Family Medicare Policy

Prospectus

1. Product – Key Features

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

COVERAGE AT A GLANCE:

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

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

2. Cover Type

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

3. Family

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

i. Self, Spouse, dependent children, and Parents on Individual Sum Insured basis;
ii. Self, Spouse, and dependent children on floater basis;
iii. Parents on floater basis.

4. Eligibility

Eligibility based on age:

i. Adults: 18 years and 65 years.
ii. Dependent Children: 91 days to 17 years, provided either or both parents are covered concurrently. In case, where both the parents of the child(ren) are already deceased, the minor child(ren) can be covered by the guardian without covering himself/herself.
iii. Dependent Children up to 91 days can be covered if the optional cover of Maternity Expenses and New Born Baby Cover is purchased on payment of additional requisite premium.
Children aged 18 years or above will continue to be covered along with parents till the age of 26 years, provided they are unmarried/unemployed and dependent.
The upper age limit will not apply to mentally challenged children.

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

Beyond 65 years, only renewals are allowed.

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

i. Newly married spouse within 60 (sixty) days of marriage.

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

5. Policy Term

One Year. Renewable annually.

6. Co-Payment

For persons with age of entry above 60 years in Family Medicare Policy, every admissible claim under *Clauses 8.A.1-8.A.6* shall be subject to a Co-payment of 10% on the admissible claim amount.

7. Sum Insured

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

8. Coverage

A. Base Covers

The Policy provides base coverage as described below in this section provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner 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:

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

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

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

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

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

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

ii. Operation theatre charges,

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

1.1 Note:

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

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

iii. All Day Care treatments as per definition of Clause II.A.10 of the Family Medicare Policy wordings are covered.

1.2 Sub-limit:

a) Cataract Surgery Limit:

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

b) Mental Illness Cover Limit:

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

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

2. Pre-Hospitalisation and Post-Hospitalisation Expenses –

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

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

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

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

a. We have accepted a claim for primary In-patient Hospitalization under *Clause 8.A.1* above.
b. The Pre-hospitalisation and Post-hospitalisation Medical Expenses are related to the same Illness or Injury.

3. Donor Expenses Cover

We will cover the In-patient Hospitalization Medical Expenses incurred for an organ donor's treatment during the Policy Period for the harvesting of the organ donated provided that:

i. The donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;

ii. We have admitted a claim towards In-patient Hospitalisation under the *Clause 8.A.1* and it is related to the same condition; organ donated is for the use of the Insured Person as certified in writing by a Medical Practitioner;

iii. We will not cover:

a. Pre-hospitalization Medical Expenses or Post-hospitalisation Medical Expenses of the organ donor;
b. Screening expenses of the organ donor;
c. Costs directly or indirectly associated with the acquisition of the donor's organ;
d. Transplant of any organ/tissue where the transplant is experimental or investigational;
e. Expenses related to organ transportation or preservation;
f. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

4. Restoration of Sum Insured

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

i. In case of policies on Individual Sum Insured basis, the Restored sum insured will be available only once to each Insured Person individually in a Policy Period.

ii. In case of policies of Family Floater basis, the Restored Sum Insured will be available only once to the whole family on floater basis during a Policy Period.

iii. Such restored Sum Insured can be utilized only for illness / disease unrelated to the illness(es) / disease(s) for which claim(s) was / were made for the same insured person.
iv. The maximum liability for a claim in a Policy Year cannot exceed the Sum Insured.
v. If the Restored Sum Insured is not utilized in a Policy Period, it shall not be carried forward to any subsequent Policy Period.

Note:

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

Illustrations with Sum Insured – Rs 5 lakh

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

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

[#] Related Illness, hence, Restored Sum Insured is not payable (clause – 8.A.5.iii)

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

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

5. Modern Treatment Methods & Advancement in Technologies:

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

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

Note: The claims under *Clause 8.A.5.iv (Oral Chemotherapy) and 8.A.5. v (Immunotherapy-Monoclonal Antibody to be given as injection)* shall be treated as post-Hospitalisation claim(s). However, the time and monetary limits as mentioned in *Clause 8.A.2* above shall not be applied.

6. Road Ambulance Cover

We will cover the costs incurred up to:

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

on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner and becomes payable if a claim has been admitted under *Clause 8.A.1* and the expenses are related to the same Illness or Injury.

