Super Top Up Medicare Policy

Prospectus

1. PRODUCT- KEY FEATURES

This Policy covers aggregate hospitalisation expenses in respect of all covered hospitalisation(s) of Insured Person/s during the policy period exceeding the Threshold Level up to a Sum Insured stated in the Policy Schedule.

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

The cover type basis shall be as specified in the Policy Schedule. The claim payable under this Policy will be the amount by which the aggregate of such Covered Expenses in respect of hospitalisations with dates of admission falling within the policy period exceeds the higher of the following:

- the Threshold Level opted for the Insured Person/family as applicable and stated in the schedule or
- the amount received/receivable under any/all Health Insurance Policies (whether or not issued by the Company)/ Reimbursement Scheme and including any amount paid earlier under this policy covering the Insured person/Family as applicable for such Covered Expenses, subject to 'Basis of Payment' Clause no. 7.7.6.F of the Policy. .

COVERAGE AT A GLANCE:

Base Cover
In-Patient Hospitalisation Expenses
Day Care Treatments
Ayurvedic Treatment
Named Modern Treatment Methods & Advancement in Technology

2. ELIGIBILITY

a. Any person aged between 18 years and 80 years can take this insurance for himself and his/her family. Beyond 80 years, only renewals are allowed

b. Allowed Relationships in a Family to be covered under a single policy:
   - **Individual Sum Insured Basis**: Self (Proposer), Spouse, Dependent Children and Parents
   - **Family Floater Basis**: Self (Proposer), Spouse, Dependent Children

c. Entry Age:
   - **Adults**: 18 years to 80 Years
   - **Dependent Children**: between the age of 3 months and 18 years shall be covered provided either or both parents are covered concurrently.
     i. Children above 18 years will cease to be covered if they are employed/self-employed or married. However, a separate policy can be taken for him or her on expiry of the current policy for which continuity benefits will be provided.
     ii. For unmarried and unemployed girls, disabled children without income dependent upon Proposer, the age limit of 18 will not apply.
     iii. Male child up to 26 years can be covered provided they pursue full-time higher studies and submit bona fide Certificate from Educational Institution

d. Midterm Inclusion of family members is allowed at pro-rata premium only in case of:
   - Newly married spouse within 60 (sixty) days of marriage

- New born baby, between the ages of 91 days to 180 days, born to mother insured under the policy.

3. SUM INSURED

Sum Insured options vary based on the Threshold/Deductible chosen by the Policyholder. The available choices are as under:

Threshold/Deductible	Sum Insured Options
₹ 2 Lakhs	₹ 3 Lakhs, ₹ 5 Lakhs
₹ 3 Lakhs	₹ 3 Lakhs, ₹ 5 Lakhs, ₹ 7 Lakhs
₹ 5 Lakhs	₹ 5 Lakhs, ₹ 10 Lakhs, ₹ 15 Lakhs

4. TERM OF POLICY

One Year. Renewable annually.

5. COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

5.1 In-Patient Hospitalisation Expenses

The company shall indemnify Reasonable and Customary medical expenses incurred for Hospitalisation of the Insured Person during the Policy year, up to the Sum Insured specified in the policy schedule, for,

A. Room, Boarding and Nursing expenses (all inclusive) incurred as provided by the Hospital/Nursing Home including nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.
B. The fees charged by the Medical Practitioner, Surgeon, Specialists and anaesthetists treating the Insured Person;
C. Anaesthetics, blood, oxygen, operation theatre charges, surgical appliances, implants, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.
D. All hospitalisation expenses (excluding cost of organ) incurred for donor in respect of organ transplant to the Insured Person provided the donation conforms to The Transplantation of Human Organs Act 1994.

5.2 Ayurvedic Treatment

The Company shall indemnify Reasonable & Customary medical expenses incurred for inpatient care treatment under Ayurveda system of medicine in an AYUSH hospital/ AYUSH day care centre.

