COMPLETE HEALTHCARE INSURANCE - PROSPECTUS

A. INTRODUCTION

The Complete Healthcare Insurance comes with comprehensive plans that reimburse medical expenses incurred in a hospital. If during the policy period one or more Insured Person(s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify, expenses towards the Coverages & Sum insured as mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions as mentioned in the Policy Wording. Maximum liability of the Company under all such Claims during each Policy Year shall be based on the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) as specified in the Policy Schedule.

B. ELIGIBILITY

a) Age Limit

- Entry Age of the Proposer-Minimum 18 years – Maximum 75 years
- Entry Age of the dependent children – Minimum 91 day– Maximum 25 years.
- Lifelong Renewals available

b) Number of Members

- The maximum number of insureds in policy would be up to 6 members (Primary Insured and 5 Family Members) and can be increased the same up to 20.
- The relationships that would be covered under the Policy are: Self, legally married spouse (as long as they continue to be married), son, daughter, mother, father, brother, sister, mother in-law, father in-law, grandfather, grandmother, grandson, granddaughter, son in-law, daughter in-law, brother in-law, sister in-law, nephew, niece.

c) Policy Period

- The Policy Term can be 1year, 2 years & 3 years.

C. BENEFIT COVERED UNDER THE POLICY

SECTION – I: BASE COVERS

C1) In-patient Treatment: We will cover expenses for hospitalization due to disease/illness/Injury during the policy period that requires an Insured Person's admission in a hospital as an inpatient. Medical expenses directly related to the hospitalization would be payable. The medical expenses include:

- Room Rent, boarding expenses
- Nursing
- Intensive Care Unit
- Medical Practitioner(s)
- Anaesthesia, blood, oxygen, operations theatre charges, surgical appliances
- Medicines, drugs and consumables
- Diagnostic Procedures

- The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure
- Modern Treatments will be covered (wherever medically necessary) up to the limit as specified below, during the Policy Period:

Sr No	**Modern Treatment Methods and Advancement in Technologies:**	**Limit (Per Policy Period)**
1	Oral Chemotherapy	10% of SI and maximum upto Rs 100,000
2	Immunotherapy – Monoclonal Antibody to be given as injection	20% of SI and maximum upto Rs 200,000
3	Intra vitreal injections	10% of SI and maximum upto Rs 75,000
4	Uterine Artery Embolization and HIFU	20% of SI and maximum upto Rs 200,000
5	Balloon Sinuplasty	10% of SI and maximum upto Rs 200,000
6	Deep Brain stimulation	50% of SI and maximum upto Rs 500,000
7	Robotic Surgeries	50% of SI and maximum upto Rs 500,000
8	Stereotactic radio surgeries	20% of SI and maximum upto Rs 250,000
9	Bronchial Thermoplasty	50% of SI and maximum upto Rs 250,000
10	Vaporisation of the prostate (Green Laser treatment or holmium laser treatment)	50% of SI and maximum upto Rs 250,000
11	IONM – (Intra Operative Neuro Monitoring)	10% of SI and maximum upto Rs 100,000
12	Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered	50% of SI and maximum upto Rs 500,000

Note: Sub Limit includes expenses under Pre & Post Hospitalization if any

C2) Day Care Procedures: The Medical Expenses for any Day Care Procedure where the procedure or Surgery is taken by You as an inpatient for less than 24 hours in a Hospital or standalone day care center but not in the outpatient department of a Hospital or standalone day care center.

C3) Pre-Hospitalization: The Medical Expenses incurred in 30 days immediately before the date the Insured Person was hospitalized will be paid

The Medical Expenses incurred within the 60 days prior to the date of Hospitalization will be paid, if

We are provided with the following at least 5 days before the Hospitalization:

1. medical documents with all details about the Illness; and

2. the date and the place of the proposed Hospitalization

C4) Post-Hospitalization: The Medical Expenses incurred in the 60 days immediately after the date the Insured Person was discharged from hospital will be paid

The Medical Expenses incurred within the 90 days prior to the date of Hospitalization will be paid, if We are provided with the following at least 5 days before the Hospitalization:

1. medical documents with all details about the Illness; and

2. the date and the place of the proposed Hospitalization

C5) Domiciliary Treatment: The Medical Expenses incurred by an Insured Person for availing medical treatment at his home which would otherwise have required Hospitalisation. We will also cover pre and post hospitalization expenses in case of domiciliary hospitalization.

C6) Organ Donor: The Medical and surgical Expenses of the organ donor for harvesting the organ where an insured person is the recipient.

C7) Ambulance: The coverage includes cost of the transportation of Insured Person through an Ambulance from a Hospital to the nearest Hospital which is prepared to admit him/her and provide the necessary medical services. If such medical services cannot satisfactorily be provided at a Hospital where Insured Person is situated, provided that transportation has been prescribed by a Medical Practitioner.

C8) Dental Treatment In case of Accident: The Medical Expenses of any Dental Treatment from a dentist provided that the Dental Treatment is required as a result of an Accident

C9) AYUSH Benefit: Medical Expenses incurred for In-patient treatment taken in AYUSH hospital.

C10) Daily Cash for Accompanying an Insured Child: A daily cash amount for one accompanying adult for each complete period of 24 hours if Hospitalization exceeds 72 hours provided that:

- The Insured Person Hospitalized is a child aged 12 years or less
- Our maximum liability shall be restricted to the amount mentioned in the Policy Schedule, and
- The days of admission and discharge shall not be counted, and We have accepted an in-patient Hospitalization claim under benefit (Section I. C1) In-patient treatment

C11) Vaccination: The Medical Expenses incurred for vaccination, including inoculation and immunizations in case of post-bite treatment.

C12) Out-patient treatment: The below mentioned expenses incurred as an Out-patient, when treatment is taken from a Medical Practitioner.

i. Out-patient Consultation
Reasonable and Customary consultation expenses of Medically necessary consultation with a Medical Practitioner, as an Out-patient to assess Your health condition for any Illness.

ii. Diagnostic Tests
Out-patient diagnostic tests taken by You from a diagnostic centre

iii. **Out-patient Dental Treatment**
Any Medically necessary Dental Treatment taken by You from dentist, provided that We will pay only for for X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same, and We will not pay for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer.

iv. **Spectacles, Contact lenses, Hearing Aids**
Either one pair of spectacles, contact lenses or hearing aids (Excluding batteries), provided that these have been prescribed for You by an Eye/ ENT specialist Medical Practitioner.

C13) Convalescence Benefit: A lump sum amount as shown in the Policy Schedule is payable, if the Insured Person is hospitalised for a minimum period of 10 consecutive days, provided that

- We have accepted claim under benefit (Section I. C1) In-patient treatment
- This benefit is payable only once to an Insured Person during each Policy Year of the Policy Period as per the plan.

C14) Mother and Child Care Benefit

i. **Routine Pregnancy:** Medical Expenses associated with the delivery of a child (including complicated deliveries and caesarean costs) while hospitalized
ii. **Pre and Post-natal expenses:** The cost of pre-natal and post-natal expenses per delivery limited up to the amount stated in the Policy Schedule
iii. **New Born Care:** Medical Expenses incurred by Your New Born Baby as an In-Patient from the first day till expiry of the Policy or the child is 91 days old whichever is earlier.

SECTION – II: ADDITIONAL BENEFITS

C1) Restore Benefit: If the base Sum Insured and No Claim Bonus (if any) is exhausted due to claims made and paid during the Policy Year or made during the Policy Year and accepted by Us as payable, then it is agreed that a Restore Sum Insured (equal to the 100% of Base Sum Insured) will be automatically available for the particular Policy Year.

SECTION – III: RENEWAL BENEFITS

C1) Cumulative Bonus:

The Insured will have an option to opt from:

A. Enhancement in Sum Insured:

- Cumulative Bonus of 10% of the Sum Insured will be applicable for every claim free year accumulating up to 50% of suminsured of the Inpatient Sum Insured for up to 10 lacs of Base SI under the Policy (Plans – Basic, Essential, Privilege and Digi-Pro) and
- 20% of the Sum Insured this year, maximum Cumulative Bonus shall not exceed 100% of the Inpatient Sum Insured from 15 Lacs to 50 Lacs of Base SI under the policy (Plus, Premier, Executive)
- In the event of a claim, the cumulative bonus shall be reduced by 10% and/or 20% (as per plan opted) of the increased Sum Insured in that following Policy Year.

Or

B. Discount in Premium:

No Claim Discount will be offered to an Insured Person at the renewal, in the event of no claim made in the policy year. This discount will be offered as per the Plan opted and where there is no claim, this will be available for maximum up to 5 years.