We will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified above under this cover, if:

a. it is medically required to transfer the Insured Person to another Hospital or diagnostic Centre during Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
b. it is medically required to transfer the Insured Person to another Hospital during Hospitalization due to lack of super specialty treatment in the existing Hospital.

7. Cost of Health Check-up

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

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

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

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

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

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

B. Optional Covers:

1. Maternity Expenses and New Born Baby Cover

a. Maternity Expenses

We shall pay the Medical Expenses incurred as an In-patient for a delivery (including caesarean section) or lawful medical termination of pregnancy during the Policy Period limited to two deliveries or terminations or either during the lifetime of the Insured Person. This benefit is applicable only when the Sum Insured is above Rs. 3 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. 40,000 in case of normal delivery and Rs. 60,000 in case of caesarean section and in no case shall the Company's liability under this clause exceed 10% of the Sum Insured, in any one Policy Period.

b. New Born Baby Cover

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

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

Special conditions applicable to Maternity Expenses and New Born Baby Cover

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

2. Daily Cash Allowance on Hospitalisation

We will pay Daily Cash Allowance to the Insured Person for every continuous and completed period of 24 hours of Hospitalisation, subject to the hospitalisation claim being admissible under the policy, as per the table below:

Sum Insured	Limit (Rs.) per day
Up to Rs. 5 Lacs	Rs. 500 per day subject to a maximum of Rs. 5000 per policy period
Above Rs. 5 Lacs and up to Rs. 15 Lacs	Rs. 1000 per day subject to a maximum of Rs. 10000 per policy period
Above Rs. 15 Lacs and up to 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 Treatment claims. Deductible equivalent to Daily Cash Allowance for the first 24 hours Hospitalization will be levied on each Hospitalisation during the Policy Period.

9. What Policy Does Not Cover

A. Waiting Periods

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

1. Pre-Existing Diseases (Code – Excl01)

i. Expenses related to the treatment of a 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.
ii. In case of enhancement of the Sum Insured, the exclusion shall apply afresh to the extent of the Sum Insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then the waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. Specified Disease/Procedure Waiting Period (Code – Excl02)
   i. Expenses related to the treatment of the listed Conditions, surgeries/treatments as per Table A and Table B below shall be excluded until the expiry of 24 months and 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.
   ii. In case of enhancement of the sum insured the exclusion shall apply afresh to the extent of the sum insured increase.
   iii. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.
   iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
   v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then the waiting period for the same would be reduced to the extent of prior coverage.
   vi. List of specific diseases/procedures:

Table A. Two years waiting period

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

Table B. Four years waiting period

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

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

B. Standard Exclusions

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

4. Investigation & Evaluation (Code – Excl04)
   i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. Rest Cure, Rehabilitation and Respite Care (Code – Excl05)
   Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, and moving around either by skilled nurses or assistants or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. Obesity/Weight Control (Code – Excl06)
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   i. Surgery to be conducted is upon the advice of the Doctor
   ii. The surgery/Procedure conducted should be supported by clinical protocols
   iii. The member has to be 18 years of age or older and
   iv. Body Mass Index (BMI):
      a. Greater than or equal to 40 or
      b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         b.1. Obesity-related cardiomyopathy
         b.2. Coronary heart disease
         b.3. Severe Sleep Apnea
         b.4. Uncontrolled Type2 Diabetes

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

8. Cosmetic or Plastic Surgery (Code – Excl08)
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of the medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

9. Hazardous or Adventure Sports (Code – Excl09)
   Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

10. Breach of Law (Code – Excl10)
    Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

11. Excluded Providers (Code – Excl11)
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed on its website/notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

12. (Code – Excl12)
    Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

13. (Code – Excl13)
    Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

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

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

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

17. Sterility and Infertility (Code – Excl17)
    Expenses related to sterility and infertility. This includes:
    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization

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

C. Specific Exclusions

1. All expenses caused by or arising from or attributable to foreign invasion, an act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped power.
2. All Illnesses/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or any nuclear waste from the combustion of nuclear fuel, nuclear/chemical/biological attack.
3. Any expenses incurred on Domiciliary Hospitalization.
4. Any expenses incurred on Out-patient treatment (OPD treatment). Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.
5. Any item(s) or treatment specified in 'List of Non-Medical Expenses– Payable/Non-Payable under this Policy' as per clauses in Annexure – 1 of the Family Medicare Policy Wordings, unless specifically covered under the Policy.
6. Any treatment related to sleep disorder or sleep apnoea syndrome.
7. 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.
8. Change of treatment from one system of medicine to another system unless recommended by the consultant/hospital under whom the treatment is taken.
9. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
10. Congenital External Diseases or Defects or anomalies.

