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

FAMILY MEDICARE POLICY – PROSPECTUS

I. PRODUCT- KEY FEATURES

The Policy provides cover on an Individual or Family Floater basis. A separate Sum Insured for each Insured Person 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.

Basic Cover:

1. In-patient Hospitalization	6. Organ Donor Benefit- When Insured Person is the Donor
2. Day care Treatment	7. Road Ambulance Cover
3. Pre and post-hospitalization expenses	8. Cost of Health Check-up
4. Ayurvedic/Homeopathic/Unani treatment	9. Modern Treatment Methods & Advancement in Technologies
5. Organ Donor's expenses cover	

Optional Cover on additional premium:

10. Restoration of Sum Insured	12. Daily Cash Allowance on Hospitalisation
11. Maternity Expenses and New Born Baby Cover	

II. ELIGIBILITY

a. Any person aged between 18 years and 65 years can take this insurance for himself and his/her family consisting of Self, Spouse and dependent children either on Individual Sum Insured basis or on floater basis. Beyond 65 years, only renewals are allowed.

b. Dependent children between the age of 91 days and 18 years shall be covered provided either or both parents are covered concurrently. Children above 18 years will continue to be covered along with parents till 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 age above 26 years, a separate policy can be taken on expiry of the current policy for which continuity benefits will be provided.

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

III. SUM INSURED

Various options are available as under:
Rs. 3 lacs, 4 lacs, 5 lacs, 6 lacs, 7 lacs, 8 lacs, 9 lacs, 10 lacs, 15 Lacs, 20 Lacs & 25 Lacs.

IV. TERM OF POLICY

One Year. Renewable annually.

V. PRE–ACCEPTANCE MEDICAL CHECK–UP

Pre–acceptance medical check–up may be required at the Company's discretion for all the members entering after the age of 60 years.

Any person may also need to undergo this pre–acceptance medical check–up if he/she has an adverse medical history as revealed from the proposal form. The cost of this check–up will be borne by the proposer. But if the proposal is accepted, then 50% of the cost of this check–up will be reimbursed to the proposer.

Pre–acceptance medical check–up shall be conducted at designated centres authorized by Us.

VI. COVERAGE

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 period:

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, 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 and such other similar medical expenses related to the treatment.

1.1

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 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 policy are covered.
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 Pre-hospitalization Medical Expenses incurred due to an Illness or Injury that occurs during the period upto 30 days prior to hospitalisation and Post- hospitalization Medical Expenses incurred due to an Illness or Injury that occurs during the period upto 60 days after the discharge from the hospital, subject to a maximum of 10% of Sum Insured.

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 policy and as also in table of benefits.

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.
We will not cover:

a. Pre-hospitalization Medical Expenses or Post-hospitalization 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 VI.1 or VI.2 and the expenses are related to the same Illness or Injury.

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. 5000 per person for policies issued on individual sum insured basis / Rs. 10000 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 network 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 form part of the sum insured and will not impact the Bonus.
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.

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 Sub-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
L	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.

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 VII.B.7 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 the first 24 hours Hospitalization benefit will be levied on each and every Hospitalisation during the Policy Period.

VII. WHAT POLICY DOES NOT COVER:

A. WAITING PERIOD - EXCLUSIONS

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

1. Pre-Existing Diseases (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 VII.A.1-3 are subject to portability regulations.

B. PERMANENT EXCLUSIONS

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

1. 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.
2. 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.
3. a) Stem cell implantation/Surgery/therapy, harvesting, storage or any kind of Treatment using stem cells except as provided for in Clause VI.10.L above; b) growth hormone therapy.
4. Congenital External Diseases, Defects or anomalies.
5. Sterility and Infertility **(Code- Excl17)**: Expenses related to sterility and infertility. This includes:
    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization
6. 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.
7. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
8. Cost of routine medical examination and preventive health check-up unless as provided for in Base Cover VI.8 above
9. Investigation & Evaluation **(Code- Excl04)**:
    a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded even if the same requires confinement at a Hospital.
    b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
10. 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.
11. 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.

