United India Insurance Company Limited
Corporate Identity Number: U93090TN1938GOI000108
Registered Office: 24 Whites Road, Chennai – 600014
IRDAI REG NO.545
Family Medicare Policy Wordings
UIN: UIIHLIP22070V042122

FAMILY MEDICARE POLICY

I. PREAMBLE

This Policy is a contract of insurance issued by UNITED INDIA INSURANCE COMPANY (hereinafter called the COMPANY) to the Proposer mentioned in the Schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The Policy is based on the statements and declaration provided in the Proposal Form by the Proposer and is subject to

i.
the receipt of full premium,

ii.
disclosure to information norm including the information provided in the Proposal Form by the Insured on behalf of him/her-self and all persons to be Insured which is incorporated in the policy and is the basis of it; and

iii.
the terms, conditions and exclusions of this Policy.

II. OPERATIVE CLAUSE

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

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

III. COVER TYPE

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

IV. DEFINITIONS

A. Standard Definitions

1. ACCIDENT is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. ANY ONE ILLNESS will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment has been taken.
3. CASHLESS FACILITY means a facility extended by the Insurer or TPA on behalf of the Insurer to the Insured, where the payments for the costs of treatment undergone by the Insured in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization is approved.
4. CONDITION PRECEDENT shall mean a policy term or condition upon which the Insurer’s liability under the policy is conditional.

5. CONGENITAL ANOMALY refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
a. Internal Congenital Anomaly: Which is not in the visible and accessible parts of the body.
b. External Congenital Anomaly: Which is in the visible and accessible parts of the body.
6. CO-PAYMENT means a cost sharing requirement under a health insurance policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
7. DAY CARE CENTRE means any institution established for day care treatment of illness and/or injuries or a medical set-up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
i.
Has qualified nursing staff under its employment
ii.
Has qualified Medical Practitioner(s) in charge
iii.
Has a fully equipped operation theatre of its own where surgical procedures are carried out-
iv.
Maintains daily records of patients and will make these accessible to the Insurance Company’s authorized personnel.
8. DAY CARE TREATMENT means medical treatment, and/or surgical procedure which is:
i.
undertaken under general or local anaesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement, and

ii.
which would have otherwise required a hospitalisation of more than twenty-four hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.
9. DEDUCTIBLE is a cost sharing requirement under a Health Insurance Policy that provides that the Insurer will not be liable for a specified rupee amount in case of Indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the Insurer. A deductible does not reduce the sum insured.
10. DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
11. DISCLOSURE TO INFORMATION NORM The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact
12. EMERGENCY CARE Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the Insured person’s health
13. GRACE PERIOD means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
14. HOSPITAL/NURSING HOME means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a Hospital with the local authorities under the Clinical establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under
-
Has qualified nursing staff under its employment round the clock.
-
Has at least 10 in-patient beds in towns having a population of less than 10 lacs and at least 15 in-patient beds in all other places;

-
Has qualified Medical Practitioner(s) in charge round the clock;
-
Has a fully equipped Operation Theatre of its own where surgical procedures are carried out;
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Maintains daily records of patients and makes these accessible to the insurance company’s authorized personnel.
The term ' Hospital / Nursing Home ' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.
For Ayurvedic treatment, hospitalisation expenses are admissible only when the treatment has been undergone in a hospital as defined in clause V.4 below.
15. HOSPITALISATION Means admission in a Hospital/Nursing Home for a minimum period of 24 In-patient care consecutive hours except for the standard day care procedures/treatments as defined above, where such admission could be for a period of less than 24 consecutive hours.
Note: 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.
16. ILLNESS means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering

the disease/ illness/ injury which leads to full recovery
(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. It needs ongoing or long-term control or relief of symptoms
3. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. It continues indefinitely
5. It recurs or is likely to recur
17. INJURY means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
18. IN-PATIENT CARE means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.
19. INTENSIVE CARE UNIT means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
20. INTENSIVE CARE UNIT (ICU) CHARGES means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
21. MATERNITY EXPENSES means;
a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
b. expenses towards lawful medical termination of pregnancy during the policy period.
22. MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
23. MEDICAL EXPENSES means those expenses that an Insured Person has necessarily and actually

incurred for medical treatment on account of illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

24. MEDICALLY NECESSARY TREATMENT is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which is required for the medical management of the illness or injury suffered by the Insured; Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity; Must have been prescribed by a Medical Practitioner; Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

25. MEDICAL PRACTITIONER is a person who holds a valid registration from the Medical Council of any State of India or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The term Medical Practitioner would include Physician, Specialist and Surgeon. The Registered Medical Practitioner should not be the Insured or any member of his family including parents and in-laws.