11. Cost of hearing aids; including optometric therapy.
12. Cost of routine medical examination and preventive health check-up unless as provided for in *clause 8.A.7*.
13. Dental treatment or surgery of any kind unless necessitated by disease or accident and requiring hospitalisation.
14. Intentional self-inflicted Injury or attempted suicide.
15. Routine eye-examination expenses, cost of spectacles, contact lenses.
16. Stem cell implantation/Surgery/Therapy, harvesting, storage or any kind of treatment using stem cells except Hematopoietic stem cells for bone marrow transplant for haematological conditions; growth hormone therapy.
17. Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, chondrocyte or osteocyte implantation, procedures using platelet rich plasma, Trans Cutaneous Electric Nerve Stimulation; Use of oral immunomodulatory/ supplemental drugs.
18. Treatments other than Allopathy and AYUSH branches of medicine.
19. 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. Please refer to clauses in Annexure-1 of the policy wordings for the complete list of non-payable items.
20. Vaccination or inoculation of any kind unless post animal bite.
21. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), Insured Person is not entitled to get the coverage for specified ICD Codes

10. Procedure For Taking a Policy

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

Notes

- The date of medical reports should not exceed 30 (thirty) days prior to the date of proposal.
- 50% of the cost of Pre-Acceptance Health check-up shall be reimbursed to the insured in cases where the proposal is accepted by the Company

11. Payment Of Premium

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

12. Loadings And Discount

i. No Claim Discount

For every claim free year, the Insured shall be entitled to a No Claim Discount of 5% on renewal premium subject to a maximum of 15%.

The No Claim Discount will be withdrawn:

a. If the policy is not renewed within the grace period allowed under the policy.
b. In the event of any claim reported under the expiring policy for policies issued on family floater basis.
c. For policies issued on Individual SI basis, only for the Insured Person, for which the claim has been reported under the expiring policy.

ii. Family Discount

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

Floater Discount

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

iii. Direct Channel Discount

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

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

iv. 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 200% of Premium excluding applicable Taxes.

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

13. Change Of Sum Insured

1. The Insured can apply for change of Sum Insured at the time of renewal, by submitting a fresh proposal form/written request to the company.
2. Any request for enhancement of Sum Insured must be accompanied by a declaration that the Insured or any other Insured Person(s) in respect of whom such enhancement is sought is not aware of any symptoms or other indications that may give rise to a claim under the policy. The Company may require such Insured Person/s to undergo a medical examination to enable the Company to take a decision on accepting the request for enhancement in the Sum Insured.
3. The acceptance of enhancement of Sum Insured would be at the discretion of the company, subject to underwriting, based on the health condition of the Insured Persons & claim history of the policy.
4. All waiting periods as defined in the Family Medicare Policy wordingsshall apply for the incremental portion of the Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

14. Cancellation

1. The policyholder may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium for the unexpired Policy Period as per the rates detailed below.

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

15. 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 15 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 persons 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.

16. Renewal Of Policy

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

1. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
2. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
3. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
4. 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.
5. No loading shall apply on renewals based on individual claims experience.

17. 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://irdai.gov.in/document-detail?documentId=393128

18. 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://irdai.gov.in/document-detail?documentId=393128

19. 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.

20. Tax Benefit

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

21. Claim Procedure

1. *Notification of Claim*

Upon the happening of any event which may give rise to a claim under this Policy, the Insured Person/Insured Person's representative shall notify the TPA (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 hospitalisation required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalisation

2. *Procedure for Cashless Claims*

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

3. *Procedure for reimbursement of Claims*

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

4. *Documents*

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

a. Duly completed claim form
b. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed along with date of diagnosis, advise for admission, investigation test reports etc. supported by the prescription from attending medical practitioner.
c. Medical history of the patient as recorded, bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.
d. Discharge certificate/ summary from the hospital.
e. Cash-memos from the Diagnostic Centre(s)/ hospital(s)/ chemist(s) supported by proper prescription.
f. Payment receipts from doctors, surgeons and anesthetists.
g. Bills, receipts, Stickers of the Implants.
h. Any other document required by company/ TPA

Note: In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other Insurer, the company may accept the duly certified documents listed under *Clause 21.4* of the policy wordings and claim settlement advice duly certified by the other Insurer subject to satisfaction of the company.