5.3 Modern Treatment Methods & Advancement in Technologies:

In case of an admissible claims under Section 5.1, expenses incurred on the following procedures (wherever medically indicated) either as in-patient or as part of day care treatment in a hospital, shall be covered. The claim shall be subject to additional sub-limits indicated against them in the table below:

Sr. No.	Treatment Methods & Advancement in Technology	Additional Sub Limit
A	Uterine Artery Embolization & High Intensity Focussed Ultrasound (HIFU)	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lakhs per policy period for claims involving Uterine Artery Embolization & HIFU
B	Balloon Sinuplasty	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lakh per policy period for claims involving Balloon Sinuplasty
C	Deep Brain Stimulation	Upto 70% of Sum Insured subject to a maximum of Rs. 10 Lakhs per policy period for claims involving Deep Brain Stimulation
D	Oral Chemotherapy	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lakhs 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 Lakhs per policy period

F	Intra vitreal Injections	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lakh per policy period
G	Robotic Surgeries (including Robotic Assisted Surgeries)	• Upto 75% of Sum Insured subject to a maximum of Rs. 10 Lakhs per policy period for claims involving Robotic Surgeries for (i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies • Upto 50% of Sum Insured subject to a maximum of Rs. 5 Lakhs per policy period for claims involving Robotic Surgeries for other diseases
H	Stereotactic Radio Surgeries	Upto 50% of Sum Insured subject to a maximum of Rs. 5 Lakhs per policy period for claims involving Stereotactic Radio Surgeries
I	Bronchial Thermoplasty	Upto 30% of Sum Insured subject to a maximum of Rs. 3 Lakhs 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 Lakhs per policy period
K	Intra Operative Neuro Monitoring (IONM)	Upto 15% of Sum Insured subject to a maximum of Rs. 1.5 Lakhs per policy period for claims involving Intra Operative Neuro Monitoring
L	Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered only	Upto 75% of Sum Insured subject to a maximum of Rs. 10 Lakhs per policy period

Note: The expenses that are not covered in this policy: are placed under *List–I of Annexure–1 of the Policy Wordings*. The list of expenses that are to be subsumed into room charges, or procedure charges or costs-of treatment: are placed under *List–II, List–III, and List–IV of Annexure–1* of the Policy Wordings respectively.

6. 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:

6.1 **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.

B. PERMANENT EXCLUSIONS

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

6.2 All expenses caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped power.

6.3 All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack.

6.4 Congenital External Diseases, Defects or anomalies.

6.5 Sterility and Infertility **(Code- Excl17)**: Expenses related to Sterility and Infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

6.6 Maternity (**Code- Excl18**):

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

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

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

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

6.9 Unproven Treatments (**Code- Excl16**): Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

6.10 Change-of-Gender treatments **(Code- Excl07)**: Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

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

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

6.13 Cost of spectacles, contact lenses.

6.14 Cost of hearing aids

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

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

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

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

6.18 Intentional self-inflicted Injury, attempted suicide.

6.19 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure. **(Code- Excl14)**

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

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

6.22 Any item(s) or treatment specified in 'list of Non-Medical Expenses – Payable/Non-Payable' as per *Annexure-1* and available on Company web site also, unless specifically covered under the Policy.

7. PROCEDURE FOR TAKING A POLICY

a. The duly completed and signed Proposal form giving details of all Insured persons along with Pre-Acceptance Health Check-up reports, if any, should be submitted to the nearest office of the Company. Additionally, details of existing and previous Health insurance Policies in respect of each Insured Person are to be provided without fail in the proposal form along with claim history. Copy of current/expiring policy may be attached.

b. The pre-acceptance health check-up reports, wherever required at Company's discretion have to be submitted at proposer's cost in the following cases:

i. Persons with adverse medical history as revealed from the proposal form
ii. Persons above 45 years of age not covered under any health insurance/benefit scheme
iii. Option of high value sum insured in relation to sum insured under existing policy below threshold level

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

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

Note:

i. Pre–acceptance medical check–up shall be conducted at designated centres authorized by us.
ii. 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.