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

27. NETWORK PROVIDER means the hospital/nursing home or health care providers enlisted by an

Insurer or by a TPA and Insurer together to provide medical services to an Insured on payment by a cashless facility. The list of Network Hospitals is maintained by and available with the TPA and the same is subject to amendment from time to time.
PPN-Preferred Provider Network means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the Insured Person. Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and website of the TPA mentioned in the schedule and is subject to amendment from time to time.
28. NEW BORN BABY means baby born during the Policy Period and is aged upto 90 days.
29. NON-NETWORK HOSPITALS means any hospital, day care centre or other provider that is not part of the network.
30. NOTIFICATION OF CLAIM is the process of notifying a claim to the Insurer or TPA within specified timelines through any of the recognised modes of communication.
31. PORTABILITY means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one Insurer to another Insurer.
32. PRE-EXISTING DISEASE means any condition, ailment, injury or disease:
a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement or
b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement
33. PRE – HOSPITALISATION MEDICAL EXPENSES
Relevant medical expenses incurred immediately 30 days before the Insured Person is hospitalised provided that:
a. Such Medical expenses are incurred for the same condition for which the Insured Person’s Hospitalisation was required; and
b. The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.
34. POST-HOSPITALISATION MEDICAL EXPENSES
Relevant medical expenses incurred immediately 60 days after the Insured Person is discharged from the hospital provided that;

a. Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
b. The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.
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35. QUALIFIED NURSE means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.
36. REASONABLE AND CUSTOMARY CHARGES mean the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/injury involved.
37. RENEWAL defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.
38. ROOM RENT shall mean the amount charged by a hospital for the Occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.
39. SURGERY OR SURGICAL PROCEDURE means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.
B. Specific Definitions
40. AGE means age of the Insured person on last birthday as on date of commencement of the Policy.

41. AIDS means Acquired Immune Deficiency Syndrome, a condition characterised by a combination of signs and symptoms, caused by Human Immunodeficiency Virus (HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions, as may be specified from time to time.
42. ASSOCIATED MEDICAL EXPENSES means hospitalisation related expenses on Surgeon, Anaesthetist, Medical Practitioner, Consultants and Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital; Anaesthetics, blood, oxygen, operation theatre charges, surgical appliances and such other similar expenses with the exception of:
i.
cost of pharmacy and consumables medicines
ii.
cost of implants/medical devices
iii.
cost of diagnostics
The scope of this definition is limited to admissible claims where a proportionate deduction is applicable, as per Note a to Section V.1.1.
43. AYUSH Treatment refers to hospitalisation treatments given Ayurveda, Unani and Homeopathy systems (covered under the Policy).
44. BREAK IN POLICY means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
45. CANCELLATION defines the terms on which the policy contract can be terminated either by the Insurer or the Insured person by giving sufficient notice to other which is not lower than a period of fifteen days.
46. CONTINUOUS COVERAGE means uninterrupted coverage of the Insured Person under the Health Insurance Policy from the date of inception of policy for the first time as mentioned in the policy schedule. However for the purpose of applying waiting periods, the break in insurance period for which the premium was not received shall be excluded from it.
47. INSURED PERSON means person(s) named in the schedule of the Policy.

48. PERIOD OF INSURANCE means the period for which this policy is taken and is in force as specified in the Schedule.
49. POLICY means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover

available to the Insured Person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured Person
50. PSYCHIATRIC DISORDER means clinically significant Psychological or behavioural syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behaviour or an expected response to a stressful life event) as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the Insured Person in respect of whom a claim is lodged.
51. PSYCHOSOMATIC DISORDER means one or more psychological or behavioural problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person’s risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after Physical examination of the Insured Person in respect of whom a claim is lodged.
52. SINGLE OCCUPANCY STANDARD AIR-CONDITIONED ROOM means an individual air-conditioned room for accommodating a single patient with attached wash room. This room may have a television, telephone and a couch. Such room must be the most economical of all such air-conditioned accommodations available in that hospital as single occupancy. This does not include deluxe room /

suite or room with additional facilities other than those stated herein.
53. SUB-LIMIT means a cost sharing requirement under a health insurance policy in which an Insurer would not be liable to pay any amount in excess of the pre-defined limit.
54. SUM INSURED means the pre-defined limit specified in the Policy Schedule that represents, the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the policy period.
55. THIRD PARTY ADMINISTRATOR (TPA) means a company registered under the IRDAI (Third Party Administrators – Health Services) Regulations, 2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purpose of providing health services as defined in the regulations.
56. WAITING PERIOD means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
57. WE/OUR/US/COMPANY means UNITED INDIA INSURANCE COMPANY LIMITED
58. YOU/YOUR means the person who has taken this Policy and is shown as Insured Person or the first Insured Person (if more than one person covered in the policy) in the Schedule.

V. COVERAGE
The coverages available under this Policy are described below.
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 and are incurred on Medically Necessary Treatment of the Insured Person.

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 Medically Necessary Treatment taken during Hospitalisation provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy Year:

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

Sum Insured	Limit (Rs.) per day
< Rs. 5 Lacs	1% of Sum Insured
Rs. 5 Lacs and Above	1% of Sum Insured or Single Occupancy Standard Air-Conditioned 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.