5. *Time Limit for submission of documents*

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

Notes:

i. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
ii. Waiver of *clause 21.5* of the policy wordings 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.
iii. The Insured Person shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
iv. All the documents submitted to TPA shall be electronically collected by us for settlement/denial of the claims by the appropriate authority.
v. Any medical practitioner or Authorised Person authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

6. *Services offered by TPA*

Servicing of claims i.e. claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims, as per the terms and conditions of the policy.

The services offered by a TPA shall not include:

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

22. 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.

23. Withdrawal Of Policy

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

24. Redressal Of Grievance

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

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

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

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

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

25. 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.

Family Medicare Policy

Table of Benefits

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

<table>
<tr><th>Features</th><th>Description</th></tr>
<tr><td>Age of Entry</td><td>Dependent Children – 91 Days to 17 years
Adults – 18 years to 65 years</td></tr>
<tr><td>Policy Type</td><td>Individual Basis/ Family Floater Basis</td></tr>
<tr><td>SI Options (for fresh proposals)</td><td>Rs. 3 lacs, 4 lacs, 5 lacs, 6 lacs, 7 lacs, 8 lacs, 9 lacs, 10 lacs, 15 Lacs, 20 Lacs & 25 Lacs</td></tr>
<tr><td>Policy Period</td><td>1 Year</td></tr>
<tr><td>Base Cover</td><td></td></tr>
<tr><td>Room Rent</td><td>
<table>
<tr><th>Sum Insured</th><th>Limit (Rs.) per day</th></tr>
<tr><td>< Rs. 5 Lacs</td><td>1% of Sum Insured</td></tr>
<tr><td>Rs. 5 Lacs and Above</td><td>1% of Sum Insured or Single Occupancy Standard Air-Conditioned Room Charges whichever is higher</td></tr>
</table>
</td></tr>
<tr><td>ICU/ICCU</td><td>
<table>
<tr><th>Sum Insured</th><th>Limit (Rs.) per day</th></tr>
<tr><td>< Rs. 5 Lacs</td><td>2% of Sum Insured</td></tr>
<tr><td>Rs. 5 Lacs and Above</td><td>Actuals</td></tr>
</table>
</td></tr>
<tr><td>Day Care Treatments</td><td>All Day Care Treatments as per the definition in the policy wordings are covered</td></tr>
<tr><td>Pre-Hospitalisation</td><td>30 Days (subject to 10% of SI combined for Pre and Post Hospitalisation)</td></tr>
<tr><td>Post-Hospitalisation</td><td>60 Days (subject to 10% of SI combined for Pre and Post Hospitalisation)</td></tr>
<tr><td>Road Ambulance</td><td>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</td></tr>
<tr><td>Modern Treatment Methods & Advancement in Tech.</td><td>Covered</td></tr>
<tr><td>Restoration of Sum Insured</td><td>Available for SI Rs.3 Lacs and above; On complete or partial exhaustion of SI, upto 100% of SI</td></tr>
<tr><td>Health Check-Up</td><td>up to 1% of average Sum Insured of preceding 3 policy years, subject to a maximum of Rs. 5000 per person if policy is on individual SI basis/ Rs. 10000 per policy period if policy is on family floater basis for a block of every three claim-free years</td></tr>
</table>

