Family Medicare Policy

Prospectus

1. Product – Key Features

Family Medicare Policy is an Indemnity-based health insurance product for you and your family that offers a wide cover. Our cashless hospitalisation network spans 14000+ hospitals pan India.

COVERAGE AT A GLANCE:

Base Cover
In-Patient Hospitalisation Expenses
All Day Care Treatments
Pre-Hospitalisation & Post Hospitalisation Expenses
Organ Donor Expenses
Restoration of Sum Insured
Road Ambulance Expenses
Modern Treatment Methods & Advancement in Technology
Home Care Treatment
Cost of Health Check-Up
Organ Donor Benefit (When Insured Person is the Donor)

Optional Covers
Maternity Expenses and New Born Baby Cover
Daily Cash Allowance on Hospitalisation

2. Cover Type

The Policy provides cover on an Individual Sum Insured basis or Family Floater Sum Insured basis. Under Individual Sum Insured basis, a separate Sum Insured for each Insured Person, is provided while under Family Floater Sum Insured basis, the Sum Insured limit is shared by the whole family of the Insured as specified in the Policy Schedule. 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. Proposer

Individual: Any person above 18 years of age

Employer: Any employer for their employee and/or the employee's family

4. Family

An adult person can take a policy for himself or his/her family consisting of all or either of:

i. Self, Spouse, dependent children, and Parents on Individual Sum Insured basis and Floater Sum Insured basis.

5. Eligibility

Eligibility based on age:

i. Adults: 18 years and 60 years.
ii. Dependent Children: 91 days to 17 years, provided either or both parents are covered concurrently. In case, where both the parents of the child(ren) are already deceased, the minor child(ren) can be covered by the guardian without covering himself/herself.
iii. Dependent Children up to 91 days can be covered if the optional cover of Maternity Expenses and New Born Baby Cover is purchased on payment of additional requisite premium.

Children aged 18 years or above will continue to be covered along with parents till the age of 26 years, provided they are unmarried/unemployed and dependent.

The upper age limit will not apply to mentally challenged children.

In the event of children becoming independent, employed, getting married, or attaining 26 years of age, a separate policy can be taken on the expiry of the current policy for which continuity benefits will be provided.

Beyond 60 years, only renewals are allowed.

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

i. Newly married spouse within 60 (sixty) days of marriage.
ii. New born baby, between the ages of 91 days to 180 days, born to mother, insured under the policy.

6. Policy Term

One Year. Renewable annually.

7. Sum Insured

For a new policy, the following Sum Insured options are available:
Rs. 3 lakhs, 4 lakhs, 5 lakhs, 6 lakhs, 7 lakhs, 8 lakhs, 9 lakhs, 10 lakhs, 15 lakhs, 20 lakhs & 25 lakhs.

8. Coverage

A. Base Covers

The Policy provides base coverage as described below in this section provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner/Mental Health Professional (in case of Mental illness) and are incurred on Medically Necessary Treatment of the Insured Person.

1. In-patient Hospitalisation Expenses Cover

i. Room, Boarding and Nursing expenses (all inclusive) incurred as provided by the Hospital/Nursing Home up to the limits provided below:

Sum Insured	**Limit (Rs.) per day**
< Rs. 5 lakhs	1% of Sum Insured
Rs. 5 lakhs and Above	1% of Sum Insured or Single Occupancy Standard AC Room Charges whichever is higher

These expenses will include nursing care, RMO charges, patient's diet charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.

ii. Charges for accommodation in Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) up to the limits provided below:

Sum Insured	**Limit (Rs.) per day**
< Rs. 5 lakhs	2% of Sum Insured
Rs. 5 lakhs and Above	Actuals

i. The fees charged by the Medical Practitioner, Surgeon, Specialists, and anesthetists treating the Insured Person;

ii. Operation theatre charges,

iii. Anesthesia, Blood, Oxygen, Surgical Appliances and/ or Medical Appliances, medicines and drugs, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory/ diagnostic tests, X-Ray, dialysis, chemotherapy, radiotherapy, and such other similar medical expenses related to the treatment.

iv. All Day Care Treatment as per definition of Clause II.A.13 of policy wordings are covered.

1.1 Note:

i. PROPORTIONATE PAYMENT CLAUSE: In case of admission to a room at rates exceeding the aforesaid limits in *clause 8.A.1*.i the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent.
Proportionate Deductions shall not be applied in respect of those hospitals where differential billing is not followed or for those expenses where differential billing is not adopted based on the room category.

ii. No payment shall be made under *clause 8.A.1.iii* other than as part of the hospitalisation bill. However, the bills raised by Surgeon, Anesthetist directly and not forming part of the hospital bill shall be paid provided a pre-numbered bill/receipt is produced in support thereof, when such payment is made ONLY by cheque/ credit card/debit card or digital/online transfer.

1.2 Sub-limit:

a) Cataract Surgery Limit:
Expenses in respect of the Cataract surgeries will be restricted to 10% of Sum Insured subject to maximum of Rs. 50,000/- per eye. This limit is applicable per hospitalisation / surgery.

b) Mental Illness Cover Limit:
In case of following mental illnesses, the actual In-patient Hospitalization expenses will be covered up to 25% of Sum Insured subject to a maximum of Rs. 3, 00,000 per policy period;

1. Schizophrenia (ICD - F20; F21; F25)
2. Bipolar Affective Disorders (ICD - F31; F34)
3. Depression (ICD - F32; F33)
4. Obsessive Compulsive Disorders (ICD - F42; F60.5)
5. Psychosis (ICD - F 22; F23; F28; F29)

2. Pre-Hospitalisation and Post-Hospitalisation Expenses –

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

i. Pre-hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 30 days prior to hospitalisation; and

ii. Post- hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 60 days after the discharge from the hospital,

Subject to a maximum of 10% of Sum Insured for Pre- and Post-Hospitalisation combined, provided that:

a. We have accepted a claim for primary In-patient Hospitalization under *Clause 8.A.1* above.
b. The Pre-hospitalisation and Post-hospitalisation Medical Expenses are related to the same Illness or Injury.
c. Home care Treatment also will be deemed as Hospitalisation for this cover.

