
- Small bowel
- Pancreas Partial or full face, hand, arm and leg transplantation (composite tissue allograft transplantation) is covered under this definition, too. The condition leading to transplantation must be deemed untreatable by any other means, as confirmed by a Specialist.

For the above definition, the following are not covered:

- Transplantation of other organs, body parts or tissues (including cornea and skin)
- Transplantation of other cells (including islet cells and stem cells other than hematopoietic)

(VII) PARALYSIS

Total and irreversible loss of muscle function to the whole of any 2 limbs as a result of injury to, or disease of the spinal cord or brain. Limb is defined as the complete arm or the complete leg. Paralysis must be present for more than 3 months, confirmed by a Consultant Neurologist and supported by clinical and diagnostic findings.

For the above definition, the following are not covered:

- Paralysis due to self-harm or psychological disorders
- Guillain-Barré-Syndrome
- Periodic or hereditary paralysis

Specimen

(VIII) BLINDNESS (LOSS OF SIGHT)

Profound vision loss of both eyes resulting from either disease or trauma that cannot be corrected by refractive correction, medication, or surgery. Profound vision loss is evidenced by either a visual acuity of 3/60 or less (0.05 or less in the decimal notation) in the better eye after best correction or a visual field of less than 10° diameter in the better eye after best correction. The diagnosis must be confirmed by a Consultant Ophthalmologist.

(IX) HEART VALVE SURGERY

The undergoing of surgery to replace or repair one or more defective heart valves. The following procedures are covered under this definition:

- Heart valve replacement or repair with full sternotomy (vertical division of the breastbone), partial sternotomy or thoracotomy
- Ross-Procedure
- Catheter-based valvuloplasty
- Transcatheter aortic valve implantation (TAVI)

The surgery must be determined to be medically necessary by a Consultant Cardiologist or Cardiac Surgeon and supported by echocardiogram or cardiac catheterisation findings.

For the above definition, the following are not covered:

- Transcatheter mitral valve clipping

(X) SURGERY OF THE DISEASE OF THE AORTA

The undergoing of surgery to treat narrowing, obstruction, aneurysm or dissection of the aorta. Minimally invasive procedures like endovascular repair are covered under this definition. The surgery must be determined to be medically necessary by a Consultant Surgeon and supported by imaging findings.

For the above definition, the following are not covered:

- Surgery to any branches of the thoracic or abdominal aorta (including aortofemoral or aortoiliac bypass grafts)
- Surgery of the aorta related to hereditary connective tissue disorders (e.g. Marfan syndrome, Ehlers–Danlos syndrome)

Surgery following traumatic injury to the aorta

(XI) MULTIPLE SCLEROSIS

Definite diagnosis of multiple sclerosis, which must be confirmed by a Consultant Neurologist and supported by all of the following criteria:

- Current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months
- Magnetic resonance imaging (MRI) showing at least two lesions of demyelination in the brain or spinal cord characteristic of multiple sclerosis

For the above definition, the following are not covered:

- Possible multiple sclerosis and neurologically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis
- Isolated optic neuritis and neuromyelitis optica

Specimen

(XII) ANGIOPLASTY

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

(XIII) APALLIC SYNDROME

A vegetative state is absence of responsiveness and awareness due to dysfunction of the cerebral hemispheres, with the brain stem, controlling respiration and cardiac functions, remaining intact. The definite diagnosis must be evidenced by all of the following:

- Complete unawareness of the self and the environment
- Inability to communicate with others
- No evidence of sustained or reproducible behavioural responses to external stimuli
- Preserved brain stem functions
- Exclusion of other treatable neurological or psychiatric disorders with appropriate neurophysiological or neuropsychological tests or imaging procedures.

The diagnosis must be confirmed by a Consultant Neurologist and the condition must be medically documented for at least one month without any clinical improvement.

(XIV) BENIGN BRAIN TUMOUR

A definite diagnosis of a benign brain tumour, which is defined as a non-malignant growth of tissue located in the cranial vault and limited to the brain, meninges or cranial nerves.

The tumour must be treated with at least one of the following:

- Complete or incomplete surgical removal
- Stereotactic radiosurgery
- External beam radiation

If none of the treatment options is possible due to medical reasons, the tumour must cause a persistent neurological deficit, which has to be documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist or Neurosurgeon and supported by imaging findings.

For the above definition, the following are not covered:

- The diagnosis or treatment of any cyst, granuloma, hamartoma or malformation of the arteries or veins of the brain
- Tumours of the pituitary gland

(XV) CHRONIC LIVER DISEASE

A definite diagnosis of severe liver disease evidenced by a Child-Pugh score of at least 7 points (Child-Pugh Class B or C). The score must be calculated by all of the following variables:

- Total bilirubin levels

Specimen

- Serum albumin levels
- Severity of ascites
- International normalized ratio (INR)
- Hepatic encephalopathy

The diagnosis must be confirmed by a Consultant Gastroenterologist and supported by imaging findings.

For the above definition, the following are not covered:

- Severe liver disease secondary to alcohol or drug use (including hepatitis B or C infections acquired by intravenous drug use)

(XVI) CHRONIC LUNG DISEASE

A definite diagnosis of severe lung disease resulting in chronic respiratory failure and evidenced by all of the following:

- FEV1 (Forced Expiratory Volume at 1 second) being less than 40% of predicted on 2 occasions at least 1 month apart
- Treatment with oxygen therapy for at least 16 hours per day for a minimum of three months
- Persistent reduction in partial oxygen pressures (PaO2) below 55mmHg (7.3 kPa) in arterial blood gas analysis measured without administration of oxygen

The diagnosis must be confirmed by a Specialist

(XVII) COMA

A definite diagnosis of a state of unconsciousness with no reaction or response to external stimuli or internal needs, which:

- results in a score of 8 or less on the Glasgow coma scale for at least 96 hours,
- requires the use of life support systems, and
- results in a persistent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The diagnosis must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

- Medically induced coma
- Any coma due to self-inflicted injury, alcohol or drug use

(XVIII) DEAFNESS (LOSS OF HEARING)

A definite diagnosis of a permanent and irreversible loss of hearing in both ears as a result ofsickness or accidental injury. The diagnosis must be confirmed by a Consultant ENT specialist and supported by an average auditory threshold of more than 90 db at 500, 1000 and 2000 hertz in the better ear using a pure tone audiogram.

(XIX) FULMINANT VIRAL HEPATITIS

A definite diagnosis of fulminant viral hepatitis evidenced by all of the following:

- Typical serological course of acute viral hepatitis
- Development of hepatic encephalopathy
- Decrease in liver size
- Increase in bilirubin levels
- Coagulopathy with an international normalized ratio (INR) greater than 1.5

Specimen

- Development of liver failure within 7 days of onset of symptoms
- No known history of liver disease

The diagnosis must be confirmed by a Consultant Gastroenterologist.

For the above definition, the following are not covered:

- All other non-viral causes of acute liver failure (including paracetamol or aflatoxin intoxication)
- Fulminant viral hepatitis associated with intravenous drug use

(XX) LOSS OF SPEECH

A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease. The condition has to be present for a continuous period of at least 6 months. The diagnosis must be confirmed by a Consultant ENT Specialist.

For the above definition, the following are not covered:

- Loss of speech due to psychiatric disorders

(XXI) MAJOR BURNS

Burns that involve destruction of the skin through its full depth to the underlying tissue (third degree burns) and covering at least 20% of the body surface as measured by "The Rule of Nines" or the "Lund and Browder Chart". The diagnosis must be confirmed by a Specialist.

For the above definition, the following are not covered:

- Third-degree burns due to self-inflicted injury
- Any first- or second-degree burns

(XXII) MOTOR NEURONE DISEASE

A definite diagnosis of one of the following motor neurone diseases :

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Primary lateral sclerosis (PLS)
- Progressive muscular atrophy (PMA)
- Progressive bulbar palsy (PBP)

The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- Feeding oneself – the ability to feed oneself when food has been prepared and made available.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist and supported by nerve conduction studies (NCS) and electromyography (EMG).

Specimen

For the above definition, the following are not covered:

- Multifocal motor neuropathy (MMN) and inclusion body myositis
- Post-polio syndrome
- Spinal muscular atrophy

(XXIII) MUSCULAR DYSTROPHY

A definite diagnosis of one of the following muscular dystrophies:

- Duchenne Muscular Dystrophy (DMD)
- Becker Muscular Dystrophy (BMD)
- Emery-Dreifuss Muscular Dystrophy (EDMD)
- Limb-Girdle Muscular Dystrophy (LGMD)
- Facioscapulohumeral Muscular Dystrophy (FSHD)
- Myotonic Dystrophy Type 1 (MMD or Steinert's Disease)
- Oculopharyngeal Muscular Dystrophy (OPMD)

The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- Feeding oneself – the ability to feed oneself when food has been prepared and made available.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist and supported by electromyography (EMG) and muscle biopsy findings.

For the above definition, the following are not covered:

- Myotonic dystrophy and other forms of myotonia

(XXIV) PULMONARY ARTERIAL HYPERTENSION

A definite diagnosis of primary pulmonary hypertension evidenced by all of the following:

- Marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain (Class III or IV of the New York Heart Association classification) over a period of 3 months
- Mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterisation

The diagnosis must be confirmed by a Consultant Cardiologist or Lung Specialist.

For the above definition, the following are not covered:

- Pulmonary hypertension secondary to lung, heart, or systemic disease
- Chronic thromboembolic pulmonary hypertension (CTEPH)
- Drug- or toxin-induced pulmonary hypertension

Specimen

(XXV) ALZHEIMER'S DISEASE (BEFORE AGE 65)

A definite diagnosis of Alzheimer's disease evidenced by all of the following:

- Loss of intellectual capacity involving impairment of memory and executive functions (sequencing, organizing, abstracting, and planning), which results in a significant reduction in mental and social functioning.
- Personality change
- Gradual onset and continuing decline of cognitive functions
- No disturbance of consciousness
- Typical neuropsychological and neuroimaging findings (e.g. CT scan)

The disease must require constant supervision (24 hours daily) [before age 65]. The diagnosis and the need for supervision must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

Other forms of dementia due to brain or systemic disorders or psychiatric conditions

(XXVI) AMYOTROPHIC LATERAL SCLEROSIS

A definite diagnosis of amyotrophic lateral sclerosis. The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- Feeding oneself – the ability to feed oneself when food has been prepared and made available.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist and supported by nerve conduction studies (NCS) and electromyography (EMG).

For the above definition, the following are not covered:

- Other forms of motor neurone disease
- Multifocal motor neuropathy (MMN) and inclusion body myositis
- Post-polio syndrome
- Spinal muscular atrophy
- Polymyositis and dermatomyositis

(XXVII) APLASTIC ANAEMIA

A definite diagnosis of aplastic anaemia resulting in severe bone marrow failure with anaemia, neutropenia and thrombocytopenia. The condition must be treated with blood transfusions and, in addition, with at least one of the following:

- Bone marrow stimulating agents
- Immunosuppressants
- Bone marrow transplantation

The diagnosis must be confirmed by a Consultant Haematologist and evidenced by bone marrow histology

Specimen

(XXVIII) ENCEPHALITIS

A definite diagnosis of acute viral encephalitis resulting in a persistent neurological deficit documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist and supported by typical clinical symptoms and cerebrospinal fluid or brain biopsy findings.

For the above definition, the following are not covered:

- Encephalitis in the presence of HIV
- Encephalitis caused by bacterial or protozoal infections
- Myalgic or paraneoplastic encephalomyelitis

(XXIX) MAJOR HEAD TRAUMA

A definite diagnosis of a disturbance of the brain function as a result of traumatic head injury. The head trauma must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- Feeding oneself – the ability to feed oneself when food has been prepared and made available.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist or Neurosurgeon and supported by typical imaging findings (CT scan or brain MRI).

For the above definition, the following are not covered:

- Any major head trauma due to self-inflicted injury, alcohol or drug use

(XXX) MEDULLARY CYSTIC DISEASE

A definite diagnosis of medullary cystic disease evidenced by all of the following:

- Ultrasound, MRI or CT scan showing multiple cysts in the medulla and corticomedullary region of both kidneys
- Typical histological findings with tubular atrophy, basement membrane thickening and cyst formation in the corticomedullary junction
- Glomerular filtration rate (GFR) of less than 40 ml/min (MDRD formula)

The diagnosis must be confirmed by a Consultant Nephrologist.

For the above definition, the following are not covered:

- Polycystic kidney disease
- Multicystic renal dysplasia and medullary sponge kidney
- Any other cystic kidney disease

Specimen

(XXXI) PARKINSON'S DISEASE – BEFORE AGE 65

A definite diagnosis of primary idiopathic Parkinson's disease, which is evidenced by at least two out of the following clinical manifestations:

- Muscle rigidity
- Tremor
- Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses)

Idiopathic Parkinson's disease must result [before age 65] in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months despite adequate drug treatment.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- Feeding oneself – the ability to feed oneself when food has been prepared and made available.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist.

The implantation of a neurostimulator to control symptoms by deep brain stimulation is, independent of the Activities of Daily Living, covered under this definition. The implantation must be determined to be medically necessary by a Consultant Neurologist or Neurosurgeon.

For the above definition, the following are not covered:

- Secondary parkinsonism (including drug- or toxin-induced parkinsonism)
- Essential tremor
- Parkinsonism related to other neurodegenerative disorders

(XXXII) SYSTEMIC LUPUS ERYTHEMATOSUS

A definite diagnosis of systemic lupus erythematosus evidenced by all of the following:

- Typical laboratory findings, such as presence of antinuclear antibodies (ANA) or anti-dsDNA antibodies.
- Symptoms associated with lupus erythematosus (butterfly rash, photosensitivity, serositis)
- Continuous treatment with corticosteroids or other immunosuppressants.

Additionally, one of the following organ involvements must be diagnosed:

- Lupus nephritis with proteinuria of at least 0.5 g/day and a glomerular filtration rate of less than 60 ml/min (MDRD formula)
- Libman-Sacks endocarditis or myocarditis
- Neurological deficits or seizures over a period of at least 3 months and supported by cerebrospinal fluid or EEG findings. Headaches, cognitive and psychiatric abnormalities are specifically excluded.

The diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologist.

Specimen

For the above definition, the following are not covered:

- Discoid lupus erythematosus or subacute cutaneous lupus erythematosus
- Drug-induced lupus erythematosus

(XXXIII) SEVERE RHEUMATIC ARTHRITIS

A definite diagnosis of rheumatoid arthritis evidenced by all of the following:

- Typical symptoms of inflammation (arthralgia, swelling, tenderness) in at least 20 joints over a period of 6 weeks at the time of diagnosis
- Rheumatoid factor positivity (at least twice the upper normal value) and/or presence of anti-citrulline antibodies
- Continuous treatment with corticosteroids
- Treatment with a combination of "Disease Modifying Anti-Rheumatic Drugs" (e.g. methotrexate plus sulfasalazine/leflunomide) or a TNF inhibitor over a period of at least 6 months.

The diagnosis must be confirmed by a Consultant Rheumatologist.

For the above definition, the following are not covered:

Reactive arthritis, psoriatic arthritis and activated osteoarthritis

(XXXIV) POLIOMYELITIS

A definite diagnosis of acute poliovirus infection resulting in paralysis of the limb muscles or respiratory muscles. The paralysis must be medically documented for at least 3 months from the date of diagnosis.

The diagnosis must be confirmed by a Consultant Neurologist and supported by laboratory tests proving the presence of the poliovirus.

For the above definition, the following are not covered:

- Poliovirus infections without paralysis
- Other enterovirus infections
- Guillain-Barré syndrome or transverse myelitis

(XXXV) TERMINAL ILLNESS

A life assured shall be regarded as terminally ill only if that life assured is diagnosed or suffering from an advanced or rapidly progressing disease condition which in the opinion of two independent medical practitioners' specializing in treatment of such illness, is not curable and will lead to death within 6 months. The insured must no longer receive active treatment other than that of palliative therapy (reducing the severity of disease symptoms). Terminal illness due to AIDS is excluded. The terminal illness must be diagnosed and confirmed by medical practitioners' registered with the Sri Lanka Medical Council and approved by the Company.

(XXXVI) CARDIOMYOPATHY

A definite diagnosis of one of the following primary cardiomyopathies:

- Dilated Cardiomyopathy
- Hypertrophic Cardiomyopathy (obstructive or non-obstructive)
- Restrictive Cardiomyopathy
- Arrhythmogenic Right Ventricular Cardiomyopathy

The disease must result in at least one of the following:

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- Left ventricular ejection fraction (LVEF) of less than 40% measured twice at an interval of at least 3 months.
- Marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain (Class III or IV of the New York Heart Association classification) over a period of at least 6 months.
- Implantation of an Implantable Cardioverter Defibrillator (ICD) for the prevention of sudden cardiac death

The diagnosis must be confirmed by a Consultant Cardiologist and supported by echocardiogram, cardiac MRI or cardiac CT scan findings.

The implantation of an Implantable Cardioverter Defibrillator (ICD) must be determined to be medically necessary by a Consultant Cardiologist.

For the above definition, the following are not covered:

- Secondary (ischaemic, valvular, metabolic, toxic or hypertensive) cardiomyopathy
- Transient reduction of left ventricular function due to myocarditis
- Cardiomyopathy due to systemic diseases
- Implantation of an Implantable Cardioverter Defibrillator (ICD) due to primary arrhythmias (e.g. Brugada or Long-QT-Syndrome)

(XXXVII) LOSS OF LIMBS

A definite diagnosis of complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis has to be confirmed by a Specialist.

For the above definition, the following are not covered:

- Loss of limbs due to self-inflicted injury

(XXXVIII) NECROTISING FASCIITIS

A definite diagnosis of necrotising fasciitis evidenced by all of the following:

- Progressive, rapidly spreading bacterial infection located in the deep fascia, with secondary necrosis of the subcutaneous tissues of the limbs or trunk
- Fever and rapid increase in C-reactive protein (CRP) levels
- Surgical resection of all necrotic tissue fournier's gangrene is covered under this definition. The diagnosis must be confirmed by a Consultant Surgeon and evidenced by microbiological or histological findings.

