SUPER HEALTHCARE INSURANCE
PROSPECTUS

With healthcare costs increasing at an exorbitant rate every year, it is very important to have a health insurance policy. But your regular health insurance policy may not be sufficient to take care of the extra expenses that may arise due to rising medical treatment cost. Universal Sompo's Super Healthcare Insurance will offer a financial cushion in the event when your hospitalisation claim bill crosses your sum insured under any other Mediclaim policy or the deductible amount.

Why Super Healthcare Insurance is different?

Universal Sompo's Super Healthcare Insurance offers higher Sum Insured with a deductible applicable for claims making higher range Sum Insured more affordable than a regular mediclaim policy with higher Sum Insured(s).

Plan Option

Top Up (*Application of deductible per claim basis*)

Options	Plan 1	Plan 2	Plan 3
Sum Insured	1, 1.5, 2, 3, 5 Lakhs	2, 3, 5, 7, 10 Lakhs	5, 7, 10, 15, 20 Lakhs
Deductible	50K, 1 Lakh	2, 3, 4, 5 Lakhs	6,7,8,9,10 Lakhs

Super Top Up (*Application of deductible on aggregate claim basis*)

Options	Gold	Diamond	Platinum
Sum Insured	2, 3, 5, 7, 10 Lakhs	3, 5, 7, 10, 15, 20 Lakhs	10, 15, 20, 30, 50, 100 Lakhs
Deductible	1, 2, 3, 4,5 Lakhs	6,7,8,9,10 Lakhs	10, 15, 20, 30, 40 Lakhs

What are the Key Features of Super Healthcare Insurance Super Healthcare Insurance?

- Higher Sum insured options up to 1 Cr with deductible limits as specified.
- No Medical tests up to 65 years or Sum Insured 20 lakhs.
- Long term Policy discount for 2 and 3 years policy.
- Free health check-up to the insured on every renewal.
- Wellness reward programme on meeting certain wellness criteria for complete wellbeing of the Insured Person.
- Medical expenses incurred prior to Hospitalization and after hospitalization are also covered.
- Medical expenses incurred for the successful organ transplant including pre-transplant medical test for legitimate donor and for harvesting the organ up to the sum insured are covered.
- In-patient Hospitalization treatment related to or for obesity are covered under Super Top up Diamond and Platinum plans.
- Maternity Expenses incurred after 9 months from the policy inception up to the specified limits under Top up: Plan 2, Plan 3 & Super Top-up: Diamond, Platinum Plan.
- 100% restoration of Base Annual Sum Insured (available for the plans with deductible limit 2 Lakh and above), if the initial sum insured including any cumulative bonus gets exhausted because of the

claims made and accepted by the company
- Tax Benefit under section 80 D of Income Tax Act 1961 on premium paid for the Policy.
- Policy is available on Individual and Family floater Basis.

What is the minimum and maximum entry age?

- Minimum entry age: (Proposer/Adults) 18 yrs; dependent Children's- 91 days
- Maximum entry age: (Adult) 80 years
- Maximum entry age for dependent children is 30 years

What is renewal age?

The policy shall ordinarily be renewable for lifetime except on grounds of fraud, moral hazard, misrepresentation by the insured person.

Who are eligible to take the policy?

- Individuals and families.
- Members covered under any Medical expenses (Hospitalization) policy. This policy covers the medical expenses in excess of the specified deductible amount.
- Members who do not have any Health policy can also opt for this policy; the expenses up to the deductible limit have to be borne by the member.

Who can be covered as dependants under Policy?

- Family Floater Sum Insured Basis: Self, Spouse, 4 dependent Children can be covered under single Sum Insured. The premium shall be calculated as per the highest age of the family member (Maximum 6 persons can covered under floater plan)
- Individual Sum Insured Basis: Self, spouse, dependent children, brother, sister, dependent parent, grandparents, grandchildren, mother-in-law, father-in-law, son-in-law, daughter in-law, dependent brother-in-law and dependent sister-in-law, Niece and Nephew.

Policy Tenure

- The Policy can be taken for 1 year/ 2 Years/ 3 Years.

Coverage's

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse actual expenses incurred in excess of the Deductible as specified in the Policy Schedule.
The company will pay for the Medical Expenses, in excess of deductible stated in the Policy Schedule either **on per admissible claim basis (for Top Up - Plan 1, Plan 2 and Plan 3)** or when the aggregate of covered medical expenses exceeds the deductible applicable **on policy per year basis (for Super Top Up – Gold, Diamond and Platinum)** depending upon the plan opted.
However, the total liability of the Company under this Policy for payment of any and all admissible Claims in aggregate/per admissible claim during the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

D.1. BASE COVERS

1. **Medical Expenses**

The company will pay Insured the Reasonable charges of Medical Expenses incurred in excess of the deductible stated in the schedule provided that the Insured members are hospitalised on the advice of a Doctor due to the Illness or accidental Bodily Injury sustained or contracted during the Policy Period.