12. 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.
13. Vaccination or inoculation of any kind unless it is post animal bite,
14. Routine eye examinations, cost of spectacles, contact lenses;
15. Refractive Error **(Code- Excl15)**: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
16. a) Cost of hearing aids; including optometric therapy; b) cochlear implants unless necessitated by an Accident or required intra-operatively.
17. Dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalisation.
18. 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.
19. 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
20. Any treatment related to sleep disorder or sleep apnoea syndrome
21. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**
22. Intentional self-inflicted Injury, attempted suicide.
23. 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.
24. 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)**.
25. Treatments other than Allopathy and Ayurvedic, Homeopathic & Unani branches of medicine.
26. Any expenses incurred on Domiciliary Hospitalization
27. Any expenses incurred on Out-patient treatment (OPD treatment)
28. 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)**
29. 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.

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 of the Policy 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 such as 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 of the Policy and available on Company web site also, unless specifically covered under the Policy.

VIII. 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 as detailed below, wherever required at Company's discretion, have to be submitted at proposer's cost in the following cases–
   i. Persons with adverse medical history (fresh entrants)
   ii. Persons above 60 years of age (fresh entrants)
   iii. Persons above 60 years of age (Break in insurance)
   iv. Persons seeking enhancement of Sum Insured.

a. Physical examination (report to be signed by the Doctor with minimum MD/MS qualification	f. Serum Creatinine
b. CBC	g. SGOT & SGPT
c. Urine Routine & Microscopic	h. ECG
d. HbA1c (Glycosylated Hemoglobin)	i. Stress Test if necessitated.
e. Lipid Profile	j. Any other investigation required by the company

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

NOTE: 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.

IX. PAYMENT OF PREMIUM

i. Premium payable annually – As per Premium Table attached.
ii. Premium can be paid online for both, new policy and renewals.
iii. The Insured shall be entitled for No Claim Discount of 5% after every claim free year under Family Medicare Policy on renewal premium and for every subsequent claim free year subject to a maximum of 15%.
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
iv. 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.

v. 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.

vi. **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 on the total premium upto a maximum of 50% of premium.

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

X. CANCELLATION CLAUSE

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

CANCELLATION AFTER PERIOD ON RISK	RATE OF PREMIUM TO BE REFUNDED
Upto one month	3/4 th 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.

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

XI. 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. If the Insured has not made any claim during the Free Look Period, the Insured shall be entitled to

i. A refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or

ii. Where the risk has already commenced and the option of return of the policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

XII. RENEWAL OF POLICY

The policy shall ordinarily be renewable except on misrepresentation by the Insured Person. grounds of fraud.

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

XIII. 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 such 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.

XIV. 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

XV. MIGRATION OF POLICY:

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 3O 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

XVI. 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.

Note: In case of any Insured Person other than the proposer under the policy, for the purpose of payment of claims in the event of death, the default nominee would be the proposer. No assignment of the policy or the benefits there under shall be permitted.

XVII. THE TAX BENEFIT

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

XVIII. 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 time limit prescribed under the policy.

b. Procedure for Cashless claims

i. Cashless claims facility shall be available in network hospitals only, if opted for TPA.
ii. This is subject to pre authorization by the TPA. The list of network provider/PPN is available on https://uiic.co.in/en/tpa-ppn-network-hospitals and the TPA's website.
iii. Intimate the claim on the TPA's toll free phone number and quote card ID number.
iv. On admission, produce the TPA ID card at the Network/ PPN Hospital Helpdesk. Cashless request form shall be completed and sent to the TPA for authorization.
v. The TPA shall process such cashless request and issue pre-authorization letter to the hospital after verification.
vi. At the time of discharge, the Insured Person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
vii. The TPA reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.
viii. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

c. Procedure for reimbursement of claims

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 a reimbursement basis on production of relevant claim papers and cash receipts.
iii. Claims for Cost of Health Check-up will be settled on reimbursement basis on production of test reports and cash receipts.

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 above 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 by the Company in genuine cases of hardship.
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.
iv. Any medical practitioner or Authorised Person authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

f. Claim Settlement (Provision of Penal Interest)

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

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

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

g. 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.

XIX. 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 pa(y acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance policy:

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

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

XX. SETTLEMENT UNDER MULTIPLE POLICIES

i. In case of multiple policies taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and 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.