<table>
<tr><td>Organ donor's medical expenses</td><td>Hospitalisation Expenses (excluding cost of organ) incurred for/by a Donor within the Sum Insured of the Insured Person</td></tr>
<tr><td>Organ Donor Benefit (When the Insured Person is the Donor)</td><td>A lump sum payment of 10% of Sum Insured</td></tr>
<tr><td>Optional Covers</td><td></td></tr>
<tr><td>Maternity Expenses & New Born Baby Cover</td><td>Available for SI above Rs.3 Lacs
<u>Maternity Expenses:</u> After continuous cover of 24 months, 10% of Sum Insured subject to a maximum of Rs. 40000 for normal/ Rs. 60000 for caesarean.
<u>New Born Baby Cover:</u> Upto 10% of SI, Upto 90 days.</td></tr>
<tr><td>Hospital Daily Cash Allowance</td><td><table><tr><th>Sum Insured (Rs.)</th><th>Limit (Rs.) per day</th></tr><tr><td>Up to Rs. 5 Lacs</td><td>Rs. 500 per day subject to a maximum of Rs. 5,000 per policy period</td></tr><tr><td>Above Rs. 5 Lacs and up to Rs. 15 Lacs</td><td>Rs. 1,000 per day subject to a maximum of Rs. 10,000 per policy period</td></tr><tr><td>Above Rs. 15 Lacs and up to Rs. 25 Lacs</td><td>Rs. 2,000 per day subject to a maximum of Rs. 20,000 per policy period</td></tr></table></td></tr>
<tr><td colspan="2">Sub-Limits (other than those mentioned above)</td></tr>
<tr><td>Cataract</td><td>10% of Sum Insured, subject to maximum of Rs. 50,000 per eye.</td></tr>
<tr><td>Named Mental Illnesses</td><td>In case of following mental illnesses, the actual In-patient Hospitalization expenses will be covered up to 25% of Sum Insured subject to a maximum of Rs. 3,00,000 per policy year;
a. Schizophrenia (ICD - F20; F21; F25)
b. Bipolar Affective Disorders (ICD - F31; F34)
c. Depression (ICD - F32; F33)
d. Obsessive Compulsive Disorders (ICD - F42; F60.5)
e. Psychosis (ICD - F 22; F23; F28; F29)</td></tr>
</table>

Premium Rate Tables

IMPORTANT INFORMATION

- All premium rates shown in this document are Annual Premium Rates in INR (₹) and are exclusive of Goods & Service Tax (GST) & Cess (if any). GST as applicable will be charged extra.
- Premium rates are applicable per individual insured person (unless explicitly specified) and will be based on their completed age.
- Premium rates in Section I are for standard healthy individuals. These may change post underwriting of proposal based on medical tests (where applicable) and information provided in the proposal form.
- Entry Age:
  - Adults: 18 to 65 years
  - Children: 91 days to 17 years
- Premium rates vary depending on the Proposer's place of residence. In this regard, the country is divided into three geographical zones: **Zone A**, **Zone B**, **Zone C**. The Zones are based on the following districts in India:

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

I. BASE COVER PREMIUM RATES (EXCL. GST)

Zone A

Sum Insured	0-17	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	75+
1,00,000	1,708	2,883	3,203	3,843	4,671	4,780	5,754	6,923	9,940	11,492	14,040	15,851	18,285
1,50,000	2,039	3,441	3,824	4,589	5,577	5,804	6,987	8,406	12,070	15,323	18,719	21,135	24,380
2,00,000	2,370	3,999	4,445	5,334	6,482	6,829	8,220	9,890	14,200	19,153	23,399	26,418	30,476
2,50,000	2,688	4,536	5,041	6,049	7,352	8,194	9,864	11,868	17,041	22,984	28,079	31,702	36,571
3,00,000	3,006	5,073	5,637	6,764	8,221	9,560	11,508	13,845	19,881	26,815	32,759	36,986	42,666
3,50,000	3,147	5,310	5,901	7,081	8,605	10,731	12,917	15,537	22,309	30,074	36,741	41,482	47,852
4,00,000	3,287	5,548	6,164	7,397	8,989	11,903	14,327	17,228	24,738	33,334	40,723	45,977	53,038
4,50,000	3,428	5,785	6,427	7,713	9,373	13,074	15,737	18,920	27,167	36,593	44,705	50,473	58,224
5,00,000	3,568	6,022	6,691	8,029	9,758	14,245	17,147	20,611	29,596	39,852	48,687	54,969	63,410
6,00,000	3,743	6,316	7,017	8,421	10,234	14,943	17,987	21,618	31,041	42,551	51,984	58,691	67,705
7,00,000	3,917	6,609	7,344	8,812	10,710	15,642	18,828	22,625	32,487	45,250	55,281	62,414	71,999
8,00,000	4,091	6,903	7,670	9,204	11,186	16,340	19,668	23,632	33,933	47,949	58,578	66,137	76,294
9,00,000	4,265	7,197	7,997	9,596	11,662	17,038	20,508	24,639	35,379	50,648	61,876	69,860	80,588
10,00,000	4,439	7,491	8,323	9,988	12,138	17,736	21,349	25,645	36,824	53,347	65,173	73,582	84,882
15,00,000	4,994	8,427	9,363	11,236	13,655	19,953	24,017	28,851	41,427	60,016	73,320	82,780	95,493
20,00,000	5,368	9,059	10,066	12,079	14,679	21,449	25,819	31,015	44,534	64,517	78,818	88,989	1,02,655
25,00,000	5,637	9,512	10,569	12,683	15,413	22,522	27,109	32,566	46,761	67,743	82,759	93,438	1,07,787

