SUPER TOP-UP MEDICARE POLICY

1. PREAMBLE

This Policy is a contract of insurance issued by United India Insurance Company Limited (hereinafter called the '**Company**') to the Proposer mentioned in the Schedule (hereinafter called the '**Policyholder**') to cover the person(s) named in the Schedule (hereinafter called the '**Insured Persons**'). The Policy is based on the statements and declaration provided in the Proposal Form by the Proposer and is subject to receipt of the full premium.

If during the Policy Period, the Insured Person(s) is required to be hospitalised for treatment of an Illness or Injury at a Hospital /Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically Necessary, Reasonable and Customary Medical Expenses towards the Coverage mentioned hereunder.

Provided further that, any amount payable under the Policy shall be subject to the terms of coverage (including any limits/sub-limits), exclusions, conditions and definitions contained herein. The maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured opted and specified in the Schedule.

Any claim under this policy shall be payable by the Company only if the aggregate of covered Medical Expenses in a policy year in respect of Hospitalisation(s) of the Insured Person (on an Individual Sum Insured basis in case of Individual Policy and on Family Floater Sum Insured basis in case of Family Floater Policy) exceeds the Threshold stated in the Schedule; subject to 'Basis of Payment' Clause no. 5.22.g.

2. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy. Where, the context so requires, references to the singular include references to the plural; references to any gender includes all genders and references to any statutory enactment includes subsequent changes to the same.

A. STANDARD DEFINITIONS

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Any One Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner(s)* comprising any of the following:
   i. Central or State Government AYUSH Hospital; or
   ii. Teaching hospital attached to AYUSH College recognised by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   iii. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognised system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with the following criterion:
      - Having at least 5 in-patient beds;
      - Having qualified AYUSH *Medical Practitioner* in charge round the clock;
      - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are carried out;
      - Maintaining daily records of the patients and making them accessible to the insurance company's authorised representative.
4. **AYUSH Day Care Centre** means and includes Community Health Care Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical

interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

a. Having qualified registered AYUSH Medical Practitioner (s) in charge;
b. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
c. Maintaining daily records of the patients and making them accessible to the insurance Company's authorized representative

5. **Cashless Facility** means a facility extended by the Insurer to the Insured, where the payments of the costs of treatment undergone by the Insured in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization is approved.
6. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional.
7. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

(a) Internal Congenital Anomaly: Congenital Anomaly which is not in the visible and accessible parts of the body.
(b) External Congenital Anomaly: Congenital Anomaly which is in the visible and accessible parts of the body.

8. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical set-up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
   i. Has qualified nursing staff under its employment
   ii. Has qualified Medical Practitioner(s) in charge
   iii. Has a fully equipped operation theatre of its own where surgical procedures are carried out;
   iv. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.
9. **Day Care Treatment** means medical treatment, and/or surgical procedure, which is:
   i. undertaken under general or local anaesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement, and
   ii. which would have otherwise required a hospitalisation of more than twenty-four hours.

   Treatment normally taken on an outpatient basis is not included in the scope of this definition.
10. **Deductible** is a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of Indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the Insurer. A deductible does not reduce the sum insured. The deductible is applicable in aggregate towards hospitalisation expenses incurred during the policy period by Insured (individual policy) or Insured family (in case of floater policy).
11. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
12. **Emergency Care** means management for an illness or injury, which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *medical practitioner* to prevent death or serious long-term impairment of the Insured Person's health
13. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

14. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    - Has qualified nursing staff under its employment round the clock;
    - Has at least 10 in-patient beds in towns having a population of less than 10 lakhs and at least 15 in-patient beds in all other places;
    - Has qualified Medical Practitioner(s) in charge round the clock;
    - Has a fully equipped Operation Theatre of its own where surgical procedures are carried out;
    - Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.
15. **Hospitalisation** means admission in a Hospital for a minimum period of 24 consecutive *'In-patient care'* hours except for the day-care treatments, where such admission could be for a period of less than 24 consecutive hours.
16. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