For the above definition, the following are not covered:

- Gas gangrene
- Gangrene caused by diabetes, neuropathy or vascular diseases

(XXXIX) LOSS OF INDEPENDENT EXISTENCE

A definite diagnosis [before age 65] of a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.

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- Feeding oneself – the ability to feed oneself when food has been prepared and made available.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis has to be confirmed by a Specialist.

3.2.4 RIGHT OF THE COMPANY TO REVISE PREMIUM AND TERMS AND CONDITIONS

The premium payable for this Benefit is guaranteed only for a period of One (01) year from the Date of Commencement this Benefit. The Company reserves the right to revise the premium rates and/or alter the terms and conditions applicable at every policy anniversary. Such change shall be implemented only after Thirty (30) days notice has been given to the Policy holder and, shall be effective from the Policy Anniversary subsequent to the notice.

3.2.5 NOTICE OF CHANGE OF OCCUPATION

Any substantial change in the occupation and nature of duties of the Life Assured must be intimated to the Company within Fourteen (14) days of such change and the Benefit under this Rider need to get re-approved by the Company. The Company shall not be liable in respect of any claim, which may arise whilst the Life Assured is engaged in any occupation substantially different to that provided in the Proposal/Application form and/or Declaration of Health.

3.2.6 NOTICE AND PROOF OF CLAIM

The Company should be served with written notice of critical illness upon which a claim may be based and such notice must be given to the Head Office or nearest branch together with the then address and the present place of residence of the Life Assured/spouse, at least within a period of Thirty (30) days from the date of sustaining such illness. Failure to give notice within such time shall give the Company a right not to entertain such claim. The evidence for proof of Critical illness has to be submitted to the Company without any expenses to the Company.

3.2.7 CONDITIONS

(i) This Suwamaga Benefit shall expire;

  (a) On the expiry date of this benefit as stipulated in the Part II of the First Schedule or
  (b) on the Policy Anniversary, following the 70th birthday of the Life Assured, whichever happens earlier; and/or
  (c) On the first instance of diagnosis or surgery of any of the Critical Illnesses listed during the currency of the Policy, irrespective of whether the benefit is paid and/ or the benefit amount.

(ii) This Rider Benefit shall lapse on expiry of the Thirty (30) days grace period if the premium remains unpaid.

(iii) The Suwamaga Benefit shall terminate if the main policy is terminated.

(iv) This Rider Benefit shall not;

  (a) Participate in profits or
  (b) Acquire a surrender value, paid-up value or a maturity value.

Specimen

(v) A Critical Illness must be diagnosed by a specialist medical practitioner and must be supported by clinical and other reports acceptable to the Company.

(vi) The Company reserves the right to appoint a specialized medical practitioner or practitioners to examine the Life Assured/s who has been diagnosed as suffering from a Critical Illness.

(vii) If the death of Life Assured, occurs within Thirty (30) days of the diagnosis of a critical Illness covered, the amount payable/paid under this benefit will be deducted from the amount payable under the Primary Benefit Life Cover indicated in the Part II of the First Schedule.

(viii) After a claim has been paid for a Critical Illness, the Life Assured shall continue the payment of premium for the other benefits, if the Life Assured is alive.

(ix) An assignee, nominee or beneficiary shall not have the right to receive any payments arising from a claim under the benefits provided in this schedule.

(x) The maximum benefit amount payable on all policies taken by an individual for this Benefit from the Company is limited to Rupees Five Million (Rs.5,000,000) and the maximum amount that can be claimed from all insurances taken from any insurer is limited to Rupees Ten Million(Rs. 10,000,000).

(xi) The spouse shall have no authority to nominate a beneficiary to receive this benefit or assign this benefit to another party during the lifetime of the Life Assured.

(xii) The cover against Angioplasty shall only come into effect if this benefit has been obtained prior to the 55th birthday of the Life Assured/s.

3.2.8 EXCLUSIONS APPLICABLE FOR THIS BENEFIT

The Company shall not be liable to make any payment under Suwamaga Benefit, if the illness of the Life Assured is occurred directly or indirectly due to;

(i) Lesions resulting from attempted suicide or intentional self-infliction; and/or

(ii) Illnesses or accidents caused by excessive ingestion of alcoholic drinks, drugs or hallucinogens (alcoholism and drug dependency) including driving while drunk (accidents occurring when the blood alcohol level is above the legally permitted level); and/or

(iii) Pre-existing conditions unless they have been declared by the Life Assured/Spouse on the proposal form/individual application form, in the health declaration section and accepted by the company in writing, on or before to the policy affirmation date, as detailed on the policy or in another amendment of the company; and/or

(iv) An accident while engaged in aviation or aeronautics in any capacity other than that of a fare paying passenger of a recognized airline, the Life Assured having at that time no duties on board the aircraft or requiring descent there from; and/or

(v) War and circumstances comparable with a state of war, invasion, act by a foreign enemy, hostilities and warlike events (with or without a declaration of war), civil war, riot, mutiny, revolution, confiscation or nationalization by order of any public or local government or authority; any act of a person acting in the name of or in connection with any organization whose activities aim to overturn a de jure or de facto government violently; and/or

(vi) Naval or military operations of the armed forces or air force and participation in operations requiring

Specimen

the use of arms or which are ordered by military authorities for combating terrorists, rebels and the like; and/or

(vii) Hazardous activities, including but not limited to scuba diving, motorcycling, parachuting,hang-gliding, rock or mountain climbing, racing of any kind other than on foot, rafting, bungee jumping, potholing; or any sports in a professional capacity unless otherwise agreed in writing by the Company; and/or

Specimen

Schedule No. 3.3

3.3 FUNERAL EXPENSES BENEFIT (FEB)

3.3.1 KEY PURPOSE AND COVERAGE

The Funeral Expenses Benefit (FEB) shall be applicable if included in this policy and shown in the Part II of the First Schedule to this policy.

The Sum Assured indicated under Funeral Expense Benefit (FEB) in the Part II of the First Schedule, shall become payable upon the death of the Life Assured prior to the expiry Date of this rider, subject to general terms and conditions of the policy and specific terms and conditions set out below.

3.3.2 WAITING PERIOD

The cover under this benefit shall commence after Three Hundred and Sixty Five (365) days after

(i) Date of Commencement of the Benefit; or
(ii) Date of Policy; or
(iii) Date of Revival/Reinstatement of the Policy whichever is later.

3.3.3 NOTICE AND PROOF OF CLAIMS

Written notice of the death upon which a claim may be based must be given to the Head Office or nearest branch of the Company within a period of Seven (07) days from the date of death. Failure to give notice within such time shall give the Company a right to repudiate such claim. The evidence for proof of death has to be submitted to the Company at the expense of the claimant.

3.3.4 CONDITIONS

(i) This Funeral Expenses Benefit shall expire;
   (a) On the expiry date of this benefit as stipulated in the Part II of the First Schedule; or
   (b) On the Policy Anniversary following the 70th birthday of the Life Assured/s; whichever happens earlier.

(ii) This Rider Benefit shall lapse on expiry of the Thirty (30) days grace period if the premium remains unpaid.

(iii) The Funeral Expense Benefit shall terminate if the main policy is terminated.

(iv) This Rider Benefit shall not;
   (a) Participate in profits or
   (b) Acquire a surrender value, paid-up value or a maturity value.

(v) The maximum sum assured on all policies taken by an individual under Funeral Expense Benefit from the Company is limited to rupees Fifty thousand (Rs.250,000/-).

(vi) The decision to admit liability under the "FEB" benefit does not bind the Company to undertake liability for any other claims/benefits under this policy and is made without prejudice to the Company's liability.

3.3.5 EXCLUSIONS APPLICABLE TO THIS BENEFIT - N/A

Specimen

Schedule No. 3.4

3.4. WAIVER OF PREMIUM BENEFIT ON DEATH (WPD)

3.4.1 KEY PURPOSE AND COVERAGE

The Waiver of Premium Benefit on Death (WPD) is included as an in-built benefit in this Policy and is shown in Part II of the First schedule.

If the death of the Life Assured occurs during the premium paying term of the Policy, the Company shall waive the regular premium payable on the Primary Benefit, falling due from the date of death of the Life Assured up to the expiry of the premium paying period of the Policy.

The Waiver of Premium Benefit on Death is subject to the general terms and conditions of the Policy and the specific terms and conditions set out below.

3.4.2 NOTICE AND PROOF OF CLAIMS

The Company must receive written notice within sixty (60) days from the date of death of the Life Assured upon which a claim may be based. Such notice must be given to the Head Office or the nearest branch of the Company. Evidence for proof of death must be submitted to the Company.

3.4.3 CONDITIONS

(i) For consideration of benefits, death of the Life assured should occur;

  (a) Before the expiry date of this benefit as stipulated in the Part II of the First Schedule; or

  (b) Before the Policy Anniversary following the 70th birthday of the Life Assured;
  whichever happens earlier.

(ii) This Rider Benefit shall lapse on expiry of the Thirty (30) days grace period if the premium remains unpaid.

(iii) The Waiver of Premium Benefit on Death shall terminate if the main policy is terminated.

(iv) This Rider Benefit shall not;

  (a) Participate in profits or

  (b) Acquire a Surrender value, Paid-up value or a Maturity value.

Specimen

Schedule No. 3.5

3.5 WAIVER OF PREMIUM BENEFIT ON TOTAL AND PERMANENT DISABILITY CAUSED BY AN ACCIDENT OR SICKNESS (WP)

3.5.1 KEY PURPOSE AND COVERAGE

The Waiver of Premium Benefit on Total and Permanent Disability due to an Accident or Sickness (WP) is included as an in - built benefit and shown in the Part II of the First Schedule to this policy.

If the Life Assured becomes totally and permanently disabled as a result of an accident or sickness and continues to be disabled over a period of not less than One Hundred and Eighty (180) days in duration the Company shall waive the Regular Premium on following Benefits, falling due from the date of and during the period of continuance of the disablement up to the expiry of the benefit.

(i) Primary Benefit
(ii) Level Term Benefit (LTB)
(iii) Funeral Expenses Benefit (FEB)
(iv) Suwamaga Benefit (SMB)

The Waiver of Premium Benefit on Total and Permanent Disability due to an Accident or Sickness is subject to the general terms and conditions of the Policy and the specific terms and conditions set out below

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3.5.2 WAITING PERIOD

The Waiver of Premium Benefit shall commence Thirty (30) days after the

(i) Date of Commencement of the Benefit; or
(ii) Date of Policy; or
(iii) Date of Revival/Reinstatement of Policy; or
(iv) Hundred and Eighty (180) days from the date of inclusion if the Benefit is included subsequently whichever is later.

3.5.3 RIGHT OF THE COMPANY TO REVISE PREMIUM AND TERMS AND CONDITIONS

The premium payable for this Benefit is guaranteed only for a period of One (01) year from the Date of Commencement of the Benefit. The Company reserves the right to revise the premium rates and/or alter the terms and conditions applicable at every policy anniversary. Such change shall be implemented only after Thirty (30) days notice has been given to the Policy holder and, shall be effective from the Policy Anniversary subsequent to the notice.

3.5.4 NOTICE OF CHANGE OF OCCUPATION

Any substantial change in the occupation of the Life Assured must be intimated to the Company in writing, within Fourteen (14) days of such change and the risks covered are required be reapproved. The Company shall not be liable in respect of any claim, if the Life Assured is engaged in any occupation at the time of disability which is substantially different to that declared in the Proposal/Application form and/or Declaration of Health.

3.5.5 NOTICE AND PROOF OF CLAIMS

The Company should be served with written notice of any injury or sickness upon which a claim may be based and such notice must be given to the Head Office or nearest branch together with the then address and the present place of residence of the Life Assured, at least within a period of Sixty (60) days from the date of sustaining such injury or sickness. Failure to give notice within such time shall give the Company a right not to entertain such claim. The evidence for proof of disability has to be submitted at expense to the Company.

Specimen

3.5.6 PROOF OF A CONTINUOUS DISABLEMENT

Though proof of Total and Permanent Disability may have been accepted as satisfactory by the Company, the Company shall be entitled to demand, at reasonable intervals from the Life Assured proof of the continuance of such disability without any expenses to the Company. If the Life Assured fails to furnish such proof, or if the Life Assured becomes able to perform any work or engage in any occupation or profession to earn or obtain any wages, compensation or profit then, all premiums falling due after the date of recovery shall become payable according to the terms and conditions of the benefits for which the premiums are waived off.

3.5.7 CONDITIONS

(i) For consideration of benefits, such Total and Permanent Disability due to an Accident or Sickness should occur;
   (a) Before the expiry date of this benefit as stipulated in the Part II of the First Schedule; or
   (b) Before the Policy Anniversary following the 70th birthday of the Life Assured; whichever happens earlier.

(ii) This Rider Benefit shall lapse on expiry of the Thirty (30) days grace period if the premium remains unpaid.

(iii) The Waiver of Premium Benefit shall terminate if the main policy is terminated.

(iv) This Rider Benefit shall not;
   (a) Participate in profits or
   (b) Acquire a surrender value, paid-up value or a maturity value.

(v) An assignee, nominee or beneficiary shall not have the right to receive any payments arising from a claim under the benefits provided in this schedule.

3.5.8 EXCLUSIONS APPLICABLE FOR THIS BENEFIT

The Company shall not be liable to make any payment under Waiver of Premium Benefit, if the Total and Permanent Disability of the Life Assured is occurred directly or indirectly due to;

(i) Lesions resulting from attempted suicide or intentional self-infliction; and/or

(ii) Illnesses or accidents caused by excessive ingestion of alcoholic drinks, drugs or hallucinogens (alcoholism and drug dependency) including driving while drunk (accidents occurring when the blood alcohol level is above the legally permitted level); and/or

(iii) Pre-existing conditions unless they have been declared by the Policyholder / Spouse on the proposal form/individual application form, in the health declaration section and accepted by the company in writing, on or before to the policy affirmation date, as detailed on the policy or in another amendment of the company; and/or

(iv) An accident while engaged in aviation or aeronautics in any capacity other than that of a fare paying passenger of a recognized airline, the Life Assured having at that time no duties on board the aircraft or requiring descent there from; and/or

(v) War and circumstances comparable with a state of war, invasion, act by a foreign enemy, hostilities and warlike events (with or without a declaration of war), civil war, riot, mutiny, revolution, confiscation or nationalization by order of any public or local government or authority; any act of a person acting in the name of or in connection with any organization whose activities aim to overturn a de jure or de facto government violently; and/or

Specimen

(vi) Naval or military operations of the armed forces or air force and participation in operations requiring the use of arms or which are ordered by military authorities for combating terrorists, rebels and the like; and/or

(vii) Nuclear risks:- e.g. exposure to nuclear energy (nuclear reactions, radiation, contamination) or nuclear waste of any type or chemical contamination; and/or

(viii) Hazardous activities, including but not limited to scuba diving, motorcycling, parachuting, hang-gliding, rock or mountain climbing, racing of any kind other than on foot, rafting, bungee jumping, potholing; or any sports in a professional capacity unless otherwise agreed in writing by the Company; and/or

(ix) Natural perils:- such as but not limited to avalanches landslides, earthquakes, floods, tsunami or tidal waves caused by earthquakes or volcanic eruptions, cyclones, storms, tempest, hurricanes, tornados & typhoons; and/or

Specimen

Schedule No. 3.6

3.6 UNION SMART HEALTH PREMIER (USHP)

3.6.1 KEY PURPOSE AND COVERAGE

The Union Smart Health Premier (USHP) Benefit shall be applicable if included in this Policy and shown in the Part II of the First Schedule to this Policy.

Union Smart Health Premier Benefit shall become operative;

(i) If the Covered Person (as indicated in the First Schedule) is hospitalized for more than Twenty-Four (24) hours continuously as a result of an Illness or Accident on the recommendation and approval of a doctor, in a Hospital and/or if a Surgery as defined under Section 3.14.4 of this Schedule is performed on the Covered Person an expense has been incurred by way of a hospital bill payment to the Hospital; or

(ii) The daily Hospital Cash Benefit under USHP as defined under Section 3.14.2 (V) of this Schedule shall become operative if the Covered Person is hospitalized for more than Twenty-Four (24) hours continuously as a result of an Illness or Accident on the recommendation and approval of a doctor, in a non-paying ward of a Government Hospital. The Cover is subject to the general terms and conditions of this Policy and the specific terms and conditions set out below.

3.6.2 BENEFIT AMOUNT

The Company shall reimburse the expenses incurred subject to the eligibility for the Benefits and the limits mentioned in the First Schedule and the Table of Benefits specified hereunder. The payment shall be paid as a Lump Sum and is subject to proof of Hospitalization and/or performed Surgery to the satisfaction of the Company. The Company disclaims any liability for any consequences of treatment administered during or due to or as a consequence of a Surgery.

The Covered Person may claim for any number of Hospitalizations and the Company shall pay the eligible amount provided that the annual limit for the year of the Covered Person has not been exhausted.

If the Benefit has been obtained as a Family Unit, the annual overall family limit, which is equivalent to the Sum Assured under this Benefit shall be shared among the Life Assured, Parents of the Life assured, spouse and children below 23 years of age named in First Schedule. The total maximum Sum Assured on all Policies taken by an individual under Union Smart Health Premier, Union Smart Health Plus, Union Smart Health and Union MediGuard Benefit from the Company is limited to Rupees Forty Million (Rs.40,000,000/-).