Zone B

Sum Insured	0-17	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	75+
1,00,000	1,459	2,462	2,736	3,283	3,990	4,083	4,915	5,913	8,491	9,816	11,992	13,539	15,619
1,50,000	1,742	2,939	3,266	3,919	4,763	4,958	5,968	7,180	10,310	13,088	15,989	18,053	20,825
2,00,000	2,024	3,416	3,797	4,556	5,537	5,833	7,021	8,447	12,130	16,360	19,987	22,566	26,031
2,50,000	2,296	3,875	4,306	5,167	6,279	6,999	8,425	10,137	14,556	19,632	23,984	27,079	31,237
3,00,000	2,568	4,333	4,815	5,778	7,022	8,166	9,829	11,826	16,981	22,904	27,982	31,592	36,444
3,50,000	2,688	4,536	5,040	6,048	7,350	9,166	11,034	13,271	19,056	25,688	31,383	35,432	40,874
4,00,000	2,808	4,739	5,265	6,318	7,678	10,167	12,238	14,716	21,131	28,472	34,784	39,272	45,303
4,50,000	2,928	4,941	5,490	6,588	8,006	11,167	13,442	16,161	23,205	31,256	38,185	43,112	49,733
5,00,000	3,048	5,144	5,715	6,858	8,335	12,168	14,647	17,605	25,280	34,041	41,586	46,952	54,163
6,00,000	3,197	5,395	5,994	7,193	8,741	12,764	15,364	18,465	26,515	36,346	44,403	50,132	57,831
7,00,000	3,345	5,645	6,273	7,527	9,148	13,360	16,082	19,325	27,749	38,651	47,219	53,312	61,499
8,00,000	3,494	5,896	6,552	7,862	9,554	13,957	16,800	20,185	28,984	40,957	50,036	56,492	65,167
9,00,000	3,643	6,147	6,830	8,196	9,961	14,553	17,518	21,045	30,219	43,262	52,852	59,672	68,836
10,00,000	3,792	6,398	7,109	8,531	10,368	15,149	18,235	21,905	31,454	45,567	55,669	62,852	72,504
15,00,000	4,266	7,198	7,998	9,597	11,664	17,043	20,515	24,644	35,386	51,263	62,627	70,708	81,567
20,00,000	4,585	7,738	8,598	10,317	12,538	18,321	22,053	26,492	38,040	55,108	67,324	76,011	87,684
25,00,000	4,815	8,125	9,028	10,833	13,165	19,237	23,156	27,817	39,942	57,863	70,690	79,812	92,068

Zone C													
Sum Insured	0-17	18-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	75+
1,00,000	1,352	2,282	2,536	3,043	3,698	3,784	4,555	5,481	7,869	9,098	11,115	12,549	14,476
1,50,000	1,614	2,724	3,027	3,633	4,415	4,595	5,531	6,655	9,556	12,130	14,819	16,732	19,301
2,00,000	1,876	3,166	3,519	4,223	5,132	5,406	6,507	7,829	11,242	15,163	18,524	20,915	24,126
2,50,000	2,128	3,591	3,991	4,789	5,820	6,487	7,809	9,395	13,490	18,196	22,229	25,098	28,952
3,00,000	2,380	4,016	4,463	5,355	6,508	7,568	9,110	10,961	15,739	21,228	25,934	29,280	33,777
3,50,000	2,491	4,204	4,671	5,605	6,812	8,496	10,226	12,300	17,662	23,809	29,086	32,840	37,883
4,00,000	2,603	4,392	4,880	5,856	7,116	9,423	11,342	13,639	19,584	26,389	32,239	36,399	41,988
4,50,000	2,714	4,580	5,088	6,106	7,421	10,350	12,459	14,978	21,507	28,969	35,391	39,958	46,094
5,00,000	2,825	4,767	5,297	6,356	7,725	11,278	13,575	16,317	23,430	31,550	38,544	43,517	50,200
6,00,000	2,963	5,000	5,555	6,666	8,102	11,830	14,240	17,114	24,574	33,686	41,154	46,464	53,600
7,00,000	3,101	5,232	5,814	6,977	8,478	12,383	14,905	17,911	25,719	35,823	43,764	49,411	56,999
8,00,000	3,239	5,465	6,072	7,287	8,855	12,936	15,571	18,708	26,863	37,960	46,375	52,358	60,399
9,00,000	3,376	5,698	6,331	7,597	9,232	13,488	16,236	19,506	28,008	40,096	48,985	55,306	63,799
10,00,000	3,514	5,930	6,589	7,907	9,609	14,041	16,901	20,303	29,153	42,233	51,595	58,253	67,199
15,00,000	3,953	6,671	7,413	8,895	10,810	15,796	19,014	22,840	32,797	47,512	58,045	65,534	75,598
20,00,000	4,250	7,172	7,969	9,562	11,621	16,981	20,440	24,554	35,256	51,076	62,398	70,449	81,268
25,00,000	4,462	7,530	8,367	10,040	12,202	17,830	21,462	25,781	37,019	53,630	65,518	73,972	85,332