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

    (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
        2. It needs ongoing or long-term control or relief of symptoms
        3. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        4. It continues indefinitely
        5. It recurs or is likely to recur
17. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
18. **In-Patient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.
19. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
20. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
21. **Maternity Expenses** mean
    a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation);
    b. expenses towards lawful medical termination of pregnancy during the policy period.
22. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.
23. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more

than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

24. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i. is required for the medical management of the illness or injury suffered by the Insured;
    ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
    iii. Must have been prescribed by a Medical Practitioner;
    iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
25. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State of India or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

    The term Medical Practitioner would include Physician, Specialist and Surgeon.
26. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
27. **Network Provider** means hospital enlisted by an Insurer, a TPA or jointly by an Insurer and a TPA to provide medical services to an Insured by a cashless facility.
28. **PPN-Preferred Provider Network** means a network of hospitals, which have agreed to a cashless packaged pricing for certain procedures for the Insured Person.

    Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and website of the TPA mentioned in the schedule and is subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.
29. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.
30. **Notification of Claim** means the process of notifying a claim to the Insurer or TPA through any of the recognised modes of communication.
31. **OPD (Out-Patient) Treatment** means the one in which the Insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
32. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer**.**
33. **Pre-Existing Disease** means any condition, ailment, injury or disease:
    a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the Insurer or its reinstatement or
    b. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the Insurer or its reinstatement
34. **Pre-Hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person, provided that:
    a. Such Medical expenses are incurred for the same condition for which the Insured Person's hospitalisation was required; and
    b. The In-patient hospitalisation claim for such Hospitalisation is admissible by the Insurer.

35. **Post-Hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days after the Insured Person is discharged from the hospital provided that:
    a. Such Medical expenses are incurred for the same condition for which the Insured Person's hospitalisation was required; and
    b. The In-patient hospitalisation claim for such hospitalisation is admissible by the Insurer.

36. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.
37. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/injury involved.
38. **Renewal** defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
39. **Room Rent** shall mean the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses.
40. **Surgery or Surgical Procedure** means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.
41. **Third Party Administrator (TPA)** means a company registered with the Insurance Regulatory & Development Authority of India (IRDAI) and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under the IRDAI (Third Party Administrators – Health Services) Regulations, 2016.
42. **Unproven/Experimental Treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

B. SPECIFIC DEFINITIONS

43. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.
44. **AYUSH treatment** means hospitalisation treatment given under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy systems.
45. **Break in policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.
46. **Continuous Coverage** means uninterrupted coverage of the Insured Person under the Top Up/ Super Top-Up Health Insurance Policy from the date of inception of policy for the first time as mentioned in the policy schedule. However, for the purpose of applying waiting periods, the break in insurance period for which the premium was not received shall be excluded from it.
47. **Epidemic** means the occurrence of more cases of a disease than would be expected in a community or region spreading rapidly during a given time period; and declared as such by the appropriate Government Authority in India.
48. **Family** means the persons named in the Policy Schedule who are the Insured Person, his/her legal spouse, Dependent Children.
49. **Insured Person** means person(s) named in the schedule of the Policy.
50. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a

condition of arrested or incomplete development of mind of a person, especially characterised by subnormality of intelligence

51. **Pandemic** means an epidemic of disease that has spread across a large region, for instance multiple continents or worldwide, affecting a substantial number of people; and declared as such by the appropriate Government Authority in India.
52. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured Person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured Person.
53. **Policy Period** means period of one policy year as mentioned in schedule for which the Policy is issued.
54. **Policy Schedule** means the Policy Schedule attaching to and forming part of the Policy.
55. **Psychiatrist** means a Medical Practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist.
56. **Sub-Limit** means a cost-sharing requirement under a health insurance policy in which an Insurer would not be liable to pay any amount in excess of the pre-defined limit.
57. **Sum Insured** means the pre-defined limit specified in the Policy Schedule that represents, the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual Sum Insured basis) or all Insured Persons (on Floater Sum Insured basis) during the policy period.
58. **Threshold** means deductible which is a cost sharing requirement under the Policy that provides that the Insurer will not be liable for a specified rupee amount which will apply before any benefits are payable by the Insurer. It does not reduce the sum insured. The threshold is applicable in aggregate towards hospitalisation expenses incurred during the policy period by Insured (individual policy) or Insured family (in case of floater policy).
59. **We/Our/Us/Company** means the United India Insurance Company Limited.
60. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