Specimen

3.6.2 (I) TABLE OF BENEFITS

	Benefit Schedule (limits in LKR)	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7	Plan 8	Plan 9
	Geographical Coverage	**Sri Lanka**								
	Annual Overall Limit (AOL) - Basic Annual Sum Insured (LKR)	**LKR 100,000/-**	**LKR 200,000/-**	**LKR 300,000/-**	**LKR 400,000/-**	**LKR 500,000/-**	**LKR 750,000/-**	**LKR 1,000,000/-**	**LKR 1,250,000/-**	**LKR 1,500,000/-**
	Limits applicable for different categories of expenses.									
1	Hospitalization benefit	Reimbursement of Hospital Room Board and ICU ward is subject to a maximum of 30% of the Basic Annual Sum Insured								
	(a) Daily Hospital Room and Board Benefit									
	Maximum Room, Boarding expenses per day 2% of the Benefit amount	LKR 4,000/-	LKR 8,000/-	LKR 6,000/-	LKR 8,000/-	LKR 10,000/-	LKR 15,000/-	LKR 20,000/-	LKR 25,000/-	LKR 30,000/-
	Maximum Room, Boarding expenses per day for treatment Outside Sri Lanka	Not Applicable								
	(b) Daily ICU Hospital Room and Board Benefit									
	Maximum Room, Boarding expenses per day 4% of the Benefit amount	LKR 4,000/-	LKR 8,000/-	LKR 12,000/-	LKR 16,000/-	LKR 20,000/-	LKR 30,000/-	LKR 40,000/-	LKR 50,000/-	LKR 60,000/-
	Maximum Room, Boarding expenses per day for treatment Outside Sri Lanka	Not Applicable								
2	**Surgical Benefit** (includes Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees & nursing charges)	As-charged, subject to the charge is the provider's usual fee for a service that does not exceed the customary fee in Sri Lanka and is reasonable based on the circumstances								
3	**Miscellaneous Hospital Services and Supplies Benefit** (Includes Operation Theatre Charges, Anesthesia, Blood, Oxygen, Medicines and Drugs, except non-medical services)	As-charged, subject to the charge is the provider's usual fee for a service that does not exceed the customary fee in Sri Lanka and is reasonable based on the circumstances								
4	**Ambulance Charges**	(i) As-charged, subject to a max. of 2% of Basic Annual Sum Insured. (ii) Benefit is payable once in a policy year, subject to the claim being admissible and payable only when a licensed ambulance service is used.								
		LKR 2,000/-	LKR 4,000/-	LKR 6,000/-	LKR 8,000/-	LKR 10,000/-	LKR 15,000/-	LKR 20,000/-	LKR 25,000/-	LKR 30,000/-

Specimen

Benefit Schedule (limits in LKR)		Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7	Plan 8	Plan 9
Geographical Coverage		Sri Lanka								
Annual Overall Limit (AOL) - Basic Annual Sum Insured (LKR)		LKR 100,000/-	LKR 200,000/-	LKR 300,000/-	LKR 400,000/-	LKR 500,000/-	LKR 750,000/-	LKR 1,000,000/-	LKR 1,250,000/-	LKR 1,500,000/-
Limits applicable for different categories of expenses.										
5	**Day Care Treatment (Hospitalization as an in-patient for less than 24 hours)**	(i) Covered only for surgeries or treatments within Sri Lanka, subject to a Basic Annual Sum Insured. (ii) Coverage is limited to covered list of day care surgeries. (iii) Out-patient procedures or treatment are not covered under the plan.								
6	**Pre-Hospitalization Expenses Benefit**	Payable up to 5% of the basic sum insured for 30 days prior to date of hospitalization. This benefit is a sub-limit of the Basic Sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.								
	(applicable for all hospitalizations, irrespective of Private or Public Hospital)									
7	**Post-Hospitalization Expenses Benefit**	Payable up to 5% of the basic sum insured for 30 days postdate of discharge from the hospital. This benefit is a sub-limit of the Basic Sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.								
	(applicable for all hospitalizations, irrespective of Private or Public Hospital)									
8	**Organ Donor Expenses**	Covered within the overall Sum Insured of the Donee and payable only for hospitalization expenses for the Donor.								
9	**Prosthesis and Implants - 20% of the Benefit amount**									
10	**Overseas treatment**	Not Applicable								
11	**Hospitalization in a non-paying ward (Public Hospitals or similar)**	0.5% of the Basic Annual Sum Insured per day, up to a maximum cap of 30% of Basic Annual Sum Insured per year.								
		Expenses pertaining to the investigations and drugs prescribed by the doctor in relation to the hospitalized condition will be payable maximum up to 70% of the Basic Annual Sum Insured per year.								
12	**Health Check-up Option**	Not Applicable								
13	**Hospital Admission Charges**	As-charged, subject to a maximum of 5% of Basic Annual Sum Assured per hospitalisation as a sub-limit within 70% of the Basic Sum Assured.								

Specimen

Benefit Schedule (limits in LKR)		Plan 10	Plan 11	Plan 12	Plan 13	Plan 14	Plan 15	Plan 16	Plan 17
Geographical Coverage		Sri Lanka							
Annual Overall Limit (AOL) - Basic Annual Sum Insured (LKR)		LKR 2,000,000/-	LKR 3,000,000/-	LKR 4,000,000/-	LKR 5,000,000/-	LKR 10,000,000/-	LKR 20,000,000/-	LKR 30,000,000/-	LKR 40,000,000/-
Limits applicable for different categories of expenses.									
1	**Hospitalization benefit**	Reimbursement of Hospital Room Board and ICU ward is subject to a maximum of 30% of the Basic Annual Sum Insured							
	(a) Daily Hospital Room and Board Benefit								
	Maximum Room, Boarding expenses per day for treatment within Sri Lanka - 2% of the Benefit amount	LKR 40,000/-	LKR 60,000/-	LKR 80,000/-	LKR 100,000/-	LKR 200,000/-	LKR 400,000/-	LKR 600,000/-	LKR 800,000/-
	Maximum Room, Boarding expenses per day for treatment Outside Sri Lanka - 3% of the Benefit amount	LKR 60,000/-	LKR 90,000/-	LKR 120,000/-	LKR 150,000/-	LKR 300,000/-	LKR 600,000/-	LKR 900,000/-	LKR 1,200,000/-
	(b) Daily ICU Hospital Room and Board Benefit								
	Maximum Room, Boarding expenses per day for treatment within Sri Lanka -4% of the Benefit amount	LKR 80,000/-	LKR 120,000/-	LKR 160,000/-	LKR 200,000/-	LKR 400,000/-	LKR 800,000/-	LKR 1,200,000/-	LKR 1,600,000/-
	Maximum Room, Boarding expenses per day for treatment Outside Sri Lanka - 6% of the Benefit amount	LKR 120,000/-	LKR 180,000/-	LKR 240,000/-	LKR 300,000/-	LKR 600,000/-	LKR 1,200,000/-	LKR 1,800,000/-	LKR 2,400,000/-
2	**Surgical Benefit** (includes Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees & nursing charges)	As-charged, subject to the charge is the provider's usual fee for a service that does not exceed the customary fee in the geographic area and is reasonable based on the circumstances.							
3	**Miscellaneous Hospital Services and Supplies Benefit** (Includes Operation Theatre Charges, Anesthesia, Blood, Oxygen, Medicines and Drugs, except non-medical services)	(i) As-charged, subject to charge is the provider's usual fee for a service that does not exceed the customary fee in the geographic area and is reasonable based on the circumstances (ii) In case of overseas treatment, there is a maximum cap of 2 visits per patient per day.							

Specimen

	Benefit Schedule (limits in LKR)	Plan 10	Plan 11	Plan 12	Plan 13	Plan 14	Plan 15	Plan 16	Plan 17
	Geographical Coverage	**Sri Lanka**							
	Annual Overall Limit (AOL) - Basic Annual Sum Insured (LKR)	**LKR 2,000,000/-**	**LKR 3,000,000/-**	**LKR 4,000,000/-**	**LKR 5,000,000/-**	**LKR 10,000,000/-**	**LKR 20,000,000/-**	**LKR 30,000,000/-**	**LKR 40,000,000/-**
	Limits applicable for different categories of expenses.								
4	**Ambulance Charges**	(i) As-charged, subject to a max. of 2% of Basic Annual Sum Insured. (ii) Benefit is payable once in a policy year, subject to the claim being admissible and payable only when a licensed ambulance service is used.							
		LKR 2,000/-	LKR 4,000/-	LKR 6,000/-	LKR 8,000/-	LKR 10,000/-	LKR 15,000/-	LKR 20,000/-	LKR 25,000/-	LKR 30,000/-
5	**Day Care Treatment (Hospitalization as an in-patient for less than 24 hours)**	(i) Covered only for surgeries or treatments , subject to a sub-limit of Basic Annual Sum Insured. (ii) The coverage is limited to the covered list of Day care surgeries. (iii) Out-patient procedures or treatment are not covered under the plan.							
6	**Pre-Hospitalization Expenses Benefit**	Payable up to 5% of the basic sum insured for 30 days prior to date of hospitalization. This benefit is a sub-limit of the Basic Sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.							
	(applicable for all hospitalizations, irrespective of Private or Public Hospital)	LKR 100,000/-	LKR 150,000/-	LKR 200,000/-	LKR 250,000/-	LKR 500,000/-	LKR 1,000,000/-	LKR 1,500,000/-	LKR 2,000,000/-
7	**Post-Hospitalization Expenses Benefit**	Payable up to 5% of the basic sum insured for 30 days postdate of discharge from the hospital. This benefit is a sublimit of the Basic Sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.							
	(applicable for all hospitalizations, irrespective of Private or Public Hospital)	LKR 100,000/-	LKR 150,000/	LKR 200,000/-	LKR 250,000/-	LKR 500,000/-	LKR 1,000,000/-	LKR 1,500,000/-	LKR 2,000,000/-
8	**Organ Donor Expenses**	Covered within the overall Sum Insured of the Donee and payable only for hospitalization expenses for the Donor.							
9	**Prosthesis and Implants -** 20% of the Benefit amount	LKR 400,000/-	LKR 600,000/-	LKR 800,000/-	LKR 1,000,000/-	LKR 2,000,000/-	LKR 4,000,000/-	LKR 6,000,000/-	LKR 8,000,000/-
10	**Overseas treatment**	In case of planned hospitalization, to be pre-intimated to the insurer and pre-authorization is mandatory. Emergency hospitalization needs to be intimated to insurer within 48 hours of hospitalization and in case a higher than eligible room category was opted for, a co-payment of 25% would be applicable on the eligible insurance claim amount.							
11	**Hospitalization in a non-paying ward (Public Hospitals or similar)**	0.5% of the Basic Annual Sum Insured per day, up to a maximum of LKR 20,000/- per day. Maximum cap is 30% of the Basic annual Sum Assured per year							
		LKR 10,000/-	LKR 15,000/-	LKR 20,000/-	LKR 20,000/-	LKR 20,000/-	LKR 20,000/-	LKR 20,000/-	LKR 20,000/-
		Expenses pertaining to the investigations and drugs prescribed by the doctor in relation to the hospitalized condition will be payable maximum up to 70% of the Basic Annual Sum Insured per year.							
12	**Health Check-up Option**	After three consecutive claim free policy years, up to 1% of the basic annual sum insured is payable for health check-up at Union Assurance empaneled medical centers.							
13	**Hospital Admission Charges**	As-charged, subject to a maximum of 5% of Basic Annual Sum Assured per hospitalisation as a sub-limit within 70% of the Basic Sum Assured.							

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3.6.2 (II) BENEFIT MULTIPLIER

If no claim has been made under Union Smart Health Premier Benefit for a full policy year and the policy is kept in force by paying due premium continuously for the policy year within the grace period, the Company may apply Benefit Multiplier, by automatically increasing Twenty Five Percent (25%) of the Union Smart Health Premier Benefit Sum Assured for the next policy year.

The maximum limit of this additionally accumulated sum assured under Benefit Multiplier is One Hundred Percent (100%) of the Union Smart Health Premier Benefit Sum Assured.

In the event a claim is made in a policy year upon applying the Benefit Multiplier, then the Sum Assured accumulated shall automatically decrease by Twenty Five Percent (25%) of Union Smart Health Premier Benefit sum assured in the following Policy Year. However, this reduction will not reduce the Sum Assured below the initial Sum Assured of Union Smart Health Premier Benefit shown in the Part II of the First Schedule.

3.6.2 (III) BENEFIT REVIVAL

In case of complete exhaustion of the annual Sum Assured limit of Union Smart Health Premier Benefit and the sum assured accumulated under Benefit Multiplier, the Company shall grant Benefit Revival once in a policy year provided that the reason for hospitalization is not directly or indirectly related to any of the preceding causes of hospitalization. In any Policy Year, the Benefit Revival shall provide an additional cover up to a maximum of One Hundred Percent (100%) of the initial Union Smart Health Premier Benefit Sum Assured and the balance sum Assured of this benefit shall not be carried forward to the subsequent policy year.

3.6.2 (IV) PRE-AND POST HOSPITALIZATION BENEFIT

The medical expenses relevant to the disease/illness/injury that result in hospitalization, incurred during a period up to Thirty (30) days prior and Thirty (30) days after hospitalization shall be considered as part of a claim admissible under Union Smart Health Premier Benefit. The amount reimbursed under pre-and post-hospitalization is subject to a maximum limit of Five Percent (5%) of the Union Smart Health Premier Benefit Sum Assured per Annum and payable for the expenses incurred during the period of pre-and post-hospitalization

3.6.2 (V) DAILY HOSPITAL CASH BENEFIT & EXPENSES RELATED TO DIAGNOSTIC TESTS / PHARMACY

In the event of hospitalization at a non-paying ward of a Government Hospital for more than Twenty Four (24) hours continuously and if the claim is being admissible, the following benefits shall be payable;

- The Daily Hospital Cash Benefit, which is Point Five Percent (0.5%) of the Union Smart Health Premier Benefit Sum Assured up to a maximum of LKR 20,000/- per day multiplied by the number of days hospitalized, subject to a maximum of 30% of the Union Smart Health Premier Benefit Sum Assured per policy year; and / or

- Reimbursement of expenses related to Diagnostic tests and Pharmacy incurred during hospitalization and prescribed by the Treating Doctor for the condition due to which covered person is hospitalized subject to the maximum of Seventy Percent (70%) of the Union Smart Health Premier Benefit Sum Assured per policy year.

3.6.2 (VI) ORGAN DONOR EXPENSES

The benefit under the hospitalization of an organ donor category covers expenses related to hospitalization of a donor for the purpose of donating an organ. This benefit is payable only in case the hospitalization claims of the organ recipient (the Donee, who is also a Member covered under this benefit) is admissible under the policy terms and conditions and accordingly the benefit with respect to the Donor is payable. This Benefit

Specimen

is not payable for any monetary transaction for an organ but pays for expense incurred by the donor for hospitalization due to surgery for removal of an organ which is being donated to the recipient Member covered under this Union Smart Health Premier benefit.

Per day benefit shall not be applicable if the said organ donor is hospitalized in a non-paying government hospital. Any payment made under the Hospitalization of an organ donor category shall be considered as a payment made within the Benefit Amount. Benefits under 01 and 02 of the Table of Benefits with respect to any claim under Hospitalization of an organ donor shall be the same as specified in the Table of Benefits as per the opted plan of Benefit amount.

3.6.2 (VI) PROSTHESIS AND IMPLANTS

If as a result of a Hospitalization that is covered under this Policy the Life Assured requires a prosthesis or surgical implant which is certified as Medically Necessary by the attending Physician, the Company shall pay the actual costs of such prosthesis and implant up to the benefit limit set forth in the Table of Benefit and First schedule of the Policy Prosthesis means an artificial device extension that replaces any limb or eye of the Life Assured.

This benefit pays for buying any prosthesis for the Life Assured to use if the following conditions are met:

- The Life Assured needs the prosthesis because of a loss of limb or eye resulting from an Injury or Illness that the Life Assured has to stay in a hospital for.

- The prosthesis is ordered by a registered medical practitioner.

- The prosthesis must be bought within 180 days after the date the Life Assured leaves hospital and the limit for this benefit (as set out in the Benefit Table) shall be based on the applicable limits as at the date of discharge from the Hospital.

The Company will only pay for one prosthesis for each limb or eye. However, if the Life Assured has to buy a prosthesis again for the same limb or eye resulting from another Injury or Illness that the Life Assured has to stay in hospital for again, the Company will pay for theprosthesis. The Company will not pay for replacing, repairing or maintaining the prosthesis. Surgical Implants means implants required during Surgery. These implants must be Reasonable and Customary approved medical consumables and stay in the Life Assured's body after the Surgery.

3.6.3 WAITING PERIOD

Union Smart Health Premier Benefit shall commence Ninety (90) days after;

- the Date of Commencement of the Cover; or
- the Date of Issue of the Policy; or
- the Date of Revival/ Reinstatement of Policy, whichever is later.

The Company may waive off the Waiting Period in the event of Hospitalizations and/or Surgical procedures required due to Accidents occurred after;

- the Date of Commencement of the Cover; or
- the Date of Issue of the Policy; or
- the Date of Revival / Reinstatement of Policy, whichever is later.

Specimen

For the following list of surgeries or ailments, a Waiting Period of Three Hundred and Sixty- Five (365) days is applicable from;

- the Date of Commencement of the Cover; or
- the Date of Issue of the Policy; or
- the Date of Revival of Policy,

Whichever is later.

	Name of Surgery / Ailment
1	Medical or Surgical management of Deviated Nasal Septum, diseases of Tonsils, Adenoids and Sinuses and related conditions (except Malignancy).
2	All types of Hernias and Benign Prostatic Hypertrophy.
3	Hydrocele / Varicocele / Spermatocoele.
4	Piles / Fissure / Fistula-in-Ano / Rectal Prolapse / Pilonidal Sinus
5	Treatment of all gynecological conditions (Such as but not limited to Uterine Fibroid, Dysfunctional Uterine Bleeding, Hysterectomy, Uterine Prolapse, Endometriosis, Adenomyosis Uteri, Ovarian Cyst etc.) except those arising from malignancy.
6	Medical or Surgical management of Prolapsed Intervertebral Disc.
7	Skin and all internal cysts/tumors/nodules/ polyps/ganglions/lipomas of any kind unless malignant.
8	Calculus Diseases of any etiology
9	Peripheral vascular diseases of any etiology, including treatment for Varicose veins.
10	All types of CRF and acute on chronic Renal Failures but not ARF, including Renal Failure due to Diabetes.
11	Osteoporosis / Pathological Fracture / Degenerative Joint Diseases including joint replacement surgeries. However, joint surgeries necessitated due to accidents would not be a part of this exclusion.
12	Cataract, Retinopathy and Retinal detachment.