3. 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 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 *Clause 8.A.1* 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.

4. Restoration of Sum Insured

If the Sum Insured is exhausted completely or partially due to claims made and paid/accepted as payable during the Policy Period, then it is agreed that a Restored Sum Insured equal to 100% of the Sum Insured will be automatically and instantly available for the particular Policy Period, provided that:

i. In case of policies on Individual Sum Insured basis, the Restored sum insured will be available only once to each Insured Person individually in a Policy Period.
ii. In case of policies of Family Floater Sum Insured basis, the Restored Sum Insured will be available only once to the whole family on floater sum insured basis during a Policy Period.
iii. Such restored Sum Insured can be utilized only for illness / disease unrelated to the illness(es) / disease(s) for which claim(s) was / were made for the same insured person.
iv. The maximum liability for a claim in a Policy Year cannot exceed the Sum Insured.
v. If the Restored Sum Insured is not utilized in a Policy Period, it shall not be carried forward to any subsequent Policy Period.

Note:

i. Restoration of Sum Insured is available only for Sum Insured options from Rs. 3 lakhs and above.
ii. The payment from the restored Sum Insured will be done only after exhaustion of the Sum Insured.

Illustrations with Sum Insured on Floater Sum Insured Basis – Rs 5 lakh

S. No.	Claimant	Hospitalisation condition	Claimed amount	Payment from SI	Payment from Restored SI	Available SI after claim	Available Restored SI after claim
1	Insured 1	Kidney Stones	1,00,000	1,00,000	0	4,00,000	5,00,000
2	Insured 1	Heart Attack	2,00,000	2,00,000	0	2,00,000	5,00,000
3	Insured 1	Cancer	4,00,000	2,00,000	2,00,000	0	3,00,000

S. No.	Claimant	Hospitalisation condition	Claimed amount	Payment from SI	Payment from Restored SI	Available SI after claim	Available Restored SI after claim
1	Insured 1	Kidney Stones	1,00,000	1,00,000	0	4,00,000	5,00,000
2	Insured 1	Heart Attack	2,00,000	2,00,000	0	2,00,000	5,00,000
3	Insured 1	Heart Attack[#]	4,00,000	2,00,000	0	0	5,00,000

[#] Related Illness, hence, Restored Sum Insured is not payable (clause – 8.A.4.iii)

S. No.	Claimant	Hospitalisation condition	Claimed amount	Payment from SI	Payment from	Available SI	Available Restored SI after claim

					Restored SI	after claim	
1	Insured 1	Kidney Stones	1,00,000	1,00,000	0	4,00,000	5,00,000
2	Insured 1	Heart Attack	2,00,000	2,00,000	0	2,00,000	5,00,000
3	Insured 2	Heart Attack*	4,00,000	2,00,000	2,00,000	0	3,00,000

* Related Illness but for different insured, hence, Sum Insured as well as Restored Sum Insured are both payable (clause – 8.A.4.iii)

5. Modern Treatment Methods & Advancement in Technologies:

In case of an admissible claim under *Clause 8.A.1*, expenses incurred on the following procedures (wherever medically indicated) shall be covered.

i. Uterine Artery Embolization and HIFU (High Intensity focused ultrasound)
ii. Balloon Sinuplasty
iii. Deep Brain Stimulation
iv. Oral Chemotherapy
v. Immunotherapy - Monoclonal Antibody to be given as an injection
vi. Intra-vitreal injections
vii. Robotic Surgeries
viii. Stereotactic Radio Surgeries
ix. Bronchial Thermoplasty
x. Vaporization of the Prostrate (Green Laser Treatment or Holmium Laser Treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem Cell Therapy; Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered

6. Road Ambulance Cover

We will cover the costs incurred up to:

i. 0.5% of the Sum Insured subject to a maximum of Rs. 2500 per event and
ii. 1% of the Sum Insured subject to a maximum of Rs. 5000 per policy period

on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner and becomes payable if a claim has been admitted under *Clause 8.A.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 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 specialty treatment in the existing Hospital.

7. Home Care Treatment

We will indemnify the Reasonable and Customary Charges for Home Care Treatment for any epidemic/ pandemic, subject to a maximum of 10% of the Sum Insured or Rs. 30,000 per person per policy period, whichever is lower.

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

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

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

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

8. Cost of Health Check-up

Expenses incurred towards cost of health check-up up to 1% of average Sum Insured of preceding 3 policy years, subject to a maximum of Rs. 5,000 per person for policies issued on individual sum insured basis/ Rs. 10,000 per policy period for policies issued on family floater sum insured basis for a block of every three claim-free years provided the health check-up is done at hospitals/diagnostic Centre authorised by us within a year from the date when it got due and the policy is in force. Payment under this benefit does not reduce the Total Sum Insured.

In case of the policy on family floater sum insured basis, if a claim is made by any of the Insured Persons, the health check-up benefits will not be available under the policy.

Note: Payment of expenses towards cost of health check-up will not prejudice the company's right to deal with a claim in case of non-disclosure of material fact and /or Pre-Existing Diseases in terms of the policy.

9. Organ Donor Benefit- When Insured Person is the Donor

A lump sum payment of 10% of Sum Insured, to take care of medical and other incidental expenses is payable to the Insured Person donating an organ provided that the donation conforms to the Transplantation of Human Organs Act 1994 (amended) and any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs.

