**United India Insurance Company Limited**
Corporate Identity Number: U93090TN1938GOI000108
Registered Office: 24 Whites Road, Chennai – 600014
**IRDAI REG NO.545**

# 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 '**Insured**') 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.

## 2. OPERATIVE CLAUSE

If during the Policy Period the Insured Person(s) is required to be hospitalized 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. 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 Insured Person (on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy) exceeds the Threshold stated in the Schedule; subject to 'Basis of Payment' Clause no. 7.6.F of Section 7.

## 3. COVER TYPE

The Policy provides cover on an Individual or Family Floater basis. A separate Sum Insured for each Insured Person, as specified in the Policy Schedule is provided under Individual basis while under Family Floater 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.

## 4. DEFINITIONS

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

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.
3. **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.
4. An **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.

5. **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

6. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

7. **Cancellation** defines the terms on which the policy contract can be terminated either by the Insurer or the Insured Person by giving sufficient notice to other which is not lower than a period of fifteen days.

8. **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.

9. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional.

10. **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.

11. **Continuous Coverage** means uninterrupted coverage of the Insured Person under our Super Top Up Medicare Policy or Top Up Medicare Policy from the time the coverage incepted under the policy provided a break in the insurance period not exceeding thirty days being grace period shall not be reckoned as an interruption in coverage for the purposes of this Clause. In case of change in Sum Insured during such uninterrupted coverage, the lowest Sum Insured would be reckoned for determining Continuous Coverage.

12. **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.

13. **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.

14. **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 hospitalization expenses incurred during the policy period by Insured (individual policy) or Insured family (in case of floater policy).

15. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

16. **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

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

18. **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.

19. **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.

20. **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

21. **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.

22. **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.

23. **Insured Person** means person(s) named in the schedule of the Policy.

24. **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.

25. **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.

26. **Maternity Expenses** mean
    a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b. expenses towards lawful medical termination of pregnancy during the policy period.

27. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

28. **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.

29. **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.

30. **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. The Registered Medical Practitioner should not be the Insured or any member of his family including parents and in-laws.

31. **Migration** means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

32. **Network Provider** means hospitals or health care providers enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a cashless facility.

    The list of Network Hospitals is maintained by and available with the TPA and the same is subject to amendment from time to time.

    **PPN-Preferred Provider Network** means a network of hospitals, which have agreed to a cashless packaged pricing for certain procedures for the Insured Person.

    Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and website of the TPA mentioned in the schedule and is subject to amendment from time to time.

33. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.

34. **Notification of Claim** means the process of notifying a claim to the Insurer or TPA through any of the recognised modes of communication.

35. **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.

36. **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

37. **Policy Period** means period of one policy year as mentioned in schedule for which the Policy is issued.

38. **Policy Schedule** means the Policy Schedule attaching to and forming part of the Policy.

39. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time-bound exclusions, from one Insurer to another.

40. **Pre-Existing Disease** means any condition, ailment, injury or disease:
    a. That is/are diagnosed by a physician within 48 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 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement

41. **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.

42. **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.

43. **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.

44. **Room Rent** shall mean the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses.

45. **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.

46. **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 basis) during the policy period.

47. **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.

48. **Third Party Administrator (TPA)** means a company registered under the IRDAI (Third Party Administrators – Health Services) Regulations, 2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purpose of providing health services as defined in the regulations.

49. **Threshold** means deductible which 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. It does not reduce the sum insured. The deductible is applicable in aggregate towards hospitalization expenses incurred during the policy period by Insured (individual policy) or Insured family (in case of floater policy).

50. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

51. **We/Our/Us/Company** means the United India Insurance Company Limited.

52. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

## 5. COVERAGE

The Policy provides base coverages as described below:

### 5.1 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, IV Fluids/Blood transfusion/injection administration charges and similar expenses.
B. The fees charged by the Medical Practitioner, Surgeon, Consultants, Specialists and anaesthetists treating the Insured Person;
C. Anaesthetics, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, relevant laboratory diagnostic tests & such similar expenses that are medically necessary.
D. All hospitalisation expenses (excluding cost of organ) incurred for donor in respect of organ transplant to the Insured Person provided the donation conforms to The Transplantation of Human Organs Act 1994.

### 5.2 Ayurvedic treatment

The Company shall indemnify Reasonable & Customary medical expenses incurred for inpatient care treatment under Ayurveda system of medicine in an AYUSH hospital/ AYUSH Day care centre as defined in Section 3.4 and 3.5 above respectively.