Three hundred and Sixty-Five days (365) days waiting period applicable for the above ailments/ Surgeries is waived off for Union Smart Health Premier Sum assured Rs. 500,000/- and above. However, the benefit payable for such ailments & surgeries during the first year from the benefit commencement date is restricted to 50% of the eligible claim amount up to a maximum of Rs. 200,000/- within the benefit limit set forth in the Table of Benefit and First schedule of the Policy

The Waiting Period is applicable for the diagnosis of the ailment or the condition which directly or indirectly results in Hospitalization and/or Surgery, where no payment shall be paid for Hospitalization and/or Surgery performed even after the Waiting Period if the diagnosis of the ailment leading to the Hospitalization and/or Surgery had occurred during the Waiting Period.

However 3.14.3 waiting period clause will not be applicable for the assured/s if specifically mentioned as “not applicable” in the first schedule.

Specimen

3.6.4 DAY CARE SURGERIES COVERED

Day care treatment /surgery is defined as surgery or treatment which does not need overnight hospital stay and which does not necessitate Post surgical hospitalized care or management. In case of a day care treatment / surgery, only surgery charges and the Doctor fee are covered and Room charges and hospital ward charges such as nursing care, ward procedures are excluded. The following are the listed Day Care Procedures and such other Surgical Operations that necessitate less than Twenty-Four (24) hours due to medical / technological advancement / infrastructure facilities and the coverage of which is subject to the terms, conditions and exclusions of the Policy.

Microsurgical operations on the middle ear	1	Stapedectomy
	2	Revision of a stapedectomy
	3	Other operations on the auditory ossicles
	4	Myringoplasty (Type -I Tympanoplasty)
	5	Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicles)
	6	Revision of a Tympanoplasty
	7	Other microsurgical operations on the middle ear
Other operations on the middle & internal ear	8	Myringotomy
	9	Removal of a tympanic drain
	10	Incision of the mastoid process and middle ear
	11	Mastoidectomy
	12	Reconstruction of the middle ear
	13	Other excisions of the middle and inner ear
	14	Fenestration of the inner ear
	15	Revision of a fenestration of the inner ear
	16	Incision (opening) and destruction (elimination) of the inner ear
	17	Other operations on the middle and inner ear
Operations on the nose & the nasal sinuses	18	Excision and destruction of diseased tissue of the nose
	19	Operations on the turbinates (nasal concha)
	20	Other operations on the nose
	21	Nasal sinus aspiration
Operations on the eyes	22	Incision of tear glands
	23	Other operations on the tear ducts
	24	Incision of diseased eyelids
	25	Excision and destruction of diseased tissue of the eyelid
	26	Operations on the canthus and epicanthus

Specimen

Operations on the eyes	27	Corrective surgery for entropion and ectropion
	28	Corrective surgery for blepharoptosis
	29	Removal of a foreign body from the conjunctiva
	30	Removal of a foreign body from the cornea
	31	Incision of the cornea
	32	Operations for pterygium
	33	Other operations on the cornea
	34	Removal of a foreign body from the lens of the eye
	35	Removal of a foreign body from the posterior chamber of the eye
	36	Removal of a foreign body from the orbit and eyeball
	37	Operation of cataract
Operations on the skin& sub-cutaneous Tissues	38	Incision of a pilonidal sinus
	39	Other incisions of the skin and subcutaneous tissues
	40	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
	41	Local excision of diseased tissue of the skin and subcutaneous tissues
	42	Other excisions of the skin and subcutaneous tissues
	43	Simple restoration of surface continuity of the skin and subcutaneous tissues
	44	Free skin transplantation, donor site
	45	Free skin transplantation, recipient site
	46	Revision of skin plasty
	47	Other restoration and reconstruction of the skin and subcutaneous tissues
	48	Chemosurgery to the skin
	49	Destruction of diseased tissue in the skin and subcutaneous tissues
Operations on the tongue	50	Incision, excision and destruction of diseased tissue of the tongue
	51	Partial glossectomy
	52	Glossectomy
	53	Reconstruction of the tongue
	54	Other operations on the tongue

Specimen

Operations on the salivary glands & Salivary ducts	55	Incision and lancing of a salivary gland and a salivary duct
	56	Excision of diseased tissue of a salivary gland and a salivary duct
	57	Resection of a salivary gland
	58	Reconstruction of a salivary gland and a salivary duct
	59	Other operations on the salivary glands and salivaryducts
Other operations on the mouth &face	60	External incision and drainage in the region of the mouth, jaw and face
	61	Incision of the hard and soft palate
	62	Excision and destruction of diseased hard and soft palate
	63	Incision, excision and destruction in the mouth
	64	Plastic surgery to the floor of the mouth
	65	Other operations in the mouth
Operations on the tonsils & adenoids	66	Transoral incision and drainage of a pharyngeal abscess
	67	Tonsillectomy without adenoidectomy
	68	Tonsillectomy with adenoidectomy
	69	Excision and destruction of a lingual tonsil
	70	Other operations on the tonsils and adenoids
Orthopedic Surgeries	71	Trauma surgery and orthopaedics
	72	Incision on bone, septic and aseptic
	73	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
	74	Suture and other operations on tendons and tendon sheath
	75	Reduction of dislocation under GA
	76	Arthroscopic knee aspiration
Operations on the breast	77	Incision of the breast
	78	Operations on the nipple
Operations on the digestive tract	79	Incision and excision of tissue in the perianal region
	80	Surgical treatment of anal fistulas
	81	Surgical treatment of haemorrhoids
	82	Division of the anal sphincter (sphincterotomy)
	83	Other operations on the anus
	84	Ultrasound guided aspirations
	85	Sclerotherapy etc.

Specimen

Operations on the digestive tract	86	Laparoscopic cholecystectomy
	87	Incision of the ovary
	88	Insufflation of the Fallopian tubes
	89	Other operations on the Fallopian tube
Operations on the female sexual organs	90	Dilatation of the cervical canal
	91	Conisation of the uterine cervix
	92	Other operations on the uterine cervix
Operations on the female sexual organs	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 prostate & 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 &tunica vaginalis testes	109	Incision of the scrotum and tunica vaginalis testes
	110	Operation on a testicular hydrocele
	111	Excision and destruction of diseased scrotal tissue
	112	Plastic reconstruction of the scrotum and tunica vaginalis testes
	113	Other operations on the scrotum and tunica vaginalis testes
Operations on the testes	114	Incision of the testes
	115	Excision and destruction of diseased tissue of the testes

Specimen

Operations on the testes	116	Reconstruction of the testes
	117	Implantation, exchange and removal of a testicular prosthesis
	118	Other operations on the testes
Operations on the spermatic cord, epididymis und ductus deferen	119	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
	120	Excision in the area of the epididymis
	121	Epididymectomy
	122	Reconstruction of the spermatic cord
	123	Reconstruction of the ductus deferens and epidididymis
	124	Other operations on the spermatic cord, epididymis and ductus deferens
Operations on the penis	125	Operations on the foreskin
	126	Local excision and destruction of diseased tissue of the penis
	127	Amputation of the penis
	128	Plastic reconstruction of the penis
	129	Other operations on the penis
Operations on the urinary system	130	Cystoscopical removal of stones
Other Operations	131	Lithotripsy
	132	Coronary angiography
	133	Haemodialysis
	134	Radiotherapy for Cancer
	135	Cancer chemotherapy

End of list of surgeries

Specimen

3.6.5 RIGHT OF THE COMPANY TO REVISE PREMIUM AND TERMS AND CONDITIONS

The premium payable for this cover in the Part II of the First Schedule to this Policy is guaranteed only for a period of One (01) year from the Date of Commencement of the Cover. The Company reserves right to review this benefit at each Policy Anniversary and revise the premium rates, change any limit and/or alter the terms and conditions applicable or to withdraw the Benefit. Such change shall be implemented only after Thirty (30) days' notice has been given to the Policyholder and, shall be effective from the next Policy Anniversary, subsequent to the notice.

3.6.6 NOTICE OF CHANGE OF OCCUPATION

Any substantial change in the occupation of the Life Assured must be intimated to the Company in writing within Fourteen (14) days of such change and the risks covered under this Benefit shall require to be re-approved. The Company shall not be liable in respect of any claim, if the Life Assured is engaged in any occupation at the time of Hospitalization and/or Surgery which is different to that described in the Proposal / Application form and/or Declaration of Health.

3.6.7 NOTICE AND PROOF OF CLAIM

Written notice or in case of Hospitalization and/or Surgery which is covered and on which the claim may be based must be given to the Company's Head Office or nearest branch within Forty-Eight (48) hours from the date of Hospitalization. Failure to give notice as stipulated above shall give the Company a right not to entertain such claim.

The Company shall, upon receipt of such notice, issue the forms required to be completed for the filing of proof of claims. The completed forms must be delivered to the Company within Ten (10) working days from the date of issue. Affirmative proof of together with original bills and original payment receipts must be submitted to the Company not later than Thirty (30) days from the date of discharge from the Hospital and at the expense of the Assured. The Covered Person or a member of Family Unit must carefully follow all the instructions issued by the Medical Consultant responsible for treatment and shall provide the Company with full information concerning the circumstances of the treatment.

The Covered Person or a member of Family Unit and his/her relatives or successors shall allow visits and examinations by the Company's experts and to conduct any enquiries considered necessary by the Company and the Company shall be released from the obligation to maintain professional secrecy consequent to and arising out of such visits by the experts. If the Covered Person does not follow the described procedure in the event of a claim, the Company shall refuse to pay any claim under this Benefit.

3.6.8 CONDITIONS

(i) The Union Smart Health Premier Benefit shall expire;
   (a) On the Expiry Date of this Benefit as stipulated in the First Schedule, or
   (b) On the Policy Anniversary, following the,

   - 70th birthday for Life Assured/ Spouse /Parent; or
   - 23rd birthday for Children Assured whichever happens earlier.

(ii) This Rider Cover shall lapse on expiry of the Thirty (30) days Grace Period if the premium remains unpaid. The Company reserves the right to decline the Reinstatement or Revival of this Cover. If the cover is Reinstated or Revived, the Waiting Period shall be applicable from the date of Reinstatement/ Revival.

Specimen

(iii) The Union Smart Health Premier Benefit shall terminate if the main Policy is terminated.

(iv) This Rider Cover shall not;
(a) Participate in profits; or
(b) Acquire a surrender value, paid-up value or a maturity value.

(v) An assignee, nominee or beneficiary shall not have the right to receive any payments arising from a claim under the Benefits provided in this Schedule.

(vi) This Benefit shall cover Hospitalizations and Surgeries performed within the Sri Lankan territories only Except for the Benefit plans 10 to 17 as specified in the first schedule of the Policy where the Union Smart Health Premier Sum Assured taken under the policy is of Two Million (Rs. 2,000,000/-) and above. The Benefit plans 10 to 17 shall cover the hospitalizations and surgeries performed with in Sri Lanka and Overseas as specified in the first schedule of the Policy.

(vii) The maximum amount that can be claimed by an individual under Smart Health Premier Benefit in any One (01) Policy Year cannot exceed One Hundred Percent (100%) of the Union Smart Health Plus Benefit Sum Assured unless the Benefit Multiplier or Benefit Revival has been affected.

(viii) The maximum Sum Assured on all Policies taken for an individual under Union Smart Health Premier Benefit from the Company is limited to Rupees Forty Million (Rs. 40,000,000/-).

(ix) Policyholder shall inform the Company of any other Medical Insurance covers which is in force during the Term of this Policy. If the Covered Person or a member of Family Unit carries other insurance covering an eligible expense insured by this Policy, the Company shall indemnify the Policyholder up to a maximum limit of eligible expenses incurred, less any payment made by other insurers subject to the maximum limits specified under First Schedule to this Policy and terms and conditions of this Benefit.

(x) This Union Smart Health Premier Benefit is only eligible for (i) Sri Lankan Citizens and (ii) Sri Lankan residents who are living for at least 6 months in Sri Lanka and with a bona-fide residential address in Sri Lanka. The coverage provided under plan 10 to 17 will get terminated if the Insured resides outside of Sri Lanka for a continuous period of 90 days and above. However, once the policyholder returns back to Sri Lanka, the benefits of the Policy will be activated and the Policy benefits will resume as per original terms and conditions.

(xi) It is mandatory for the Policyholder to obtain prior written approval from the Company in case of treatment in overseas (Worldwide excluding USA and Canada). Reimbursement of hospital expenses of Overseas hospitalizations shall be considered subject to the maximum limits specified under First Schedule to this Policy and terms and conditions of this Benefit and the payments will be made in Sri Lankan Rupees in accordance to the currency exchange rate applicable to the date of Hospitalization quoted by Central Bank of Sri Lanka.

(xiv) In the event the Company admits liability for any claim, the Company may at its absolute discretion settle such claim either to the Policyholder or the relevant Hospital or any other relevant service provider. Any payment directly made to a Hospital or any service provider by the Company shall be treated as a full and final discharge of liability of the Company with respect to the claim for which the liability was admitted by the Company and be construed as a payment made to the Policyholder for the purpose of this benefit.

(xv) In the event the Life Assured agrees to the application of a Deductible on claims in a policy year and selects any one of the Deductible optional amounts as specified in the Policy Schedule, the Life Assured shall first bear the expenses of claims (Payable and duly notified to the Company) equivalent to such Deductible and shall only become entitled for claims after exhausting the Deductible amount.

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3.6.9 EXCLUSIONS APPLICABLE TO THIS COVER

The Company shall not be liable to make any payment on Hospitalizations and/or Surgeries performed, if the reason/cause for the Hospitalization/Surgery is directly or indirectly due to;

(i) Lesions resulting from attempted suicide or self or intentional infliction (including but not limited to the use or misuse of any intoxicating drugs or alcohol); and/or

(ii) Any complications arising out of or ailments requiring treatment due to use or abuse of any substance, drug or alcohol including driving while drunk and treatment for de-addiction; and/or

(iii) Pre-existing conditions (i.e. any condition, whether diagnosed or not, ailment or injury or related condition(s) for which Insured has been diagnosed, received medical treatment, had signs and / or symptoms, prior to inception of Insured's first Policy with the Insurer. It would also mean any direct or indirect complications arising out of pre-existing conditions whether known or unknown to the Insured) unless they have been declared by the Policyholder on the Proposal form/ Health Declaration form and accepted by the Company in writing, on or before the Date of Issue of the Policy indicated in the First Schedule or in any amendment issued by the Company; and/or

(iv) War and circumstances comparable with a state of war, invasion, act by a foreign enemy, hostilities and warlike events (with or without a declaration of war), civil war, riot, mutiny, revolution, confiscation or nationalization by order of any public or local government or authority; any act of a person acting in the name of or in connection with any organization whose activities aim to overturn a de jure or de facto government violently; and/or

(v) Naval or military operations of the armed forces or air force and participation in operations requiring the use of arms or which are ordered by military authorities for combating terrorists, rebels and the like; and/or

(vi) Nuclear risks: e.g. exposure to nuclear energy (nuclear reactions, radiation, contamination) or nuclear waste of any type or chemical contamination; and/or

(vii) Hazardous activities, including but not limited to scuba diving, motorcycling, parachuting, hang-gliding, rock or mountain climbing, racing of any kind other than on foot, rafting, bungee jumping, potholing, hunting, steeple chasing, polo playing, winter sports, ice hockey; or any sport in a professional capacity unless otherwise agreed in writing by the Company; and/or

(viii) Natural perils: such as but not limited to avalanches, landslides, earthquakes, floods, tsunami or tidal waves caused by earthquakes or volcanic eruptions, cyclones, storms, tempest, hurricanes, tornados & typhoons; and/or

(ix) Experimental treatments and treatments of purely diagnostic nature such as (but not limited to) biopsy, endoscopy, laparoscopy, arthroscopy, x-ray or laboratory examinations, other diagnostics studies not consistent with or incidental to diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a hospital or nursing home; and/or

(x) The cost of spectacles, contact lenses, hearing aids, crutches, wheelchairs, artificial limbs, dentures, artificial teeth and all other external appliances, Prosthesis and/or devices, unless specifically accepted by the Company.; and/or

(xi) Surgeries due to change of life (menopause), pregnancy, miscarriage and abortion, neonatal procedures, amniocentesis and child birth, voluntary medical termination of pregnancy; and/or

Specimen

(xii) Sterilization, insemination (e.g. artificial insemination), reversal of sterilization, sex transformation surgeries or infertility and in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) procedures, zygote intra-fallopian transfer (ZIFT) procedures, embryo transport; donor ovum and related costs or any other Surgery or procedure performed due to infertility, sub fertility of family planning; and/or

(xiii) Congenital or birth defects, anomalies and condition arisen as a result of underlining chromosomal disorder (E.g. Down's Syndrome); and/or

(xiv) Genetic disorders and stem cell implantation / surgery/storage; and/or

(xv) Cosmetic or aesthetic treatments of any description, Lasik treatment for refractive error or any form of plastic surgery, unless necessary for the treatment of Illness or accidental Bodily Injury; and/or

(xvi) Organ transplant as a donor for a third party or costs of donor screening or treatment; and/or

(xvii) Treatments which are not required medically or not recommended by a qualified Doctor or Surgery or a procedure performed not as a treatment of or as a consequence of an Illness or Injury; and/or

(xviii) Treatment for idiopathic epilepsy and psychiatric conditions, mental disorders and conditions arising as a result of insanity; and/or

(xix) Surgery or a procedure performed due to obesity, weight reduction or weight management;and/or

(xx) Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident; and/or

(xxi) Officially (by World Health Organization and/ or national law) recognized epidemics/ pandemics or Government screening programs; and/ or

(xxii) Sexually transmitted Diseases (venereal diseases), any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus or Variant/ mutant viruses and/or any syndrome or condition of a similar kind commonly referred to as AIDS; and/or

(xxiii) Treatments not carried out by a qualified Physician/Surgeon or service rendered by a provider with the same legal residence as the insured person or who is a member of the insured's family, including spouse, brother, sister, parent or child; and/or

(xxiv) Treatment by non-allopathic methods, naturotherapy, acupuncture, aromatherapy and Ayurvedic treatments; and/or

(xxv) Any kind of Service charges, Surcharges, Registration charges etc. levied by the Hospital; and/or

(xxvi) Expenses incurred on items for personal comfort like television, telephone, etc. incurred during and which have been specifically charged for in the bills issued by the Hospital / nursing home; and/or

(xxvii) External medical equipment of any kind used at home as post care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Ambulatory Peritoneal Dialysis (C.A.P.D) and Oxygen concentrator for Bronchial Asthmatic condition; and/or

(xxviii) Dental treatment or surgery of any kind unless required as a result of Accidental Bodily Injury to natural teeth requiring treatment; and/or

Specimen

(xxix) Convalescence, general debility, "Run-down" condition, rest cure, Congenital Internal and /or external illness/disease/defect; and/or

(xxx) Vaccinations or inoculations of any kind; and/or

(xxxi) Vitamins, tonics, nutritional supplements unless forming part of the treatment for injury or disease as certified by the attending Medical Practitioner; and/or

(xxxii) Surgery to correct deviated septum and hypertrophied turbinate unless necessitated by an accidental body injury and proved to the satisfaction of the Company that the condition is a result of an accidental injury; and/or

(xxxiii) Outpatient Diagnostic, Medical and Surgical procedures other than the listed Day care procedures, or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change; and/or

(xxxiv) Expenses incurred at Hospital or Nursing Home primarily for diagnosis irrespective of Twenty-Four (24) hours without diagnosis of any disease which does not require any follow up treatment covered under this Policy. This would also include stay in a hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner, which ordinarily can be given without; and/or

(xxxv) Treatments taken at any institution which is primarily a rest home or convalescent facility, a place for custodial care, a facility for the aged or alcoholic or drug addicts or for the treatment of psychiatric or mental disorders; even if the institution has been registered as a hospital or nursing home with the Appropriate Authorities; and/or.