B. Charges for accommodation in Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) upto the limits provided below:

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

C. The fees charged by the Medical Practitioner, Surgeon, Specialists and anaesthetists treating the Insured Person;
D. Operation theatre charges,
E. Anaesthesia, 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, orthopaedic 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.
1.1 Note:
a. PROPORTIONATE PAYMENT CLAUSE: In case of admission to a room at rates exceeding the aforesaid limits in Clause V.1.A, 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.
b. No payment shall be made under 1.C other than as part of the hospitalisation bill. However, the bills raised by Surgeon, Anaesthetist directly and not forming part of the hospital bill shall be paid provided a pre-numbered bill/receipt is produced in support thereof, when such payment is made ONLY by cheque/ credit card/debit card or digital/online transfer.

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 upto 25% of Sum Insured subject to a maximum of Rs.

3,00,000 per policy year;
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. Day Care Treatment Cover-
We will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:
i.
The Medical Expenses are incurred in case of Day Care Treatment or Surgery undertaken for the Illness/ condition covered under Base Cover that requires less than 24 hours Hospitalisation due to advancement in technology, including for any procedure which requires a period of specialized observation or care after completion of the procedure undertaken by an Insured Person as Day Care Treatment. All Day Care Treatments as defined in the Section IV.A.8 of the policy above are covered.
ii.
The Day Care Treatment is for Medically Necessary Treatment and follows the written Medical Advice;

iii.
Procedures/treatments usually done on out-patient basis are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours or carried out in Day Care Centres. Diagnostic Services are also not covered under this benefit.

3. 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 upto 30 days prior to hospitalisation; and
b. Post- hospitalisation Medical Expenses incurred due to an Illness or Injury during the period upto 60 days after the discharge from the hospital,
Subject to a maximum of 10% of Sum Insured, provided that:
i.
We have accepted a claim for primary In-patient Hospitalization under Section V.1 or V.2 above;
ii.
The Pre-hospitalisation and Post-hospitalisation Medical Expenses are related to the same Illness or Injury.
iii.
The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Any One Illness.

4. Ayurvedic/Homeopathic/Unani treatment –
We will pay the reasonable & customary Charges incurred as in-patient for an Insured Person in case of Medically Necessary Treatment taken during Hospitalisation subject to the limits linked to the Sum Insured, as mentioned in the table below;
Sum Insured (Rs.)
Limit per Policy Period (Rs.)- Upto
Upto 3,00,000
10,000

>3,00,000 to 15,00,000
15,000
>15,00,000
25000

Subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in an AYUSH HOSPITAL as defined hereunder:

AYUSH HOSPITAL is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising any of the following
i.
Central or State Government AYUSH Hospital; or
ii.
Teaching hospital attached to AYUSH College recognised by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
iii.
AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognised system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with the following criterion

•
Having at least 5 in-patient beds;
•
Having qualified AYUSH Medical Practitioner in charge round the clock;
•
Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are carried out;
•
Maintaining daily records of the patients and making them accessible to the insurance company's authorised representative.

5. 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. 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.

7. 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 Section V.1 or V.2 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.

8. Cost of Health Check-up
Expenses incurred towards cost of health check-up up to 1% of average Sum Insured of preceding 3 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 floater 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 sum Insured.
In case of the policy on floater 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. Modern Treatment Methods & Advancement in Technologies:
In case of an admissible claims under Section V.1/ V.2 as applicable, 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 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 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 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 per policy period for claims involving Robotic Surgeries for other diseases

H

Stereotactic Radio Surgeries

Upto 50% of Sum Insured 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 Neuro Monitoring (IONM)

Upto 15% of Sum Insured per policy period for claims
involving Intra Operative Neuro Monitoring
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Stem Cell Therapy: Hematopoietic stem cells
for bone marrow transplant for
haematological conditions to be covered only
No additional sub-limit

Note on Co-payment:
For persons with age of entry above 60 years in Family Medicare Policy, every admissible claim under Base Cover 1 to 5, 7 and 9 above shall be subject to a Co-payment of 10% on the admissible claim amount.

OPTIONAL COVERS:
10. Restoration of Sum Insured
If the Basic Sum Insured is exhausted completely or partially due to claims made and paid/ accepted as payable during the Policy Year, then it is agreed that a Restore Sum Insured equal to 100% of the Basic Sum Insured will be automatically and instantly available for the particular Policy Year, provided that:
a. In case of policies on Individual Sum Insured basis the Restore sum insured, will be available to each Insured Person individually and in case of a floater policy, the restore Sum Insured will be

available for all Insured Persons on floater basis.
b. A single claim in a Policy Year cannot exceed the Basic Sum Insured.
c. Such restored Sum Insured can be utilized only for illness / disease unrelated to the illness / diseases for which claim(s) was / were made.
d. The Restoration of Sum Insured will be applied only once during a Policy Year for family floater policy. For Policy on Individual Sum Insured basis, the restore facility will be available once to each Insured Person individually in a policy year.
e. If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

10.1 Automatic Restoration of Basic Sum Insured is available only for sum insured options from Rs. 3,00,000 and above.

10.2 For persons with age of entry above 60 years in Family Medicare Policy, every admissible claim under this optional cover shall be subject to a Co-payment of 10% on the admissible claim amount.

