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

Prospectus

1. PRODUCT – KEY FEATURES

This is an annual aggregate deductible policy. This Policy covers an aggregate of covered Medical Expenses in respect to Hospitalisation(s) of the Insured Person (on Individual basis in case of Individual Policy and Family Floater basis in case of Family Floater Policy) during the policy period exceeding the Threshold Level up to the Sum Insured stated in the policy. The cover type basis shall be as specified in the Policy Schedule.

COVERAGE AT A GLANCE:

Base Cover
In-Patient Hospitalisation Expenses
Day Care Treatments
Pre-Hospitalisation & Post Hospitalisation Expenses
Home Care Treatment Expenses
Organ Donor Expenses
Road Ambulance Expenses
Named Modern Treatment Methods & Advancement in Technology

Optional Cover
Daily Cash Allowance on Hospitalisation

2. COVER TYPE

The Policy provides cover on an Individual basis or Family Floater basis. A separate Sum Insured and threshold limit for each Insured Person is provided under Individual basis while under Family Floater basis, the Sum Insured limit and threshold limit is shared by the whole family of the Insured 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.

3. ELIGIBILITY

a. Any person aged between 18 years and 65 years can take this insurance for himself/herself and his/her family consisting of:
   i. Self, Spouse, Dependent Children, Parents and Parents-in-law on Individual Sum Insured basis or
   ii. Self, Spouse and Dependent Children on Family Floater basis.

b. Dependent children between the age of 91 days and 18 years shall be covered provided either or both parents are covered concurrently. Children above 18 years will continue to be covered along with parents till they complete 26 years and provided they are unmarried/unemployed and dependent. In the event of children becoming independent, employed, or getting married, a separate policy can be taken on the expiry of the current policy for which continuity benefits will be provided. The upper age limit will not apply to mentally challenged children.

c. Midterm inclusion of family members is allowed at pro-rata premium only in case of:
   i. Newly married spouse within 60 (sixty) days of marriage.
   ii. Parents of Newly married spouse within 60 (sixty) days of marriage.
   iii. New born baby, between the ages of 91 days to 180 days, born to mother insured under the policy or the adopted child between the ages of 91 days to 18 years within 60 (sixty) days of date of adoption.

4. POLICY TERM

One Year. Renewable annually.

5. SUM INSURED

The various Sum Insured options available under the policy for fresh proposals are as follows:

THRESHOLD LIMIT	SUM INSURED
2 Lacs	3 Lacs, 5 Lacs
3 Lacs	3 Lacs, 5 Lacs, 7 Lacs
5 Lacs	5 Lacs, 10 Lacs, 15 Lacs, 20 Lacs, 45 Lacs, 70 Lacs, 95 Lacs
10 Lacs	10 Lacs, 15 Lacs, 20 Lacs, 40 Lacs, 65 Lacs, 90 Lacs
15 Lacs	15 Lacs, 35 Lacs, 60 Lacs, 85 Lacs
20 Lacs	20 Lacs, 30 Lacs, 55 Lacs, 80 Lacs
25 Lacs	25 Lacs, 50 Lacs, 75 Lacs

6. COVERAGE

The coverages available under this policy are classified as **Base Cover** and **Optional Cover**. Base Cover refers to the coverage available as default under Super Top-Up Medicare Policy whereas Optional Cover is available only upon payment of additional premium.

BASE COVER

The Policy provides base coverage as described below in this section:

6.1 In-Patient Hospitalisation Expenses Cover

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of 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.
These expenses will include nursing care, RMO 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. Anaesthesia, 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.

6.1.1 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

6.2 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 Lacs	Upto 30 days immediately prior to hospitalisation
10 Lacs and above	Upto 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 Lacs	Upto 60 days immediately after the discharge from the hospital
10 Lacs and above	Upto 90 days immediately after the discharge from the hospital

Provided that:

i. We have accepted a claim for primary In-patient Hospitalization under Section 6.1 above;
ii. The Pre-hospitalisation and/or 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.