If a claim is made in any particular year, the discount accrued shall be reduced at the same rate at which it has accrued.

C2) Health Check up:

We will reimburse the cost of a Preventive Health Check-up, up to the limits specified below as per plan of the Insured Person who was covered during the previous Policy Year. This Cover does NOT carry forward if it is not claimed and shall not be provided if the Policy is not Renewed further. The below mentioned limits are applicable for each Insured Person per Policy Year in case of Individual Policy and cumulatively for all Insured Persons per Policy Year in case of Family Floater Policy.

Sum Insured (1 Lac to 10 Lac)	**Sum Insured Plan (15 Lacs to 50 Lacs)**
On each Claims-free Renewal of the Policy	On each continuous Renewal of the Policy

Limits:

TYPE / PLAN	**Basic**	**Essential**	**Privilege**	**Plus**	**Premier**	**Executive**	**Digi-Pro**
	Limit up to						
Individual	health check-up coupon			1000	1250	1500	500
Family Floater	Two health check-up coupon			2200	3000	3500	1250

SECTION – IV: VALUE ADDED SERVICES (APPLICABLE ONLY FOR BASIC, ESSENTIAL & PRIVILEGE)

***We* will provide the following complimentary and wellness offerings during the period for which the *Policy* remains valid**

C1) Dial-a-Doctor:

You may seek medical advice from a doctor through the telephonic or online mode

C2) Health Educational Library for People (HELP):

Get access to Our Health Education Library for People has many features such as:

- Ask a health expert
- Health Talks
- Online health Guides and Videos
- Live Chat

C3) Second Opinion:

Get a second opinion on your health condition.

C4) Specialist Consultation with Two follow up session

We shall arrange for a Specialist e-Consultation with Two follow up sessions for seeking expert opinion on any *Chronic Condition* suffered by *You.*

C5) Wellness Package:

Avail discounts on health and wellness products and services listed on our website.

C6) *24x7 Customer Service*

The 24x7 Universal Sompo Customer Service Centre is committed to making sure that *You* get the care needed. *You* can receive assistance with:

- Questions on claims, benefit levels and cover
- Claims processing
- General benefit and plan inquiries

C7) Newsletter:

Get a monthly newsletter with dieting tips, nutritional information and similar other health related articles.

SECTION – V: ADD ON COVERS

C1) Personal Accident

If You avail this option by paying an additional premium to Us, We will pay You the Sum Insured as mentioned in Your Policy Schedule, on happening of below mentioned contingencies

- **Accidental Death:** A lump sum amount for death resulting from Accidental Bodily Injury within 12 months from date of Accident.
- **Accidental Permanent Total Disablement:** A lump sum amount will be paid for below mentioned permanent total disability conditions resulting from

an Accident within 12 months from date of Accident

1. Loss of sight of both eyes; or
2. Actual loss by Physical Separation of both hands or both feet or one entire hand and one entire foot; or
3. Loss of use of both hands or both feet or of one hand and one foot without Physical Separation, Provided that, such disablement shall as a direct consequence thereof permanently disable the Insured person from resuming his normal occupation or engaging in similar gainful employment.

C2) Critical Illness

If You avail this option by paying an additional premium to Us, We will pay You the Sum Insured as mentioned in Your Policy Schedule, in case You are diagnosed as suffering from the covered Critical Illnesses or undergoing covered Surgical Procedures for the first time in Your life. Provided that,

We will not make any payment if You are diagnosed as suffering from Critical Illness within 90 days of taking the Policy.

No claim under this option shall be admissible if the Critical Illness or the Surgical Procedure is a consequence of or arising out of any pre-existing conditions/ diseases.

Cover under this Policy shall cease upon payment of the compensation on the happening of a Critical Illness and/ or Surgical Procedure and no further payment will be made for any consequent disease or any dependent diseases

1. **First Heart Attack - Of Specified Severity**

   The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

   - a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
   - new characteristic electrocardiogram changes
   - elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

   Exclusions

   - Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
   - Other acute Coronary Syndromes
   - Any type of angina pectoris.

2. **Permanent Paralysis Of Limbs**

   Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

3. **Cancer of specified severity**

I) A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

II) Exclusions

- All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

4. Open Chest CABG

The actual undergoing of open chest Surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner.

Exclusions

- Angioplasty and/or any other intra-arterial procedures
- Any key-hole or laser Surgery.

5. Open Heart Replacement Or Repair Of Heart Valves

The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

6. Coma of Specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and

- permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

Exclusions

The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

7. Kidney Failure requiring regular dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

8. Major Organ /Bone Marrow Transplant

The actual undergoing of a transplant of:

One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

Exclusion

Other stem-cell transplants

Where only islets of langerhans are transplanted

9. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extra cranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

Exclusion

Transient ischemic attacks (TIA)

Traumatic Injury of the brain

Vascular disease affecting only the eye or optic nerve or vestibular functions

10. Multiple Sclerosis with persisting symptoms

I) The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

iii. Neurological damage due to SLE is excluded.

11. Motor Neurone Disease With Permanent Symptoms

Motor neurone disease diagnosed by a specialist Medical Practitioner as spinal muscular

atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

C3) Hospital Daily Cash

With an additional premium, a daily cash amount will be payable as specified in the Policy Schedule per day. If You receive treatment as an In-patient for an eligible medical condition Provided that,

- We have accepted a claim under (Section I.C1) Inpatient Treatment Benefit
- You are hospitalized for more than 3 days,
- This benefit shall not apply to time spent by You in an Intensive Care Unit.

C4) Sub limits:

Medical Expenses incurred during Hospitalization (including its related Pre and Post Hospitalization expenses, if applicable) due to the below mentioned Surgeries / Medical Procedures or any medical treatment pertaining to an Illness/ Injury upon admissibility would become payable by Us subject to limits as per the table below:

S. No	Surgeries / Medical Procedures	Sub-limits (Rs.)		
		A[1]	B[2]	C
1	Cataract per eye	10,000	15,000	20,000
2	Other Eye Surgeries	15,000	22,000	35,000
3	ENT	15,000	22,000	35,000
4	Surgeries for Tumours/Cysts/Nodule/Polyp	20,000	30,000	60,000
5	Stone in Urinary System	20,000	30,000	40,000
6	Hernia Related	20,000	30,000	60,000
7	Appendectomy	20,000	30,000	40,000
8	Knee Ligament Reconstruction *Surgery*	40,000	60,000	90,000
9	Hysterectomy	20,000	30,000	60,000
10	Fissures/Piles/Fistulas	15,000	22,000	35,000
11	Spine & Vertebrae related	40,000	60,000	90,000
12	Cellulites/Abscess	15,000	22,000	35,000
13	Other Surgeries & Procedures	25,000	37,000	55,000
14	All *Medical Expenses* for any treatment not involving *Surgery*/*Medical Procedure*	10,000	15,000	25,000

For the purpose of applicability of the said sub-limits, multiple Hospitalizations pertaining to the same Illness or Procedure / Surgery occurring within a period of 45 days from the date of discharge of the first Hospitalization shall be considered as one Hospitalization.

No other sublimit other than the ones mentioned above shall apply if You choose to avail this option under the Policy.

[1] Sublimit A and B may be opted for Sum Insured(s) 1 Lakh and 2 Lakh

[1] Sublimit C may be opted for Sum Insured above 2 Lakh

C5) Treatment in Tiered Network:

If *You* avail this option, *You* agree that If *You* are hospitalized in a *Hospital* other than a *Network Provider* then, *You* shall bear 10% of the claim payable under the *Policy* and *Our* liability, if any, shall only be in excess of that sum.

The company ensures that discount of 5% if treatment is taken in tiered network and 10% co-pay if treatment is taken in non-tiered network.

C6) Extension under Pre-Hospitalization

On payment of additional premium, the limit of Pre-Hospitalization expenses of 30 days will be modified to 90 days.

C7) Extension under Post-Hospitalization

On payment of additional premium, the limit of Post-Hospitalization expenses of 60 days will be modified to 120 days.

C8) Maternity and Childcare Benefit Waiting Period Modification

On payment of additional premium, Waiting Period of 36 months stands modified to 24 Months.

i. Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium Waiting Period(Section VII.4) of 36 months stands modified to 24 Months.

ii. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

iii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

C9) Coverage for Non-Medical Items

Notwithstanding anything to the contrary contained in the Policy, it is hereby declared and agreed that, on payment of additional premium, expenses otherwise not payable as specified under List-I of Annexure A mentioned in Section I.b shall be considered and paid by the Company up to the limit specified in Policy Schedule.
Subject to terms and conditions of the policy.