11. 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 Lacs, 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. 40000 in case of normal delivery and Rs. 60000 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 upto 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 clause 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.

11.1
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 these two clauses.
vi.
Subject to the terms & conditions, the Policy covers New Born Baby beyond 90 days only on payment of requisite premium.
If this Option is in force in respect of the Insured Person, then the relevant part of Exclusion VI.B.14 will be deemed inoperative for the purpose of this Option.

12. 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
Upto Rs. 5 Lacs
Rs. 500 per day subject to a maximum of Rs. 5000 per policy period
Above Rs. 5 Lacs and upto
Rs. 15 Lacs

Rs. 1000 per day subject to a maximum of Rs. 10000 per policy period
Above Rs. 15 Lacs and upto
Rs. 25 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. Deductible equivalent to Daily Cash Allowance for the first 24 hours Hospitalization will be levied on each Hospitalisation during the Policy Period.

VI. STANDARD EXCLUSIONS & WAITING PERIODS
A. WAITING PERIODS
The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

1. Pre-Existing Disease (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.

2. Specific Disease/ Procedure Waiting Period (Code- Excl02):
a. 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 48 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.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. 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.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures:

Table A. Two years waiting period
1. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
10. Piles, Fissures and Fistula-in-ano;

Pilonidal sinus
2. Benign ENT disorders
11. Prolapse intervertebral Disc and Spinal Diseases unless arising from Accident
3. Benign prostatic hypertrophy
12. Benign Skin Disorders
4. Cataract
13. Calculus diseases
5. Acid Peptic diseases
14. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapse of uterus
6. Gout and Rheumatism
15. Any treatment for varicose veins and ulcers including surgical intervention
7. Hernia of all types
16. Polycystic ovarian disease
8. Hydrocele
17. Internal Congenital Anomaly
9. Non infective Arthritis

Table B. Four years waiting period
1. Joint Replacement due to Degenerative condition, unless necessitated due to an accident.
2. Age-related Osteoarthritis & Osteoporosis
3. Age-related Macular Degeneration (ARMD)
4. Named Mental Illnesses:
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)
5. All Neurodegenerative disorders

3. First Thirty Days Waiting Period (Code- Excl03):
a. 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.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

The exclusions under VI.A.1-3 are subject to Portability Regulations.
B. STANDARD PERMANENT EXCLUSIONS
The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:
1. Investigation & Evaluation (Code- Excl04):
a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are

excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
2. Rest Cure, rehabilitation and respite care (Code- Excl05): Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
3. Obesity/ Weight Control (Code- Excl06): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
A. Surgery to be conducted is upon the advice of the Doctor
B. The surgery/procedure conducted should be supported by clinical protocols
C. The member has to be 18 years of age or older and
D. Body Mass Index (BMI);
a. greater than or equal to 40 or
b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i.
Obesity-related cardiomyopathy
ii.
Coronary heart disease
iii.
Severe Sleep Apnoea
iv.
Uncontrolled Type2 Diabetes
4. 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.

5. Cosmetic or Plastic Surgery (Code- Excl08): Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident, burn(s) or cancer or as part of

medically necessary treatment. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
6. 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.
7. 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.
8. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12)
9. 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)
10. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure. (Code- Excl14)
11. Refractive Error (Code- Excl15): Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

12. 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.
13. 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
14. 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

15. All expenses caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped power.
16. 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.
17. a) Stem cell implantation/Surgery/therapy, harvesting, storage or any kind of Treatment using stem cells except as provided for in Clause V.9.L above; b) growth hormone therapy.

18. Congenital External Diseases, Defects or anomalies.
19. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
20. Cost of routine medical examination and preventive health check-up unless as provided for in Base Cover V.8
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21. Vaccination or inoculation of any kind unless it is post animal bite.
22. Routine eye-examinations, cost of spectacles, contact lenses.
23. a) Cost of hearing aids; including optometric therapy; b) cochlear implants unless necessitated by an Accident or required intra-operatively.
24. Dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalisation.
25. Any treatment related to sleep disorder or sleep apnoea syndrome
26. Intentional self-inflicted Injury, attempted suicide.
27. Treatments other than Allopathy and Ayurvedic, Homeopathic & Unani branches of medicine.
28. Any expenses incurred on Domiciliary Hospitalization
29. Any expenses incurred on Out-patient treatment (OPD treatment)
30. Unless used intra-operatively, any expenses incurred on prosthesis, corrective devices; 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 and

please refer to Annexure-1 for the complete list of non-payable items.
31. Change of treatment from one system of medicine to another system unless recommended by the consultant/hospital under whom the treatment is taken.
32. 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.
33. 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
34. Any item(s) or treatment specified in 'list of expenses (non-medical) – payable/ non-payable' as per Annexure-1 and available on Company web site also, unless specifically covered under the Policy.