6.3 Home Care Treatment Expenses:

We will pay 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 Basis
< 10 Lacs	15,000 per incident	15000 per incident subject to a maximum of Rs. 30000 per policy
10 Lacs 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 a 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 the parenteral administration of medicines;
f. Cost of Pulse oximeter, Nebulizer and Rental cost for Oxygen cylinder, oxygen concentrator, if needed.

6.4 Organ Donor Expenses Cover:

We will cover the In-patient Hospitalization 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-hospitalization 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.

6.5 Road Ambulance Cover

We will cover the expenses incurred:

i. subject to a maximum of Rs. 2500 per event; and further
ii. 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 Section 6.1 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 Hospitalization 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 Hospitalization due to lack of super speciality treatment in the existing Hospital.

6.6 Modern Treatment Methods & Advancement in Technologies

In case of an admissible claim under section 6.1, 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 Limit
A	Uterine Artery Embolization & High Intensity Focussed Ultrasound (HIFU)	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lacs per policy period for claims involving Uterine Artery Embolization & HIFU
B	Balloon Sinuplasty	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lac per policy period for claims involving Balloon Sinuplasty
C	Deep Brain Stimulation	Upto 70% of Sum Insured subject to a maximum of Rs. 10 Lacs per policy period for claims involving Deep Brain Stimulation
D	Oral Chemotherapy	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lacs per policy period for claims involving Oral Chemotherapy
E	Immunotherapy- Monoclonal Antibody to be given as an injection	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lacs per policy period
F	Intra vitreal Injections	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lac per policy period
G	Robotic Surgeries (including Robotic-Assisted Surgeries)	• Upto 75% of Sum Insured subject to a maximum of Rs. 10 Lacs 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 Lacs per policy period for claims involving Robotic Surgeries for other diseases
H	Stereotactic Radio Surgeries	Upto 50% of Sum Insured subject to a maximum of Rs. 5 Lacs per policy period for claims involving Stereotactic Radio Surgeries
I	Bronchial Thermoplasty	Upto 30% of Sum Insured subject to a maximum of Rs. 3 Lacs per policy period for claims involving Bronchial Thermoplasty
J	Vaporisation of the Prostate (Green laser treatment or holmium laser treatment)	Upto 30% of Sum Insured subject to a maximum of Rs. 2 Lacs per policy period
K	Intra-operative Neuromonitoring (IONM)	Upto 15% of Sum Insured subject to a maximum of Rs. 1.5 Lacs per policy period for claims involving Intra Operative Neuro Monitoring
L	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 Lacs per policy period

OPTIONAL COVERS

6.7 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, as per the table below:

Threshold	Limit (Rs.) per day
< Rs. 5 Lacs	Rs. 500 per day subject to a maximum of Rs. 5000 per policy period
Rs. 5 Lacs	Rs. 1000 per day subject to a maximum of Rs. 10000 per policy period
> Rs. 5 Lacs	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.

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

7. WHAT POLICY DOES NOT COVER

A. WAITING PERIOD - EXCLUSIONS

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 the waiting period mentioned below:

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

B.1 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:

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.
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. **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

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.
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.
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.
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.
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.
10. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (**Code-Excl12**)
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)**
12. Dietary supplements and substances that can be purchased without a 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**)
13. **Refractive Error** (**Code-Excl15**): Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.
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.
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
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

17. All expenses caused by or arising from or attributable to foreign invasion, an 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.
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.
19. Stem cell implantation/Surgery, harvesting, storage or any kind of treatment using stem cells except as provided for in clause 3.6 (12) of the policy wordings; growth hormone therapy.
20. Congenital external diseases or defects or anomalies.
21. **a)** Routine eye-examination expenses, cost of spectacles, contact lenses; **b)** Cost of hearing-aids;

22. Intentional self-inflicted injury; attempted suicide.
23. Treatments other than Allopathic and AYUSH branches of medicine.
24. Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP).
25. Dental treatment or surgery of any kind unless necessitated by disease or accident and requiring hospitalisation
26. 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
27. Any item(s) or treatment specified in 'List of Non-Medical Expenses– Payable/Non-Payable' as per *Annexure – 1* of the policy and available on Company web site also, unless specifically covered under the Policy.
28. Any expenses incurred on OPD (Out-Patient) Treatment
29. Vaccination or inoculation of any kind unless it is post animal bite.