This benefit is subject to the Policy (Family Medicare Policy) having been continuously in force for at least 12 (twelve) months in respect of that Insured Person

B. Optional Covers:

1. Maternity Expenses and New Born Baby Cover

a. Maternity Expenses

We shall pay the Medical Expenses incurred as an In-patient for a delivery (including caesarean section) or lawful medical termination of pregnancy during the Policy Period limited to two deliveries or terminations or either during the lifetime of the Insured Person. This benefit is applicable only when the Sum Insured is above Rs. 3 Lakhs, and available only to the Insured or his spouse, provided that:

i. Family Medicare Policy with this optional cover has been continuously in force for a period of minimum 24 months.
ii. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.
iii. Company's maximum liability per delivery or termination shall be limited to 10% of the Sum Insured as stated in the Schedule subject to a maximum of Rs. 40,000 in case of normal delivery and Rs. 60,000 in case of caesarean section and in no case shall the Company's liability under this clause exceed 10% of the Sum Insured, in any one Policy Period.

b. New Born Baby Cover

New born Baby shall be covered from day one up to the age of 90 days and expenses incurred for treatment taken in Hospital as in-patient shall only be payable, provided that:

i. Claim under Maternity Expenses under *Clause 8.B.1.a* is admissible under the Policy
ii. Company's liability shall be limited to 10% of the Sum Insured as stated in the Schedule.
iii. In case the 90-days period for the New Born Baby is spread over two Policy Periods, the aggregate liability of the Company, for all claims in respect of the New Born Baby, shall be limited to 10% of the Sum Insured of the Policy under which Maternity claim was admitted.

Special conditions applicable to Maternity Expenses and New Born Baby Cover

i. These benefits are admissible only if the expenses are incurred in Hospital/Nursing Home as in-patients in India.
ii. Surrogate or vicarious pregnancy is not covered.
iii. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.
iv. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.
v. Pre-Hospitalisation and Post-Hospitalisation benefits are not available under clauses 8.B.1.a and 8.B.1.b.
vi. Subject to the terms & conditions, the Policy covers New Born Baby beyond 90 days only on payment of requisite premium.
vii. If this Option is in force in respect of the Insured Person,
    a) The relevant part of *clause 9.B.18* will be deemed inoperative.
    b) *The waiting period for "Internal Congenital Anomaly"* from Table A of *Clause 9.A.2* will be deemed inoperative for the New Born Baby throughout the time such baby is continuously covered under this product.

2. 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:

Sum Insured	**Limit (Rs.) per day**
Up to Rs. 5 Lakhs	Rs. 500 per day subject to a maximum of Rs. 5000 per policy period
Above Rs. 5 Lakhs and up to Rs. 15 Lakhs	Rs. 1000 per day subject to a maximum of Rs. 10000 per policy period

Above Rs. 15 Lakhs and up to Rs. 25 Lakhs	Rs. 2000 per day subject to a maximum of Rs. 20000 per policy period

The aggregate of Daily Cash Allowance during the policy period shall not exceed 'per policy period limits' as mentioned in the table above.
Daily Cash Allowance will not be payable for Day Care Treatment claims. Deductible equivalent to Daily Cash Allowance for the first 24 hours Hospitalization will be levied on each Hospitalisation during the Policy Period.

9. What Policy Does Not Cover

A. Waiting Periods

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

1. Pre-Existing Diseases (Code – Excl01)

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

2. Specified Disease/Procedure Waiting Period (Code – Excl02)

i. Expenses related to the treatment of the listed Conditions, surgeries/treatments as per Table A and Table B below shall be excluded until the expiry of 24 months and 36 months respectively of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
ii. In case of enhancement of the sum insured the exclusion shall apply afresh to the extent of the sum insured increase.
iii. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then the waiting period for the same would be reduced to the extent of prior coverage.
vi. List of specific diseases/procedures:

Table A. 24 months waiting period

Non infective Arthritis	Piles, Fissures and Fistula-in-ano; Pilonidal sinus

Benign ENT disorders	Prolapse intervertebral Disc and Spinal Diseases unless arising from Accident
Benign prostatic hypertrophy	Benign Skin Disorders
Cataract	Calculus diseases
Acid Peptic diseases	Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapse of uterus
Gout and Rheumatism	Any treatment for varicose veins and ulcers including surgical intervention
Hernia of all types	Polycystic ovarian disease
Hydrocele	Internal Congenital Anomaly
All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps	

Table B. 36 months waiting period

Joint Replacement due to Degenerative condition, unless necessitated due to an accident.
Age-related Osteoarthritis & Osteoporosis
Age-related Macular Degeneration (ARMD)
Named Mental Illnesses: Schizophrenia (ICD - F20; F21; F25) Bipolar Affective Disorders (ICD - F31; F34) Depression (ICD - F32; F33) Obsessive Compulsive Disorders (ICD - F42; F60.5) Psychosis (ICD - F 22; F23; F28; F29)
All Neurodegenerative disorders

3. 30-Day Waiting Period (Code – Excl03)
   i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
   iii. The within-referred waiting period is made applicable to the enhanced sum insured in the event of granting a higher sum insured subsequently.

B. Standard Exclusions

The company shall not be liable to make any payment under this Policy respect of any expenses incurred by You in connection with or in respect of:

4. 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.

5. 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, and moving around either by skilled nurses or assistants or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. 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:
        b.1. Obesity-related cardiomyopathy
        b.2. Coronary heart disease
        b.3. Severe Sleep Apnea
        b.4. Uncontrolled Type2 Diabetes

7. 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.

8. 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 the 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.

9. 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.

10. 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.

11. 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 on 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.

12. (Code – Excl12)

Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

13. (Code – Excl13)
    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.

14. (Code – Excl14)
    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 a hospitalisation claim or day care procedure.

15. Refractive Error (Code – Excl15)
    Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

16. 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.