3. COVERAGE

A. Cover Type

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

B. Base Cover

The Policy provides base coverages as described below:

3.1 In-patient Hospitalisation Expenses Cover

We shall indemnify the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Hospitalisation provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy Period:

A. Room, Boarding and Nursing expenses (all inclusive) incurred as provided by the Hospital/Nursing Home including nursing care, RMO charges, Patient's Diet Charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.
B. Charges for accommodation in Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU)
C. The fees charged by the Medical Practitioner, Surgeon, Specialists and anaesthetists treating the Insured Person;

D. Anaesthetics, blood, oxygen, operation theatre charges, surgical appliances, implants, prosthetic devices implanted during surgical procedure, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

3.1.1 Other In- patient Expenses

i. Dental treatment, necessitated due to disease or injury
ii. Plastic surgery necessitated due to disease or injury
iii. All the day care treatments
iv. Mental Illness Cover: The Company shall indemnify the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist (as defined in Clause 2.B.55) or a professional having a post-graduate degree (Ayurveda) in Manovigyan Evum Manas Roga or a Post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a postgraduate degree (Siddha) in Sirappu Maruthuvam.

3.1.2 Notes to In-patient Expenses Cover

i. Expenses of Hospitalisation for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.
ii. We will pay the charges under Clause 3.1 C only if:
    a. The treatment or advice of the Medical Practitioner, Surgeon, Specialists and anaesthetists has been specifically sought by the Hospital; and
    b. The consultation charges are included in the Hospital's bill. However, the bills raised by Surgeon, Anaesthetist directly and not forming part of the hospital bill shall be paid provided a pre-numbered bill/receipt is produced in support thereof, when such payment is made ONLY by cheque/ credit card/debit card or digital/online transfer.

3.2 Pre-Hospitalisation and Post-Hospitalisation Expenses –

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

a. Pre-hospitalisation Medical Expenses incurred due to an Illness or Injury during the period subject to following limits:

Threshold	Limit
<10 Lakhs	up to 30 days immediately prior to hospitalisation
10 Lakhs and above	up to 60 days immediately prior to hospitalisation

b. Post- hospitalisation Medical Expenses incurred due to an Illness or Injury during the period subject to following limits:

Threshold	Limit
<10 Lakhs	up to 60 days immediately after the discharge from the hospital
10 Lakhs and above	up to 90 days immediately after the discharge from the hospital

Provided that:

i. We have accepted a claim for primary In-patient Hospitalisation under Clause 3.1 above;
ii. The Pre-hospitalisation and Post-hospitalisation Medical Expenses are related to the same Illness or Injury.
iii. Home Care Treatment also will be deemed as hospitalisation for this cover.

3.3 Home Care Treatment Expenses:

We will indemnify the Reasonable and Customary Charges for Home Care Treatment for any epidemic/ pandemic subject to the limits linked to the Threshold, as mentioned in the table below:

Threshold (Rs.)	Limit (Rs.) Upto	
	Individual SI Basis	**Floater SI Basis**
< 10 Lakhs	15,000 per incident	15000 per incident subject to a maximum of Rs. 30000 per policy
10 Lakhs and above	30,000 per incident	30000 per incident subject to a maximum of Rs. 60000 per policy

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

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

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

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

3.4 Organ Donor Expenses Cover

We will cover the In-patient Hospitalisation Medical Expenses incurred for an organ donor's treatment during the Policy Period for the harvesting of the organ donated up to the Sum Insured provided that:

i. the donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
ii. We have admitted a claim towards In-patient Hospitalisation under the Base Cover and it is related to the same condition; organ donated is for the use of the Insured Person as certified in writing by a Medical Practitioner;
iii. We will not cover:
   a. Pre-hospitalisation Medical Expenses or Post-hospitalisation Medical Expenses of the organ donor;
   b. Screening expenses of the organ donor;
   c. Costs directly or indirectly associated with the acquisition of the donor's organ;
   d. Transplant of any organ/tissue where the transplant is experimental or investigational;
   e. Expenses related to organ transportation or preservation;
   f. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

3.5 Road Ambulance Cover

We will cover the expenses incurred:

- subject to a maximum of Rs. 2500 per event; and further
- subject to a maximum of Rs. 5000 per policy period

on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner and becomes payable if a claim has been admitted under Clause 3.1 and the expenses are related to the same Illness or Injury.