XXI. 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.

XXII. WITHDRAWAL OF POLICY

i. In 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. 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.

XXIII. GRIEVANCE REDRESSAL/INSURANCE OMBUDSMAN

In case of any grievance the Insured Person may contact the Company through:
Website: www.uiic.co.in
Toll free: 1800 425 333 33
E-mail: customercare@uiic.co.in
Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd., 19, IV Lane, Nungambakkam High Road, Chennai, Tamil Nadu- 600034

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

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

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

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

FAMILY MEDICARE POLICY

Table of Benefits (brief indicative features only)

Features	Description
Age of Entry	18 years to 65 years, Children 3 m to 26 yrs
Policy Type	Individual Basis/ Family Floater Basis
Sum Insured (SI) Options for Fresh Proposals	Rs. 3 lacs, 4 lacs, 5 lacs, 6 lacs, 7 lacs, 8 lacs, 9 lacs, 10 lacs, 15 Lacs, 20 Lacs & 25 Lacs
Hospitalisation, Pre and Post Hospitalisation, Daycare procedures	Hospitalisation, Pre (30 days) and Post (60 days) Hospitalisation subject to a maximum of 10% of Sum Insured, All Daycare procedures as defined in policy are covered
Pre-existing disease	Covered after 48 months of continuous coverage
Room charges	SI < Rs.5 Lacs: 1% of SI; SI 5 Lacs and above: 1% of SI or Single Standard AC Room whichever is more
ICU Charges	SI < Rs.5 Lacs: 2% of SI; SI 5 Lacs and above: Actual
Limit for Cataract Surgery	10% of SI, Up to Rs.50,000 per eye.
Limit for 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)	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
Ayurvedic/Homeopathic/Unani Treatment	SI Upto Rs.3Lacs: Rs.10000 ; SI above Rs.3 Lacs upto Rs.15 Lacs: Rs.15000; SI Above Rs.15 Lacs: Rs.25000
Organ donor's medical expenses	Hospitalisation Expenses (excluding cost of organ) incurred for/by a Donor within the Sum Insured of the Insured Person
Organ Donor Benefit- When Insured Person is the Donor	A lump sum payment of 10% of Sum Insured
Road Ambulance Charges	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.
Health check-up	up to 1% of average Sum Insured of preceding 3 years, subject to a maximum of Rs. 5000 per person if policy is on individual SI basis/ Rs. 10000 per policy period if policy is on floater basis for a block of every three claim-free years
Modern Treatment Methods & Advancement in Technologies	Expenses incurred on following procedures covered subject to additional limits: 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 b. Balloon Sinuplasty: Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lac per policy period c. Deep Brain Stimulation: Upto 70% of Sum Insured per policy period d. Oral Chemotherapy: Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lacs per policy period 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):

	a. 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 b. 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 i. Bronchial Thermoplasty: Upto 30% of Sum Insured subject to a maximum of Rs. 3 Lacs per policy period 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 l. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered only: No additional sub-limit
Restoration of Sum Insured (Optional)	Available for SI Rs.3 Lacs and above; On complete or partial exhaustion of SI, upto 100% of SI
Maternity Expenses & New Born Baby Cover (Optional)	Available for SI above Rs.3 Lacs Maternity Expenses: After continuous cover of 24 months, 10% of Sum Insured subject to a maximum of Rs. 40000 for normal/ Rs. 60000 for caesarean. New Born Baby Cover: Upto 10% of SI, Upto 90 days.
Hospital Daily Cash Allowance (Optional)	For SI Options Upto 5 Lacs/> 5 Lacs upto 15 Lacs / > Rs.15 Lacs Upto Rs.25 Lacs: Rs. 500/1000/2000 per day respectively, Max. Rs. 5000/10000/20000 respectively