17. 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

18. Maternity (Code- Excl18)
    i Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
    ii Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

C. Specific Exclusions

1. 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.
2. All Illnesses/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or any nuclear waste from the combustion of nuclear fuel, nuclear/chemical/biological attack.
3. Any expenses incurred on Domiciliary Hospitalization.
4. Any expense incurred on multi-focal or toric lenses during cataract or any other eye-related surgery, except to the extent of the cost of a unifocal lens.
5. Any expenses incurred on Out-patient treatment (OPD treatment). Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.
6. Any item(s) or treatment specified in 'List of Non-Medical Expenses under this Policy' as per clauses in Annexure – 1 of the Family Medicare Policy Wordings, unless specifically covered under the Policy.

7. Any treatment related to sleep disorder or sleep apnoea syndrome.
8. 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.
9. Change of treatment from one system of medicine to another system unless recommended by the consultant/hospital under whom the treatment is taken.
10. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
11. Congenital External Diseases or Defects or anomalies.
12. Cost of hearing aids; including optometric therapy.
13. Cost of routine medical examination and preventive health check-up unless as provided for in *clause 8.A.8*.
14. Dental treatment or surgery of any kind unless necessitated by disease or accident and requiring hospitalisation.
15. ; 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 instruments used in treatment of sleep apnoea syndrome; Infusion pump, Oxygen concentrator, Ambulatory devices, sub cutaneous insulin pump and also any medical equipment, which are subsequently used at home. This is indicative. Please refer to clauses in Annexure-1 for the complete list of non-payable items.
16. Intentional self-inflicted Injury or attempted suicide.
17. Routine eye-examination expenses, cost of spectacles, contact lenses.
18. Stem cell implantation/Surgery/Therapy, harvesting, storage or any kind of treatment using stem cells except Hematopoietic stem cells for bone marrow transplant for haematological conditions; growth hormone therapy.
19. Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, chondrocyte or osteocyte implantation, procedures using platelet rich plasma, Trans Cutaneous Electric Nerve Stimulation; Use of oral immunomodulatory/ supplemental drugs.
20. Unless used intra-operatively, any expenses incurred on prosthesis, corrective devices
21. Vaccinations or inoculations of any kind, except when required as part of hospitalization or a day care procedure for treatment following an animal bite.
22. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), Insured Person is not entitled to get the coverage for specified ICD Codes

10. Procedure For Taking a Policy

1. The duly completed and signed Proposal form giving details of all Insured persons and a signed copy of the Prospectus along with Pre-Acceptance Health Check-up reports, if any, should be submitted to the nearest office of the Company.
2. The pre-acceptance health check-up reports, wherever required at Company's discretion have to be submitted at proposer's cost.

Notes

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

11. Payment Of Premium

1. Applicable premium must be paid before the commencement of risk for this Policy to come into effect.
2. Premium payable – As per the Premium tables attached. The Premium can be paid online for renewals.
3. PAN details must be submitted by the insured. In case PAN is not available, Form 60 or Form 61 must be submitted.

12. Loadings, Discount and No Claim Rewards

i *No Claim Rewards:*

The Insured Person(s) shall be eligible for a No Claim Reward if no claim is reported under the expiring policy and the policy is renewed with Us without any break in policy. The No Claim Reward may either be a No Claim Discount (NCD), calculated as a percentage of the renewal premium, or a Cumulative Bonus (CB), calculated as a percentage of the expiring policy's Sum Insured. There are a maximum of 15 slabs of NCR, with each slab representing one claim-free year. In case no claim is reported, the Policyholder must choose one of the following options at the time of renewal. If no choice is explicitly made as per clause V.B.7.iii of policy wordings, the option selected in the expiring policy will be deemed chosen. If the option to choose an NCR is not exercised at the first renewal, the policyholder will automatically be entitled to the Cumulative Bonus.

a. No Claim Discount (NCD):

The Insured Person(s) shall receive a 5% discount on the renewal premium for the first 5 slabs, and a 2.5% discount for each subsequent slab, up to a maximum of 50%.

b. Cumulative Bonus (CB):

The Cumulative Bonus shall increase by 20% for the first 5 slabs, and by 10% for each subsequent slab, up to a maximum of 200% of the Sum Insured under the current policy year.

Notes on Cumulative Bonus (CB):

i. If the Insured Person(s) were covered under the expiring policy on an individual sum insured basis and had accumulated a CB, but renew on a floater sum insured basis, only the lowest CB slab among the insured persons will be carried forward in the renewed policy.
ii. If the Insured Person(s) covered under a floater sum insured policy with an accumulated CB choose to split the policy into two or more floater or individual policies upon renewal, the CB from the expiring policy will be apportioned among the renewed policies in proportion to their respective Sum Insured.
iii. If there is an enhancement of the Sum Insured at the time of renewal, the CB will be calculated on the Sum Insured from the last completed policy year.
iv. If the Sum Insured is reduced at the time of renewal, the CB will be reduced in the same proportion as the decrease in the Sum Insured in the current policy.

Notes on No Claim Rewards (NCR):

i. If a claim is reported in any particular year, the NCR accrued shall be reduced at the same rate at which it has accrued.
ii. Where the policy is on individual sum insured basis, the NCR shall be available to each insured person separately. If a claim is reported, the NCR will reduce by one slab as it was accrued for that person only.
iii. Where the policy is on floater sum insured basis, the NCR shall be available for the entire family. If a claim is reported from any insured person, the NCR will reduce by one slab as it was accrued for the entire family.
iv. If the policyholder opts to switch from the No Claim Discount (NCD) to the Cumulative Bonus (CB) or vice versa at the time of renewal, the premium and sum insured shall be suitably adjusted to ensure that the policyholder gets the benefit of either of the options only.
v. If a claim is reported in the expiring policy and notified to us after acceptance of the renewal premium, applicable No Claim Rewards will be adjusted accordingly.

ii *Family Discount*

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

iii *Floater Discount*

If the policy is issued on Family Floater Sum Insured basis, a Family Floater Discount will be allowed based on the family composition.

iv *Direct Channel Discount*

A discount is applicable for fresh policies purchased online through the Company's website or directly from United India's office, without any agent or an intermediary.