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

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

3.6 Modern Treatment Methods & Advancement in Technologies:

In case of an admissible claims under Clause 3.1, expenses incurred on the following procedures (wherever medically indicated) either as in-patient or as part of day care treatment in a hospital, shall be covered. The claim shall be subject to additional sub-limits indicated against them in the table below:

Sr. No.	Treatment Methods & Advancement in Technology	Additional Sub Limit
1	Uterine Artery Embolization & High Intensity Focussed Ultrasound (HIFU)	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lakhs per policy period for claims involving Uterine Artery Embolization & HIFU
2	Balloon Sinuplasty	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lakh per policy period for claims involving Balloon Sinuplasty
3	Deep Brain Stimulation	Upto 70% of Sum Insured subject to a maximum of Rs. 10 Lakhs per policy period for claims involving Deep Brain Stimulation
4	Oral Chemotherapy	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lakhs per policy period for claims involving Oral Chemotherapy
5	Immunotherapy- Monoclonal Antibody to be given as injection	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lakhs per policy period
6	Intra vitreal Injections	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lakh per policy period
7	Robotic Surgeries (including Robotic Assisted Surgeries)	• Upto 75% of Sum Insured subject to a maximum of Rs. 10 Lakhs per policy period for claims involving Robotic Surgeries for (i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies • Upto 50% of Sum Insured subject to a maximum of Rs. 5 Lakhs per policy period for claims involving Robotic Surgeries for other diseases
8	Stereotactic Radio Surgeries	Upto 50% of Sum Insured subject to a maximum of Rs. 5 Lakhs per policy period for claims involving Stereotactic Radio Surgeries
9	Bronchial Thermoplasty	Upto 30% of Sum Insured subject to a maximum of Rs. 3 Lakhs per policy period for claims involving Bronchial Thermoplasty
10	Vaporisation of the Prostate (Green laser treatment or holmium laser treatment)	Upto 30% of Sum Insured subject to a maximum of Rs. 2 Lakhs per policy period
11	Intra-operative Neuromonitoring (IONM)	Upto 15% of Sum Insured subject to a maximum of Rs. 1.5 Lakhs per policy period for claims involving Intra Operative Neuro Monitoring
12	Stem Cell Therapy: Hematopoietic stem cells for bone marrow	Upto 75% of Sum Insured subject to a maximum of Rs. 10 Lakhs per policy period

	transplant for haematological conditions to be covered only	

C. Optional Cover:

3.7 Daily Cash Allowance on Hospitalisation

We will pay Daily Cash Allowance to the insured person for every continuous and completed period of 24 hours of Hospitalisation, subject to the hospitalisation claim being admissible under the policy and also subject to the limits linked to the Threshold, as per the table below:

Threshold	Limit (Rs.) per day
< Rs. 5 Lakhs	Rs. 500 per day subject to a maximum of Rs. 5000 per policy period
Rs. 5 Lakhs	Rs. 1000 per day subject to a maximum of Rs. 10000 per policy period
Above Rs. 5 Lakhs	Rs. 2000 per day subject to a maximum of Rs. 20000 per policy period

The aggregate of Daily Cash Allowance during the policy period shall not exceed 'per policy period limits' as mentioned in the table above.

3.7.1 Daily Cash Allowance will not be payable for Day Care Procedure claims where the hospitalisation is less than 24-hours. Deductible equivalent to Daily Cash Allowance for the first 24-hours of hospitalisation will be levied on each hospitalisation during the Policy Period.

4. STANDARD EXCLUSIONS & WAITING PERIODS

A. WAITING PERIOD

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

4.1 Pre-Existing Disease Waiting Period (Code- Excl01):

a. Expenses related to the treatment of disclosed pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Product) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

B. STANDARD PERMANENT EXCLUSIONS

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

4.2 Investigation & Evaluation (**Code-Excl04**):

i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;
ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.3 Rest Cure, Rehabilitation and Respite Care (**Code-Excl05**): Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. any services for people who are terminally ill to address physical, social, emotional, and spiritual needs.