(xxxvi) Treatments in health hydro, spas, nature care clinics and the like.

Specimen

Schedule No. 3.7

3.7 UNION HEALTH 360 (UH360)

3.7.1 KEY PURPOSE AND COVERAGE

The Union Health 360 (UH360) Benefit shall be applicable if included in this Policy and shown in the Part II of the First Schedule to this Policy.

Union Health 360 Benefit shall become operative;

(i) If the Covered Person (as indicated in the First Schedule) is hospitalized for more than Twenty-Four (24) hours continuously as a result of an Illness or Accident on the recom mendation and approval of a doctor, in a Hospital and/or if a Surgery as defined under Section 4 of this Schedule is performed on the Covered Person and an expense has been incurred by way of a hospital bill payment to the Hospital; or

(ii) The daily Hospital Cash Benefit under UH360 as defined under Section 3.2.6.2 (V) of this Schedule shall become operative if the Covered Person is hospitalized for more than Twenty-Four (24) hours continuously as a result of an Illness or Accident on the recommendation and approval of a doctor, in a non-paying ward of a Government Hospital; or

(iii) If the Covered Person is required to obtain a treatment/purchase of medicines which is defined and covered under section 3.2.6.2 (VIII) Routine Dental Benefit and Section 2.2 (X) Routine Optical Benefit as a medical necessity on the recommendation and approval of a Doctor and an expense has been incurred as a result of the treatment/ purchase of medicines.

The Cover is subject to the general terms and conditions of this Policy and the specific terms and conditions set out below.

3.7.2 BENEFIT AMOUNT

The Company shall reimburse the expenses incurred subject to the eligibility for the Benefits and the limits mentioned in the First Schedule and the Table of Benefits in section 3.2.6.2 (I) specified hereunder. The payment shall be made subject to the submission of a detailed original bill and original payment receipt as the proof for the expense incurred along with a proof of Hospitalization and/or performed Surgery and/ or a treatment, purchase of medicines as recommended and prescribed by a Doctor to the satisfaction of the Company. The Company disclaims any liability for any consequences of treatment administered during or due to or as a consequence of a Surgery.

The Covered Person may claim for any number of Hospitalizations and the Company shall pay the eligible amount provided that the annual limit for the year of the Covered Person has not been exhausted. If the Benefit has been obtained as a Family Unit, the annual overall family limit, which is equivalent to the Sum Assured under this Benefit shall be shared among the Life Assured, Parents of the Life assured, Spouse and children below Twenty Three (23) years of age named as Covered Persons under Union Health 360 in the First Schedule. The total maximum Sum Assured on all Policies taken by an individual under Union Health 360 Union Smart Health Premier, Union Smart Health Plus, Union Smart Health and Union Medi Guard Benefit from the Company is limited to Rupees Sixty Million (Rs.60,000,000/-).

Specimen

3.7.2 (I) TABLE OF BENEFITS

Benefit Schedule (Limits in LKR)	Plan 1/2	Plan 3/4	Plan 5/6	Plan 7/8	Plan 9/10	Plan 11/12	Plan 13/14	Plan 15/16
Geographical Coverage	**Sri Lanka Only OR Sri Lanka, India, Singapore, Thailand and Malaysia**				**Sri Lanka, India, Singapore, Thailand and Malaysia OR Worldwide Excluding USA and Canada) as specified in the policy schedule.**			
Annual Overall Limit (AOL) - Basic Annual Sum Insured (LKR)	**LKR 300,000/-**	**LKR 500,000/-**	**LKR 750,000/-**	**LKR 1,000,000/-**	**LKR 2,000,000/-**	**LKR 3,000,000/-**	**LKR 4,000,000/-**	**LKR 5,000,000/-**

Limits applicable for different categories of expenses

1	**Hospitalization benefit**	Reimbursement of Hospital Room Board and ICU ward is subject to a maximum of 30% of the Basic Annual Sum Insured.
	(a) Daily ICU Hospital Room and Board Benefit	
	Maximum Room, Boarding expenses per day within Sri Lanka	Single Private AC Room. In case policy holder opts for a higher than eligible room category, a flat 25% co-payment on the eligible insurance amount would be applicable. Co-payment on the entire hospital bill will not be applicable for hospitalization within Sri Lanka. However, customer will have to pay the difference of room charge, if opted for a higher room category.
	Maximum Room, Boarding expenses per day for treatment Outside SriLanka	
	(b) Daily ICU Hospital Room and Board Benefit	
	Maximum Room, Boarding expenses per day within Sri Lanka	As per the Actual
	Maximum Room, Boarding expenses per day for treatment Outside Sri Lanka	
2	**Surgical Benefit** (includes Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees)	(i) As-charged, subject to charge is the provider's usual fee for a service that does not exceed the customary fee in the geographic area and is reasonable based on the circumstances. (ii) In case of overseas treatment, there is a maximum cap of 2 visits per patient per day.
3	**Miscellaneous Hospital Services and Supplies Benefit** (Includes Operation Theatre Charges, Anesthesia, Blood, Oxygen, Medicines and Drugs, except non-medical services)	(i) As-charged, subject to charge is the provider's usual fee for a service that does not exceed the customary fee in the geographic area and is reasoable based on the circumstances. (ii) In case of overseas treatment, there is a maximum cap of 2 visits per patient per day.
4	**Ambulance Charges**	(i) As-charged, subject to a max. of 2% of Basic Annual Sum Insured. (ii) Benefit is payable once in a policy year, subject to the claim being admissible and payable only when a licensed ambulance sevice is used.

Specimen

Benefit Schedule (Limits in LKR)	Plan 1/2	Plan 3/4	Plan 5/6	Plan 7/8	Plan 9/10	Plan 11/12	Plan 13/14	Plan 15/16
Geographical Coverage	**Sri Lanka Only OR Sri Lanka, India, Singapore, Thailand and Malaysia**				**Sri Lanka, India, Singapore, Thailand and Malaysia OR Worldwide Excluding USA and Canada) as specified in the policy schedule.**			
Annual Overall Limit (AOL) - Basic Annual Sum Insured (LKR)	**LKR 300,000/-**	**LKR 500,000/-**	**LKR 750,000/-**	**LKR 1,000,000/-**	**LKR 2,000,000/-**	**LKR 3,000,000/-**	**LKR 4,000,000/-**	**LKR 5,000,000/-**
Limits applicable for different categories of expenses								
5	**Day Care Treatment** (Hospitalization as an inpatient for less than 24 hours)	(i) Covered only for surgeries or treatments subject to a Basic Annual Sum Insured. (ii) Coverage is limited to covered list of day care surgeries. (iii) Out-patient procedures or treatment are not covered under the plan.						
6	**Pre- Hospitalization Expenses Benefit** (applicable for all hospitalizations, irrespective of Private or Public Hospital)	Payable up to 5% of the basic sum insured for 30 days prior to date of hospitalization. This benefit is a sublimit of the Basic Sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.						
		LKR 15,000/-	LKR 25,000/-	LKR 37,500/-	LKR 50,000/-	LKR 100,000/-	LKR 150,000/-	LKR 200,000/-	LKR 250,000/-
7	**Post- Hospitalization Expenses Benefit** (applicable for all hospitalizations, irrespective of Private or Public Hospital)	Payable up to 5% of the basic sum insured for 30 days postdate of discharge from the hospital. This benefit is a sub-limit of the Basic Sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.						
		LKR 15,000/-	LKR 25,000/-	LKR 37,500/-	LKR 50,000/-	LKR 100,000/-	LKR 150,000/-	LKR 200,000/-	LKR 250,000/-
8	**Organ Donor Expenses**	Covered within the overall Sum Insured of the Donee and payable only for hospitalization expenses for the Donor.						
9	**Prosthesis and Implants –**	As-charged, subject to a max. sub-limit of 20% of Basic Annual Sum Insured						
		LKR 60,000/-	LKR 100,000/-	LKR 150,000/-	LKR 200,000/-	LKR 400,000/-	LKR 600,000/-	LKR 800,000/-	LKR 1,000,000/-
10	**Overseas treatment**	In case of planned hospitalization, to be pre-intimated to the insurer and pre-authorization is mandatory. Emergency hospitalization needs to be intimated to insurer within 48 hours of hospitalization and in case a higher than eligible room category was opted for, a co-payment of 25% would be applicable on the eligible insurance claim amount.						
11	**Hospitalization in a non-paying ward (Public Hospitals or similar)** (Geographical coverage – Sri Lanka only)	0.5% of the Basic Annual Sum Insured per day, up to a maximum Rs.20,000/ per day.						
		LKR 1,500/-	LKR 2,500/-	LKR 3,750/-	LKR 5,000/-	LKR 10,000/-	LKR 15,000/-	LKR 20,000/-	LKR 20,000/-
		Expenses pertaining to the investigations and drugs prescribed by the doctor in relation to the hospitalized condition will be payable maximum up to 70% of the Basic Annual Sum Insured per year						

Specimen

Benefit Schedule (Limits in LKR)		Plan 1/2	Plan 3/4	Plan 5/6	Plan 7/8	Plan 9/10	Plan 11/12	Plan 13/14	Plan 15/16
Geographical Coverage		**Sri Lanka Only OR Sri Lanka, India, Singapore, Thailand and Malaysia**				**Sri Lanka, India, Singapore, Thailand and Malaysia OR Worldwide Excluding USA and Canada) as specified in the policy schedule.**			
Annual Overall Limit		**LKR**	**LKR**	**LKR**	**LKR**	**LKR**	**LKR**	**LKR**	**LKR**
		300,000/-	**500,000/-**	**750,000/-**	**1,000,000/-**	**2,000,000/-**	**3,000,000/-**	**4,000,000/-**	**5,000,000/-**
Limits applicable for different categories of expenses									
12	**Wellbeing Cover** (Geographical coverage - Sri Lanka only)	After two consecutive claim free policy years, up to 2% of the basic annual sum insured up to a maximum of Rs.50,000/ is payable for health check-up at hospitals registered under Private Health Care Service Regulatory Council in Sri Lanka (PHSRC).							
		LKR 6000/-	LKR 10,000/-	LKR 15,000/-	LKR 20,000/-	LKR 40,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-
13	**Hospital Admission Charges**	As-charged, subject to a maximum of 5% of Basic Annual Sum Assured per hospitalization as a sub-limit within 70% of the Basic Sum Assured.							
14	**Routine Dental Benefit** (Geographical coverage - Sri Lanka only)	This pay-out is a sub-limit of the annual sum insured							
		LKR 5,000/-	LKR 5,000/-	LKR 5,000/-	LKR 10,000/-	LKR 10,000/-	LKR 10,000/-	LKR 10,000/-	LKR 10,000/-
15	**Critical Illness Reimbursement Benefit**	Subject to a maximum of 50% of the SA and a lifetime limit of 2 times of Basic Sum Assured. Each year the 50% reinstates but capped to an absolute lifetime limit							
		LKR 150,000/-	LKR 250,000/-	LKR 375,000/-	LKR 500,000/-	LKR 1,000,000/-	LKR 1,500,000/-	LKR 2,000,000/-	LKR 2,500,000/-
Optional Benefits									
16	**Maternity Benefit** (Geographical coverage - Sri Lanka only)	NVD 50,000/- LSCS- 100,000/-	NVD- 75,000/- LSCS- 150,000/-	NVD- 75,000/- LSCS- 150,000/-	NVD- 75,000/- LSCS- 150,000/-	NVD- 75,000/- LSCS- 150,000/-	NVD- 100,000/- LSCS- 200,000/-	NVD- 100,000/- LSCS- 200,000/-	NVD- 100,000/- LSCS- 200,000/-
17	**Routine Optical Benefit** (Geographical coverage - Sri Lanka only)	LKR 7,500/-	LKR 12,500/-	LKR 18,750/-	LKR 25,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-

Specimen

Benefit Schedule (Limits in LKR)		Plan 17/18	Plan 19/20	Plan 21/22	Plan 23/24	Plan 25/26	Plan 27/28	Plan 29/30	Plan 31/32
Geographical Coverage		**Sri Lanka, India, Singapore, Thailand and Malaysia Or Worldwide (Excluding USA and Canada) as specified in the policy schedule**							
Annual Overall Limit (AOL) - Basic Annual Sum Insured (LKR)		**LKR 10,000,000/-**	**LKR 15,000,000/-**	**LKR 20,000,000/-**	**LKR 25,000,000/-**	**LKR 30,000,000/-**	**LKR 40,000,000/-**	**LKR 50,000,000/-**	**LKR 60,000,000/-**
Limits applicable for different categories of expenses									
1	**Hospitalization benefit**	Reimbursement of Hospital Room Board and ICU ward is subject to a maximum of 30% of the Basic Annual Sum Insured.							
	(a) Daily Hospital Room and Board Benefit								
	Maximum Room, Boarding expenses per day within Sri Lanka	Single Private AC Room. In case policy holder opts for a higher than eligible room category, a flat 25% co-payment on the eligible insurance amount would be applicable. Co-payment on the entire hospital bill will not be applicable for hospitalization within Sri Lanka. However, customer will have to pay the difference of room charge, if opted for a higher room category.							
	Maximum Room, Boarding expenses per day for treatment Outside SriLanka								
	(b) Daily ICU Hospital Room and Board Benefit								
	Maximum Room, Boarding expenses per day within Sri Lanka	As per the Actual							
	Maximum Room, Boarding expenses per day for treatment Outside Sri Lanka								
2	**Surgical Benefit** (includes Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees)	(i) As-charged, subject to charge is the provider's usual fee for a service that does not exceed the customary fee in the geographic area and is reasonable based on the circumstances. (ii) In case of overseas treatment, there is a maximum cap of 2 visits per patient per day.							
3	**Miscellaneous Hospital Services and Supplies Benefit** (Includes Operation Theatre Charges, Anesthesia, Blood, Oxygen, Medicines and Drugs, except non-medical services)	(i) As-charged, subject to charge is the provider's usual fee for a service that does not exceed the customary fee in the geographic area and is reasoable based on the circumstances. (ii) In case of overseas treatment, there is a maximum cap of 2 visits per patient per day.							
4	**Ambulance Charges**	(i) As-charged, subject to a max. of 2% of Basic Annual Sum Insured. (ii) Benefit is payable once in a policy year, subject to the claim being admissible and payable only when a licensed ambulance sevice is used.							