VII. TERMS AND CLAUSES
A. STANDARD GENERAL TERMS AND CLAUSES

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

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

3. Claim Settlement (provision for Penal Interest)
i.
The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii.
In the case of delay in the payment of a claim, the Company shall be liable to pay interest to

the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii.
However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
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iv.
In case of delay beyond stipulated 45 days, the company shall be liable to pay interest to the Policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

4. Multiple Policies:
i.
ln case of multiple policies taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Insured Person shall have the right to require a

settlement of his/her claim in terms of any of his/her policies. ln all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii.

lnsured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii.

If the amount to be claimed exceeds the sum insured under a single policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

iv.

Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

5. Fraud:

lf any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/Policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance policy:

a)

the suggestion, as a fact of that which is not true and which the Insured Person does not

believe to be true;
b)
the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
c)
any other act fitted to deceive; and
d)
any such act or omission as the law specially declares to be fraudulent
The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

6. 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 below:

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CANCELLATION AFTER PERIOD ON RISK
RATE OF PREMIUM TO BE REFUNDED

Upto one month
3/4th of the annual rate
>one month and upto three months 1/2 of the annual rate
>three months and upto six months 1/4th of the annual rate
Exceeding six months
No refund

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

7. Migration:
The Insured Person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. lf 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

8. 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

9. Renewal of Policy:
The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation 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

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

11. 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.

12. 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 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. lf 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;

13. Redressal of grievance
In case of any grievance the Insured Person may contact the Company through:

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

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

refer
the
link
https://uiic.co.in/en/customercare/grievance

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Insurance Ombudsman offices have been provided as Annexure-2.

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

14. 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. ln the event of death of the Policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder

whose discharge shall be treated as full and final discharge of its liability under the policy.

B. SPECIFIC TERMS AND CLAUSES

15. Claim Procedure
a. Notification of claim
Upon the happening of any event which may give rise to a claim under this Policy, the Insured Person/Insured Person's representative shall notify the TPA (if claim is processed by TPA)/company (if claim is processed by the company) in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:
i.
Within 24 hours from the date of emergency hospitalization 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 Hospitalization.

b. Procedure for Cashless claims

i.
Cashless facility for treatment in network hospitals only shall be available to Insured if opted for claim processing by TPA.
ii.
Treatment may be taken in a network provider/PPN hospital and is subject to pre authorization by the TPA. Booklet containing list of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the TPA mentioned in the schedule.

iii.
Call the TPA’s toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference
iv.
On admission in the network provider/PPN hospital, produce the ID card issued by the TPA at the Hospital Helpdesk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.
v.
The TPA upon getting cashless request form and related medical information from the Insured Person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
vi.
At the time of discharge, the Insured Person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
vii.
The TPA reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.
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viii.
Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor’s

advice and submit the claim documents to the TPA for possible reimbursement.

c. Procedure for reimbursement of claims

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 (if claim is processed by TPA)/company (if claim is processed by the company) 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.

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.

d. Documents

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

i.

Duly completed claim form

ii.

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.

iii.

Medical history of the patient recorded, bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.

iv.

Discharge certificate/ summary from the hospital.

v.

Cash-memo from the Diagnostic Centre(s)/ hospital(s)/ chemist(s) supported by proper prescription.

vi.

Payment receipts from doctors, surgeons and anaesthetist.

vii.

Bills, receipt, Sticker of the Implants.

viii.

Any other document required by company/ TPA

Note

In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other Insurer, the company may accept the duly certified documents listed under condition VII.6.d and claim settlement advice duly certified by the other Insurer subject to satisfaction of the company.

e. Time Limits for Submission of Documents:

Type of claim	Time limit for submission of documents to company/TPA
Reimbursement of hospitalisation and pre hospitalisation expenses (limited to 30 days)	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post-hospitalisation expenses (limited to 60 days)	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
Note:
i.
Waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
United India Insurance Company Limited
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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.
All the documents submitted to TPA shall be electronically collected by us for settlement/denial of the claims by the appropriate authority.
v.
Any medical practitioner or Authorised Person authorised by the TPA / Company shall be

allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

f. 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.

16. Premium:
a. Unless full premium is paid before commencement of risk, this Policy shall have no effect.

b. Premium can be paid online for both, new policy and renewals.
c. PAN details must be submitted by the Insured. In case PAN is not available, Form 60 or Form 61 must be submitted.
d. Tax rebate available as per provision of Income Tax rules under Section 80-D.

17. Place of treatment and Payment:
a. This Policy covers only medical/surgical treatment taken in India.
b. Admissible claims shall be payable only in Indian Rupees.
c. Payment shall be made directly to Network Hospital if cashless facility is applied for before treatment and accepted by TPA. If TPA does not accept the request for Cashless facility, bills shall be submitted after payment under Reimbursement. However, submission of claim papers does

not mean admission of claim.

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

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

Policy issued shall constitute complete contract of insurance.

20. Change of Sum Insured

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

21. Arbitration
i.
If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two

arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

ii.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

iii.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

22. Limitation:

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

VIII. LOADING & DISCOUNTS

a. No Claim Discount

The Insured shall be entitled for No Claim Discount of 5% every claim free year under Family Medicare Policy on renewal premium and for every subsequent claim free year subject to a maximum of 15%.