4.4 **Obesity/ Weight Control** (**Code-Excl06**): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

i. Surgery to be conducted is upon the advice of the Doctor
ii. The surgery/Procedure conducted should be supported by clinical protocols
iii. The member has to be 18 years of age or older and
iv. Body Mass Index (BMI)
    a. greater than or equal to 40 or
    b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        i. Obesity-related cardiomyopathy
        ii. Coronary heart disease
        iii. Severe Sleep Apnoea
        iv. Uncontrolled Type2 Diabetes

4.5 **Change-of-Gender treatments** (**Code-Excl07**): Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.6 **Cosmetic or Plastic Surgery** (**Code-Excl08**): Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the Insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.7 **Hazardous or Adventure sports (Code- Excl09)**: Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

4.8 **Breach of law: (Code-Excl10)**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.9 **Excluded Providers: (Code-Excl11)**

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

4.11 Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code-Excl13)**

4.12 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure. (**Code-Excl14**)

4.13 **Refractive Error** (**Code-Excl15**): Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

4.14 **Unproven Treatments** (**Code- Excl16**): Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.15 **Sterility and Infertility** (**Code-Excl17**): Expenses related to Sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

4.16 **Maternity** (**Code- Excl18**):

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

C. SPECIFIC PERMANENT EXCLUSIONS

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

4.18 All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack.

4.19 Stem cell implantation/Surgery, harvesting, storage or any kind of Treatment using stem cells except as provided for in clause 3.6 (12) above; growth hormone therapy.

4.20 Congenital External Diseases or Defects or anomalies.

4.21 **a)** Routine eye-examination expenses, cost of spectacles, contact lenses; **b)** Cost of hearing aids;

4.22 Intentional self-inflicted Injury, attempted suicide.

4.23 Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP).

4.24 Dental treatment or surgery of any kind unless necessitated by disease or accident and requiring hospitalisation

4.25 Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state

4.26 Any item(s) or treatment specified in 'List of Non-Medical Expenses– Payable/Non-Payable' as per *Annexure – 1* and available on Company web site also, unless specifically covered under the Policy. This list of excluded items include External and/or durable Medical /Non-medical equipment of any kind used for diagnosis and/or treatment Ambulatory devices, i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, elastocrepe bandages, external orthopaedic pads, sub-cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer, alpha / water bed and also any medical equipment, which are subsequently used at home.

4.27 Any expenses incurred on OPD (Out-Patient) Treatment

4.28 Vaccinations or inoculations of any kind, except when required as part of hospitalisation or a daycare procedure for treatment following an animal bite.

5. GENERAL TERMS AND CONDITIONS

A. Standard Terms & Conditions

5.1 Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

5.2 Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the policy.

5.3 Complete Discharge

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

5.4 Multiple Policies

In case of multiple policies taken by an Insured Person can file for claim settlement as per his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer

In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, provided a written request for same has been submitted by the Insured Person.

5.5 Fraud

If any claim made by the Insured Person is in any respect fraudulent, or if any false statement or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/ Policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.
For the purpose of this clause, the expression “fraud” means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/ any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance policy:

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

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

5.6 Free Look Period

The free look period shall be applicable on new Super Top-up Medicare policies and not on renewals or at the time of porting/migrating the policy. The Insured shall be allowed a free look period of 30 days from the date of receipt of the policy, whether received electronically or otherwise, to review the terms and conditions of the policy and to return the same if not acceptable.

If the Insured has not made any claim during the free look period, he/she shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

5.7 Cancellation

i. The policyholder may request for cancellation of the policy by giving 7 days' written notice. The Insurer shall refund proportionate premium for unexpired policy period, if there is no claim (s) reported during the policy period.

ii. The Company may cancel the policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

5.8 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Insured Person from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Insured Person at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

5.9 Renewal of Policy

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

i. The Company will give notice for renewal.

ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.

v. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

vi. No loading shall apply on renewals based on individual claims experience.

5.10 Withdrawal of Policy

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

5.11 Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

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

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

5.13 Migration

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

5.14 Portability:

The Insured Person will be provided facility to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health Insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

5.15 Redressal of Grievance

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

Website: www.uiic.co.in

Toll free: 1800 425 333 33

E-mail: customercare@uiic.co.in

Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd.,
24, Whites Road, Chennai, Tamil Nadu- 600014

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

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

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the **office of Insurance Ombudsman** of the respective area/region for redressal of grievance as per Insurance

Ombudsman Rules 2017 and its amended from time to time. The contact details of the Insurance Ombudsman offices have been provided as *Annexure- 2*.