Specimen

Benefit Schedule (Limits in LKR)	Plan 17/18	Plan 19/20	Plan 21/22	Plan 23/24	Plan 25/26	Plan 27/28	Plan 29/30	Plan 31/32
Geographical Coverage	**Sri Lanka, India, Singapore, Thailand and Malaysia Or Worldwide (Excluding USA and Canada) as specified in the policy schedule**							
Annual Overall Limit (AOL) - Basic Annual Sum Insured (LKR)	**LKR 10,000,000/-**	**LKR 15,000,000/-**	**LKR 20,000,000/-**	**LKR 25,000,000/-**	**LKR 30,000,000/-**	**LKR 40,000,000/-**	**LKR 50,000,000/-**	**LKR 60,000,000/-**

Limits applicable for different categories of expenses

5	**Day Care Treatment** (Hospitalization as an inpatient for less than 24 hours)	(i) Covered only for surgeries or treatments subject to a Basic Annual Sum Insured. (ii) Coverage is limited to covered list of day care surgeries. (iii) Out-patient procedures or treatment are not covered under the plan.							
6	**Pre- Hospitalization Expenses Benefit** (applicable for all hospitalizations, irrespective of Private or Public Hospital)	Payable up to 5% of the basic sum insured for 30 days prior to date of hospitalization. This benefit is a sublimit of the Basic Sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.							
		LKR 500,000/-	LKR 750,000/-	LKR 1,000,000/-	LKR 1,250,000/-	LKR 1,500,000/-	LKR 2,000,000/-	LKR 2,500,000/-	LKR 3,000,000/-
7	**Post- Hospitalization Expenses Benefit** (applicable for all hospitalizations, irrespective of Private or Public Hospital)	Payable up to 5% of the basic sum insured for 30 days postdate of discharge from the hospital. This benefit is a sub-limit of the Basic Sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.							
		LKR 500,000/-	LKR 750,000/-	LKR 1,000,000/-	LKR 1,250,000/-	LKR 1,500,000/-	LKR 2,000,000/-	LKR 2,500,000/-	LKR 3,000,000/-
8	**Organ Donor Expenses**	Covered within the overall Sum Insured of the Donee and payable only for hospitalization expenses for the Donor.							
9	**Prosthesis and Implants –**	As-charged, subject to a max. sub-limit of 20% of Basic Annual Sum Insured							
		LKR 2,000,000/-	LKR 3,000,000/-	LKR 4,000,000/-	LKR 5,000,000/-	LKR 6,000,000/-	LKR 8,000,000/-	LKR 10,000,000/-	LKR 12,000,000/-
10	**Overseas treatment**	In case of planned hospitalization, to be pre-intimated to the insurer and pre-authorization is mandatory. Emergency hospitalization needs to be intimated to insurer within 48 hours of hospitalization and in case a higher than eligible room category was opted for, a co-payment of 25% would be applicable on the eligible insurance claim amount.							
11	**Hospitalization in a non-paying ward (Public Hospitals or similar)** (Geographical coverage – Sri Lanka only)	0.5% of the Basic Annual Sum Insured per day, up to a maximum Rs.20,000/ per day.							
		LKR 20,000/-	LKR 20,000/-	LKR 20,000/-	LKR 20,000/-	LKR 20,000/-	LKR 20,000/-	LKR 20,000/-	LKR 20,000/-
		Expenses pertaining to the investigations and drugs prescribed by the doctor in relation to the hospitalized condition will be payable maximum up to 70% of the Basic Annual Sum Insured per year							

Specimen

Benefit Schedule (Limits in LKR)		Plan 17/18	Plan 19/20	Plan 21/22	Plan 23/24	Plan 25/26	Plan 27/28	Plan 29/30	Plan 31/32
Geographical Coverage		**Sri Lanka Only OR Sri Lanka, India, Singapore, Thailand and Malaysia**				**Sri Lanka, India, Singapore, Thailand and Malaysia OR Worldwide Excluding USA and Canada) as specified in the policy schedule.**			
Annual Overall Limit		**LKR**	**LKR**	**LKR**	**LKR**	**LKR**	**LKR**	**LKR**	**LKR**
		10,000,000/-	15,000,000/-	20,000,000/-	25,000,000/-	30,000,000/-	40,000,000/-	50,000,000/-	60,000,000/-
Limits applicable for different categories of expenses									
12	**Wellbeing Cover** (Geographical coverage - Sri Lanka only)	After two consecutive claim free policy years, up to 2% of the basic annual sum insured up to a maximum of Rs.50,000/ is payable for health check-up at hospitals registered under Private Health Care Service Regulatory Council in Sri Lanka (PHSRC).							
		LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-
13	**Hospital Admission Charges**	As-charged, subject to a maximum of 5% of Basic Annual Sum Assured per hospitalization as a sub-limit within 70% of the Basic Sum Assured.							
14	**Routine Dental Benefit** (Geographical coverage - Sri Lanka only)	This pay-out is a sub-limit of the annual sum insured							
		LKR 5,000/-	LKR 5,000/-	LKR 5,000/-	LKR 10,000/-	LKR 10,000/-	LKR 10,000/-	LKR 10,000/-	LKR 10,000/-
Optional Benefits									
15	**Maternity Benefit** (Geographical coverage - Sri Lanka only)	NVD 150,000/- LSCS- 300,000/-	NVD 150,000/- LSCS- 300,000/-	NVD 150,000/- LSCS- 300,000/-	NVD 150,000/- LSCS- 300,000/-	NVD 150,000/- LSCS- 300,000/-	NVD 150,000/- LSCS- 300,000/-	NVD 150,000/- LSCS- 300,000/-	NVD 150,000/- LSCS- 300,000/-
16	**Routine Optical Benefit** (Geographical coverage - Sri Lanka only)	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-	LKR 50,000/-

Specimen

3.7.2 (II) BENEFIT MULTIPLIER

If no claim has been made under Union Health 360 Benefit for a full policy year and the policy is kept in force by paying due premiums continuously for the policy year within the grace period, the Company may apply Benefit Multiplier, by automatically increasing Twenty Five Percent (25%) of the Basic Annual Sum Assured of Union Health 360 Benefit for the next policy year.

The maximum limit of this additionally accumulated Sum Assured under Benefit Multiplier is One Hundred Percent (100%) of the Basic Annual Sum Assured of Union Health 360 Benefit subject to a maximum of Rupees One Hundred Million (Rs. 100,000,000/-)

In the event a claim made from any Individual or a family member within the family floater plan in a policy year upon applying the Benefit Multiplier, then the Sum Assured accumulated shall automatically decrease by Twenty Five Percent (25%) of Union Health 360 Benefit sum assured in the following Policy Year. However, this reduction will not reduce the Sum Assured below the Basic Annual Sum Assured of Union Health 360 Benefit shown in the Part II of the First Schedule.

In the event of a Sum Assured reduction during the term of the benefit, the accumulated multiplier benefit will also get reduced proportionately to the reduced Basic Annual Sum Assured of Union Health 360. The Benefit limits specified under Routine Dental Benefit, Maternity Benefit, , Critical Illness reimbursement Benefit and Routine Optical Benefit in the Table of Benefit in section 3.2.6.2 (I) will not be increased due to the application of Benefit Multiplier.

3.7.2 (III) BENEFIT REVIVAL

In case of a complete exhaustion of the Basic Annual Sum Assured limit of Union Health 360 Benefit and the sum assured accumulated under Benefit Multiplier, the Company shall grant Benefit Revival once in a policy year provided that the reason for hospitalization is not directly or indirectly related to any of the preceding causes of hospitalization. In any Policy Year, the Benefit Revival shall provide an additional cover up to a maximum of One Hundred Percent (100%) of the Basic Annual Sum Assured of Union Health 360 Benefit and the balance sum Assured of this benefit shall not be carried forward to the subsequent policy year.

The Benefit Revival is applicable for all covers except Routine Dental Benefit, Maternity Benefit, Critical Illness reimbursement Benefit, Wellbeing cover and Routine Optical Benefits.

3.7.2 (IV) PRE-AND POST HOSPITALIZATION BENEFIT

The medical expenses relevant to the disease/illness/injury that result in hospitalization, incurred during a period up to Thirty (30) days prior and Thirty (30) days after hospitalization shall be considered as part of a claim admissible under Union Health 360 Benefit. The pre-post hospitalization benefit is payable only if the hospitalization claim is admissible. The amount reimbursed under pre-and post-hospitalization is subject to a maximum limit of Five Percent (5%) of the Union Health 360 Benefit Sum Assured per Annum and payable for the expenses incurred during the period of pre-and post-hospitalization.

3.7.2 (V) DAILY HOSPITAL CASH BENEFIT & EXPENSES RELATED TO DIAGNOSTIC TESTS /PHARMACY

In the event of hospitalization at a non-paying ward of a Government Hospital for more than Twenty Four (24) hours continuously and if the claim is being admissible, the following benefits shall be payable;

- The Daily Hospital Cash Benefit, which is Point Five Percent (0.5%) of the Union Health 360 Benefit Basic Annual Sum Assured up to a maximum of Rupees Twenty Thousand (Rs 20,000/-) per day multiplied by the number of days hospitalized, subject to a maximum of Thirty percent (30%)of the Union Health 360 Benefit Sum Assured per policy year; and / or
- Reimbursement of expenses related to Diagnostic tests and Pharmacy incurred during hospitalization and prescribed by the Treating Doctor for the condition due to which covered person is hospitalized subject to the maximum of Seventy Percent (70%) of the Union Health 360 Benefit Sum Assured per policy year.

3.7.2 (VI) ORGAN DONOR EXPENSES

The benefit under the hospitalization of an Organ Donor category covers expenses related to hospitalization of a Donor for the purpose of donating an organ. This benefit is payable only in case the hospitalization claims of the organ recipient (the Donee, who is also a Member covered under this benefit) is admissible under the policy terms and conditions and accordingly the benefit with respect to the Donor is payable. This Benefit is not payable for any monetary transaction for an organ but pays for expense incurred by the Donor for hospitalization due to surgery for removal of an organ which is being donated to the recipient Member covered under this Union Health 360 benefit.

Per day benefit shall not be applicable if the said Organ Donor is hospitalized in a non-paying government hospital.

Any payment made under the Hospitalization of an Organ Donor category shall be considered as a payment made within the Benefit Amount. Benefits under 01 and 02 categories (Hospitalization and Surgical benefit)of the Table of Benefits in section 3.2.6.2 (I) with respect to any claim under Hospitalization of an organ donor shall be the same as specified in the Table of Benefits in section 3.2.6.2 (I) as per the opted plan of Benefit amount.

Specimen

3.7.2 (VII) PROSTHESIS AND IMPLANTS

If as a result of a Hospitalization that is covered under this Policy, the Life Assured requires a Prosthesis or Surgical implant which is certified as Medically Necessary by the attending Physician, the Company shall pay the actual costs of such Prosthesis and Implant up to the benefit limit set forth in the Table of Benefit and First schedule of the Policy

Prosthesis means an artificial device extension that replaces any limb or eye of the Life Assured. This benefit pays for buying any prosthesis for the Life Assured to use if the following conditions are met:

- The Life Assured needs the prosthesis because of a loss of limb or eye resulting from an Injury or Illness that the Life Assured has to stay in a hospital for.
- The prosthesis is ordered by a registered medical practitioner.
- The prosthesis must be bought within One Hundred and Eighty (180) days after the date the Life Assured leaves hospital and the limit for this benefit (as set out in the Benefit Table) shall be based on the applicable limits as at the date of discharge from the Hospital.

The Company will only pay for one prosthesis for each limb or eye. However, if the Life Assured has to buy a prosthesis again for the same limb or eye resulting from another Injury or Illness that the Life Assured has to stay in hospital for again, the Company will pay for the prosthesis. The Company will not pay for replacing, repairing or maintaining of the prosthesis.
Surgical Implants means implants required during Surgery. These implants must be Reasonable and Customary approved medical consumables and stay in the Life Assured's body after the Surgery.

3.7.2 (VIII) ROUTINE DENTAL BENEFIT

Expenses covered under Routine Dental Benefits are;

i. Dental filling or restoration
ii. Examinations
iii. X- Rays
iv. Extraction of Teeth
v. Root anal Treatment
vi. Treatment of gum disease

Claim settlements under Routine Dental Benefit shall be considered only on reimbursement basis as per the limits specified in the Table of Benefits in section 3.2.6.2 (I) subject to submission of original bills, original payment receipt, description of the service (issued by a registered Dentist/Dental surgeon) and claim form

This cover is applicable for treatments taken within Sri Lanka only by the Life Assured, Spouse and Children named as Covered Persons under Union Health 360 in the First Schedule.

The limit will not be increased due to application of Benefit Multiplier and not get reinstated due to activation of Revival Benefit.

For the above definition, the following are not covered

i. Scaling and cleaning
ii. Mouth guards, gum shields or any dental appliances.
iii. Implants and all costs associated with the preparation and fitting of such a device (including crowns and bridges).
iv. Bleaching or other tooth whitening and orthodontics.
v. Cosmetic Treatment, meaning dental Treatment not necessary for the establishment or maintenance of oral health.
vi. Specialist Treatment, meaning any form of dental care or Treatment beyond the scope of the average

Specimen

competent Dentist.

vii. Wisdom teeth extraction, other than those extracted at the Dentist's surgery.

viii. Treatment, care, repair to, or in connection with 'tooth jewellery'.

ix. Any Treatment required as a result of damage or Injury caused whilst training for, or participating in, contact sports unless recommended mouth protection is worn.

x. Expense for prosthetic organs and equipment, including prosthetic tooth or dental inventions.

3.7.2 (IX) MATERNITY BENEFIT

The benefit under Maternity Benefit is applicable If the Life assured has opted for the benefit and it is stated in the First Schedule of the policy.

Under Maternity Benefit, only the medical expenses for the delivery of a child (Normal deliveries inclusive of vacuum and forceps delivery or surgical delivery), miscarriages in a hospital in Sri Lanka will be covered. Maternity Benefit will be limited to Two (02) deliveries including miscarriages happened during the Term of the benefit prior attaining age Forty Five (45)

This cover is applicable only for Life Assured or Spouse and the age of the Assured at the time of enrollment must be less than Forty (40) years and this benefit will cease at the date of expiry of the Maternity Benefit as specified in the First Schedule, irrespective of incurring of claims. This Maternity Benefit can be availed only at the commencement of the policy and/or inclusion of the Union Health 360 Once the Maternity Benefit is opted, removal of the benefit will not be allowed during the term of the benefit. Claim settlements under Maternity Benefit shall be considered only on reimbursement basis subject to the limits specified in the Table of Benefits in section 2.2 (I).

The Maternity Benefit limit will not be increased due to application of Benefit Multiplier and not get reinstated due to activation of Revival Benefit. If the Life assured has opted for a deductible amount, it will not be applied for claims under Maternity Benefit.

For the above definition, the following are not covered:

a) Any fertility, sub fertility treatment or assisted conception operation or sterilization procedure, birth control related treatment, treatment for sexual dysfunction and voluntary termination of pregnancy.

b) Private nursing cost.

c) Routine visits, any diagnostic tests, treatment/consultancy for maternity related conditions and non medical expenses

d) Any expenses related to the new born baby

3.7.2 (X) ROUTINE OPTICAL BENEFIT

The Routine Optical Benefit is applicable If the Life assured has opted for the benefit and it is stated in the First Schedule of the policy.

Expenses incurred within Sri Lanka for treatment to correct refractive errors of the eye prescribed by an Ophthalmologist/eye surgeon for correction of short-slightness and purchased from a registered optician will be covered under Routine Optical Benefit. This Routine Optical Benefit is applicable only for the Life Assured and Spouse named as Covered Persons under Union Health 360 in First Schedule.

The cover is granted once in every two years as stated below;

i. Fees Charged for eye examinations. (Maximum once per two years)

ii. The cost of spectacle frames, corrective lenses as prescribed. (Maximum one pair per two years)

Claim settlements under Routine Optical Benefit shall be considered only on reimbursement basis subject to the limits specified in the Table of Benefits in section 3.2.6.2 (I) upon submission of original prescription,

Specimen

original bill, the original payment receipt and a completed claim form.

The Routine Optical Benefit limit will not be increased due to application of Benefit Multiplier and not get reinstated due to activation of Revival Benefit. If the Life assured has opted for a deductible amount, it will not be applied for claims under Routine Optical Benefit.

For the above definition, the following are not covered

a) Any claim directly or indirectly from costs of tinted / reactive lenses, sunglasses, non-corrective contact lenses, whether prescribed or not and laser eye surgery or any other similar technique.
b) Normal lenses without vision correction
c) lenses of cosmetic use
d) Intra Ocular lenses
e) computer glasses and eye protectors
f) reading lenses
g) Post care and maintenance of spectacles including contact lens solutions
h) Repairing charges of spectacles

3.7.2 (XI) WELLBEING COVER

After two consecutive claim free policy years, up to Two Percent (2%) of the Basic Annual Sum Assured of the Union Health 360 Benefit Subject to a maximum of Rupees Fifty Thousand (Rs.50,000/-) is payable per year as Wellbeing Cover for health check-up at a hospitals registered under Private Health Care Service Regulatory Council in Sri Lanka (PHSRC). Claim settlements under Wellbeing Cover shall be considered only on reimbursement basis subject to the limits specified in the Table of Benefits in section 3.2.6.2 (I). Any balance sum Assured of this benefit and / or Unclaimed benefit amount shall not be carried forward to the subsequent policy year.

The Wellbeing Cover limit will not be increased due to application of Benefit Multiplier and not get reinstated due to the activation of Revival Benefit. If the Life assured has opted for a deductible amount, it will not be applied for claims under Wellbeing Cover. This cover is applicable only for the Life Assured and Spouse named as Covered Persons under Union Health 360 in First Schedule.

Claims made under Maternity Benefit, and Routine Optical Benefit shall not have an impact on the entitlement of Wellbeing cover.

3.7.2 (XII) CRITICAL ILLNESS REIMBURSEMENT BENEFIT

As stated in the Table of Benefit a Critical Illness reimbursement Benefit is provided up to maximum of Fifty Percent (50%) of the Basic annual Sum Assured per annum of Union Health 360 for the following illnesses subject to the conditions stated below.

The claim settlements happen only on reimbursement basis subject to the limits specified. Lifetime limit is restricted to Two (02) times of the Basic Annual sum assured of Union Health 360 Benefit. This Critical Illness Reimbursement Benefit will get activated only after the complete exhaustion of the annual Sum Assured limit of Union Health 360 Benefit, the sum assured accumulated under Benefit Multiplier and revival benefit if applicable. The benefit will cease once the lifetime limit is utilized.

This Benefit will be applicable only for plans one (01) to eight (08) as specified in the Schedule and Table of Benefit under the condition number 3.2.6.2 (1). The Critical Illness Reimbursement Benefit limit will not be increased due to application of Benefit Multiplier and not get reinstated due to activation of Revival Benefit.

This benefit is applicable for all the assureds covered under Union Health 360 benefit and as specified in the first schedule.

Specimen

1) CANCER

Any malignant tumour positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The diagnosis must be confirmed by a Specialist.

Unless not specifically excluded, leukaemia, malignant lymphoma and myelodysplastic syndrome are covered under this definition.