C10) Condition waiver under Restore Benefit

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium Condition under Section II.C1.c stands deleted. All other terms and conditions are applicable as per Restore Benefit.

C11) Pre-Existing Disease Waiting Period Waiver

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, waiting period applicable to all Pre-Existing Diseases for each Insured Person before benefits are payable under the Policy is modified to 12 Months.

For the purpose of this extension, Waiting Period Section VI.1 shall be modified.

C12) Outpatient Dental Waiting Period Modification

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, waiting period of 36 months applicable to Section1.C13.iii. Out-patient Dental Treatment is modified to 24 Months.

C13) Emergency Travelling Allowance

The company will pay Your Travelling expenses incurred up to the maximum amount as specified in Policy Schedule, to reach hospital through Ambulance, paid Cabs or Auto in case of medical emergency or transferring the Insured member(s) to the nearest Hospital. If a claim is accepted under In-patient hospitalization. This coverage will be in addition to the limit mentioned against Ambulance charges (C7)

C14) Second Opinion

We will reimburse Your expenses incurred towards a second opinion from Network Medical Practitioner if an Insured Person is diagnosed with the below mentioned Illnesses during the Policy Period.

The expert opinion would be directly sent to the Insured Person.

1. First Heart Attack - Of Specified Severity
2. Cancer of specified severity
3. Open Chest CABG
4. Open Heart Replacement Or Repair Of Heart Valves
5. Coma Of Specified Severity
6. Kidney Failure requiring regular dialysis
7. Major Organ /Bone Marrow Transplant
8. Stroke resulting in permanent symptoms
9. Kidney Failure requiring regular dialysis
10. Permanent Paralysis Of Limbs
11. Motor Neurone Disease With Permanent Symptoms

This benefit can be availed by an insured person once during a Policy Year & can be claimed under this benefit only.

C15) Rest Cure, Rehabilitation and Respite Care [Nursing Care] Expenses Extension

Notwithstanding anything mentioned herein to the contrary, it is hereby declared and agreed that, on payment of additional premium, Exclusion Section VII.2/ Exclusion Code (Excl-05) is deleted.

For the purpose of this extension, expenses related to rest cure, rehabilitation and respite care [Nursing Care] are included under the scope of cover up to the limit specified in Policy Schedule.

C16) Obesity/ Weight Control Expenses Extension [twenty four months waiting period]

Notwithstanding anything mentioned herein to the contrary, it is hereby declared and agreed that, on payment of additional premium, Exclusion Section VII.3/ Exclusion Code (Excl-06) is deleted.

For the purpose of this extension, expenses related to the surgical treatment of obesity are included under the scope of cover up to the limit specified in Policy Schedule.

C17) Sterility and Infertility Treatment Expenses Extension [twenty four months waiting period]

Notwithstanding anything mentioned herein to the contrary, it is hereby declared and agreed that, on payment of additional premium, Exclusion Section VII.14/ Exclusion Code (Excl-17) stands deleted.

For the purpose of this extension expenses related to sterility and infertility which include:

- Any type of contraception, sterilization
- Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- Gestational Surrogacy
- Reversal of sterilization
- Procedures can be done Maximum up to 2 times in a Lifetime

are included under the scope of cover up to the limit specified in Policy Schedule.

C18) Enhanced Organ Donor Expenses

We will pay the Medical Expenses for an organ donor's treatment for the harvesting of the organ donated upto the Sum insured specified in the policy schedule, provided that

- The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 and the organ donated is for Your use, and
- We will pay the donor's Pre and Post Hospitalization expenses or any other medical treatment for the donor consequent on the harvesting, and
- We have accepted an inpatient Hospitalization claim under benefit Section I -C1In-patient treatment

C19) Premium Waiver

Notwithstanding anything mentioned herein to the contrary, it is hereby declared and agreed that, on payment of additional premium, we agree to waive the renewal premium for fourth (4^{th}) year of the Complete Healthcare Insurance Policy, provided

- There is no claim during the term of the policy for preceding three years.
- This premium waiver benefit is usable for and limited only to First time insured of this Policy
- The same can be availed only once in a lifetime.

C20) Global Cover

In consideration of payment of additional premium by the Insured Member(s). The Company will reimburse for Medical Expenses of the Insured Person incurred outside India

but not more than 180 consecutive days up to the sum insured, provided that the diagnosis was made in India and referred by Medical Practioner for which the insured member(s) travels abroad for treatment. The Medical Expenses payable shall be limited to Inpatient and day care Hospitalization. Insured member(s) can contact us for any claim assistance. The payment of any claim under this benefit will be in Indian Rupees based on the rate of exchange as on the date of invoice, published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for claims payment. If these rates are not published on the date of invoice, the exchange rate next published by RBI shall be considered for conversion. Only basic sum insured along with Cumulative Bonus can be used for this and not the restored sum insured. Subject to terms and conditions of the policy.

Condition:

- Prior written approval of the Company will be required before leaving the country for treatment purpose.
- The Company shall require the following additional documents supporting the claim under this benefit:
  - **a.** Proof of diagnosis in India
  - **b.** Insured's Passport and Visa
  - **c.** Medical Practioner's Advice/Prescription

C21) Medically Advised Support Devices

We will reimburse the charges incurred by Insured during the Policy Period on account of procuring medically necessary prosthetic or artificial devices or any other medical device prescribed by the Registered Medical Practitioner as arising due to admission claim under 'Section I.C1.'This benefit shall be limited to maximum amount as mentioned in Policy Schedule

C22) Co-payment

It is hereby declared and agreed that each claim under the Policy shall be subject to an agreed Co-payment as specified in the schedule is applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

C23) Home Care Treatment

We will reimburse the cost incurred towards Home Care Treatment up to the sum insured mentioned in the Policy Schedule. For the purpose of this benefit, Home Care Treatment means a treatment availed by the Insured Person at home which in normal course would require care and treatment at a Hospital, but it is actually taken at home, provided that:
Applicability: Only for Pandemic Disease.

a. The Medical Practitioner advices the Insured Person to undergo Treatment at Home;

b. There is a continuous active lie of treatment with monitoring of the Health status by a Medical Practitioner for each day through the duration of the Home Care Treatment.

c. Daily monitoring chart including records of treatment administered duly signed by the treating Doctor is maintained.

C24) Wellness Benefit:

The Company offers a comprehensive program to maintain the health and overall wellbeing of the insured person.
The Wellness Services and Activities Are Categorized As Below:

1. **Everyday Care**
   The insured person can avail discounts on outpatient consultation, pharmaceuticals and diagnostics tests through our empaneled Network providers. The list of such network providers will be updated from time to time and can be obtained from Our website, mobile application or by calling our call centre. *The Company will* assist in scheduling appointments for consultation and diagnostic test as per time convenience of the insured person. Alternatively, the insured person may also schedule his/her own appointment themselves by contacting the Network Provider or through the mobile application. The insured person(s) can avail these facilities as many number of time as the client wishes to avail.
   i. **OPD Consultation:** The Company offers family/general physician as well as special consultations at discounted rates from the Network Providers. The insured person(s) can also store the prescription letters and bills in the electronic health portal system provided by the Company.
   ii. **Diagnostic Services:** The Company offers diagnostic facilities at discounted rates from the Network Providers. The insured person(s) can also store these medical test reports and bills in the electronic health portal system provided by the Company.
   iii. **Pharmacies:** If the insured person(s) want to obtain medicines and consumables prescribed by a medical practitioner, he/she can avail the same at discounted rates subject to a valid prescription from the Network providers. The medicines can be also ordered through the Mobile App or our Web portal.

2. **Complete Wellness & HealthCare**
   The Company *offers* a comprehensive program to maintain the health and overall wellbeing of the insured person. The insured person is provided with an individual access to web based Health portal at Company's website and/or a Wellness mobile application by the Company where he/she can perform various healthcare activities as listed below.
   i. **Health Risk Assessment (HRA):** HRA is process of health risk assessment with the help of a questionnaire, by collecting the information from the insured in a systematic manner and evaluate their health risks. The Health Risk Assessment generates a statistical estimate of insured person's overall health risk status and quality of lifestyle. The HRA shall be self-performed by the insured person. We will aid the insured person to complete the HRA whenever required.
   ii. **Electronic Health Records:** the Insured person can store the medical test reports, prescriptions and other consultation papers in the personalized portal which gets digitized to help create a complete health profile of the insured person. The medical test reports along with HRA as specified above will provide a health score to depict the health status of the insured person.
   iii. **Health Screening:** Basis the health score of the insured person, the insured person shall be categorized as Healthy, in which case there will be no trigger for medical screening. If the score depicts unhealthy status, medical screening is advised to the insured person along with a "Health Goal" which is identified post identification of risk factors for improving insured person's overall well-being.