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

5.16 Nomination

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

B. Specific Terms & Conditions

5.17 Basis of Insurance:

a. This policy is issued on the basis of the truth and accuracy of statements in the Proposal.
b. This policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of fraud, misrepresentation or misdescription or non-disclosure of any material fact.
c. The Proposal Form, Prospectus, Pre-acceptance Health check-up report (if carried out) and the Policy issued shall constitute complete contract of insurance.

5.18 Premium

a. Unless full premium is paid before commencement of risk, this Policy shall have no effect.
b. Premium can be paid online for both, new policy and renewals.

5.19 Notice & Communication

i. Any notice, direction or instruction or any other communication related to the Policy should be made in writing.
ii. For ID card, PPN/network provider related issues, claim serviced by TPA, communication should be made to the TPA or through any other electronic modes at contact address as specified in the Policy Schedule. For policy related issues or change in address, communication should be made to the policy issuing office or through any other electronic modes at contact address as specified in the Policy Schedule..
iii. The Insured shall notify the policy issuing office in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.
iv. No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us.

5.20 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

5.21 Territorial Limit

a. This Policy covers only medical/surgical treatment taken in India.
b. Admissible claims shall be payable only in Indian Rupees.

5.22 Claim Procedure

a. Notification of claim

Upon the happening of any event which may give rise to a claim under this Policy, the Insured Person/Insured Person's representative shall notify the TPA/company in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:

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

b. Procedure for Cashless claims

i. For the first claim under the Policy (i.e., the claim in which cumulative medical expenses exceeds the threshold) cashless facility shall be available provided all evidences and documents are produced prior to cashless authorization, to substantiate that the Cumulative Medical Expenses exceeds the Threshold. For all subsequent claims under the Policy cashless facility shall be available as usual, subject to sl. no ii to ix below.
ii. Cashless facility for treatment shall be available to the Insured in hospitals subject to pre-authorization by TPA.
iii. The booklet containing a list of network provider/PPN hospitals shall be provided by the TPA. An updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the TPA mentioned in the schedule.
iv. The Insured shall call the TPA's toll-free phone number provided on the health ID card for intimation of claim and related assistance. The Insured may inform the ID number for easy reference
v. On admission in the network provider/PPN hospital, the Insured shall produce the ID card issued by the TPA at the Hospital Helpdesk. Cashless-request-form available on the Company's website shall be completed and sent to the TPA for authorization.
vi. The TPA upon getting cashless-request-form and related medical information from the Insured Person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
vii. At the time of discharge, the Insured Person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
viii. The TPA reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.
ix. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

c. Procedure for reimbursement of claims

i. In non-network hospitals payment must be made up-front and for reimbursement of claims the Insured Person may submit the necessary documents to TPA within the prescribed time limit.
ii. Claims for Pre and Post-Hospitalisation will be settled on reimbursement basis on production of relevant claim papers and cash receipts to the TPA within the prescribed time limit.

d. Documents

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

i. Duly completed claim form
ii. Photo Identity proof of the patient
iii. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed or Operation Theatre (OT) Notes, along with date of diagnosis, advise for admission, investigation test reports etc. supported by the prescription from attending medical practitioner.
iv. Medical history of the patient as recorded, Hospital bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner.
v. Discharge certificate/ summary from the hospital.
vi. Cash-memo/ bills/ invoices from the Diagnostic Centre(s)/ hospital(s)/ chemist(s) supported by proper prescription.

vii. Payment receipts from doctors, surgeons and anaesthetist, wherever applicable.
viii. Bills/invoices, receipt, Bar Code and Stickers of the Implants and Prosthetics (if used and only in case of surgery/ surgical procedure.
ix. MLR (Medico Legal Report copy if carried out and FIR (First Information Report) if registered, wherever applicable)
x. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xi. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs. 1 Lakh as per AML Guidelines
xii. Any other document required by the company/ TPA