***Note for all premium tables**: Premium for ages 66 years and above are applicable only for Renewals.*

II. OPTIONAL COVER PREMIUM RATES (EXCL. GST)

1. Maternity & New Born Baby Cover

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

2. Daily Cash Allowance on Hospitalisation

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

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

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

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

III. DISCOUNTS

- **Family Discount:** In case a single policy covers more than one member of the family, a discount of 5% is offered on the premium of each and every member of the family. This discount is only applicable for policies taken on Individual Sum Insured basis.
  Note: Family Discount is not applicable on Optional Cover premium rates.
- **Direct Channel Discount**: A discount is applicable for fresh policies purchased online through the Company's website or directly from United India's office, without any agent or an intermediary. For renewals, the discount shall be offered provided that both the renewing policy and expiring policy are without any agent or an intermediary.
- **No Claim Discount**: For every claim free year, a No Claim Discount of 5% is offered on renewal premium subject to a maximum of 15%. In case of a claim reported during a policy year, No Claim Discount shall be withdrawn for succeeding policy year.

  Note: No Claim Discount is not applicable on Optional Cover premium rates.
- **Floater Discount**: For policies taken on floater basis, a floater discount is offered on the premium of each and every member of the family as follows:

Family Composition	Floater Discount
1 Adult + any no. of Children	15%
2 Adults	25%
2 Adults + any no. of Children	25%

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

IV. LOADINGS

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

Note:

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

Family Medicare Policy

Benefit/Premium Illustration

Please note:

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

ILLUSTRATIONS

Illustration 1: Self, Spouse and 2 Dependent Children

Age of Insured Member	Coverage opted on Individual basis covering each member of the family separately (at a single point in time)		Coverage opted on Individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
45	9,560	3,00,000	9,560	5%	9,082	3,00,000	27,927	25%	20,945	3,00,000
40	8,221	3,00,000	8,221	5%	7,810	3,00,000				
21	5,073	3,00,000	5,073	5%	4,820	3,00,000				
18	5,073	3,00,000	5,073	5%	4,819	3,00,000				
Total Premium for all members of the family is Rs. 27,927, when each member is covered separately.			Total Premium for all members of the family is Rs. 26,531, when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 20,945.			
Sum Insured available for each individual is Rs. 3,00,000/-			Sum Insured available for each individual is Rs. 3,00,000/-				Sum Insured of Rs. 3,00,000 is available for the entire family.			

Illustration 2: Self and Spouse

Age of Insured Member	Coverage opted on Individual basis covering each member of the family separately (at a single point in time)		Coverage opted on Individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
62	39,852	5,00,000	39,852	5%	37,859	5,00,000	69,448	25%	52,086	5,00,000
56	29,596	5,00,000	29,596	5%	28,116	5,00,000				
Total Premium for all members of the family is Rs. 69,448, when each member is covered separately.			Total Premium for all members of the family is Rs. 65,976, when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 55,559.			
Sum Insured available for each individual is Rs. 5,00,000/-			Sum Insured available for each individual is Rs. 5,00,000/-				Sum Insured of Rs. 5,00,000 is available for the entire family.			