For renewals, the discount shall be offered provided that both the renewing policy and expiring policy are without any agent or an intermediary.

v *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 Inception Date of the first Policy including subsequent renewal(s).

The loadings are applicable on individual ailments only. In case of loading on two or more ailments, the loadings shall apply in conjunction on additive basis.

Note: The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Clause 9.A.1 above shall be applied on illness/condition, as applicable.

13. Change Of Sum Insured

1. The Insured can apply for change of Sum Insured at the time of renewal, by submitting a fresh proposal form/written request to the company.
2. Any request for enhancement of Sum Insured must be accompanied by a declaration that the Insured or any other Insured Person(s) 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.
3. The acceptance of enhancement of Sum Insured would be at the discretion of the company, subject to underwriting, based on the health condition of the Insured Persons & claim history of the policy.
4. All waiting periods as defined in the Family Medicare Policy wordings shall apply for the incremental portion of the Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

14. Cancellation

1. The policyholder may cancel his/her Policy at any time during the term by giving 7 days' notice in writing. The insurer shall refund proportionate premium for unexpired policy period, if there is no claim(s) reported during the policy period.
2. The Company may cancel the policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

15. Policy Cancellation for Premium payment through Lending Partner

If the premium tendered/paid towards the policy has been financed through a Lending Partner, and the policy is cancelled by invocation of the terms stated by the policy holder in the "*Letter* to the Insurer" or If the refund of premium is due for any reason whatsoever, the refund will be effected to the *a*ccount which is mentioned by the policy holder in the "Letter to the Insurer" submitted by the policy holder.

16. Free Look Period

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

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

17. Renewal Of Policy

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

1. The Company will give notice for renewal.
2. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
3. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
4. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
5. 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 except when premium is paid in instalment.
6. No loading shall apply on renewals based on individual claims experience.

18. Migration Of Policy

The Insured Person will be provided a facility to migrate the policy (including all members) to other health insurance products/plans offered by the company by applying for migration of the policy. 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.

19. Portability

The Insured Person will be provided facility to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 30 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.

20. 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.

21. Tax Benefit

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

22. Claim Procedure

1. Notification of Claim

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

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

2. Procedure for Cashless Claims

i. Cashless facility for treatment taken in hospitals is subject to preauthorization by the TPA.
ii. 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. The customer may call the TPA's toll free phone number provided in the policy copy/on the health ID card for intimation of claim and related assistance. Please keep the ID number handy for easy reference.
iv. 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 filled and submitted 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

3. Procedure for reimbursement of Claims

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

4. Documents

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

a. Duly completed claim form
b. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed along with date of diagnosis, advise for admission, investigation test reports etc. supported by the prescription from attending medical practitioner.
c. Medical history of the patient as recorded, bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.

d. Discharge certificate/ summary from the hospital.
e. Cash-memos from the Diagnostic Centre(s)/ hospital(s)/ chemist(s) supported by proper prescription.
f. Payment receipts from doctors, surgeons and anesthetists.
g. Bills, receipts, Stickers of the Implants.
h. 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 *Clause 22.4* and claim settlement advice duly certified by the other Insurer subject to satisfaction of the company.

5. *Time Limit for submission of documents*

Type of Claim	Time Limit for submission of the documents to the Company/TPA
Reimbursement of hospitalisation, day care and pre-hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital.
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post-hospitalisation treatment.
Reimbursement of Cost of Health Check-up	Within 15 (fifteen) days from Health Check-up

Notes:

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. Waiver of *clause 22.5* 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.
iv. 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.
v. All the documents submitted to TPA shall be electronically collected by us for settlement/denial of the claims by the appropriate authority.
vi. 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.

6. *Services offered by TPA*

Servicing of claims i.e. claim admissions and assessments, under this Policy by way of preauthorization 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.

23. 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.

24. Withdrawal Of Policy

1. In the likelihood of this product being withdrawn in future, the Company will intimate the Policyholders about the same 90 days prior to expiry of the policy.
2. 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 waiting period as per IRDAI guidelines, provided the policy has been maintained without a break

25. Redressal Of Grievance

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

Website: **www.uiic.co.in**
Toll-free: 1800 425 333 33
E-mail: **customercare@uiic.co.in**
Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd.,
24, Whites Road, Chennai, Tamil Nadu- 600014

The 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 of the Family Medicare Policy Wordings.

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

26. REGULATIONS

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

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Insurance is the subject matter of Solicitation.