8. PROCEDURE FOR TAKING A POLICY

a. The duly completed and signed Proposal form giving details of all the Insured Persons along with the pre-acceptance health check-up reports (wherever required at Company's discretion), if any, should be submitted to the nearest office of the Company.

b. The reports required are:

Physical examination (report to be signed by the Doctor with minimum MD/MS qualification	Serum Creatinine
CBC	SGOT & SGPT
Urine Routine & Microscopic	ECG
HbA1c (Glycosylated Haemoglobin)	Stress Test if necessitated
Lipid Profile	Any other investigation required by the company

The date of medical reports should not exceed 30 (thirty) days prior to the date of proposal.

i. Pre–acceptance medical check–up shall be conducted at designated centres authorized by us.
ii. The cost of the Pre-Acceptance Health check-up shall be borne by the proposer. However, 50% of the cost of Pre-Acceptance Health check-up shall be reimbursed to the Insured in cases where the proposal is accepted by the Company.

9. PAYMENT OF PREMIUM

a. Full premium must be paid before the commencement of risk for this Policy to come into effect.

b. Premium payable – As per Premium Table attached.

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

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

iii. **Underwriting Loading for Pre-existing Conditions**: We may apply a risk loading on the premium payable (excluding statutory levies & taxes) based on your health status, if accepted at the time of underwriting. Loadings will be applied from the Inception Date of the first Policy including subsequent renewal(s).

The loadings are applicable to individual ailments only. In case of loading on two 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.

We shall inform You about the applicable risk loading through a counter offer letter or through an electronic mode, as the case may be and You would need to revert with consent and additional premium (if any), within the duration specified in the counter offer.

In case, You neither accept the counter offer nor revert to Us within the specified duration, We shall not accept your proposal and will return the amount received, if any. Your Policy will not be issued unless We receive Your consent.

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 Section 7.A.1 above shall be applied on illness/condition, as applicable.

iv. **Discounts**:

i. **Family Discount**: A discount of 5% is offered on the total premium only if the policy is taken on individual Sum Insured basis and covers the Policyholder and any one or more of the following:

a. Spouse
b. Dependent Children
c. Parent(s)/ Parent(s)-in-law

ii. **Online Discount**: A discount of 10% will be 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.

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

10. CHANGE OF SUM INSURED

i. The Insured Person can apply for a 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 decide on accepting the request for enhancement in the Sum Insured.

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

iv. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

11. CANCELLATION

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

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

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

12. 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's) 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.
Provided no claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of the 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.

13. FREE LOOK PERIOD

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
The Insured Person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the Insured has not made any claim during the Free Look Period, the Insured shall be entitled to:

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

14. RENEWAL

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.

15. MIGRATION OF POLICY

The Insured Person will have the option to migrate the policy to other similar 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

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

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.

18. TAX BENEFIT

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

19. 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 in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit
as under:

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

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 network hospitals only.
iii. Treatment may be taken in a network provider/PPN hospital and is subject to pre-authorization by the TPA. The 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.
iv. 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
v. On admission in the network provider/PPN hospital, please produce the ID card issued by the TPA at the Hospital Helpdesk. Cashless-request-form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.
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 the 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-Hospitalization will be settled on reimbursement basis on production of relevant claim papers and cash receipts within the prescribed time limit.

D. Supporting Documents

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

i. Duly completed claim form
ii. 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 the date of diagnosis, advice 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.
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 Lac as per AML Guidelines
xii. Any other document required by 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 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 19.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 Limit for Submission of Documents

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

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 Policy or all insured persons in case of Family 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.

19.1 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.

20. 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.