N.B: No Claim Discount will be withdrawn if policy is not renewed within the grace period allowed under the policy or in the event of any claim reported under the expiring policy.

b. Family Discount

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

c. 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 online through the Company's website and all subsequent renewals are only made through the Company's website.

d. 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. However, maximum risk loading per individual shall not exceed 50% of Premium excluding applicable Taxes. 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 upto a maximum of 50% of premium.

Details of applicable loadings by ailments/ condition are listed as under:

S.No.

List of Acceptable Conditions
(subject to other co-existing conditions)
Applicable
Underwriting
Loading (%)
1
Haemolytic Anaemia
10
2
Asthma
10
3
Epilepsy
10
4
Renal Stones
10
5
Diabetes Mellitus
20
6
Hypertension
20

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

IX. IRDAI REGULATIONS

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

* * * * * * * * * * *

United India Insurance Company Limited
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UNITED INDIA INSURANCE COMPANY LIMITED
Policy Issuing Office Address
PH: (****) ******* EMAIL:****@****

FAMILY MEDICARE POLICY
UIN NO. UIIHLIP22070V042122
POLICY NO.:

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

Insured
Name

Address

Agent Name

:
Agent Code

:
Mobile/Landline Number/Email
: /

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

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

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

REGD. & HEAD OFFICE, 24, WHITES ROAD, CHENNAI – 600014Website: http://www.uiic.co.in
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Registered Office: 24 Whites Road, Chennai – 600014
IRDAI REG NO.545

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FAMILY MEDICARE POLICY SCHEDULE

Policy Number

Previous Policy No
Name/ID Of Insured

Tel. (O)

Tel(R)

Fax

Business/Occupation
None
Mobile

Email

Period Of Insurance
From --:-- Hrs of dd/mm/yyyy

To Midnight of dd/mm/yyyy
Policy Type

Individual Sum Insured Basis/ Family Floater Basis

Insured Details

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

3

4

Sl no
Insured Name
Sum Insured

Premium
Restore
Premium if
opted for
Hospital Daily
cash Limit (per
day/per policy)
Hospital Daily
cash Premium
if opted for
Maternity Exp. & New
Born Baby Cover
Premium if opted for
Pre-Existing
Disease/
condition loading
Inception
Date of
first policy
1

2

3

4

Total Basic Premium

Net Premium

Add Hospital Daily Cash Premium

Add CGST@ 9% of Premium

Add Maternity Expenses/ New Born Baby Cover Premium

Add SGST @ 9% of Premium

Add Restore Premium

Total Premium Payable

Add PED Loading

Receipt No

Less No Claim Discount

Less Family Discount

Receipt Date

Agent Name

Agent/Broker Code

Agent Contact Number

Dev Officer Code

Customer GST No.:

Office GST No.:

SAC Code:

Invoice No. & Date:

Amount Subject to Reverse Charges

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

QR

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

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

Authorised Signatory.

Affix
Policy
Stamp
Here
United India Insurance Company Limited
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POLICY NO.:
UIN:
Details of TPA
Please contact the following TPA for Issue of Identity Cards, Cashless Approvals & Claims Settlement.

Name of TPA

Address

Toll Free number

Contact Details
For General
Enquiries
For Cashless approval
For Claim intimation
For Grievances
Telephone
Numbers

Email IDs

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ANNEXURE – 1

FAMILY MEDICARE POLICY

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

List I – Optional Items

Sr. No	Item	Payable / Not Payable
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERVICES	Not Payable
4	BELTS/ BRACES	Payable for cases who have undergone surgery of thoracic or lumbar spine.
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7		

CARRY BAGS
Not Payable
8
EMAIL / INTERNET CHARGES
Not Payable
9
FOOD CHARGES (OTHER THAN PATIENT’S DIET PROVIDED BY HOSPITAL)
Not Payable
10
LEGGINGS
Payable in case of varicose vein surgery
11
LAUNDRY CHARGES
Not Payable
12
MINERAL WATER
Not Payable
13
SANITARY PAD
Not Payable
14
TELEPHONE CHARGES
Not Payable
15
GUEST SERVICES
Not Payable
16
CREPE BANDAGE

Not Payable
17
DIAPER OF ANY TYPE
Not Payable
18
EYELET COLLAR
Not Payable
19
SLINGS
Reasonable costs for one sling in case of upper arm fractures is payable
20
BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
Part of Cost of Blood, not payable
21
SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
Part of room charge not payable separately
22
Television Charges
Payable under room charges not if separately levied
23
SURCHARGES
Part of Room Charge, Not payable separately
24
ATTENDANT CHARGES
Not Payable - Part of Room Charges
25