8. PAYMENT OF PREMIUM

i. Unless full premium is paid before commencement of risk, this Policy shall have no effect.
ii. Premium can be paid online for both, new policy and renewals.

9. CANCELLATION CLAUSE

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

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

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

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

10. FREE LOOK PERIOD

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy. This condition is also not applicable for existing Insureds who migrate to this policy.

The Insured shall be allowed a period of fifteen days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, 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, a deduction towards the proportionate risk premium for period of cover or
iii. where only a part of insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

11. RENEWAL

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the Insured Person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the Insured had made a claim or claims in the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.
v. No loading shall apply on renewals based on individual claims experience

12. ENHANCEMENT OF SUM INSURED

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

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

13. 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 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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

14. 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

15. 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.

16. THE TAX BENEFIT

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

17. CLAIM PROCEDURE

A. Notification of claim

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

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

B. Procedure for Cashless claims

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

C. Procedure for reimbursement of claims

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

D. Documents

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

i. Duly completed claim form
ii. Photo Identity proof of the patient
iii. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed or Operation Theatre (OT) Notes, along with date of diagnosis, advise for admission, investigation test reports etc. supported by the prescription from attending medical practitioner.
iv. Medical history of the patient recorded, bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.
v. Discharge certificate/ summary from the hospital.
vi. Cash-memo/ bills/ invoices from the Diagnostic Centre(s)/ hospital(s)/ chemist(s) supported by proper prescription.
vii. Payment receipts from doctors, surgeons and anaesthetist.
viii. Bills, receipt, Sticker of the Implants.
ix. MLR (Medico Legal Report copy if carried out and FIR (First Information Report) if registered, wherever applicable)
x. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled Cheque
xi. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs. 1 Lakh as per AML Guidelines
xii. Any other document required by company/ TPA

Note

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

E. Time Limits for Submission of Documents:

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

Note:

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

F. Basis of Payment

i. Any claim under this policy shall be payable by the Company only if
   a. it is in respect of Covered Expenses specified in this Policy and
   b. the aggregate of Covered Expenses in respect of hospitalisation/s of Insured Person in case of Individual Policy or all Insured Persons in case of Family Floater Policy exceeds the Threshold Level
ii. The claim payable under this Policy will be the amount by which the aggregate of such Covered Expenses in respect of hospitalisations with dates of admission falling within the policy period exceeds the higher of the following:

a. the Threshold Level opted for the insured person/family as applicable and stated in the schedule or
b. the amount received/receivable under any/all Health Insurance Policies (whether or not issued by the Company)/ Reimbursement Scheme and including any amount paid earlier under this policy covering the Insured person/family as applicable for such Covered Expenses, subject to multiple policy clause.

iii. Each claim, if more than one, during the period of this policy shall be separately subject to the above Basis of Payment.
iv. In no case shall the Company be liable to pay any sum in excess of the Sum Insured in aggregate of all claims during the period of this Policy.

G. Claim Settlement (provision for Penal Interest)

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

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

H. Services Offered by TPA

Servicing of claims i.e. claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims, as per the terms and conditions of the policy.
The services offered by a TPA shall not include

i. Claim settlement and claim rejection;
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

18. REVISION/ MODIFICATION OF THE POLICY

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The Insured Person shall be notified three months before the changes are affected.

19. WITHDRAWAL OF POLICY

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

20. 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/

21. 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.

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Insurance is the subject matter of Solicitation.