"Health Goal", which basically takes a deep dive in the identified risk areas to establish the focus points in that particular risk area.

3. **Health Coach**

The insured person will be assigned a dedicated Health Coach who will take care of the complete wellbeing of the Insured Person(s). The service will offer immediate and complete assistance to the Insured Person looking after his/her day-to-day health care. Post the complete health profile building of the Insured Person, Health Coach will interact with the Insured Person as per Health requirement.

4. **Disease Management Program (On payment of additional Premium)**

Those insured person(s) who get detected or assessed as high risk in the HRA or are already suffering from chronic diseases, the Company offers a variety of Disease Management Programs (DMP). This service aims to help the insured person cope with their disease and show them ways of dealing with them in everyday life. The DMP aims to improve the Insured Person/s quality of life. The DMP is provided for diseases or conditions like Asthma, Diabetes, Hypertension, Thyroid, Heart related, Maternity, Obesity, Tropical diseases etc.

Based on the identified DMP, the Company will assign a Health Coach for online diet Consultation & tracking mechanism, indulging the insured person into physical activities, encouraging for meditation and breathing techniques at home or online counselling through Company's Health Portal and/or Mobile Application. The insured person(s) will also be provided with services like exercise reminders, medicine and diagnostic test reminders, training videos, health blogs, digitization of health records etc.

5. **Wellness Reward Program:**

The Wellness Reward Program (WRP) aims to encourage the insured person to perform certain activities to stay active and medically fit. WRP is an award program wherein the Insured Person can earn the reward points termed as "*USGI Coins*" by performing the activities as mentioned in the below Table. The points can be redeemed against array of options provided as mentioned hereunder which would help the Insured to improve his/her overall Health Status.

i. For an individual as well as Family Floater policy, the earning of USGI coins shall be considered on individual member basis up to the maximum limit as specified under every category per policy year.
ii. The Company shall specify the Wellness Rewards – Earning and Redemption categories as well as Earned but not utilized USGI coins in the policy schedule. The details of USGI coins would also be available at the Company's Health Portal and/or Mobile Application.
iii. USGI coins earned in this section of the policy are valid up to 4 years from the date of renewal of this policy (including any grace period applicable) and would not be carried forward thereafter.
iv. Each USGI coin shall have the value equivalent to Rs.0.25.
v. The USGI coins can be earned in the following ways as mentioned in the given Table:

Table: Earn Rewards (in form of USGI coins)

Activities for Earning Wellness Rewards		Rewards/ USGI Coins earned by Individual	Max USGI Coins earned by Individual Per Policy Year
On completion of HRA on Health Portal/Mobile application	HRA Completion within 90 days from Policy Inception Date	500	500
HRA outcome without any adverse report	Cover 2.5 to 3.5 lakhs steps in a month	100/month	500
HRA Outcome of having Large waist size (> 40 inches)	Cover minimum 2 lakhs steps in a month	100/month	500
	Cover above 2 lakh steps in a month	150/month	1000
Blood pressure for a known case of Hypertension	Blood Pressure is below or equal to -	150/month	500
	SBP:120-140 mm/Hg		
	DBP: 80-90 mm/Hg		
	SBP - Systolic Blood Pressure; DBP – Diastolic Blood Pressure		
Blood sugar levels for a known case of Diabetes	HBA1C within normal limits ≤ 5.6	150/quarter	500
Lipid profile Level for a known case of Dyslipidemia	Lipid level are normal within range as applicable to the Laboratory	150/quarter	500
Body Mass Index (BMI) for a known case of High BMI Insured Person /s >=30 optimum BMI	BMI between 31 to 35 and reduce your BMI to the Optimum range	100/quarter	200
	BMI between 35 to 39 and reduce your BMI to the optimum range	150/quarter	300
	BMI between 40 to 42 and reduce your BMI to the optimum range	250/quarter	500
Health Tests for Heart Related, Blood Sugar, Thyroid/Lipid etc. Monitoring	on Submission of Reports	150/quarter	300
Annual membership for Dance/Zumba/Aerobic/Gymnastic/ Yoga/Gym/Swimming	Provide attendance Register/letter/medal/trophies/BIB number (as applicable) from the respective facility provider.	150/quarter	400
Participate in professional sport events like Marathon/Cyclothon/Swimathon	Provide attendance Register/letter/medal/trophies/BIB number (as applicable) from the respective facility provider.	100 /event	500
Competitive Sports: School Level	Participation Certificate from School	20/sport	50
Competitive Sports: National/State Level	Participation Certificate from relevant sports authority	75/sport	150
Download the Wellness		150	150

Application			
Refer a Friend to buy USGI policy		100/referral	300
Sum Insured Enhancement		100	100
Pledge to Quit Smoking		150	150
Water Intake	3-4 litres per day, to be updated on App	50/month	200

Redemption of USGI coins:

Sr. No	Categories to Redeem the USGI Coins	Limit on Redemption
1	Facilities as mentioned under ' Health & Wellness Program: Everyday Healthcare'	20% of USGI coins upto Rs.200
2	Dental Care except cosmetic treatment	30% of USGI coins upto Rs.300
3	Cost of Vaccinations	30% of USGI coins upto Rs.300
4	Cost of Spectacle Lenses	30% of USGI coins upto Rs.300
5	Laser surgery for correction of refractory errors	30% of USGI coins upto Rs.300
6	Any Hospitalizations which is Non-admissible as per the Policy terms and conditions as specified under ' In-patient Hospitalization'	50% of USGI coins upto Rs.500
7	You can also redeem your Rewards against Claim of yours/your family member/s who are insured with Us under retail Health Indemnity product	20% of USGI coins upto Rs.200
8	Discount on premium while renewing your Policy	30% of USGI coins upto Rs.300

C25) Emergency Assistance Service

The company will provide the below services which will be available when the Insured/Insured member(s) is/are more than 150 kilometers away from their residential address as provided in the Proposal Form. The services would be provided by the company /through our appointed Service provider, with prior intimation and acceptance by the Company.

a. **Medical Consultation, Evaluation and Referral**: In case of any emergency, The Company/our Service Provider will evaluate, troubleshoot and make immediate recommendations including referrals to qualified doctors and/or hospitals.
b. **Medical Monitoring and Case Management:** A team of doctors, nurses, and other medically trained personnel would be in regular communication with the attending physician and hospital, monitors appropriate levels of care and relay necessary and legally permissible information to the members of the Family / employer.

c. **Emergency Medical Evacuation**: If the Insured / Insured member/s becomes ill or injured in an area where appropriate care is not available, the Company /via Service Provider will intervene and use available transportation, equipment and personnel necessary to evacuate the Individual safely to the nearest facility for medical care. This shall also include Air Ambulance services if required.

d. **Medical Repatriation (Transportation):** When medically necessary, as determined by Company and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as mentioned in the Schedule, provided that the Insured Person is medically cleared for travel via commercial carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.

e. **Compassionate Visit:** When an Insured Person/s is/are hospitalized for more than seven (7) consecutive days, The Company/ Service Provider will arrange for a family member or a personal friend to travel to visit the Insured Person/s, by providing an appropriate means of transportation.

C26. Health Pay Add On:

The Insured person will be offered a Health Pay Card program under the Policy as an exclusive benefit tailored for healthcare needs. The Health Pay Card is a credit card facility provided by our network bank. This card can be used to pay for all types of covered Medical Expenses incurred due sickness/injury within the policy period. The card cannot be used for any other expenses other than Covered Medical expenses.

Specific Conditions:

i. The Health Pay Card is offered in partnership with the bank.
ii. The maximum amount that an insured can select for this card is up to his/her base Sum Insured
iii. The final decision of approval/rejection of the card and the limit shall be with the network bank basis their internal guidelines
iv. One Time Processing fees of Rs.300 shall be charged by USGI for providing this facility and shall be fully borne by the Insured Person.
v. Incase of Family floater Policy, we shall be offering one card only
vi. Charges and fees, as may be applicable from time to time, are payable by policyholder/Cardholder for specific services provided by the card issuing bank to the Cardholder or for defaults committed by the Cardholder with reference to his/her Card account
vii. The expenses done using the Health Pay card may or may not be covered under the insurance policy.
viii. The expenses done using the Health Pay card and which are covered under the policy shall be reimbursed basis the policy terms and conditions only
ix. In no case, it shall be binding on the insurance company to settle the claim before the health pay card bill payment date.