Family 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>Description</th></tr>
<tr><td>Age of Entry</td><td>Dependent Children – 91 Days to 17 years
Adults – 18 years to 60 years</td></tr>
<tr><td>Policy Type</td><td>Individual Basis/ Family Floater Basis</td></tr>
<tr><td>SI Options (for fresh proposals)</td><td>Rs. 3 lakhs, 4lakhs, 5 lakhs, 6 lakhs, 7 lakhs, 8 lakhs, 9 lakhs , 10 lakhs, 15 lakhs, 20 lakhs & 25 lakhs</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><table><tr><th>Sum Insured</th><th>Limit (Rs.) per day</th></tr><tr><td>< Rs. 5 lakhs</td><td>1% of Sum Insured</td></tr><tr><td>Rs. 5 lakhsand Above</td><td>1% of Sum Insured or Single Occupancy Standard Air-Conditioned Room Charges whichever is higher</td></tr></table></td></tr>
<tr><td>ICU/ICCU</td><td><table><tr><th>Sum Insured</th><th>Limit (Rs.) per day</th></tr><tr><td>< Rs. 5 lakhs</td><td>2% of Sum Insured</td></tr><tr><td>Rs. 5 lakhs and Above</td><td>Actuals</td></tr></table></td></tr>
<tr><td>Day Care Treatments</td><td>All Day Care Treatments as per the definition in the policy wordings are covered</td></tr>
<tr><td>Pre-Hospitalisation</td><td>30 Days (subject to 10% of SI combined for Pre and Post Hospitalisation)</td></tr>
<tr><td>Post-Hospitalisation</td><td>60 Days (subject to 10% of SI combined for Pre and Post Hospitalisation)</td></tr>
<tr><td>Road Ambulance</td><td>0.5% of the Sum Insured subject to a maximum of Rs. 2,500 per event and
1% of the Sum Insured subject to a maximum of Rs. 5,000 per policy period</td></tr>
<tr><td>Modern Treatment Methods & Advancement in Tech.</td><td>Covered</td></tr>
<tr><td>Restoration of Sum Insured</td><td>Available for SI Rs.3 lakhsand above; On complete or partial exhaustion of SI, up to 100% of SI</td></tr>
<tr><td>Home care Treatment</td><td>Covered for any epidemic/pandemic, subject to a maximum 10% of the SI or Rs 30,000 per person per policy period, whichever is lower</td></tr>
</table>

<table>
<tr><td>Health Check-Up</td><td>up to 1% of average Sum Insured of preceding 3 policy years, subject to a maximum of Rs. 5,000 per person if policy is on individual SI basis/ Rs. 10,000 per policy period if policy is on family floater sum insured basis for a block of every three claim-free years</td></tr>
<tr><td>Organ donor’s medical expenses</td><td>Hospitalisation Expenses (excluding cost of organ) incurred for/by a Donor within the Sum Insured of the Insured Person</td></tr>
<tr><td>Organ Donor Benefit (When the Insured Person is the Donor)</td><td>A lump sum payment of 10% of Sum Insured</td></tr>
<tr><td colspan="2">Optional Covers</td></tr>
<tr><td>Maternity Expenses & New Born Baby Cover</td><td>Available for SI above Rs.3lakhs
<u>Maternity Expenses:</u> After continuous cover of 24 months, 10% of Sum Insured subject to a maximum of Rs. 40,000 for normal/ Rs. 60,000 for caesarean.
<u>New Born Baby Cover:</u> Upto 10% of SI, Upto 90 days.</td></tr>
<tr><td>Hospital Daily Cash Allowance</td><td><table>
<tr><th>Sum Insured (Rs.)</th><th>Limit (Rs.) per day</th></tr>
<tr><td>Up to Rs. 5 lakhs</td><td>Rs. 500 per day subject to a maximum of Rs. 5,000 per policy period</td></tr>
<tr><td>Above Rs. 5 lakhsand up to Rs. 15 lakhs</td><td>Rs. 1,000 per day subject to a maximum of Rs. 10,000 per policy period</td></tr>
<tr><td>Above Rs. 15 lakhsand up to Rs. 25 lakhs</td><td>Rs. 2,000 per day subject to a maximum of Rs. 20,000 per policy period</td></tr>
</table></td></tr>
<tr><td colspan="2">Sub-Limits (other than those mentioned above)</td></tr>
<tr><td>Cataract</td><td>10% of Sum Insured, subject to maximum of Rs. 50,000 per eye.</td></tr>
<tr><td>Named Mental Illnesses</td><td>In case of following mental illnesses, the actual In-patient Hospitalization expenses will be covered up to 25% of Sum Insured subject to a maximum of Rs. 3,00,000 per policy year;
a. Schizophrenia (ICD - F20; F21; F25)
b. Bipolar Affective Disorders (ICD - F31; F34)
c. Depression (ICD - F32; F33)
d. Obsessive Compulsive Disorders (ICD - F42; F60.5)
e. Psychosis (ICD - F 22; F23; F28; F29)</td></tr>
</table>

Premium Rate Tables

IMPORTANT INFORMATION

- All premium rates shown in this document are Annual Premium Rates in INR (₹) and are exclusive of Goods & Service Tax (GST) & Cess (if any). GST as applicable will be charged extra.
- Premium rates are applicable per individual insured person (unless explicitly specified) and will be based on their completed age.
- Premium rates in Section I are for standard healthy individuals. These may change post underwriting of proposal based on medical tests (where applicable) and information provided in the proposal form.
- Entry Age:
  - Adults: 18 to 60 years
  - Children: 91 days to 17 years
- Premium rates vary depending on the Proposer's place of residence. In this regard, the country is divided into three geographical zones: **Zone A**, **Zone B**, **Zone C**. The Zones are based on the following districts in India:

Zone	Districts
A	All Districts in NCT of Delhi (incl. Shahdara), Faridabad, Palwal, Gurugram, Rohtak, Jhajjar, Ghaziabad, Gautam Buddh Nagar, Bulandshahr, Ahmedabad, Ahmedabad City, Gandhi Nagar, Vadodara, Surat, Mumbai, Mumbai Suburban, Thane, Raigad (MH), Palghar
B	Ahmed Nagar, Amritsar, Anand, Bengaluru, Bhopal, Chennai, Coimbatore, Dakshina Kannada, Ernakulam, Howrah, Hyderabad, Indore, Jaipur, Jalgaon, Jodhpur, Kanpur Nagar, Kheda, Kolhapur, Kolkata, Kottayam, Krishna, Lucknow, Ludhiana, Nagpur, Nashik, North 24 Parganas, Pune, Rajkot, Ranga Reddy, Solapur, Thiruvananthapuram, Tiruvallur, Valsad, Visakhapatnam.
C	Rest of India