EXTRA DIET OF PATIENT (OTHER THAN THAT
WHICH FORMS PART OF BED CHARGE)
Not Payable; however, Patient Diet as covered under clause
V.1.A provided by hospital only is payable
26
BIRTH CERTIFICATE
Not Payable
27
CERTIFICATE CHARGES
Not Payable
28
COURIER CHARGES
Not Payable
29
CONVEYANCE CHARGES
Not Payable
30
MEDICAL CERTIFICATE
Not Payable
31
MEDICAL RECORDS
Not Payable
32
PHOTOCOPIES CHARGES
Not Payable
33
MORTUARY CHARGES
Payable up to 24 hours, shifting charges not payable
34

WALKING AIDS CHARGES
Not Payable
35
OXYGEN CYLINDER (FOR USAGE OUTSTDE
THE HOSPITAL)
Not Payable
36
SPACER
Not Payable
37
SPIROMETRE
Device not payable
38
NEBULIZER KIT
Not Payable
39
STEAM INHALER
Not Payable

40
ARMSLING

Not Payable
41
THERMOMETER
Not Payable
42
CERVICAL COLLAR
Not Payable
43
SPLINT
Not Payable
44
DIABETIC FOOT WEAR
Not Payable
45
KNEE BRACES (LONG/ SHORT/ HINGED)
Not Payable
46
KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
Not Payable
47
LUMBO SACRAL BELT
Payable for cases who have undergone surgery of lumbar spine.
48
NIMBUS BED OR WATER OR AIR BED
CHARGES
Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at a reasonable cost of approximately Rs 200/- day
49

AMBULANCE COLLAR
Not Payable
50
AMBULANCE EQUIPMENT
Not Payable
51
ABDOMINAL BINDER
Payable for cases who have undergone surgery of lumbar spine.
52
PRIVATE NURSES CHARGES- SPECIAL
NURSING CHARGES
Payable in post-hospitalisation
53
SUGAR FREE Tablets
Payable -Sugar free variants of admissible medicines are not
excluded
54
CREAMS POWDERS LOTIONS (Toiletries are
not payable, only prescribed medical
pharmaceuticals payable)
Payable when prescribed
55
ECG ELECTRODES
Up to 5 electrodes are required for every case visiting OT or ICU.
For longer stay in ICU, may require a change and at least one set
every second day is payable.
56
GLOVES
Sterilized Gloves payable / unsterilized gloves not payable

57
NEBULISATION KIT
Payable reasonably if used during hospitalisation
58
ANY KIT WITH NO DETAILS MENTIONED
[DELIVERY KIT, ORTHOKIT, RECOVERY KIT,
ETC]
Not Payable
59
KIDNEY TRAY
Not Payable
60
MASK
Not Payable
61
OUNCE GLASS
Not Payable
62
OXYGEN MASK
Not Payable
63
PELVIC TRACTION BELT
Payable in case of PIVD requiring traction
64
PAN CAN
Not Payable
65
TROLLEY COVER
Not Payable

66
UROMETER, URINE JUG
Not Payable
67
AMBULANCE
Payable
68
VASOFIX SAFETY
Payable - maximum of 3 in 48 hours and then 1 in 24 hours

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

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

EAU DE-COLOGNE / ROOM FRESHNERS
8
FOOT COVER
9
GOWN
10
SLIPPERS
11
TISSUE PAPER
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12
TOOTH PASTE
13
TOOTH BRUSH
14
BED PAN
15
FACE MASK
16
FLEXI MASK
17

HAND HOLDER
18
SPUTUM CUP
19
DISINFECTANT LOTIONS
20
LUXURY TAX
21
HVAC
22
HOUSE KEEPING CHARGES
23
AIR CONDITIONER CHARGES
24
IM IV INJECTION CHARGES
25
CLEAN SHEET
26
BLANKET/WARMER BLANKET
27
ADMISSION KIT
28
DIABETIC CHART CHARGES
29
DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30
DISCHARGE PROCEDURE CHARGES
31
DAILY CHART CHARGES

32
ENTRANCE PASS / VISTOR’S PASS CHARGES
33
EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34
FILE OPENING CHARGES
35
INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36
PATIENT IDENTIFICATION BAND / NAME TAG
37
PULSE OXIMETER CHARGES

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

Sr. No
Item
1
HAIR REMOVAL CREAM
2
DISPOSABLES RAZORS CHARGES (for site preparations)
3
EYE PAD
4
EYE SHIELD
5
CAMERA COVER
6
DVD, CD CHARGES

7
GAUZE SOFT
8
GAUZE
9
WARD AND THEATRE BOOKING CHARGES
10
ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11
MICROSCOPE COVER
12
SURGICAL BLADES, HARMONIC SCALPEL, SHAVER
13
SURGICAL DRILL
14
EYE KIT
15
EYE DRAPE
16
X-RAY FILM
17
BOYLES APPARATUS CHARGES
18
COTTON
19
COTTON BANDAGE
20
SURGICAL
21

APRON
22
TORNIQUET
23
ORTHOBUNDLE, GYNAEC BUNDLE

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

Sr. No
Item
1
ADMISSION/REGISTRATION CHARGS
2
HOSPITALISATION FOR EVALUATION/DIAGNOSTIC PURPOSE
3
URINE CONTAINER
4
BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5
BIPAP MACHINE