**5.3 Modern Treatment Methods & Advancement in Technologies:**

In case of an admissible claims under Section 5.1, 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<br>• 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 Neuro Monitoring (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 transplant for haematological conditions to be covered only | Upto 75% of Sum Insured subject to a maximum of Rs. 10 Lakhs per policy period |

## 6. EXCLUSIONS

**A. WAITING PERIODS**

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:

**6.1 Pre-Existing Disease Waiting Period (Code- Excl01):**

a. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.

b. 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 (Health Insurance) 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 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

**B. 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:

6.2 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.

6.3 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.

6.4 Congenital External Diseases, Defects or anomalies.

6.5 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

6.6 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.

6.7 Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.

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

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

6.9 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.

6.10 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.

6.11 Cosmetic or Plastic Surgery **(Code- Excl08)**: Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident, burn(s) or cancer or as part of medically necessary treatment. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

6.12 Vaccination or inoculation of any kind unless it is post animal bite.

6.13 Cost of spectacles, contact lenses.

6.14 Cost of hearing aids

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

6.16 Rest Cure, rehabilitation and respite care **(Code- Excl05)**: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

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

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

6.18 Intentional self-inflicted Injury, attempted suicide.

6.19 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)**

6.20 Naturopathy Treatment, acupressure, acupuncture, magnetic and such other experimental treatment including drug experimental therapy, which is not based on established medical practice in India.

6.21 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and/or treatment and/or monitoring and/or maintenance and/or support including CPAP, CAPD, Infusion pump, Oxygen concentrator, Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings of any kind, Diabetic foot wear, Glucometer/Thermometer and similar related items and also any medical equipment, which are subsequently used at home.

6.22 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.

## 7. GENERAL TERMS AND CONDITIONS

**7.1 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).

**7.2 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.

**7.3 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.

**7.4 Place of treatment and Payment:**

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

**7.5 Communication:**

a. All communication should be in writing.
b. For ID card, PPN/network provider related issues, claim serviced by TPA, communication should be made to the TPA at the address mentioned in the schedule. For claim serviced by the company, policy related issues or change in address, communication should be made to the policy issuing office at the address mentioned in the schedule.
c. The company or TPA shall communicate to the Insured Person at the address mentioned in the schedule.
d. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorised official of the Company.

**7.6 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 (if claim is processed by TPA)/company (if claim is processed by the company) in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:

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

**B. Procedure for Cashless claims**

i. Cashless facility for treatment in network hospitals only shall be available to insured if opted for claim processing by TPA.
ii. Treatment may be taken in a network provider/PPN hospital and is subject to pre authorization by the TPA. Booklet containing list of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the TPA mentioned in the schedule.
iii. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference
iv. On admission in the network provider/PPN hospital, produce the ID card issued by the TPA at the Hospital Helpdesk. Cashless request form available with the network provider/PPN/TPA shall be completed and sent to the TPA for authorization.
v. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
vi. At the time of discharge, the insured person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
vii. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
viii. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

**C. Procedure for reimbursement of claims**

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

**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 recorded, bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.
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.
viii. Bills, receipt, Sticker of the Implants.
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 company/ TPA

**Note**

In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under condition 7.7.d and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

**E.** Time Limits for Submission of Documents:

| Type of claim | Time limit for submission of documents to company/TPA |
|---|---|
| Reimbursement of hospitalisation expenses | Within 15 (fifteen) days of date of discharge from hospital |
| In case of post-hospitalisation expenses (limited to 60 days after discharge from hospital) | Within 15 (fifteen) days of date of completion of such treatment. |

Note:

i. Waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
ii. Any medical practitioner or Authorised Person authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

**F. 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 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 higher of the following:
   a. the Threshold Level opted for the insured person/family as applicable and stated in the schedule or
   b. the amount 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, subject to multiple policy clause.

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.

**G. Claim Settlement (provision for Penal Interest)**

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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

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

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

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

**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.

**7.7 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.

**7.8 Settlement under Multiple Policies:**

i. In case of multiple policies taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies, even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and condition of this policy.
iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.
iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

**7.9 Cancellation Clause:**

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

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

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

b. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

**7.10 Renewal Clause:**

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

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

**7.11 Enhancement of Sum Insured**

The Insured may seek enhancement of Sum Insured in writing at or before payment of premium for renewal, which may be granted at the discretion of the Company. However, notwithstanding enhancement, for claims arising in respect of ailment, disease or injury contracted or suffered during a preceding policy period, liability of the company shall be only to the extent of the Sum Insured under the policy in force at the time when it was contracted or suffered during the currency of such renewed policy or any subsequent renewal thereof.