TABLE OF BENEFITS

<table>
<tr><td>Name</td><td>Super Top Up Medicare Policy</td></tr>
<tr><td>Product Type</td><td>Individual/Floater</td></tr>
<tr><td>Category of Cover</td><td>Indemnity</td></tr>
<tr><td>Sum Insured</td><td>
<table>
<tr><th>Threshold/Deductible</th><th>Sum Insured Options</th></tr>
<tr><td>₹ 2 Lakhs</td><td>₹ 3 Lakhs, ₹ 5 Lakhs</td></tr>
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</table>
On Individual Basis – SI shall apply to each individual family member
On Floater Basis – SI shall apply to the entire family</td></tr>
<tr><td>Policy Period</td><td>1 Year</td></tr>
<tr><td>Eligibility</td><td>Policy can be availed by persons between the age of 18 years and 65 years, as Proposer.
Policy can be availed for Self and the following family members:
Individual Sum Insured Basis: Legally wedded spouse, Dependent Children and Parents
Family Floater Basis: Legally wedded spouse and Dependent Children
Dependent Children (i.e. natural or legally adopted) between the age 3 months to 18 years. If the child above 18 years of age is employed/self-employed or married, he or she shall be ineligible for coverage in the subsequent renewals</td></tr>
<tr><td>Grace Period</td><td>30 days</td></tr>
<tr><td rowspan="2">Hospitalisation Expenses</td><td>Expenses of Hospitalisation for a minimum period of 24 consecutive hours only shall be admissible</td></tr>
<tr><td>Time limit of 24 hours shall not apply when treatment is undergone in a Day Care Centre.</td></tr>
<tr><td>AYUSH</td><td>Expenses incurred for inpatient care treatment under Ayurveda system of medicine shall be covered up to sum insured, during each policy year as specified in the policy schedule.</td></tr>
<tr><td>Pre-Existing Disease</td><td>Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 4 years.</td></tr>
</table>

SUPER TOP UP MEDICARE POLICY – PREMIUM RATES

- All premium rates in this document are **Annual Premium Rates in INR (₹)** and are **exclusive of Goods & Service Tax (GST) & Cess (if any)**. GST as applicable will be charged extra.

I. RATES FOR INDIVIDUAL SUM INSURED BASIS

Rates per Insured Person			
Threshold: ₹ 2 Lakhs			
Sum Insured	**0 – 45 Years**	**46 – 60 Years**	**> 60 Years**
3,00,000	2,100	2,600	2,900
5,00,000	2,900	3,600	4,000

Rates per Insured Person			
Threshold: ₹ 3 Lakhs			
Sum Insured	**0 – 45 Years**	**46 – 60 Years**	**> 60 Years**
3,00,000	1,700	2,100	2,300
5,00,000	2,300	2,900	3,200
7,00,000	2,900	3,600	4,000

Rates per Insured Person			
Threshold: ₹ 5 Lakhs			
Sum Insured	**0 – 45 Years**	**46 – 60 Years**	**> 60 Years**
5,00,000	1,900	2,300	2,600
10,00,000	3,700	4,600	5,100
15,00,000	5,200	6,500	7,200

II. RATES FOR FAMILY FLOATER SUM INSURED BASIS

Threshold: ₹ 2 Lakhs						
Sum Insured	**2 Persons in Family**			**> 2 Persons in Family**		
	0 – 45 Years	**46 – 60 Years**	**> 60 Years**	**0 – 45 Years**	**46 – 60 Years**	**> 60 Years**
3,00,000	3,400	4,200	4,600	4,200	5,200	5,800
5,00,000	4,600	5,800	6,400	5,800	7,200	8,000

Threshold: ₹ 3 Lakhs						
Sum Insured	**2 Persons in Family**			**> 2 Persons in Family**		
	0 – 45 Years	**46 – 60 Years**	**> 60 Years**	**0 – 45 Years**	**46 – 60 Years**	**> 60 Years**
3,00,000	2,700	3,400	3,700	3,400	4,200	4,600
5,00,000	3,700	4,600	5,100	4,600	5,800	6,400
7,00,000	4,600	5,800	6,400	5,800	7,200	8,000

Threshold: ₹ 5 Lakhs						
Sum Insured	**2 Persons in Family**			**> 2 Persons in Family**		
	0 – 45 Years	**46 – 60 Years**	**> 60 Years**	**0 – 45 Years**	**46 – 60 Years**	**> 60 Years**
5,00,000	3,000	3,700	4,200	3,800	4,600	5,200
10,00,000	5,900	7,400	8,200	7,400	9,200	10,200
15,00,000	8,300	10,400	11,500	10,400	13,000	14,400