For the above definition, the following are not covered:

- Any tumour histologically classified as pre-malignant, non-invasive or carcinoma in situ (including ductal and lobular carcinoma in situ of the breast and cervical dysplasia CIN-1, CIN-2 and CIN-3).
- Any prostate cancer unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- Chronic lymphocytic leukaemia unless having progressed to at least Binet Stage B
- Basal cell carcinoma and squamous cell carcinoma of the skin and malignant melanoma stage IA (T1aN0M0) unless there is evidence for metastases
- Papillary thyroid cancer less than 1 cm in diameter and histologically described as T1N0M0
- Papillary micro-carcinoma of the bladder histologically described as Ta
- Polycythemia rubra vera and essential thrombocythemia
- Monoclonal gammopathy of undetermined significance
- Gastric MALT Lymphoma if the condition can be treated with Helicobacter- eradication
- Gastrointestinal stromal tumour (GIST) stage I and II according to the AJCC Cancer Staging Manual, Seventh Edition (2010)
- Cutaneous lymphoma unless the condition requires treatment with chemotherapy or radiation.
- Microinvasive carcinoma of the breast (histologically classified as T1mic) unless the condition requires mastectomy, chemotherapy or radiation
- Microinvasive carcinoma of the cervix uteri (histologically classified as stage IA1) unless the condition requires hysterectomy, chemotherapy or radiation

2) MULTI-ORGAN TRANSPLANT (INCLUDING BONE MARROW)

The undergoing as a recipient of an allograft or isograft transplant of one or more of the followin:

- Heart
- Kidney
- Liver (including split liver and living donor liver transplantation)
- Lung (including living donor lobe transplantation or single-lung transplantation)
- Bone marrow (allogeneic hematopoietic stem cell transplantation preceded by total bone marrow ablation)
- Small bowel
- Pancreas

Partial or full face, hand, arm and leg transplantation (composite tissue allograft transplantation) is covered under this definition, too. The condition leading to transplantation must be deemed untreatable by any other means, as confirmed by a Specialist.

For the above definition, the following are not covered:

- Transplantation of other organs, body parts or tissues (including cornea and skin)
- Transplantation of other cells (including islet cells and stem cells other than hematopoietic)

Specimen

3) BRAIN SURGERY

The actual undergoing of surgery to the brain, under general anaesthesia, during which a Craniotomy with removal of bone flap to access the brain is performed.

The following are excluded:

a) Burr hole procedures, trans-phenoidal procedures and other minimally invasive procedures such as irradiation by gamma knife or endovascular embolizations, thrombolysis and stereotactic biopsy, and, b) brain surgery as a result of an accident

The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

4) CHRONIC KIDNEY FAILURE

Chronic and irreversible failure of both kidneys, as a result of which either regular haemodialysis or peritoneal dialysis is instituted or renal transplantation is carried out. The dialysis must be medically necessary and confirmed by a Consultant Nephrologist.

For the above definition, the following are not covered:

- Acute reversible kidney failure with temporary renal dialysis

5) CORONARY ARTERY BYPASS GRAFT (CABG) SURGERY

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

- Angioplasty and/or any other intra-arterial procedures

6) SURGERY OF AORTA

The undergoing of surgery to treat narrowing, obstruction, aneurysm or dissection of the aorta. Minimally invasive procedures like endovascular repair are covered under this definition.
The surgery must be determined to be medically necessary by a Consultant Surgeon and supported by imaging findings.

For the above definition, the following are not covered:

- Surgery to any branches of the thoracic or abdominal aorta (includingaortofemoral or aortoiliac bypass grafts)
- Surgery of the aorta related to hereditary connective tissue disorders (e.g. Marfan syndrome, Ehlers–Danlos syndrome)
- Surgery following traumatic injury to the aorta

7) HEART VALVE SURGERY

The undergoing of surgery to replace or repair one or more defective heart valves. The following procedures are covered under this definition:

- Heart valve replacement or repair with full sternotomy (vertical division of the breastbone), partial sternotomy or thoracotomy
- Ross-Procedure

Specimen

- Catheter-based valvuloplasty
- Transcatheter aortic valve implantation (TAVI)

The surgery must be determined to be medically necessary by a Consultant Cardiologist or Cardiac Surgeon and supported by echocardiogram or cardiac catheterization findings.

For the above definition, the following are not covered:

- Transcatheter mitral valve clipping

3.7.2 (XIII) DEDUCTIBLE OPTION

In the event the Life Assured agrees by providing his consent in the insurance proposal to the application of a Deductible on claims in a policy year and selects any one of the Deductible optional amounts as specified in the Policy Schedule/subsequent Endorsement, the Life Assured shall first bear the expenses of claims (Payable and duly notified to the Company) equivalent to such Deductible and shall only become entitled for claims after exhausting the Deductible amount.

In the event of a sum assured reduction, the Deductible amount will also be changed and the Life Assured has the option of selecting the Deductible options available under the reduced benefit plan.

The Deductible option removal is enabled only if the Main assured's age is Forty-Five (45) and below at policy commencement or at the inclusion of the benefit. The selected Deductible option can be removed only after completion of 10 years of premium payment and after attaining the age specified and agreed at the proposal stage. Deductible option removal will not be allowed during the term of the rider unless it is agreed and stated in the proposal form at the time of policy commencement or inclusion of the rider. The removal of the Deductible option will be effective from the next Policy Anniversary after receipt of the written consent for the removal and subject to the receipt of the applicable premium. Once opted, the Deductible amount cannot be reduced during the term of the policy unless there is a sum assured reduction of the Union Health 360.

This Deductible Option is applicable for all covers except Maternity Benefit, and Routine Optical Benefit.

3.7.3 WAITING PERIOD

Union Health 360 Benefit shall commence Ninety (90) days after;

- the Date of Commencement of the Cover; or
- the Date of Issue of the Policy; or
- the Date of Revival/ Reinstatement of Policy,

whichever is later.

The Company may waive off the Waiting Period in the event of Hospitalizations and/or Surgical procedures required due to Accidents occurred after;

- the Date of Commencement of the Cover; or
- the Date of Issue of the Policy; or
- the Date of Revival / Reinstatement of Policy,

whichever is later.

For the following list of surgeries or ailments, a Waiting Period of Three Hundred and Sixty-Five (365) days is applicable from;

- the Date of Commencement of the Cover; or
- the Date of Issue of the Policy; or
- the Date of Revival of Policy,

Whichever is later.

Specimen

	Name of Surgery / Ailment
1	Medical or Surgical management of Deviated Nasal Septum, diseases of Tonsils, Adenoids and Sinuses and related conditions (except Malignancy).
2	All types of Hernias and Benign Prostatic Hypertrophy.
3	Hydrocele / Varicocele / Spermatocoele.
4	Piles / Fissure / Fistula-in-Ano / Rectal Prolapse / Pilonidal Sinus
5	Treatment of all gynecological conditions (Such as but not limited to Uterine Fibroid, Dysfunctional Uterine Bleeding, Hysterectomy, Uterine Prolapse, Endometriosis, Adenomyosis Uteri, Ovarian Cyst etc.) except those arising from malignancy.
6	Medical or Surgical management of Prolapsed Intervertebral Disc.
7	Skin and all internal cysts/tumors/nodules/ polyps/ganglions/lipomas of any kind unless malignant.
8	Calculus Diseases of any etiology
9	Peripheral vascular diseases of any etiology, including treatment for Varicose veins.
10	All types of CRF and acute on chronic Renal Failures but not ARF, including Renal Failure due to Diabetes.
11	Osteoporosis / Pathological Fracture / Degenerative Joint Diseases including joint replacement surgeries. However, joint surgeries necessitated due to accidents would not be a part of this exclusion.
12	Cataract, Retinopathy and Retinal detachment.

Three hundred and Sixty-Five days (365) days waiting period applicable for the above ailments/ Surgeries is waived off for Union Health 360 Sum assured Rs. 500,000/- and above. However, the benefit payable for such ailments & surgeries during the first year from the benefit commencement date is restricted to 50% of the eligible claim amount up to a maximum of Rs. 200,000/- within the benefit limit set forth in the Table of Benefit and First schedule of the Policy.

The Waiting Period is applicable for the diagnosis of the ailment or the condition which directly or indirectly results in Hospitalization and/or Surgery, where no payment shall be paid for Hospitalization and/ or Surgery performed even after the Waiting Period if the diagnosis of the ailment leading to the Hospitalization and/or Surgery had occurred during the Waiting Period.

3.7.3.1 ROUTINE DENTAL BENEFIT

Cover shall become effective Hundred and Eighty (180) days after,

- the Date of Commencement of the Cover; or
- the Date of Issue of the Policy; or
- the Date of Revival/ Reinstatement of Policy, whichever is later.

3.7.3.2 MATERNITY BENEFIT

Cover shall become effective after Twenty-Four (24) months after,

- the Date of Commencement of the Cover; or
- the Date of Issue of the Policy; or
- the Date of Revival/ Reinstatement of Policy, whichever is later.

Specimen

Miscarriage will be covered after Hundred and Eighty (180) days from the above dates.

3.7.3.3 ROUTINE OPTICAL BENEFIT

Cover shall become effective after Twenty (24) months after,

- the Date of Commencement of the Cover; or
- the Date of Issue of the Policy; or
- the Date of Revival/ Reinstatement of Policy, whichever is later.

3.7.4 DAY CARE SURGERIES COVERED

Day care treatment /surgery is defined as surgery or treatment which does not need overnight hospital stay and which does not necessitate Post surgical hospitalized care or management. In case of a day care treatment / surgery, only surgery charges and the Doctor fee are covered and Room charges and hospital ward charges such as nursing care, ward procedures are excluded. The following are the listed Day Care Procedures and such other Surgical Operations that necessitate less than Twenty-Four (24) hours due to medical / technological advancement / infrastructure facilities and the coverage of which is subject to the terms, conditions and exclusions of the Policy.

3.7.5 RIGHT OF THE COMPANY TO REVISE PREMIUM AND TERMS AND CONDITIONS

The premium payable for this cover in the Part II of the First Schedule to this Policy is guaranteed only for a period of One (01) year from the Date of Commencement of the Cover. The Company reserves right to review this benefit at each Policy Anniversary and revise the premium rates, change any limit and/or alter the terms and conditions applicable or to withdraw the Benefit. Such change shall be implemented only after Thirty (30) days' notice has been given to the Policyholder and, shall be effective from the next Policy Anniversary, subsequent to the notice.

3.7.6 NOTICE OF CHANGE OF OCCUPATION

Any substantial change in the occupation of the Life Assured must be intimated to the Company in writing within Fourteen (14) days of such change and the risks covered under this Benefit shall require to be reapproved. The Company shall not be liable in respect of any claim, if the Life Assured is engaged in any occupation at the time of Hospitalization and/or Surgery which is different to that described in the Proposal / Application form and/or Declaration of Health.

3.7.7 NOTICE AND PROOF OF CLAIM

In case of Hospitalization and/or Surgery which is covered and on which the claim may be based, a written notice must be given to the Company's Head Office or nearest branch within Forty-Eight (48) hours from the date of Hospitalization. Failure to give notice as stipulated above shall give the Company a right not to entertain such claim.

The Company shall, upon receipt of such notice, issue the forms required to be completed for the filing of proof of claims. The completed forms must be delivered to the Company within Ten (10) working days from the date of issue. Affirmative proof acceptable to the satisfaction of the company together with original bills and original payment receipts must be submitted to the Company not later than Thirty (30) days from the date of discharge from the Hospital / and at the expense of the Assured.

The Covered Person or a member of Family Unit must carefully follow all the instructions issued by the Medical Consultant responsible for treatment and shall provide the Company with full information concerning the circumstances of the treatment.

Specimen

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

Specimen

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

Specimen

	69	Excision and destruction of a lingual tonsil
	70	Other operations on the tonsils and adenoids
Orthopaedic Surgeries	71	Trauma surgery and orthopaedics
	72	Incision on bone, septic and aseptic
	73	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
	74	Suture and other operations on tendons and tendon sheath
	75	Reduction of dislocation under GA
	76	Arthroscopic knee aspiration
Operations on the breast	77	Incision of the breast
	78	Operations on the nipple
Operations on the digestive tract	79	Incision and excision of tissue in the perianal region
	80	Surgical treatment of anal fistulas
	81	Surgical treatment of haemorrhoids
	82	Division of the anal sphincter (sphincterotomy)
	83	Other operations on the anus
	84	Ultrasound guided aspirations
	85	Sclerotherapy etc.
	86	Laparoscopic cholecystectomy
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 prostate & 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

Specimen

	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 & tunica vaginalis testes	109	Incision of the scrotum and tunica vaginalis testes
	110	Operation on a testicular hydrocele
	111	Excision and destruction of diseased scrotal tissue
	112	Plastic reconstruction of the scrotum and tunica vaginalis testes
	113	Other operations on the scrotum and tunica vaginalis testes
Operations on the testes	114	Incision of the testes
	115	Excision and destruction of diseased tissue of the testes
	116	Reconstruction of the testes
	117	Implantation, exchange and removal of a testicular prosthesis
	118	Other operations on the testes
Operations on the spermatic cord, epididymis und ductusdeferen	119	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
	120	Excision in the area of the epididymis
	121	Epididymectomy
	122	Reconstruction of the spermatic cord
	123	Reconstruction of the ductus deferens and epididimis
	124	Other operations on the spermatic cord, epididymis and ductus deferens
Operations on the penis	125	Operations on the foreskin
	126	Local excision and destruction of diseased tissue of the penis
	127	Amputation of the penis
	128	Plastic reconstruction of the penis
	129	Other operations on the penis
Operations on the urinary system	130	Cystoscopical removal of stones
Other Operations	131	Lithotripsy
	132	Coronary angiography
	133	Haemodialysis
	134	Radiotherapy for Cancer
	135	Cancer chemotherapy

End of list of surgeries

Specimen

The Covered Person or a member of Family Unit and his/her relatives or successors shall allow visits and examinations by the Company's experts and to conduct any enquiries considered necessary by the Company and the Company shall be released from the obligation to maintain professional secrecy consequent to and arising out of such visits by the experts.

If the Covered Person does not follow the described procedure in the event of a claim, the Company shall refuse to pay any claim under this Benefit.

3.7.8 CONDITIONS

(i) The Union Health 360Benefit shall expire;

a) On the Expiry Date of this Benefit as stipulated in the First Schedule, or
b) On the Policy Anniversary, following the,

- 75th birthday for Life Assured/ Spouse /Parent; or
- 23rd birthday for Children Assured whichever happens earlier.

(ii) This Rider Cover shall lapse on expiry of the Thirty (30) days Grace Period if the premium remains unpaid. The Company reserves the right to decline the Reinstatement or Revival of this Cover. If the cover is Reinstated or Revived, the Waiting Period shall be applicable from the date of Reinstatement/ Revival.

(iii) The Union Health 360Benefit shall terminate if the main Policy is terminated.

(iv) This Rider Cover shall not;

a) Participate in profits; or
b) Acquire a surrender value, paid-up value or a maturity value

.

(v) An assignee, nominee or beneficiary shall not have the right to receive any payments arising from a claim under the Benefits provided in this Schedule.

(vi) This Benefit shall cover Hospitalizations and Surgeries performed within the Sri Lankan territories or Overseas countries as per the Geographical coverage selected & stated in the first schedule

(vii) The maximum amount that can be claimed by an individual under Union Health 360Benefit in any One (01) Policy Year cannot exceed One Hundred Percent (100%) of the Union Health 360Benefit Sum Assured unless the Benefit Multiplier or Benefit Revival has been affected.

(viii) The maximum Sum Assured on all Policies taken for an individual under any health reimbursement rider issued from the Company is limited to Rupees Sixty Million (Rs. 60,000,000/-).

(ix) Any Medically Necessary Treatment done will be reimbursed if they are considered usual, customary, and reasonable.

(x) Union Health 360 Benefit Sum Assured cannot be enhanced during the term of the policy.

(xi) Policyholder shall inform the Company of any other Medical Insurance covers which is in force during the Term of this Policy. If the Covered Person or a member of Family Unit carries other insurance covering an eligible expense insured by this Policy, the Company shall indemnify the Policyholder up to a maximum limit of eligible expenses incurred, less any payment made by other insurers subject to the maximum limits specified under First Schedule to this Policy and terms and conditions of this Benefit.

Specimen

(xii) This Union Health 360Benefit is only eligible for (i) Sri Lankan Citizens and (ii) Sri Lankan residents who are living for at least 6 months in Sri Lanka and with a bona-fide residential address in Sri Lanka. The overseas coverage will get terminated if the Insured resides outside of Sri Lanka for a continuous period of 90 days and above. However, once the policyholder returns back to Sri Lanka, the benefits of the Policy will be activated and the Policy benefits will resume as per original terms and conditions.

(xiii) It is mandatory for the Policyholder to obtain prior written approval from the Company in case of an overseas hospitalization. Reimbursement of hospital expenses of Overseas hospitalizations shall be considered subject to the maximum limits specified under First Schedule to this Policy and terms and conditions of this Benefit. The payments will be made in Sri Lankan Rupees in accordance to the currency exchange rate quoted by the Central Bank of Sri Lanka applicable on the date of Hospital bill. In the event the Company admits liability for any claim, the Company may at its absolute discretion settle such claim either to the Policyholder or the relevant Hospital or any other relevant service provider. Any payment directly made to a Hospital or any service provider by the Company shall be treated as a full and final discharge of liability of the Company with respect to the claim for which the liability was admitted by the Company and be construed as a payment made to the Policyholder for the purpose of this benefit.