21. 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 the 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 cumulative bonus, waiver of the waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

22. 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- 600034

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

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

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the **office of Insurance Ombudsman** of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Insurance Ombudsman offices have been provided as Annexure – 3 of the Policy Wordings.

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

23. 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.

----------o----------

Insurance is the subject matter of Solicitation.

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

Table of Benefits

The following table of Benefits is intended as a brief indicative list for quick and easy reference. For details of what your coverage is, please refer to your Policy Schedule along with the Policy Wordings.

<table>
<tr><th>Features</th><th></th></tr>
<tr><td>Age of Entry</td><td>18-65 years (Children above 91 days of age can be covered provided one or both the parents are covered)</td></tr>
<tr><td>Sum Insured Options for fresh proposals</td><td>
<table>
<tr><td>THRESHOLD LIMIT</td><td>SUM INSURED</td></tr>
<tr><td>2 Lacs</td><td>3 Lacs, 5 Lacs</td></tr>
<tr><td>3 Lacs</td><td>3 Lacs, 5 Lacs, 7 Lacs</td></tr>
<tr><td>5 Lacs</td><td>5 Lacs, 10 Lacs, 15 Lacs, 20 Lacs, 45 Lacs, 70 Lacs, 95 Lacs</td></tr>
<tr><td>10 Lacs</td><td>10 Lacs, 15 Lacs, 20 Lacs, 40 Lacs, 65 Lacs, 90 Lacs</td></tr>
<tr><td>20 Lacs</td><td>20 Lacs, 30 Lacs, 55 Lacs, 80 Lacs</td></tr>
<tr><td>25 Lacs</td><td>25 Lacs, 50 Lacs, 75 Lacs</td></tr>
</table>
</td></tr>
<tr><td>Policy Period</td><td>1 Year</td></tr>
<tr><td colspan="2">Base Cover</td></tr>
<tr><td>Room Rent</td><td>Room, Boarding and Nursing expenses (all-inclusive) incurred as provided by the Hospital/Nursing Home</td></tr>
<tr><td>ICU/ICCU</td><td>Actuals</td></tr>
<tr><td>Day Care Treatments</td><td>All as per Definition</td></tr>
<tr><td>Pre-Hospitalisation</td><td>Pre-hospitalisation Medical Expenses incurred due to an Illness or Injury during the period subject to limit:
<table>
<tr><th>Threshold</th><th>Limit</th></tr>
<tr><td><10 Lacs</td><td>upto 30 days immediately prior to hospitalisation</td></tr>
<tr><td>10 Lacs and above</td><td>upto 60 days immediately prior to hospitalisation</td></tr>
</table>
</td></tr>
<tr><td>Post-Hospitalisation</td><td>Post- hospitalisation Medical Expenses incurred due to an Illness or Injury during the period subject to limit:
<table>
<tr><th>Threshold</th><th>Limit</th></tr>
<tr><td><10 Lacs</td><td>upto 60 days immediately after the discharge from the hospital</td></tr>
<tr><td>10 Lacs and above</td><td>upto 90 days immediately after the discharge from the hospital</td></tr>
</table>
</td></tr>
<tr><td>Home Care Treatment</td><td>Reasonable and Customary Charges for Home Care Treatment subject to the limits, as under:
<table>
<tr><th rowspan="2">Threshold (Rs.)</th><th colspan="2">Limit (Rs.) Upto</th></tr>
<tr><th>Individual SI Basis</th><th>Floater Basis</th></tr>
<tr><td>< 10 Lacs</td><td>15,000 per incident</td><td>15000 per incident subject to a maximum of Rs. 30000 per policy</td></tr>
<tr><td>10 Lacs and above</td><td>30,000 per incident</td><td>30000 per incident subject to a maximum of Rs. 60000 per policy</td></tr>
</table>
</td></tr>
<tr><td>Organ Donor Expenses</td><td>Actuals within the overall Sum Insured</td></tr>
<tr><td>Road Ambulance</td><td>Covered up to Actuals subject to a maximum of Rs. 2500 per event & a maximum of Rs. 5000 per policy period</td></tr>
<tr><td>Modern Treatment Methods#</td><td>Covered with sub-limits</td></tr>
<tr><td colspan="2">Optional Cover</td></tr>
<tr><td>Hospital Daily Cash</td><td>For every continuous and completed period of 24 hours of Hospitalisation, subject to the hospitalisation claim being admissible under the policy, as under:
<table>
<tr><th>Threshold</th><th>Limit (Rs.) per day</th></tr>
<tr><td>< Rs. 5 Lacs</td><td>Rs. 500 per day subject to a maximum of Rs. 5000 per policy period</td></tr>
<tr><td>Rs. 5 Lacs</td><td>Rs. 1000 per day subject to a maximum of Rs. 10000 per policy period</td></tr>
<tr><td>Above Rs. 5 Lacs</td><td>Rs. 2000 per day subject to a maximum of Rs. 20000 per policy period</td></tr>
</table>
</td></tr>
</table>