D. WAITING PERIOD

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:

D.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 36 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

D.2 Specific Waiting Period (Code-Excl02)

1. Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage, as may be the case after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
2. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
3. 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.
4. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
5. If the Insured Person is continuously covered without any break under the policy, then waiting period for the same would be reduced to the extent of prior coverage.

List of specific diseases/procedures:

i . Illnesses

Arthritis if non-infective; calculus diseases of gall bladder and urogenital system; cataract; fissure/fistula in anus, hemorrhoids, pilonidal sinus, gastric and duodenal ulcers; gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); osteoarthritis and osteoporosis if age related; polycystic ovarian diseases; sinusitis and related disorders and skin tumors unless malignant.

ii. Treatments

Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by

malignancy; joint replacement; myomectomy for fibroids; *Surgery* of gallbladder and bile duct unless necessitated by malignancy; *Surgery* of genito urinary system unless necessitated by malignancy; *Surgery* of benign prostatic hypertrophy; *Surgery* of hernia; *Surgery* of hydrocele; *Surgery* for prolapsed inter vertebral disk; *Surgery* of varicose veins and varicose ulcers; *Surgery* on tonsils and sinuses; *Surgery* for nasal septum deviation.

D.3 First Thirty Days 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 higher sum insured subsequently.

D.4 Maternity Expenses (Code-Excl18) [Thirty six months waiting period]

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage and the related lawful medical termination of pregnancy during the policy period.

are included under the scope of cover up to the limit specified in Policy Schedule.

Special Provision:
This coverage would only be available for insured in the age band of 18-45 years.

D.5 Out-patient Treatment Waiting Period of 3 years The expenses covered under benefit I) Out – Patient treatment shall be excluded for a period of 3 years unless You were insured continuously and without interruption for at least 3 years under any other Indian insurer's or Our individual health insurance Policy for reimbursement of medical costs incurred by You as an Out-patient in a Hospital or Out-patient Treatment centre

Treatment For Congenital Diseases
Congenital Internal Disease or Defects or anomalies shall be covered after twenty-four months of Continuous Coverage.
Congenital External Disease or Defects or anomalies shall be covered after thirty-six months of Continuous Coverage, but such cover for Congenital External Disease or Defects or anomalies shall be limited to 10% of the average Sum Insured in the preceding four years.

E. 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:

E.1 Investigation & Evaluation (Code-Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

E.2 Rest Cure, Rehabilitation and Respite Care (Code-Excl05)

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

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, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

E.3 Obesity/ Weight Control (Code-Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor

2) The surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMl);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

E.4 Change-of-Gender Treatments: (Code-Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

E.5 Cosmetic or plastic Surgery: (Code-Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medical 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.

E.6 Hazardous or Adventure sports: (Code-Excl09)

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

E.7 Breach of law: (Code-Excl10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

E.8 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 in 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.

E.9 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.**(Code-Excl12)**

E.10 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code-Excl13)**

E.11 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 hospitalization claim or day care procedure **(Code-Excl14)**

E.12 Refractive Error:(Code-Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

E.13 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.

E.14 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

E.15 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

E.16 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

- **a)** Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
- **b)** Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
- **c)** Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or' biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

E.17 Any expenses incurred on OPD treatment.

E.18 Treatment taken outside the geographical limits of India.

E.19 In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

SECTION F: PRE-POLICY CHECK UP

Under certain circumstances such as declaration(s) in the proposal form or if you or any of the applicant are/is above 45 years of age, we may ask you to undergo below mentioned medical check-up to help us understand your health condition in a better way.

More the level of your cover, more is the exposure of risk to us, hence, the medical tests we may require you to undergo shall vary as per your level of cover chosen as under

Age /SI	1lac to 20lac	30 to 40 lac	50 lac
0-90 days	**Required documents+ UW approval	**Required documents+ UW approval	**Required documents+ UW approval
91days to 45 yrs	STP	Set 1	Set 2
46 yrs to 55 yrs	Set 1	SET 2	SET 3
56 yrs to 65 yrs	SET 2	SET 3	SET 4
65 yrs to 70 yrs	SET 4	SET 4	SET 4

**Must fulfil below age eligibility criteria
Additional records- Vaccination record, Paediatric consultation, delivery notes + discharge summary, any other relevant documents** optional subject to UW decision.

Set 1	Medical Examination Report
Set 2	Medical Examination Report, CBC, ESR, ECG, Routine Urine Analysis, FBS, Hba1c
Set 3	Set 2+ SGOT, serum creatinine, Triglyceride
Set 4	Set 2 + LFT,RFT, Lipid profile

SECTION G: GENERAL TERMS AND CLAUSE

G.1 Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

G.2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person,

shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

(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). The Clause shall be suitably modified by the insurer based on the amendment(s), if any to the relevant provisions of Protection of Policyholder's Interests Regulations, 2017)

G.3 Claim Settlement (provision for Penal Interest)

i The Company shall settle or reject a claim, as the case may be, within 15 days from the date of submission of the claim.

ii In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt date of receipt of intimation to till the date of payment.

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 15 days from the date of submission of claim.

iv In case of delay beyond stipulated 15 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of intimation to till the date of payment.

G.4 Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

G.5 Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

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

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

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

G.6 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or

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

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

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

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

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

G.7 Cancellation

The Insured may cancel this Policy by giving 7 days' written notice, and in such an event, the Company shall refund premium for the unexpired Policy Period as per the rates detailed below.

a) If no claim has been made during the policy period, a proportionate refund of the premium will be issued based on the number of unexpired days. The date of cancellation request will be considered as expiry date of coverage

b) If the claim has been made in the current policy year, the premium for the remaining policy year(s) will be refunded on cancellation

G.8 Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per the IRDAI guidelines on Migration at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. lf such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration. The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

G.9 Portability

The insured person will have the option to port the policy to other insurers as per IRDAI guidelines related to portability at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. lf such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an lndian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

G.10 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud or non disclosure or misrepresentation by the insured person.

i. The Company will endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

G.11 Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

G.12 Moratorium Period

After completion of Sixty continuous months under the policy, no look back is to be applied. This period of Sixty months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and, subsequently, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would, however, be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

G.13 Premium Payment in Installments

If the insured person has opted for Payment of Premium on an instalment basis i.e .monthly, Quarterly, Half Yearly as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms to the contrary elsewhere in the policy).

i. The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.
ii. If the premium is paid in installments during the policy period, coverage will be available during such Grace period.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

G.14 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.

G.15 Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

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

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

G.16 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.

G.17 Redressal of Grievance

If You have a grievance about any matter relating to the Policy, or Our decision on any matter, or the claim, you can address Your grievance as follows:

Step 1: Contact us

Write us at:

Customer Service Universal Sompo General Insurance Co. Ltd.
Unit No. 601 & 602, 6th Floor, Reliable Tech Park, Thane- Belapur Road, Airoli, Navi Mumbai, Maharashtra – 400708

E- mail Address
contactus@universalsompo.com
For more details:
www.universalsompo.com
Toll Free Numbers: 1800-22-4030 or 1800-200-4030
Senior Citizen toll free number: 1800-267-4030

Step 2: Grievance Cell

If the resolution you received, does not meet your expectations, you can directly write to our Grievance Id. After examining the matter, the final response would be conveyed within two weeks from the date of receipt of your complaint on this email id.

Customer Service Universal Sompo General Insurance Co. Ltd.
Unit No. 601 & 602, 6th Floor, Reliable Tech Park, Thane- Belapur Road, Airoli, Navi Mumbai, Maharashtra – 400708

E- mail Address:
grievance@universalsompo.com

For more details:
www.universalsompo.com

Visit Branch Grievance Redressal Officer (GRO) - Walk into any of our nearest branches and request to meet the GRO.

- We will acknowledge receipt of your concern Immediately
- Seek and obtain further details, if any, from the complainant (permitted only once) Within one week
- Within 2 weeks of receiving your grievance, we will respond to you with the best solution.
- We shall regard the complaint as closed incase on non-receipt of reply from the complainant Within 8 weeks from the date of registration of the grievance

Step 3: Chief Grievance Redressal Officer

In case, you are not satisfied with the decision/resolution of the above office or have not received any response within 15 working days, you may write or email to:

Customer Service Universal Sompo General Insurance Co. Ltd.
Unit No. 601 & 602, 6th Floor, Reliable Tech Park, Thane- Belapur Road, Airoli, Navi Mumbai, Maharashtra – 400708

E- mail Address:
gro@universalsompo.com

For more details:
www.universalsompo.com

For updated details of grievance officer, kindly refer the link
https://www.universalsompo.com/resourse-grievance-redressal

Step 4: Insurance Ombudsman
Bima Bharosa Portal link: https://bimabharosa.irdai.gov.in/
You can approach the Insurance Ombudsman depending on the nature of grievance and financial implication, if any.
Information about Insurance Ombudsmen, their jurisdiction and powers is available on the website of the Insurance Regulatory and Development Authority of India (IRDAI) at www.irdai.gov.in, or of the General Insurance Council at https://www.gicouncil.in/, the Consumer Education Website of the IRDAI at http://www.policyholder.gov.in, or from any of Our Offices.
The updated contact details of the Insurance Ombudsman offices can be referred by clicking on the Insurance ombudsman official site**: https://www.cioins.co.in/Ombudsman.**
Note: Grievance may also be lodged at IRDAI- **https://bimabharosa.irdai.gov.in/.**
Note: Please refer the Contact details of the Insurance Ombudsman mentioned in Annexure B.