Note

i. The Insured shall preserve and submit all original documents and/ or certified copies of documents related to all hospitalisation(s) during the policy period to enable the Company to calculate the cumulative medical expenses and threshold, for determining admissibility and payment of claims.
ii. In the event of a claim lodged as per the Settlement under multiple policies clause (Clause 5.4) and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under Clause 5.22.d and claim settlement advice duly certified by the other Insurer subject to satisfaction of the Company. In all such cases, any amount payable under this Policy for any covered expense shall be reduced by any amount paid/ payable by the other insurer for the same expense during the same hospitalisation.

e. Time Limits for Submission of Documents:

Type of claim	Time limit for submission of documents to TPA
Reimbursement of hospitalisation and pre-hospitalisation expenses	Within 15 (fifteen) days of the date of discharge from hospital
Reimbursement of post-hospitalisation expenses	Within 15 (fifteen) days from completion of post-hospitalisation treatment or after the limit for the maximum post-hospitalisation period as per Clause 3.2.b is over, whichever occurs earlier

f. Claim Assessment

We will assess all admissible indemnity claims under the Policy in the following progressive order:

i. Limit/ Sub Limit on Medical Expenses as applicable under the policy
ii. Opted Threshold Amount

g. Basis of Payment

i. Any claim under this policy shall be payable by the Company only if
   a. it is in respect of Covered Expenses specified in this Policy and
   b. the aggregate of Covered Expenses in respect of hospitalisation/s of insured person in case of individual Sum Insured policy or all Insured Persons in case of family floater policy exceeds the Threshold Level
ii. The claim payable under this Policy will be the amount:
   - by which the aggregate of such Covered Expenses in respect of hospitalisations with dates of admission falling within the policy period exceeds the Threshold Level opted for the Insured Person/Family as applicable and stated in the schedule,
   - after deducting any amount above threshold received/receivable under any/all Health Insurance Policies (whether or not issued by the Company)/ Reimbursement Scheme and including any amount paid earlier under this policy covering the Insured Person/Family as applicable for such covered expenses.

iii. Each claim, if more than one, during the period of this policy shall be separately subject to the above Basis of Payment.
iv. In no case shall the Company be liable to pay any sum in excess of the Sum Insured in aggregate of all claims during the period of this Policy.

h. Services Offered by TPA

Servicing of claims i.e. claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims, as per the terms and conditions of the policy.

The services offered by a TPA shall not include

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

5.22.1 Notes on Claim Procedure:

i. Waiver of condition of timelines as mentioned above may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
ii. The Company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
iii. The Insured Person shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
iv. Any medical practitioner or Authorised Person authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

5.23 Change of Sum Insured

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

5.24 Automatic change in Coverage under the policy

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

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

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

Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the policy will be effective.

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

5.25 Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

5.26 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the policy shall be determined by the Indian court and according to Indian law.

5.27 Endorsements (Changes in Policy)

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the Company. Any change made by the Company shall be evidenced by a written endorsement signed and stamped.

5.28 Terms and Conditions of the Policy

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

C. Other Terms & Conditions

5.29 Loading & Discounts

a. Family Discount

In case of policies issued on Individual Sum Insured Basis, 5% family discount is allowed if more than one person of a family is covered.

b. Online Discount

A Discount of 10% is applicable for fresh policies purchased online through the Company's website. For renewals, the same discount of 10% shall be offered provided the original policy was purchased either directly from our office without any intermediary or online through the Company's website and all subsequent renewals are only made through the Company's website.

c. Underwriting Loading for Pre-existing Conditions

A risk loading is applicable on the premium payable (excluding statutory levies & taxes) based on the Insured Person's health status, if accepted at the time of underwriting. Loadings are to be applied from Inception Date of the first Policy including subsequent renewal(s).

The loadings are applicable on individual ailments only. In case of loading on two or more ailments, the loadings shall apply in conjunction on additive basis. In case of floater policies, where more than one individual have applicable loading for pre-existing condition, the highest of the total loading of the individuals irrespective of age, shall be applied.

Note: The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Waiting period as mentioned in Clause 4.1 above shall be applied on illness/condition, as applicable.

d. Staff Discount

A Discount of 15% is applicable for fresh and renewal policies purchased directly from office for all the working and retired employees of United India Insurance Co. Ltd.

5.30 IRDAI Regulations

This policy is subject to Provisions of Insurance Act, 1938, IRDAI (Insurance Product) Regulations 2024 and IRDAI (Protection of Policyholders' Interest) Regulations 2024 as amended from time to time.