I. BASE COVER PREMIUM RATES (EXCL. GST)

Zone A

Sum Insured	0-17	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	75+
1,00,000	2,071	3,495	3,883	4,660	5,663	5,796	6,932	8,340	11,975	12,361	15,139	17,092	19,717
1,50,000	2,472	4,172	4,636	5,564	6,762	7,038	8,417	10,127	14,542	16,482	20,185	22,790	26,290
2,00,000	2,873	4,848	5,389	6,467	7,860	8,280	9,903	11,914	17,108	20,602	25,232	28,487	32,862
2,50,000	3,259	5,500	6,112	7,335	8,914	9,936	11,883	14,297	20,529	24,723	30,278	34,185	39,434
3,00,000	3,645	6,151	6,835	8,202	9,968	11,592	13,864	16,680	23,951	28,843	35,324	39,882	46,007
3,50,000	3,816	6,439	7,154	8,585	10,433	13,012	15,562	18,718	26,877	32,349	39,618	44,730	51,599
4,00,000	3,986	6,726	7,474	8,969	10,899	14,432	17,261	20,756	29,803	35,855	43,912	49,578	57,191
4,50,000	4,156	7,014	7,793	9,352	11,365	15,852	18,959	22,793	32,729	39,361	48,205	54,425	62,784
5,00,000	4,327	7,301	8,113	9,735	11,831	17,272	20,658	24,831	35,655	42,867	52,499	59,273	68,376
6,00,000	4,538	7,658	8,508	10,210	12,408	18,119	21,670	26,044	37,396	45,770	56,055	63,287	73,007
7,00,000	4,749	8,014	8,904	10,685	12,985	18,965	22,682	27,257	39,138	48,673	59,610	67,302	77,637
8,00,000	4,960	8,370	9,300	11,160	13,562	19,812	23,695	28,470	40,880	51,577	63,165	71,316	82,268
9,00,000	5,171	8,726	9,696	11,635	14,140	20,658	24,707	29,683	42,622	54,480	66,721	75,330	86,899
10,00,000	5,382	9,082	10,092	12,110	14,717	21,504	25,719	30,896	44,363	57,383	70,276	79,344	91,529
15,00,000	6,055	10,218	11,353	13,624	16,556	24,193	28,934	34,758	49,909	64,556	79,061	89,262	102,971
20,00,000	6,509	10,984	12,204	14,645	17,798	26,007	31,104	37,365	53,652	69,397	84,991	95,957	110,693
25,00,000	6,834	11,533	12,815	15,378	18,688	27,307	32,660	39,233	56,334	72,867	89,240	100,755	116,228

Zone B

Sum Insured	0-17	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	75+
1,00,000	1,769	2,985	3,317	3,981	4,837	4,951	5,921	7,124	10,229	10,559	12,931	14,600	16,842
1,50,000	2,112	3,563	3,960	4,752	5,776	6,011	7,190	8,650	12,421	14,078	17,242	19,466	22,456
2,00,000	2,454	4,141	4,603	5,524	6,714	7,072	8,458	10,177	14,613	17,598	21,552	24,333	28,070
2,50,000	2,784	4,698	5,221	6,265	7,614	8,487	10,150	12,212	17,535	21,117	25,862	29,199	33,684
3,00,000	3,114	5,254	5,838	7,006	8,514	9,901	11,842	14,248	20,458	24,637	30,173	34,066	39,297
3,50,000	3,259	5,500	6,111	7,333	8,912	11,114	13,293	15,988	22,957	27,632	33,840	38,207	44,074
4,00,000	3,405	5,745	6,384	7,661	9,310	12,327	14,743	17,729	25,457	30,626	37,508	42,348	48,851
4,50,000	3,550	5,991	6,657	7,988	9,708	13,540	16,194	19,469	27,956	33,621	41,175	46,488	53,628
5,00,000	3,696	6,237	6,930	8,315	10,106	14,753	17,645	21,210	30,455	36,616	44,843	50,629	58,404
6,00,000	3,876	6,541	7,268	8,721	10,599	15,476	18,510	22,246	31,943	39,096	47,880	54,058	62,360
7,00,000	4,056	6,845	7,606	9,127	11,092	16,199	19,375	23,282	33,430	41,575	50,917	57,487	66,315
8,00,000	4,237	7,149	7,944	9,532	11,585	16,922	20,239	24,318	34,918	44,055	53,954	60,916	70,271
9,00,000	4,417	7,454	8,282	9,938	12,078	17,645	21,104	25,354	36,406	46,535	56,991	64,344	74,226
10,00,000	4,597	7,758	8,620	10,344	12,571	18,368	21,969	26,390	37,894	49,015	60,028	67,773	78,181
15,00,000	5,172	8,728	9,697	11,637	14,142	20,664	24,715	29,689	42,630	55,141	67,531	76,245	87,954
20,00,000	5,560	9,382	10,425	12,510	15,203	22,214	26,568	31,916	45,828	59,277	72,596	81,963	94,551
25,00,000	5,838	9,851	10,946	13,135	15,963	23,325	27,897	33,511	48,119	62,241	76,226	86,061	99,278