G.18. Enhancement of Sum Insured
You may seek enhancement of Sum Insured in writing before payment of premium for renewal, which may be granted at Our discretion. Before granting such request for enhancement of Sum Insured, We have the right to have You examined by a Medical Practitioner authorized by Us or the TPA. Our consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner and subject to limits as stated by the Company.
Enhancement of Sum Insured will not be considered for:
In respect of any enhancement of Sum Insured, exclusions code – Excl01, Excl02 and Excl03 would apply to the additional Sum Insured from such date.

SECTION H: CLAIM PROCEDURE

H.1 Procedure for Cashless claims:

Follow below steps to avail Cashless facility through our In house Health Claims Management:

Step I: Locate nearest Hospital by visiting our website or web portal or call our Health Helpline 1800 200 4030.

Step II: Visit Network hospital and show your Health Serve Card issued by the company along with Valid Photo ID proof and get 'Cashless Request Form' from Insurance helpdesk of the hospital.

Step III: Fill your details in the 'Cashless Request Form' & submit it to the Hospital Insurance helpdesk.

Step IV: Hospital verifies the patient details and sends duly filled Cashless Request Form to Universal Sompo

Step V: Universal Sompo Health team will review and judge the admissibility of the Cashless Request as per Policy Terms &Conditions and the same will be communicated to Insured and Hospital with in 60 mins for Initial Cashless request & 3 hrs for discharge request on their registered mobile number & Email ID respectively.

You can now avail cashless facility from non-network hospitals.
To avail the treatment under cashless from non-network hospitals, please find the below steps.
Prior Intimation is required for processing cashless from non-network hospitals:
➢ Inform us (Toll Free Helpline – 1800 200 4030) minimum 48 hours before admission for planned hospitalization and with 24 hours of admission for emergency hospitalization across India.

➢ Mail us at healthserve@universalsompo.com

H.2 Procedure for reimbursement of claims:
Follow below steps to avail reimbursement facility through our In house Health Claims Management:

Step I: Visit our Web Portal to register claim or Call our Health Helpline 1800 200 4030 or email us at healthserve@universalsompo.com and inform about your claim.

Step II: Visit hospital and undergo your treatment. Settle your hospitalization bill and collect all the documents after discharge from the hospital.

Step III: Fill in Reimbursement Claim Form and submit all original documents to our below mention office for reimbursement.
Universal Sompo General Insurance Company Limited,
Health Claims Management Office,
1st FloorC-56- A/13,
Block- C Sector- 62,
Noida,
Uttar Pradesh, Pincode: 201309

Step IV: On receipt of document your claim will processed as per Terms & Conditions of policy and the same will be communicated over SMS & Email.
Step V: Outcome of the claim will be communicated within 15 days from date of Submission of claim

H.3 Documents to be submitted:

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

I. Claim form duly filled and signed by the Insured
II. Certificate from attending medical practitioner mentioning the first symptoms and date of occurrence of ailment.
III. All treatment papers of current ailment including previous treatment papers if any.
IV. Original Discharge Card from the hospital, Indoor Case Papers.
V. All original medical Investigation reports (viz. X-ray, ECG, Blood test etc).
VI. Original hospital bill and receipts.
VII. Original bills of chemist, medical practitioner, medical investigation, etc. supported by the doctor's prescription.
VIII. NEFT details and Personalized cancelled cheque/ Passbook copy in the name of proposer for electronic fund transfer.
IX. Valid Photo ID Proof of the patient.
X. For accident Cases: MLC (Medico Legal Certificate) / FIR (First Information report).
XI. Copy of latest valid address proof of proposer like electricity bill, water bill or telephone bill or updated bank statement along with copy of PAN card & Aadhaar Card as per AML/KYC Norms.

The above list of documents is indicative. In case of any further document requirement, our team shall contact you on receipt of your claim documents by us.

Note:

1. Documentation consistent with Telemedicine Practice Guidelines [2020] circulated by the Medical Council of India shall also be allowed under this policy along with the ones involving standard, in-person consultation with a medical practitioner.
2. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
3. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
4. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

SECTION I: BENEFIT STRUCTURE

Age Group	18 years to 75 years						
	Child Age 91 Day to 25 Year						
Relationships Covered	Self, legally married spouse (as long as they continue to be married), son, daughter, mother, father, brother, sister, mother in-law, father in-law, grandfather, grandmother, grandson, granddaughter, son in-law, daughter in-law, brother in-law, sister in-law, nephew, niece.						
Maternity Allowed age group	18 - 45 years						
PPC	Medicals shall be arranged by Company. If Proposal is not accepted premium shall be refunded to Proposer after deducting 100% medical cost. If the proposal is accepted, 50% cost of Health check-up cost will be refunded to the Insured.						
Policy Type	Individual / Family Floater						
Policy Period	1Year 2 Year 3 Year						
Benefits	**Basic**	**Essential**	**Privelege**	**Plus**	**Premier**	**Executive**	**Digi-Pro**
Sum Insured (In Lakhs)	**1,2 lakhs**	**3,4,5 Lakhs**	**6,7,8,9,10 lakhs**	**15, 20 lakhs**	**25,30 lakhs**	**40,50 lakhs**	**1-10 lakhs**
SECTION I: BASE COVERS							
Inpatient Treatment	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI
Day Care Procedures	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI
Pre-Hospitalisation	30 days can be extended upto 60 days	30 days can be extended upto 60 days	30 days can be extended upto 60 days	30 days can be extended upto 60 days	30 days can be extended upto 60 days	30 days can be extended upto 60 days	30 days can be extended upto 60 days
Post-Hospitalisation	60 days, can be extended upto 90 days	60 days, can be extended upto 90 days	60 days, can be extended upto 90 days	60 days, can be extended upto 90 days	60 days, can be extended upto 90 days	60 days, can be extended upto 90 days	60 days, can be extended upto 90 days
Domiciliary Treatment	upto 20% of Base SI	upto 20% of Base SI	upto 20% of Base SI	upto 20% of Base SI	upto 20% of Base SI	upto 20% of Base SI	upto 20% of Base SI

Organ Donor	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI
Ambulance	Up to 1% of SI or Rs 1,000 or actuals whichever is less.	Up to 1% of SI or Rs 2,000 or actuals whichever is less.	Up to 1% of SI or Rs 3,000 or actuals whichever is less.	Up to 1% of SI or Rs 5,000 or actuals whichever is less.	Up to 1% of SI or Rs 10,000 or actuals whichever is less.	Up to 1% of SI or Rs 25,000 or actuals whichever is less.	Up to 1% of SI or Rs 3000 or actuals whichever is less.
Dental Treatment in case of Accidents	Inpatient Dental Treatment -Upto 100% of In-patient Treatment Sum Insured.	Inpatient Dental Treatment -Upto 100% of In-patient Treatment Sum Insured.	Inpatient Dental Treatment -Upto 100% of In-patient Treatment Sum Insured.	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI
AYUSH Benefit	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI	Covered upto SI
Daily Cash for accompanying an Insured child	NA	Rs 300 per day subject to maximum of Rs 9,000.	Rs 500 per day subject to maximum of Rs 15,000.	Rs.1000 per Day subject to maximum of Rs 30,000.	Rs.2000 per Day subject to maximum of Rs 60,000.	Rs.5000 per Day subject to maximum of Rs 1,50,000.	NA
Vaccination (in case of Post Bite Treatment)	Inpatient treatment- Upto 100% of In-patient Treatment Sum Insured or actuals whichever is less.	Inpatient treatment- Upto 100% of In-patient Treatment Sum Insured or actuals whichever is less.	Inpatient treatment- Upto 100% of In-patient Treatment Sum Insured or actuals whichever is less.	Inpatient treatment- Upto 100% of In-patient Treatment Sum Insured or actuals whichever is less.	Inpatient treatment- Upto 100% of In-patient Treatment Sum Insured or actuals whichever is less.	Inpatient treatment- Upto 100% of In-patient Treatment Sum Insured or actuals whichever is less.	NA
Out-Patient Treatment Cover after waiting period of 3 years a) Out-	Covered up to 1% of SI or actuals whichever is less subject to maximum	Covered up to 1% of SI or actuals whichever is less subject to maximum	Covered up to 1% of SI or actuals whichever is less subject to maximum	Covered up to 1% of SI or actuals whichever is less subject to maximum	Covered up to 1% of SI or actuals whichever is less subject to maximum	Covered up to 1% of SI or actuals whichever is less subject to maximum	NA