RESTORATION OF SUM INSURED OPTIONAL COVER – ILLUSTRATION

Example A Policy Period: 1st April, 2018 to 31st March, 2019 Basic Sum Insured: Rs. 5 Lacs					
Claim Number	**Basic SI + Restore SI**	**Ailment / Disease**	**Hospitalisation Amount**	**Claim Payable**	**Balance SI (Basic + Restore)**
1st Claim	5,00,000	By Pass	5,50,000	5,00,000	0 + 5,00,000
2nd Claim	0 + 5,00,000	Hepatitis	1,00,000	1,00,000	0 + 4,00,000
3rd Claim	0 + 4,00,000	Stroke	4,50,000	4,00,000	0 + 0
4th Claim	0 + 0	Appendicitis	50,000	0	0 + 0

Example B Policy Period: 1st April, 2018 to 31st March, 2019 Basic Sum Insured: Rs. 5 Lacs					
Claim Number	**Basic SI + Restore SI**	**Ailment / Disease**	**Hospitalisation Amount**	**Claim Payable**	**Balance SI (Basic + Restore)**
1st Claim	5,00,000	Hepatitis	5,50,000	5,00,000	0 + 5,00,000
2nd Claim	0 + 5,00,000	Hepatitis (same member)	1,00,000	0 (Restoration not available on same disease)	0 + 5,00,000
3rd Claim	0 + 5,00,000	Appendicitis	2,00,000	2,00,000	0 + 3,00,000
4th Claim	0 + 3,00,000	Stroke	4,00,000	3,00,000	0 + 0
5th Claim	0 + 0	Dengue	50,000	0	0 + 0

Example C Policy Period: 1st April, 2018 to 31st March, 2019 Basic Sum Insured: Rs. 5 Lacs					
Claim Number	**Basic SI + Restore SI**	**Ailment / Disease**	**Hospitalisation Amount**	**Claim Payable**	**Balance SI (Basic + Restore)**
1st Claim	5,00,000	Hepatitis	5,50,000	5,00,000	0 + 5,00,000
2nd Claim	0 + 5,00,000	Hepatitis (another member as 1st Claim)	1,00,000	1,00,000	0 + 4,00,000
3rd Claim	0 + 4,00,000	Appendicitis	2,00,000	2,00,000	0 + 2,00,000
4th Claim	0 + 2,00,000	Stroke	4,00,000	2,00,000	0 + 0
5th Claim	0 + 0	Dengue	50,000	0	0 + 0

Example D Policy Period: 1st April, 2018 to 31st March, 2019 Basic Sum Insured: Rs. 5 Lacs					
Claim Number	**Basic SI + Restore SI**	**Ailment / Disease**	**Hospitalisation Amount**	**Claim Payable**	**Balance SI (Basic + Restore)**
1st Claim	5,00,000	Hepatitis	3,00,000	3,00,000	2,00,000 + 5,00,000
2nd Claim	2,00,000 + 5,00,000	Stroke	4,00,000	4,00,000	0 + 3,00,000
3rd Claim	0 + 3,00,000	Appendicitis	2,00,000	2,00,000	0 + 1,00,000
4th Claim	0 + 1,00,000	Hepatitis (same member as 1st Claim)	2,00,000	0 (Restoration not available on same disease)	0 + 1,00,000
5th Claim	0 + 1,00,000	Dengue	1,75,000	1,00,000	0 + 0

Example E Policy Period: 1st April, 2018 to 31st March, 2019 Basic Sum Insured: Rs. 5 Lacs					
Claim Number	**Basic SI + Restore SI**	**Ailment / Disease**	**Hospitalisation Amount**	**Claim Payable**	**Balance SI (Basic + Restore)**
1st Claim	5,00,000	Lung Cancer	3,00,000	3,00,000	2,00,000 + 5,00,000
2nd Claim	2,00,000 + 5,00,000	Lung Cancer (same member as 1st Claim)	4,00,000	2,00,000 (Restoration not available on same disease)	0 + 5,00,000
3rd Claim	0 + 5,00,000	Appendicitis	2,00,000	2,00,000	0 + 3,00,000
4th Claim	0 + 3,00,000	Hepatitis	2,50,000	2,50,000	0 + 50,000
5th Claim	0 + 50,000	Hepatitis (same member as 4th Claim)	1,75,000	0 (Restoration not available on same disease)	0 + 50,000
6th Claim	0 + 50,000	Stroke	3,50,000	50,000	0 + 0