3.7.9 EXCLUSIONS APPLICABLE TO THIS BENEFIT

The Company shall not be liable to make any payment on Hospitalizations and/or Surgeries performed, if the reason/cause for the Hospitalization/Surgery is directly or indirectly due to;

(i) Lesions resulting from attempted suicide or self or intentional infliction (including but not limited to the use or misuse of any intoxicating drugs or alcohol); and/or

(ii) Any complications arising out of or ailments requiring treatment due to use or abuse of any substance, drug or alcohol including driving while drunk and treatment for de-addiction; and/or

(iii) Pre-existing conditions (i.e. any condition, whether diagnosed or not, ailment or injury or related condition(s) for which Insured has been diagnosed, received medical treatment, had signs and / or symptoms, prior to inception of Insured's first Policy with the Insurer. It would also mean any direct or indirect complications arising out of pre-existing conditions whether known or unknown to the Insured) unless they have been declared by the Policyholder on the Proposal form/ Health Declaration form and accepted by the Company in writing, on or before the Date of Issue of the Policy indicated in the First Schedule or in any amendment issued by the Company; and/or

(iv) War and circumstances comparable with a state of war, invasion, act by a foreign enemy, hostilities and warlike events (with or without a declaration of war), civil war, riot, mutiny, revolution, confiscation or nationalization by order of any public or local government or authority; any act of a person acting in the name of or in connection with any organization whose activities aim to overturn a de jure or de facto government violently; and/or

(v) Naval or military operations of the armed forces or air force and participation in operations requiring the use of arms or which are ordered by military authorities for combating terrorists, rebels and the like; and/or

(vi) Nuclear risks: e.g. exposure to nuclear energy (nuclear reactions, radiation, contamination) or nuclear waste of any type or chemical contamination; and/or

(vii) Hazardous activities, including but not limited to scuba diving, motorcycling, parachuting,

Specimen

hangliding, rock or mountain climbing, racing of any kind other than on foot, rafting, bungee jumping, potholing, hunting, steeple chasing, polo playing, winter sports, ice hockey; or any sport in a professional capacity unless otherwise agreed in writing by the Company; and/or

(viii) Natural perils: such as but not limited to avalanches, landslides, earthquakes, floods, tsunami or tidal waves caused by earthquakes or volcanic eruptions, cyclones, storms, tempest, hurricanes, tornados & typhoons; and/or

(ix) Experimental treatments and treatments of purely diagnostic nature such as (but not limited to) biopsy, endoscopy, laparoscopy, arthroscopy, x-ray or laboratory examinations, other diagnostics studies not consistent with or incidental to diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a hospital or nursing home; and/or

(x) The cost of spectacles, contact lenses, hearing aids, crutches, wheelchairs, artificial limbs, dentures, artificial teeth and all other external appliances, Prosthesis and/or devices, unless specifically accepted by the Company and/or covered under the scope of Routine optical Benefit & Routine Dental Benefit; and/or

(xi) Surgeries due to change of life (menopause), childbirth and miscarriage (unless specifically obtained under maternity benefit), abortion, pregnancy, neonatal procedures, amniocentesis and child birth, voluntary medical termination of pregnancy; and/or

(xii) Sterilization, insemination (e.g. artificial insemination), reversal of sterilization, sex transformation surgeries or infertility and in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT) procedures, zygote intra-fallopian transfer (ZIFT) procedures, embryo transport; donor ovum and related costs or any other Surgery or procedure performed due to infertility, sub fertility of family planning; and/or

(xiii) Congenital or birth defects, anomalies and condition arisen as a result of underlining chromosomal disorder (E.g., Down's Syndrome); and/or

(xiv) Genetic disorders and stem cell implantation / surgery/storage; and/or

(xv) Cosmetic or aesthetic treatments of any description, Lasik treatment for refractive error or any form of plastic surgery, unless necessary for the treatment of Illness or accidental Bodily Injury; and/or

(xvi) Organ transplant as a donor for a third party or costs of donor screening or treatment; and/or

(xvii) Treatments which are not required medically or not recommended by a qualified Doctor or Surgery or a procedure performed not as a treatment of or as a consequence of an Illness or Injury; and/or

(xviii) Treatment for idiopathic epilepsy and psychiatric and psychological conditions, mental disorders, and conditions arising as a result of insanity; and/or.

(xix) Surgery or a procedure performed due to obesity, weight reduction or weight management; and/or

(xx) Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident; and/or

(xxi) Officially (by World Health Organization and/ or national law) recognized epidemics/ pandemics or Government screening programs; and/ or

Specimen

(xxii) Sexually transmitted Diseases (venereal diseases), any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus or Variant/mutant viruses and/or any syndrome or condition of a similar kind commonly referred to as AIDS; and/or

(xxiii) Treatments not carried out by a qualified Physician/Surgeon or service rendered by a provider with the same legal residence as the insured person or who is a member of the insured's family, including spouse, brother, sister, parent or child; and/or

(xxiv) Treatment by non-allopathic methods, neurotherapy, acupuncture and aromatherapy; and/or

(xxv) Any kind of Service charges, Surcharges, Registration charges etc. levied by the Hospital;and/or

(xxvi) Expenses incurred on items for personal comfort like television, telephone, etc. incurred during and which have been specifically charged for in the bills issued by the Hospital / nursing home; and/or

(xxvii) External medical equipment of any kind used at home as post care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Ambulatory Peritoneal Dialysis (C.A.P.D) and Oxygen concentrator for Bronchial Asthmatic condition; and/or

(xxviii) Dental treatment or surgery of any kind unless required as a result of Accidental Bodily Injury to natural teeth requiring treatment; other than the coverage specified under Routine Dental Benefit and/or

(xxix) Convalescence, general debility, "Run-down" condition, rest cure, Congenital Internal and /or external illness/disease/defect; and/or

(xxx) Vaccinations or inoculations of any kind; and/or

(xxxi) Vitamins, tonics, nutritional supplements unless forming part of the treatment for injury or disease as certified by the attending Medical Practitioner; and/or

(xxxii) Surgery to correct deviated septum and hypertrophied turbinate unless necessitated by an accidental body injury and proved to the satisfaction of the Company that the condition is a result of an accidental injury; and/or

(xxxiii) Outpatient Diagnostic Medical and Surgical procedures other than the listed Day care procedures, or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change; and/or

(xxxiv) Expenses incurred at Hospital or Nursing Home primarily for diagnosis irrespective of Twenty-Four (24) hours without diagnosis of any disease which does not require any follow up treatment covered under this Policy. This would also include stay in a hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner, which ordinarily can be given without; and/or

(xxxv) Treatments taken at any institution which is primarily a rest home or convalescent facility, a place for custodial care, a facility for the aged or alcoholic or drug addicts or for the treatment of psychiatric or mental disorders; even if the institution has been registered as a hospital or nursing home with the Appropriate Authorities; and/or.

(xxxvi) Treatments in health hydro, spas, nature care clinics and the like.

Specimen

Schedule No. 4

4. DEFINITIONS APPLICABLE TO THIS POLICY

4.1 Key Definitions

"Alteration"
Amendment/change to an attached description of additional or alternative provisions to the Policy. Alterations are effective only when signed by the Company and accepted by the Policy holder.

"Applicant/Proposer"
A person applying for the insurance policy by filling in and signing an application form.

"Application form/Proposal form"
A form used to apply for coverage under this policy.

"Basic Sum Assured"
Is the minimum Benefit payable on the Policy in the event of death of the Life Assured.

"Benefit"
Extent or degree of service, persons covered are entitled to receive based on their insurance contract with the Company.

"Claimant"
The Policy holder, Nominee, Assignee or any other legally interested person (for example, the heir or administrator or executor of a deceased Policy holder) who wishes to make a claim to receive any Benefits under the Policy.

"Company"
Refers to Union Assurance PLC, bearing Company No.PQ 12.

"Coverage" or "Covered"
The entitlement of a Covered Person to Benefit(s) provided under the Policy, subject to the terms, conditions, limitations and Exclusions of the Policy. Benefit(s) must be provided;

(i) When the Policy is in force; and
(ii) Prior to the date of the individual termination conditions if any; and
(iii) Only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

"Covered Person"
Either the Policy holder or a Policy holder's dependant, applicable only during the effective period of Coverage of such person under the Policy is in effect.

"Date of Commencement"
The date from which this insurance contract commences. Date of Inclusion The date from which coverage for new covered person as a newborn or newly adopted child or newly married spouse (including the spouse's children) commences.

"Date of Maturity"
The date on which the contract ends beyond which the Policy shall no longer be in-force.

Specimen

"Date of Policy"/"Date of Issue"
The date on which the Proposer is accepted under this Policy as a Policy holder or dependent.

"Dependant"
The Policy holder's legally married spouse, an unmarried dependent child of the Policy holder or Policy holder's spouse (including a natural child, step child or a legally adopted child) aged more than Six (06) months.

The principal place of residence of the spouse or unmarried dependent child must be with the Policy holder unless company approves other arrangements. The term "Dependant shall" not include any unmarried dependent child more than Eighteen (18) years old.

"Endorsement"
The variation(s), if any, annexed to this Policy Document, modifying or varying any terms or conditions contained in this Policy.

"Exclusions"
The Benefits and events excluded from Coverage of this Policy and apply to all covered persons.

"Expiry Date"
The date on which the covers and Benefits provided under the Policy cease.

"Grace Period"
The length of time after the date a premium is due and unpaid during which the Policy remains in force. If a premium is paid during the Grace Period, the premium is considered to have been paid on time.

"Investment Account"
A notional individual account created and administered by the Company for this Policy.

"Life Assured"
The individual named in the Policy Schedule whose life is insured under this Policy. If no person is specifically named, shall mean the Policy holder.

"Nominee"
A person whose name has been nominated by the Policy holder in writing and acknowledged by the Company and who is entitled to receive a Benefit upon the death of the Life Assured. Such nomination shall be in line with Section 43 of the Regulation of Insurance Industry Act No.43 of 2000 (RII Act) and Section 544 of the Civil Procedure Code (CPC).

"Policy"
The document that contains the regulatory conditions, privileges and the Exclusions applicable to the relevant insurance contract.

"Policy Owner/Holder"
The person who owns this Policy and can exercise all rights, privileges and options available under this Policy.

"Policy Year"
The year commencing on the Date of Commencement or anniversary thereof.

"Pre-existing condition"
Any medical condition or any related condition (e.g. illnesses, symptoms, treatments, pains) that have arisen at some point prior to the commencement of this Coverage, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which the Policy holder or insured dependant know,

Specimen

knew or could reasonably have been assumed to have known, will be deemed to be preexisting. Conditions arising between signing the application form and confirmation of acceptance by the Company, will equally be deemed to be pre-existing.

"Premium"
Premium payable by the Policy holder either in regular installments or as a Lump Sum to secure the cover under the Policy.

"Primary Benefit"
The Benefit provided under the main Policy. This includes the amount payable on death or at maturity.

"Proposal Form"
A form used to apply for Coverage under this Policy, on which the contract is based.

"Schedule"
The part and parcel of the Policy document issued by the Company to evidence the Insurance.

"Sum Assured"
The maximum amount payable in the event of a respective incident such as Death, Disability, Critical Illness ,Surgery etc.

"Term of the Policy"
The period during which Policy provides cover.

"Vesting Date"
Is the date on which the life assured nominee/s upon death of Life Assured attain/s the rights to receive benefits under the policy provided that the policy has not been surrendered.

"Waiting period"
The period of time starting from the Policy inception date or enrolment date of new Covered Person during which a specified medical condition or type of treatment is not covered under this Policy.

4.2 Key Definition in respect of Additional Rider (supplementary) Benefits

"Accident"
Shall mean an event or continuous series of events, which are violent, unforeseen, involuntary, external and visible in nature, with or without an apparent cause, which causes "Bodily Injury".

"Accidental Death" shall mean a death:
(i) Which is caused by "Bodily Injury" resulting from an Accident, and
(ii) Which occurs solely, directly due to the said Bodily Injury and/or independently of any other causes, and
(iii) Which occurs within Ninety (90) days of the occurrence of such Accident but before the expiry of the Benefit.

"Bodily Injury" means injuries that are evidenced by external signs such as contusion, bruise and wound except in case of drowning and internal injuries.

"Congenital disease"
Is a disease/abnormality/disability which exists at the time of birth, as a result of hereditary factors or conditions picked up during pregnancy up to the time of birth, or discovered later, at any time during the person's life.

Specimen

"Disease"
A physical condition marked by a pathological deviation from the normal healthy state characterized by an identifiable group of signs or symptoms.

"Doctor"/Physician
A person qualified by a degree in medicine and registered with the Democratic Socialist Republic of Sri Lanka Medical Council or legally licensed by or registered with the medical authorities of the country where he or she is engaged in his or her medical practice.
"Eligibility"

Requirements about the entitlement to Benefit on the Policy.

"Hospital"
An institution,

(i) Which is licensed under statutory regulations of Democratic Socialist Republic of Sri Lanka, or of similar standard to Democratic Socialist Republic of Sri Lanka (where similarity is determines by the Company).
(ii) Which has more than one legally qualified doctor present at all time (with basic MBBS or MD Degree in western medicine).
(iii) Which is primarily engaged in providing to in-patient, diagnostics services and therapeutic services for diagnosis, treatment and care, capable of performing surgical operations, by or under the continuous supervision of a legally qualified doctor, which has at all times the services of registered and qualified nurses who are under constant supervision of a doctor.
(iv) Which has an Intensive Care Unit.
(v) Which is a place where daily records of in-patients are maintained and are accessible to the Company's Authorized Officer.
(vi) A place where in-patients facilities are available and which uses generally recognized scientific methods.
(vii) The following are excluded, and will not be considered as Hospitals.
    (a) Ayurvedic Hospitals or any institution maintained solely for the purpose of providing indigenous, homeopathic or acupuncture treatment.
    (b) Places of rest cures, convalescence cures, custodial care and sanatoriums.
    (c) Homes for persons declared incapable of managing their affairs, homes for the aged, alcoholics, drug addicts, mentally disturbed persons, invalids or persons in need of care.

"Illness"
A physical condition marked by a pathological deviation from the normal healthy state characterized by an identifiable group of signs or symptoms.

"Injury"
Bodily damage resulting from an Accident and independently of all other causes.

"Lump sum"
Payment of a fixed sum in case of a covered Benefit under this Policy.

"Partial Disability"
A state of incapacity of specified part/parts of the body of an individual, solely and directly due to an accident and independent of any other causes. The "Accident" is as per the definition given herein.

"Physician"
Means a person qualified by a degree in medicine & registered with the Democratic Socialists Republic of Sri Lanka Medical Council or legally licensed by or registered with the medical authorities of the country where he/she is practicing.

Specimen

"Policy Anniversary"
A date that is an exact number of years after the policy commencement.

"Rider Benefits"
A provision of the insurance Policy that is added separately to the basic Policy and that provides additional Benefits at additional cost.

"Sickness"
A physical condition marked by a pathological deviation from the normal healthy state characterized by an identifiable group of signs or symptoms.

"Surgeon"
A person qualified by a medical degree having either MS/FRCS in Surgery, or MS in Gynaecology and Obstetrics or MRCOG/FRCOG, and duly registered or licensed with the medical authorities of the country where he or she engaged in his or her medical practice.

"Surgery / Surgical Procedure"
Shall mean physical or instrumental intervention on body tissue by a qualified surgeon in antiseptic theater environment under local, spinal or general anesthesia using typical surgical instruments:

(a) to incise, excise , electro cauterize, repair, revise or reconstruct any organ or body part; or
(b) to reduce a fracture or dislocation by manipulation; or
(c) to remove stones and foreign bodies from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or urethra.

"Surgery List"
List of all Surgeries covered under this Policy.

"Total and Permanent Disability"
A disability is Total and Permanent where an individual suffers from a state of incapacity due to an Accident or Sickness and which incapacity is total and permanent and:

(i) Which is such that there is not at that time, nor at any time thereafter, any work, occupation or profession which the Life Assured can ever perform or follow sufficiently to earn or obtain any wage, remuneration or profit; or
(ii) Which takes the form of;

    (a) Total and irrecoverable loss of sight in both eyes; or
    (b) Total and irrecoverable loss of the use of two limbs at or above the wrist or the ankle; or
    (c) Total and irrecoverable loss of sight in one eye and total and irrecoverable loss of the use one limb at or above the wrist or ankle.

Specimen

Annexure 1

For a detailed explanation of the surrender charge calculation, please refer to section 2.7 in the Terms and Conditions of the policy document.

Policy Year	Surrender Charge		
	Term 10-14	Term 15-19	Term 20 & above
1	100%	100%	100%
2	100%	100%	100%
3	100%	100%	100%
4	50%	40%	30%
5	42%	36%	28%
6	34%	32%	26%
7	26%	28%	24%
8	18%	24%	22%
9	10%	20%	20%
10	2%	16%	18%
11	2%	12%	16%
12	2%	8%	14%
13	2%	4%	12%
14	2%	2%	10%
15		2%	8%
16		2%	6%
17		2%	4%
18		2%	2%
19		2%	2%
20			2%
21			2%
22			2%
23			2%
24			2%
25			2%
26			2%
27			2%
28			2%
29			2%
30			2%

Specimen

Annexure II
A 67/70 Ultimate Mortality Rates

AGE	Q X	AGE	Q X	AGE	Q X
0	0.00073	38	0.00115	76	0.06819
1	0.00068	39	0.00129	77	0.07458
2	0.00063	40	0.00144	78	0.08150
3	0.00058	41	0.00162	79	0.08897
4	0.00053	42	0.00183	80	0.09703
5	0.00049	43	0.00207	81	0.10571
6	0.00045	44	0.00234	82	0.11504
7	0.00042	45	0.00264	83	0.12506
8	0.00040	46	0.00298	84	0.13580
9	0.00038	47	0.00336	85	0.14727
10	0.00037	48	0.00378	86	0.15952
11	0.00037	49	0.00426	87	0.17255
12	0.00037	50	0.00479	88	0.18638
13	0.00040	51	0.00538	89	0.20104
14	0.00047	52	0.00603	90	0.21651
15	0.00061	53	0.00675	91	0.23281
16	0.00081	54	0.00756	92	0.24992
17	0.00106	55	0.00844	93	0.26783
18	0.00100	56	0.00942	94	0.28651
19	0.00094	57	0.01050	95	0.30593
20	0.00089	58	0.01169	96	0.32605
21	0.00084	59	0.01299	97	0.34680
22	0.00080	60	0.01443	98	0.36815
23	0.00076	61	0.01601	99	0.39000
24	0.00072	62	0.01775	100	0.41229
25	0.00069	63	0.01965	101	0.43493
26	0.00067	64	0.02174	102	0.45783
27	0.00066	65	0.02403	103	0.48090
28	0.00065	66	0.02654	104	0.50403
29	0.00065	67	0.02927	105	0.52714
30	0.00065	68	0.03227	106	0.55012
31	0.00067	69	0.03554	107	0.57289
32	0.00070	70	0.03911	108	0.59534
33	0.00074	71	0.04300	109	0.61738
34	0.00079	72	0.04723	110	0.63895
35	0.00086	73	0.05184	111	1.00000
36	0.00094	74	0.05685		
37	0.00103	75	0.06229		

The risk premium for the cost of Life cover provided under the Primary Benefit/Basic Sum Assured in Part II of the First Schedule is calculated based on the above A67/70 Ultimate mortality rates for current age nearer birthday + 3 years

Specimen