patient Consultation b) Diagnostic Tests c) Dental Treatment d)Spectacles, Contact Lens, Hearing Aids	of Rs 2,500.	of Rs 5,000.	of Rs 7,500.	of Rs 7,500.	of Rs 7,500.	of Rs 7,500.	
Convalescence Benefit	Flat Rs. 10,000 per member when Hospitalisation exceeds 10 days.	Flat Rs. 10,000 per member when Hospitalisation exceeds 10 days.	Flat Rs. 10,000 per member when Hospitalisation exceeds 10 days.	Flat Rs. 15,000 per member when Hospitalisation exceeds 10 days	Flat Rs. 20,000 per member when Hospitalisation exceeds 10 days	Flat Rs. 20,000 per member when Hospitalisation exceeds 10 days	NA
Mother and Child Care Benefits i. Routine Pregnancy ii. Pre and Post-natal expenses iii. New Born Care	NA	Normal Delivery: up to Rs 15,000 or actuals whichever is less Caesarean Delivery: up to Rs 25,000 (including pre and post natal expenses up to Rs 2,000) or actuals whichever is less	Normal Delivery: Up to Rs 25,000 or actuals whichever is less Caesarean Delivery: Up to Rs 50,000 (including pre and post natal expenses up to Rs 2,000) or actuals whichever is less	For Sum Insured 15 lakhs: Up to Rs 25,000 or actuals whichever is less For Normal Delivery Up to Rs 50,000 (including pre and post natal expenses up to Rs 2,000) or actuals whichever is less for Caesarean Delivery	For Sum Insured 25 lakhs & 30 Lakhs: Rs 75000 For Normal & Caesarean Delivery	**For Sum Insured 30 Lakhs:** Rs 1,00,000 For Normal & Caesarean Delivery **For Sum Insured 50 Lakhs:** Rs 2,00,000 For Normal & Caesarean Delivery	NA

				For Sum Insured 20 Lakhs: Rs 50000 For Normal & Caesarean Delivery			
SECTION II: ADDITIONAL BENEFITS							
Restore Benefit	Covered upto 100% of BASE SI	Covered upto 100% of BASE SI	Covered upto 100% of BASE SI	Covered upto 100% of BASE SI	Covered upto 100% of BASE SI	Covered upto 100% of BASE SI	NA
SECTION III: RENEWAL BENEFITS							
Cumulative Bonus	The Insured will have an option to opt from: **a) Enhancement in Sum Insured** 10% in increase in SI for every claims free year subject to maximum of 50%. The increased SI shall be decreased by 10% in event of claim but SI shall not be reduced Or	The Insured will have an option to opt from: **a) Enhancement in Sum Insured** 10% in increase in SI for every claims free year subject to maximum of 50%. The increased SI shall be decreased by 10% in event of claim but SI shall not be reduced	The Insured will have an option to opt from: **a) Enhancement in Sum Insured** 10% in increase in SI for every claims free year subject to maximum of 50%. The increased SI shall be decreased by 10% in event of claim but SI shall not be reduced	The Insured will have an option to opt from: **a) Enhancement in Sum Insured** 20% (up to 100%) The increased SI shall be decreased by 20% in event of claim but SI shall not be reduced Or **b. Discount in Premium:**	The Insured will have an option to opt from: **a) Enhancement in Sum Insured** 20% (up to 100%) The increased SI shall be decreased by 20% in event of claim but SI shall not be reduced Or **b. Discount in Premium:**	The Insured will have an option to opt from: **a) Enhancement in Sum Insured** 20% (up to 100%) The increased SI shall be decreased by 20% in event of claim but SI shall not be reduced Or **b. Discount in Premium:**	The Insured will have an option to opt from: **a) Enhancement in Sum Insured** 10% in increase in SI for every claims free year subject to maximum of 50%. The increased SI shall be decreased by 10% in event of claim but SI shall not be reduced

	b. Discount in Premium: No Claim Discount will be offered to an Insured Person at the renewal, in the event of no claim made in the policy year. This discount will be offered as per the Plan opted and where there is no claim, this will be available for maximum up to 5 years. If a claim is made in any particular year, the discount accrued shall be reduced at the same rate at which it	Or **b. Discount in Premium:** No Claim Discount will be offered to an Insured Person at the renewal, in the event of no claim made in the policy year. This discount will be offered as per the Plan opted and where there is no claim, this will be available for maximum up to 5 years. If a claim is made in any particular year, the discount accrued shall be reduced at the same rate at	Or **b. Discount in Premium:** No Claim Discount will be offered to an Insured Person at the renewal, in the event of no claim made in the policy year. This discount will be offered as per the Plan opted and where there is no claim, this will be available for maximum up to 5 years. If a claim is made in any particular year, the discount accrued shall be reduced at the same rate at	No Claim Discount will be offered to an Insured Person at the renewal, in the event of no claim made in the policy year. This discount will be offered as per the defined grid mentioned below for every renewal where there is no claim, this will be available for maximum up to 10 years. If a claim is made in any particular year, the discount accrued shall be reduced at the same rate at which it	No Claim Discount will be offered to an Insured Person at the renewal, in the event of no claim made in the policy year. This discount will be offered as per the defined grid mentioned below for every renewal where there is no claim, this will be available for maximum up to 10 years. If a claim is made in any particular year, the discount accrued shall be reduced at the same rate at which it	No Claim Discount will be offered to an Insured Person at the renewal, in the event of no claim made in the policy year. This discount will be offered as per the defined grid mentioned below for every renewal where there is no claim, this will be available for maximum up to 10 years. If a claim is made in any particular year, the discount accrued shall be reduced at the same rate at which it	Or **b. Discount in Premium:** No Claim Discount will be offered to an Insured Person at the renewal, in the event of no claim made in the policy year. This discount will be offered as per the defined grid mentione d below for every renewal where there is no claim, this will be available for maximum up to 10 years. If a claim is made in any

	has accrued.	which it has accrued.	which it has accrued.	has accrued.	has accrued.	has accrued.	particular year, the discount accrued shall be reduced at the same rate at which it has accrued.
Health Check-up	Limits in (Rs) On each continuous Claims-free Renewal of the Policy			Limits in (Rs) On each continuous Renewal of the Policy			
	health check-up coupon			1000	1250	1500	500
	Two health check-up coupon			2200	3000	3500	1250
SECTION IV: VALUE ADDED BENEFITS							
Dial a Doctor	Covered	Covered	Covered	NA	NA	NA	NA
Health Educational Library for People(HELP)	Covered	Covered	Covered	NA	NA	NA	NA
Second Option	Not Covered	Covered	Covered	NA	NA	NA	NA
Specialist Consultation with Two follow up session	Not Covered	Covered	Covered	NA	NA	NA	NA
Wellness Package	Covered	Covered	Covered	NA	NA	NA	NA
24x7 Customer Service	Covered	Covered	Covered	NA	NA	NA	NA
Newsletter	Covered	Covered	Covered	NA	NA	NA	NA
SECTION V: ADD-ON COVERS							