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

BENEFIT / PREMIUM ILLUSTRATION

Super Top-Up Medicare Policy

Please note that the premium rates specified in the illustrations below are standard premium rates exclusive of any loadings and GST.

ILLUSTRATIONS

Illustration 1: Self, Spouse and 2 Dependent Children

Age of Insured Member	Coverage opted on Individual basis covering each member of the family separately (at a single point in time)		Coverage opted on Individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
45	1,471	3,00,000	1,471	5%	1,397.45	3,00,000	5,252	44%	2,940	3,00,000
40	1,471	3,00,000	1,471	5%	1,397.45	3,00,000				
21	1,155	3,00,000	1,155	5%	1,097.25	3,00,000				
18	1,155	3,00,000	1,155	5%	1,097.25	3,00,000				
Total Premium for all members of the family is Rs. 5,252, when each member is covered separately.			Total Premium for all members of the family is Rs. 4,989, when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 2,940.			
Sum Insured available for each individual is Rs. 3,00,000 with a threshold level of Rs. 2,00,000/-			Sum Insured available for each individual is Rs. 3,00,000 with a threshold level of Rs. 2,00,000/-				Sum Insured of Rs. 3,00,000 is available for the entire family with a threshold level of Rs. 2,00,000/-			

Illustration 2: Self and Spouse

Age of Insured Member	Coverage opted on Individual basis covering each member of the family separately (at a single point in time)		Coverage opted on Individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
59	1,785	3,00,000	1,785	5%	1,695.75	3,00,000	3,570	19%	2,891	3,00,000
56	1,785	3,00,000	1,785	5%	1,695.75	3,00,000				
Total Premium for all members of the family is Rs. 3,570, when each member is covered separately.			Total Premium for all members of the family is Rs. 3,392, when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 3,570.			
Sum Insured available for each individual is Rs. 3,00,000 with a threshold level of Rs. 3,00,000/-			Sum Insured available for each individual is Rs. 3,00,000 with a threshold level of Rs. 3,00,000/-				Sum Insured of Rs. 3,00,000 is available for the entire family with a threshold level of Rs. 3,00,000/-			

Illustration 3: Self and Spouse

Age of Insured Member	Coverage opted on Individual basis covering each member of the family separately (at a single point in time)		Coverage opted on Individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
69	21,924	95,00,000	21,924	5%	20827.8	95,00,000	41,580	19%	33,810	95,00,000
62	19,656	95,00,000	19,656	5%	18673.2	95,00,000				
Total Premium for all members of the family is Rs. 41,580, when each member is covered separately.			Total Premium for all members of the family is Rs. 39,501, when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 33,810.			
Sum Insured available for each individual is Rs. 95,00,000 with a threshold level of Rs. 5,00,000/-			Sum Insured available for each individual is Rs. 95,00,000 with a threshold level of Rs. 5,00,000/-				Sum Insured of Rs. 95,00,000 is available for the entire family with a threshold level of Rs. 5,00,000/-			