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ANNEXURE – 1

SUPER TOP-UP MEDICARE POLICY

List of Non-Medical Expenses under this Policy – Payable/Not Payable

List I – Optional Items

Sr. No	Item	Payable / Not Payable
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERVICES	Not Payable
4	BELTS/ BRACES	Payable for cases who have undergone surgery of thoracic or lumbar spine.
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7	CARRY BAGS	Not Payable
8	EMAIL / INTERNET CHARGES	Not Payable
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
10	LEGGINGS	Payable in case of varicose vein surgery
11	LAUNDRY CHARGES	Not Payable
12	MINERAL WATER	Not Payable
13	SANITARY PAD	Not Payable
14	TELEPHONE CHARGES	Not Payable
15	GUEST SERVICES	Not Payable
16	CREPE BANDAGE	Not Payable
17	DIAPER OF ANY TYPE	Not Payable
18	EYELET COLLAR	Not Payable
19	SLINGS	Reasonable costs for one sling in case of upper arm fractures is payable
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge, not payable separately
22	Television Charges	Payable under room charges, not if separately levied
23	SURCHARGES	Part of Room Charge, Not payable separately
24	ATTENDANT CHARGES	Not Payable - Part of Room Charges
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Not payable
26	BIRTH CERTIFICATE	Not Payable
27	CERTIFICATE CHARGES	Not Payable
28	COURIER CHARGES	Not Payable
29	CONVEYANCE CHARGES	Not Payable
30	MEDICAL CERTIFICATE	Not Payable
31	MEDICAL RECORDS	Not Payable
32	PHOTOCOPIES CHARGES	Not Payable
33	MORTUARY CHARGES	Payable up to 24 hours, shifting charges not payable
34	WALKING AIDS CHARGES	Not Payable
35	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSPITAL)	Not Payable
36	SPACER	Not Payable
37	SPIROMETRE	Device not payable

38	NEBULIZER KIT	Not Payable
39	STEAM INHALER	Not Payable
40	ARMSLING	Not Payable
41	THERMOMETER	Not Payable
42	CERVICAL COLLAR	Not Payable
43	SPLINT	Not Payable
44	DIABETIC FOOT WEAR	Not Payable
45	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
47	LUMBO SACRAL BELT	Payable for cases who have undergone surgery of lumbar spine.
48	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/- day
49	AMBULANCE COLLAR	Not Payable
50	AMBULANCE EQUIPMENT	Not Payable
51	ABDOMINAL BINDER	Payable for cases who have undergone surgery of lumbar spine.
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Not Payable
53	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
55	ECG ELECTRODES	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day is payable.
56	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
57	NEBULISATION KIT	Payable reasonably if used during hospitalisation
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
59	KIDNEY TRAY	Not Payable
60	MASK	Not Payable
61	OUNCE GLASS	Not Payable
62	OXYGEN MASK	Not Payable
63	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction
64	PAN CAN	Not Payable
65	TROLLEY COVER	Not Payable
66	UROMETER, URINE JUG	Not Payable
67	AMBULANCE	Not Payable
68	VASOFIX SAFETY	Payable - maximum of 3 in 48 hours and then 1 in 24 hours

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

Sr. No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU DE-COLOGNE / ROOM FRESHNERS

8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISTOR'S PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSE OXIMETER CHARGES

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

Sr. No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHIELD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUZE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE

20	SURGICAL
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sr. No	Item
1	ADMISSION/REGISTRATION CHARGS
2	HOSPITALISATION FOR EVALUATION/DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP-COST
8	HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES, DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABS
16	SCRUB SOLUTIONS / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Annexure-2

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

Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman & Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh, Chhattisgarh	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Pan bazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in
Kerala, Lakshadweep, Mahe- a part of Union Territory of Puducherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340

Jurisdiction	Office of the Insurance Ombudsman
	Email: bimalokpal.kolkata@cioins.co.in
Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Bihar, Jharkhand	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in

The updated details of Insurance Ombudsman are also available at:

- IRDAI website: https://www.irdai.gov.in/
- General Insurance Council website: https://www.gicouncil.in/
- Our Company Website: https://uiic.co.in/
- From any of the offices of our Company