Personal Accident	upto 100% of BASE SI	upto 100% of BASE SI	upto 100% of BASE SI	Option 1- 100% Option 2- 200%	Option 1- 100% Option 2- 200%	Option 1- 100% Option 2- 200%	NA
Critical Illness	Covers 11 CI's upto 100% of Sum Insured maximum upto Rs. 5,00,000/-.	Covers 11 CI's upto 100% of Sum Insured maximum upto Rs. 5,00,000/-.	Covers 11 CI's 100% of Sum Insured maximum upto Rs. 5,00,000/-.	Covers 11 CI's upto 100% of Sum Insured maximum upto Rs. 5,00,000/-.	Covers 11 CI's upto 100% of Sum Insured maximum upto Rs. 5,00,000/-.	Covers 11 CI's upto 100% of Sum Insured maximum upto Rs. 5,00,000/-.	NA
Hospital Daily Cash (when Hospitalisation exceeds 3 days) maximum number of days payable are 7 days	Rs 200 per day	Rs 500 per day	Rs 1,000 per day	Rs 2,000 per day	Rs 3,500 per day	Rs 5,000 per day	NA
Sub limits Applicability	No sublimit applicable under base Policy. Avail discount of 7.5% for choosing Sublimit A Avail discount of 5% for choosing Sublimit B	No sub limits applicable under base Policy Avail discount of 10% for choosing Sublimit A Avail discount of 7.5% for choosing Sublimit B Avail discount of 5% for	No sub limits applicable under base Policy Avail discount of 10% for choosing Sublimit A Avail discount of 7.5% for choosing Sublimit B Avail discount of 5% for	No sub limits applicable under base Policy Avail discount of 10% for choosing Sublimit A Avail discount of 7.5% for choosing Sublimit B Avail discount of 5% for	No sub limits applicable under base Policy Avail discount of 10% for choosing Sublimit A Avail discount of 7.5% for choosing Sublimit B Avail discount of 5% for	No sub limits applicable under base Policy Avail discount of 10% for choosing Sublimit A Avail discount of 7.5% for choosing Sublimit B Avail discount of 5% for	No sub limits applicable under base Policy Avail discount of 10% for choosing Sublimit A Avail discount of 7.5% for choosing Sublimit B Avail discount

		choosing Sublimit C	choosing Sublimit C	choosing Sublimit C	choosing Sublimit C	choosing Sublimit C	of 5% for choosing Sublimit C
Treatment only in tiered Network	5% discount if treatment is taken in tiered network and 10% co-pay shall be applicable for taking treatment in non-tiered network.	5% discount if treatment is taken in tiered network and 10% co-pay shall be applicable for taking treatment in non-tiered network.	5% discount if treatment is taken in tiered network and 10% co-pay shall be applicable for taking treatment in non-tiered network.	5% discount if treatment is taken in tiered network and 10% co-pay shall be applicable for taking treatment in non-tiered network.	5% discount if treatment is taken in tiered network and 10% co-pay shall be applicable for taking treatment in non-tiered network.	5% discount if treatment is taken in tiered network and 10% co-pay shall be applicable for taking treatment in non-tiered network.	NA
Extension Under Pre-Hospitalization	90 days	90 days	90 days	90 days	90 days	90 days	NA
Extension Under Post-Hospitalization	120 days	120 days	120 days	120 days	120 days	120 days	NA

Maternity (and Childcare Benefit) Waiting Period Modification	Waiting Period modified to 24 months	Waiting Period modified to 24 months	Waiting Period modified to 24 months	Waiting Period modified to 24 months	Waiting Period modified to 24 months	Waiting Period modified to 24 months	NA
Coverage for Non-Medical Items	Upto Rs 1000	Upto Rs 2000	Upto Rs 5000	Upto Rs 7500	Upto Rs 10000	Upto Rs 20000	NA
Condition Waiver under Restore Benefit/ Covalescene Benefit	Covered	Covered	Covered	Covered	Covered	Covered	NA
Pre-Existing Disease Waiting Period Waiver	Pre-Existing Disease Waiting period is modified to 12 months	Pre-Existing Disease Waiting period is modified to 12 months	Pre-Existing Disease Waiting period is modified to 12 months	Pre-Existing Disease Waiting period is modified to 12 months	Pre-Existing Disease Waiting period is modified to 12 months	Pre-Existing Disease Waiting period is modified to 12 months	Pre-Existing Disease Waiting period is modified to 12 months
Out-Patient Dental Waiting Period modification	Waiting period of 36 months applicable to Outpatient Dental Treatment is modified to 24 months	Waiting period of 36 months applicable to Outpatient Dental Treatment is modified to 24 months	Waiting period of 36 months applicable to Outpatient Dental Treatment is modified to 24 months	Waiting period of 36 months applicable to Outpatient Dental Treatment is modified to 24 months	Waiting period of 36 months applicable to Outpatient Dental Treatment is modified to 24 months	Waiting period of 36 months applicable to Outpatient Dental Treatment is modified to 24 months	Waiting period of 36 months applicable to Outpatient Dental Treatment is modified to 24 months
Emergency Travelling Allowance	Up to 1% of SI or Rs 1,000 or actuals	Up to 1% of SI or Rs 2,000 or actuals	Up to 1% of SI or Rs 3,000 or actuals	Up to 1% of SI or Rs 5,000 or actuals	Up to 1% of SI or Rs 10,000 or actuals	Up to 1% of SI or Rs 25,000 or actuals	NA

	whichever is less.	whichever is less.	whichever is less.	whichever is less.	whichever is less.	whichever is less.	
Second Opinion	1 Consultation in a Policy Year upto 2500	1 Consultation in a Policy Year upto 2500	1 Consultation in a Policy Year upto 2500	1 Consultation in a Policy Year upto 5000	1 Consultation in a Policy Year upto 5000	1 Consultation in a Policy Year upto 10,000	NA
Rest Cure, Rehabilitation and Respite Care [Nursing Care] Expenses Extension - Max 10 days	per day Rs 1000	per day Rs 1000	per day Rs 1000	per day Rs 2000	per day Rs 5000	per day Rs 5000	NA
Obesity/ Weight Control Expenses Extension [twenty four months waiting period]	25000	25000	50000	100000	100000	100000	NA
Sterility and Infertility Treatment Expenses Extension [twenty four months waiting period]	NA	NA	NA	Upto Rs 50,000	Upto Rs 50,000	Upto Rs1,00,000	NA
Organ Donor	Upto Rs 50000	Upto Rs 1 lakh	upto Rs 2 lakhs	Upto Rs 5 lakhs	Upto Rs 5 lakhs	Upto Rs 5 lakhs	NA

(Enhanced)							
Premium Waiver	Covered	Covered	Covered	Covered	Covered	Covered	NA
Global Cover	NA	NA	NA	Covered	Covered	Covered	NA
Medically Advised Support Devices	upto 15000	upto 15000	upto 15000	upto 25000	upto 50000	Upto 100000	NA
Co-Payment	10-50%	10-50%	10-50%	10-50%	10-50%	10-50%	NA
Home Care Treatment (Applicability: Only for Pandemic Diseases)- Max upto 5 days	5% of Base SI or Rs 25,000, whichever is lower	5% of Base SI or Rs 25,000, whichever is lower	5% of Base SI or Rs 25,000, whichever is lower	5% of Base SI or Rs 25,000, whichever is lower	5% of Base SI or Rs 25,000, whichever is lower	5% of Base SI or Rs 25,000, whichever is lower	NA
Wellness Benefit Disease Management	Wellness Rewards+ App	Wellness Rewards+ App	Wellness Rewards+ App	Wellness Rewards + App + Health Coach	Wellness Rewards + App + Health Coach	Wellness Rewards + App + Health Coach	Wellness Rewards+ App
Emergency Assistnace Services	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Health Pay Card Add On	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Discount

a. **Family Discount:** Discount on applicable premium, if 2 or more than 2 family members are covered on Individual Sum Insured basis in the same policy. This discount is available on Fresh as well as on Renewal of the Policy. The discount is as follows:

Number of members	Discount
1	0.0%
2	2.5%
3	5.0%
>3	7.5%

b. **Direct Policy Discount:** 15% discount on the applicable premium for customers approaching the Company directly without any intermediary.

c. **Loyalty Discount:** 5% discount on the applicable premium for existing policyholders holding any retail policy of the Company. The existing policy should not have expired at the time of inception of this proposed policy.

d. **Employee Discount:** 15% discount on the applicable premium for employees on roll of the Company.

e. **Long term discount:**
Applicable when the policy term is beyond one year

Policy Term (Year)	Discount
1	0%
2	5%
3	7.5%

The maximum discount applicable is 35%.

DISCLAIMER: THE ABOVE IS DESCRIPTIVE ONLY. THE ACTUAL TERMS AND CONDITIONS CAN BE FOUND IN THE POLICY DOCUMENT. INSURED'S ARE ADVISED TO READ THE POLICY DOCUMENT COMPLETELY FOR A FULL DESCRIPTION OF THE TERMS AND CONDITIONS OF COVERAGE AND THE EXCLUSIONS RELATING THERETO.

Registered & Corp Office: Universal Sompo General Insurance Company Ltd. 8th Floor & 9th Floor (South Side), Commerz International Business Park, Oberoi Garden City, Off Western Express Highway, Goregaon East, Mumbai 400063, Toll free no: 1800-22-4030/1800-200-4030, IRDAI Reg no: 134, CIN# U66010MH2007PLC166770 E-mail: contactus@universalsompo.com, website link www.universalsompo.com