Any such request for enhancement must be accompanied by a declaration that the insured or any other insured person in respect of whom such enhancement is sought is not aware of any symptoms or other indications that may give rise to a claim under the policy. The Company may require such insured person/s to undergo a Medical examination to enable the company to take a decision on accepting the request for enhancement in the Sum Insured. 50% of the cost of the Medical examination will be reimbursed to the insured person on acceptance of the request for enhancement of sum insured.

**7.12 Arbitration**

i. If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

**7.13 Limitation**

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

**7.14 Free Look Period**

The free look period shall be applicable at the inception of the first policy and the Insured shall be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.
If the Insured has not made any claim during the free look period, he/she shall be entitled to –

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

This condition is not applicable for existing insureds who migrate to this policy.

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

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

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

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

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

**7.18 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 affected.

**7.19 Withdrawal of Policy:**

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

## 8. Redressal of Grievance

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

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

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

For updated details of grievance officer, kindly refer the link https://uiic.co.in/en/customercare/grievance
If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the **office of Insurance Ombudsman** of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Insurance Ombudsman offices have been provided as *Annexure-2*.

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

## 9. IRDAI Regulations

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

* * * * * * * * * * *

# UNITED INDIA INSURANCE COMPANY LIMITED

**Policy Issuing Office Address**

**PH: (****) *******  **EMAIL:****@******

**Super Top Up Medicare Policy**

**UIN NO. IRDA/NL-HLT/UII/P-H/V.II/231/13 -14**

**POLICY NO.:**

| **PERIOD OF INSURANCE** |
|---|
| **FROM --:-- Hrs on dd/mm/yyyy** |
| **To MIDNIGHT on dd/mm/yyyy** |

***Insured***

**Name**

**Address**

**Agent Name** :

**Agent Code** :

**Mobile/Landline Number/Email** : /

**IMPORTANT NOTICE: KINDLY UPDATE YOUR AADHAAR NO. AND PAN/FORM 60. PLEASE IGNORE IF ALREADY UPDATED.**

**For any Information, Service Requests and Grievances please write to officecode@uiic.co.in**

# United India Insurance Company Limited

Corporate Identity Number: U93090TN1938GOI000108
Registered Office: 24 Whites Road, Chennai – 600014
**IRDAI REG NO.545**

**For ID Cards & Claim Intimations Please contact the TPA mentioned in the Policy document.**

REGD. & HEAD OFFICE, 24, WHITES ROAD, CHENNAI – 600014 Website: http://www.uiic.co.in

## SUPER TOP UP POLICY SCHEDULE

| | | | | | |
|---|---|---|---|---|---|
| Policy Number | | | Previous Policy No | | |
| Name/ID Of Insured | | | | | |
| Tel. (O) | | Tel(R) | | Fax | |
| Business/Occupation | None | Mobile | | Email | |
| Period Of Insurance | From --:-- Hrs of dd/mm/yyyy | | To Midnight of dd/mm/yyyy | | |
| **Policy Type** | **Individual Sum Insured Basis/ Family Floater Basis** | | | | |
| Floater Threshold | **No Column in case of Individual SI Basis Policy** | **Floater Sum Insured** | **No Column in case of Individual SI Basis Policy** | | |

**Insured Details**

| Sl no | Insured Name | Date of Birth (dd/mm/yyyyy) | Gender | Relation | Occupation | Pre-Existing Disease /Condition declared |
|---|---|---|---|---|---|---|
| 1 | x | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

| Sl no | Insured Name | Threshold | Sum Insured | Nominee Name | Nominee Relation | Inception Date of first policy |
|---|---|---|---|---|---|---|
| 1 | | No Column in case of Floater SI Policy | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

| | | | |
|---|---|---|---|
| **Agent Name** | | Net Premium | |
| **Agent Contact Number** | | Add CGST@ 9% of Premium | |
| **Agent/Broker Code** | | Add SGST @ 9% of Premium | |
| **Dev Officer Code** | | Total Premium Payable | |
| | | Receipt No | |
| | | Receipt Date | |

| | | | |
|---|---|---|---|
| **Customer GST No.:** | | Office GST No.: | |
| **SAC Code:** | | **Invoice No. & Date:** | |
| **Amount Subject to Reverse Charges** | | | |

**Anti-Money Laundering Clause**:-In the event of a claim under the policy exceeding ₹ 1 lakh or a claim for refund of premium exceeding ₹1 lakh, the insured will comply with the provisions of AML policy of the company. The AML policy is available in all our operating offices as well as Company's web site.