Zone C													
Sum Insured	0-17	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	75+
1,00,000	1,640	2,767	3,074	3,689	4,484	4,588	5,488	6,603	9,481	9,786	11,985	13,531	15,609
1,50,000	1,957	3,303	3,670	4,405	5,353	5,572	6,664	8,017	11,512	13,048	15,980	18,042	20,813
2,00,000	2,275	3,838	4,266	5,120	6,222	6,555	7,839	9,432	13,544	16,310	19,975	22,552	26,016
2,50,000	2,580	4,354	4,839	5,807	7,057	7,866	9,407	11,319	16,252	19,572	23,970	27,063	31,219
3,00,000	2,886	4,870	5,411	6,493	7,891	9,177	10,975	13,205	18,961	22,834	27,965	31,573	36,422
3,50,000	3,021	5,097	5,664	6,797	8,260	10,301	12,320	14,818	21,277	25,610	31,364	35,411	40,849
4,00,000	3,156	5,325	5,917	7,100	8,629	11,425	13,665	16,431	23,594	28,385	34,763	39,249	45,276
4,50,000	3,290	5,553	6,170	7,404	8,997	12,550	15,009	18,045	25,910	31,161	38,163	43,087	49,704
5,00,000	3,425	5,780	6,422	7,707	9,366	13,674	16,354	19,658	28,227	33,937	41,562	46,925	54,131
6,00,000	3,592	6,062	6,736	8,083	9,823	14,344	17,155	20,618	29,606	36,235	44,377	50,103	57,797
7,00,000	3,760	6,344	7,049	8,459	10,280	15,014	17,957	21,578	30,984	38,533	47,191	53,280	61,463
8,00,000	3,927	6,626	7,362	8,835	10,737	15,684	18,758	22,539	32,363	40,832	50,006	56,458	65,129
9,00,000	4,094	6,908	7,676	9,211	11,194	16,354	19,560	23,499	33,742	43,130	52,821	59,636	68,795
10,00,000	4,261	7,190	7,989	9,587	11,651	17,024	20,361	24,459	35,121	45,428	55,635	62,814	72,461
15,00,000	4,793	8,089	8,988	10,785	13,107	19,152	22,906	27,517	39,511	51,107	62,590	70,666	81,518
20,00,000	5,153	8,696	9,662	11,594	14,090	20,589	24,624	29,580	42,474	54,940	67,284	75,966	87,632
25,00,000	5,411	9,130	10,145	12,174	14,795	21,618	25,855	31,059	44,598	57,687	70,648	79,764	92,014

***Note for all premium tables**: Premium for ages 61 years and above are applicable only for Renewals.*

II. OPTIONAL COVER PREMIUM RATES (EXCL. GST)

1. Maternity & New Born Baby Cover

All Zones, All Ages	
Base Sum Insured	Premium rate (Rs.) per family
3,50,000	12,000
4,00,000	13,750
4,50,000	15,500
5,00,000	17,000
6,00,000	20,350
7,00,000	20,600
8,00,000	20,850
9,00,000	21,000
10,00,000	21,200
15,00,000	22,000
20,00,000	23,000
25,00,000	23,500

2. Daily Cash Allowance on Hospitalisation

- **Individual SI policies**
- **All Zones**
- **Premium rates (Rs.) per Insured Person**

Age of Insured Person	Base SI ≤ 5 Lakhs	5 Lakhs < Base SI ≤ 15 Lakhs	Base SI > 15 Lakhs
≤ 50 Years	300	600	1,200
51 – 60 Years	400	800	1,600
> 60 Years	500	1,000	2,000

- **Floater policies**
- **All Zones**
- **Premium rates (Rs.) per family**

Age of Oldest Insured Person	Base SI ≤ 5 Lakhs	5 Lakhs < Base SI ≤ 15 Lakhs	Base SI > 15 Lakhs
≤ 50 Years	400	800	1,600
51 – 60 Years	500	1,000	2,000
> 60 Years	600	1,200	2,400

III. DISCOUNTS

- **Family Discount:** In case a single policy covers more than one member of the family, a discount of 5% is offered on the premium of each and every member of the family. This discount is only applicable for policies taken on Individual Sum Insured basis.
  Note: Family Discount is not applicable on Optional Cover premium rates.

- **Direct Channel Discount**: A discount is applicable for fresh policies purchased online through the Company's website or directly from United India's office, without any agent or an intermediary. For renewals, the discount shall be offered provided that both the renewing policy and expiring policy are without any agent or an intermediary.

- **No Claim Rewards (NCR):** For every claim free year, the policy holder is entitled for NCR either as a No Claim Discount (max up to 50%) or a Cumulative Bonus (max up to 200%).
  Note: No Claim Rewards is not applicable on Optional Cover premium rates.
  Please refer to policy wordings/prospectus for details.

- **Floater Discount**: For policies taken on floater basis, a floater discount is offered on the premium of each and every member of the family as follows:

Family Floater Discount		
Criteria	**Age between 40 years and 50 years**	**All other cases**
One Adult + Any no. of Parents	20%	15%
One Adult + Any number of child	20%	15%
One Adult + Any number of child + Any no. of Parents	30%	30%
Two Adults	30%	25%
Two Adults+ Any no. of children	30%	25%
Two Adults+ Any no. of Parents	30%	30%
Two Adults+ Any no. of children + Any no. of Parents	30%	30%

Note: Floater Discount is not applicable on Optional Cover premium rates.

IV. LOADINGS

We may apply a risk loading on the premium payable (excluding statutory levies & taxes) based on information declared in the proposal form and the health status of the persons proposed for insurance. Loadings will be applied from the Inception Date of the first Policy including subsequent renewal(s).

Note:

- The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Policy Terms and Conditions shall be applied on illness/condition, as applicable.
- Loadings are not applicable on Optional Cover premium rates.

Family Medicare Policy

Benefit/Premium Illustration

Please note:

1. Premium rates specified in the illustrations below are standard premium rates exclusive of any loadings and GST.
2. Rates shown below are for Zone A of FMP.

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	11,952	3,00,000	11,952	5%	11,355	3,00,000	34,222	25%	25,667	3,00,000
40	9,968	3,00,000	9,968	5%	9,470	3,00,000				
21	6.151	3,00,000	6.151	5%	5,843	3,00,000				
18	6,151	3,00,000	6,151	5%	5,843	3,00,000				
Total Premium for all members of the family is Rs. 34,222, when each member is covered separately.			Total Premium for all members of the family is Rs. 32,511, when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 25,667.			
Sum Insured available for each individual is Rs. 3,00,000/-			Sum Insured available for each individual is Rs. 3,00,000/-				Sum Insured of Rs. 3, 00,000 is available for the entire family.			