6
CPAP/ CAPD EQUIPMENTS
7
INFUSION PUMP-COST
8
HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC
9
NUTRITION PLANNING CHARGES – DIETICIAN CHARGES, DIET CHARGES
10
HIV KIT
11
ANTISEPTIC MOUTHWASH
12
LOZENGES
13
MOUTH PAINT
14
VACCINATION CHARGES
15
ALCOHOL SWABS
16
SCRUB SOLUTIONS / STERILLIUM
17
GLUCOMETER & STRIPS
18
URINE BAG

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Annexure-2
The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction
Office of the Insurance Ombudsman
Gujarat , UT of Dadra and
Nagar Haveli, Daman and
Diu
Office of the Insurance Ombudsman, Jeevan
Prakash Building, 6th floor, Tilak Marg, Relief
Road, Ahmedabad – 380 001.
Tel No: 079 - 25501201/02/05/06.
Email:bimalokpal.ahmedabad@ecoi.co.in
Karnataka
Office of the Insurance Ombudsman, Jeevan
Soudha Building, PID No. 57-27-N-19 Ground
Floor, 19/19, 24th Main Road, JP Nagar, Ist
Phase, Bengaluru – 560 078.
Tel.: 080 - 26652048 / 26652049.

Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and
Chhattisgarh
Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.
Tel.: 0755 - 2769201 / 2769202. Fax: 0755 – 2769203
Email: bimalokpal.bhopal@ecoi.co.in
Odisha
Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009.
Tel.: 0674 - 2596461 /2596455. Fax: 0674 – 2596429
Email:bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana,
Himachal Pradesh, Jammu
and Kashmir, UT of
Chandigarh
Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017.
Tel.: 0172 - 2706196 / 2706468. Fax: 0172 – 2708274
Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, UT–
Pondicherry Town and
Karaikal (which are part of

UT of Pondicherry)
Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.
Tel.: 044 - 24333668 / 24335284. Fax: 044 – 24333664
Email: bimalokpal.chennai@ecoi.co.in
Delhi
Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.
Tel.: 011 - 23232481/23213504.
Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya,
Manipur, Mizoram,
Arunachal Pradesh,
Nagaland and Tripura
Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (ASSAM).
Tel.: 0361 - 2632204 / 2602205.
Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh,
Telangana and UT of
Yanam – a part of the UT
of Pondicherry
Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad

- 500 004.
Tel.: 040 - 67504123 / 23312122. Fax: 040 – 23376599
Email: bimalokpal.hyderabad@ecoi.co.in

Rajasthan

Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.
Tel.: 0141 – 2740363.
Email: Bimalokpal.jaipur@ecoi.co.in

Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry

Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.
Tel.: 0484 - 2358759 / 2359338. Fax: 0484 – 2359336
Email: bimalokpal.ernakulam@ecoi.co.in

West Bengal, UT of Andaman and Nicobar Islands, Sikkim

Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.
Tel.: 033 - 22124339 / 22124340. Fax: 033 - 22124341

Email: bimalokpal.kolkata@ecoi.co.in
istricts of Uttar Pradesh :
Laitpur, Jhansi, Mahoba,
Hamirpur, Banda,
Chitrakoot, Allahabad,
Mirzapur, Sonbhabdra,
Fatehpur, Pratapgarh,
Jaunpur,Varanasi, Gazipur,
Jalaun, Kanpur, Lucknow,
Unnao, Sitapur,
Lakhimpur, Bahraich,
Barabanki, Raebareli,
Sravasti, Gonda, Faizabad,
Amethi, Kaushambi,
Balrampur, Basti,
Ambedkarnagar,
Sultanpur, Maharajgang,
Santkabirnagar, Azamgarh,
Kushinagar, Gorkhpur,
Deoria, Mau, Ghazipur,
Chandauli, Ballia,
Sidharathnagar.
Office of the Insurance Ombudsman, 6th Floor,
Jeevan Bhawan, Phase-II, Nawal Kishore Road,
Hazratganj, Lucknow - 226 001.
Tel.: 0522 - 2231330 / 2231331. Fax: 0522 -
2231310
Email: bimalokpal.lucknow@ecoi.co.in
Goa,

Mumbai Metropolitan
Region
excluding
Navi
Mumbai & Thane
Office of the Insurance Ombudsman, 3rd Floor,
Jeevan Seva Annexe, S. V. Road, Santacruz (W),
Mumbai - 400 054.
Tel.: 022 - 26106552 / 26106960. Fax: 022 -
26106052
Email: bimalokpal.mumbai@ecoi.co.in
State of Uttarakhand and
the following Districts of
Uttar Pradesh:
Agra, Aligarh, Bagpat,
Bareilly, Bijnor, Budaun,
Bulandshehar, Etah,
Kannauj, Mainpuri,
Mathura, Meerut,
Moradabad,
Muzaffarnagar, Oraiyya,
Pilibhit, Etawah,
Farrukhabad, Firozbad,
Gautambodhanagar,
Ghaziabad, Hardoi,
Shahjahanpur, Hapur,
Shamli, Rampur,
Kashganj, Sambhal,
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