Date of Proposal and Declaration: 31/03/2018

IN WITNESS WHEREOF, the undersigned being duly authorised has hereunto set his/her hand at <Office Location> <Office Code> on this __ day of ,<Month> ,<Year>.

**For and On behalf of**
**United India Insurance Co. Ltd.**

Affix Policy Stamp Here

**Authorised Signatory.**

***POLICY NO.***:
***UIN:***

**Details of TPA**

Please contact the following TPA for Issue of Identity Cards, Cashless Approvals & Claims Settlement.

| **Name of TPA** | | | | |
|---|---|---|---|---|
| **Address** | | | | |
| **Toll Free number** | | | | |
| **Contact Details** | **For General Enquiries** | **For Cashless approval** | **For Claim intimation** | **For Grievances** |
| **Telephone Numbers** | | | | |
| **Email IDs** | | | | |

***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) | Patient Diet provided by hospital is 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 hrs, 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 hrs and then 1 in 24 hrs |

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***

## Details of Insurance Ombudsmen

| Jurisdiction | Office of the Insurance Ombudsman |
|---|---|
| Gujarat, Dadra & Nagar Haveli, Daman and Diu | Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001.<br>Tel No: 079 - 25501201/02/05/06. Email: bimalokpal.ahmedabad@ecoi.co.in |
| Karnataka | Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078.<br>Tel.: 080 - 26652048 / 26652049. Email: bimalokpal.bengaluru@ecoi.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.<br>Tel.: 0755 - 2769201 / 2769202. Fax: 0755 – 2769203<br>Email: bimalokpal.bhopal@ecoi.co.in |
| Orissa | Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009.<br>Tel.: 0674 - 2596461 /2596455. Fax: 0674 – 2596429<br>Email: bimalokpal.bhubaneswar@ecoi.co.in |
| Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh | Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017.<br>Tel.: 0172 - 2706196 / 2706468. Fax: 0172 – 2708274<br>Email: bimalokpal.chandigarh@ecoi.co.in |
| Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry) | Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.<br>Tel.: 044 - 24333668 / 24335284. Fax: 044 – 24333664<br>Email: bimalokpal.chennai@ecoi.co.in |
| Delhi | Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.<br>Tel.: 011 - 23232481/2321350 4. Email: bimalokpal.delhi@ecoi.co.in |
| Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura | Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (ASSAM).<br>Tel.: 0361 - 2632204 / 2602205. Email: bimalokpal.guwahati@ecoi.co.in |
| Andhra Pradesh, Telangana, and Yanam - part of Territory of Pondicherry | 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.<br>Tel.: 040 - 67504123 / 23312122. Fax: 040 – 23376599<br>Email: bimalokpal.hyderabad@ecoi.co.in |
| Rajasthan | Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.<br>Tel.: 0141 – 2740363. Email: Bimalokpal.jaipur@ecoi.co.in |
| Kerala, Lakshadweep, Mahe- a part of Pondicherry | Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.<br>Tel.: 0484 - 2358759 / 2359338. Fax: 0484 – 2359336<br>Email: bimalokpal.ernakulam@ecoi.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.<br>Tel.: 033 - 22124339 / 22124340. Fax: 033 - 22124341<br>Email: bimalokpal.kolkata@ecoi.co.in |
| Districts of Uttar Pradesh:<br>Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, 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, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar | Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.<br>Tel.: 0522 - 2231330 / 2231331. Fax: 0522 - 2231310<br>Email: bimalokpal.lucknow@ecoi.co.in |

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| 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.<br>Tel.: 022 - 26106552 / 26106960. Fax: 022 - 26106052<br>Email: bimalokpal.mumbai@ecoi.co.in |
| State of Uttarakhand and the following Districts of Uttar Pradesh:<br>Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kasganj, 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.<br>Tel.: 0120-2514250 / 2514252 / 2514253. Email: bimalokpal.noida@ecoi.co.in |
| Bihar, Jharkhand | Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006.<br>Tel.: 0612-2680952. Email: bimalokpal.patna@ecoi.co.in |
| Maharashtra, Area 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.<br>Tel.: 020-41312555. Email: bimalokpal.pune@ecoi.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