1.1. In Patient Hospitalisation Expenses

In-patient Hospitalisation Medical Expenses as stated below:

- Room Rent boarding expenses
- Nursing Charges
- Intensive Care Unit
- Medical Practitioner(s)
- Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, Medicines, drugs and consumables
- Intravenous fluids, blood transfusion, injection administration charges
- Diagnostic procedures
- The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure

1.2. Day Care Treatment

The Company will pay for the Medical Expenses for day care treatment/ surgical procedures, taken by the Insured as an inpatient for less than 24 hours in a Hospital or day care centre but not in the outpatient department of a Hospital or day care centre as enlisted in the list of Day care Treatment/Procedures annexed to this Policy and also available on company's website.

1.3. Pre-Hospitalization Expenses:

The Company will pay for the Medical Expenses incurred during the policy period ,for the period as stated in Policy Schedule immediately before Insured were hospitalized , provided that:

- Such Medical Expenses were incurred for the same illness/injury for which subsequent Hospitalisation was required, and
- We have accepted an inpatient Hospitalisation claim under Medical expenses.

1.4. Post-Hospitalization Expenses:

The Company will pay for the Medical Expenses incurred during the policy period for the period as stated in Policy Schedule immediately after Insured were discharged post Hospitalisation provided that:

- Such costs are incurred in respect of the same illness/injury for which the earlier Hospitalisation was required, and
- We have accepted an inpatient Hospitalisation claim under Medical expenses

1.5. Organ Donor Expenses:

The Company will pay the in-patient Hospitalization Medical Expenses for a successful organ transplant including pre-transplant medical tests for legitimate donor and for harvesting the organ up to the sum insured mentioned in policy schedule, provided that:

i. The organ donor is any person whose organ has been made available in compliance with The Transplantation of Human Organ Act 1994, The Transplantation of Human Organs Act (Amendment) 2011(or any amendments thereafter); and other applicable Central / State Rules / Regulations, as applicable, in respect of transplantation of human organs.

ii. The organ donated is for the use of the Insured Person who has been medically advised to undergo organ transplant , and

iii. The Company has accepted an In-patient Hospitalization claim for the Insured member under medical expenses.

iv. The policy will not cover expenses towards the donor in respect of:
   a) Any Pre Hospitalisation Medical Expenses or Post Hospitalisation Medical Expenses other than pre-transplant medical test for legitimate organ donor and cost of organ harvesting;
   b) Costs directly or indirectly associated to the acquisition of the organ/ or cost of organ.
   c) Any other medical treatment or complication in respect of the donor, consequent to harvesting.
   d) Claims which have NOT been admitted under in-patient Hospitalization Medical Expenses for the insured.

1.6. In Patient AYUSH Hospitalization

The Company will pay for the medical expenses incurred as per guidelines for reimbursement/settlement of AYUSH treatment expenditure claims under insurance coverage attached as Annexure III as an in-patient treatment taken under AYUSH in any of the following:

i. Government hospital or in any institute recognized by government and/or accredited by Quality Council of India/ National Accreditation Board for Hospitals and Healthcare Providers excluding centre for spas, massage and health rejuvenation procedures.

ii. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH).

iii. AYUSH Hospitals having registration with a Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria:
   a) has at least fifteen in-patient beds;
   b) has minimum five qualified and registered AYUSH doctors;
   c) has qualified paramedical staff under its employment round the clock;
   d) has dedicated AYUSH therapy sections;
   e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

1.7. Domiciliary Hospitalization

The Company will pay for the medical expenses incurred by Insured member(s) for medical treatment taken at home which would otherwise have required In–Patient Hospitalization, provided that:

- The condition for which the medical treatment is required continues for at least 3 days, in such a case the Company will pay the reasonable charge of any necessary medical treatment for the entire period, and
- If the Company accept a claim under this Cover then the Company will not make any payment for Post-Hospitalization Expenses but the company will pay Pre-Hospitalization expenses for up to the maximum days as mentioned in benefit structure for number of days under Pre- hospitalization benefit, and
- No payment will be made if the condition for which You require medical treatment is:
   1. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza
   2. Arthritis, Gout and Rheumatism
   3. Chronic Nephritis and Nephritic Syndrome
   4. Diarrhoea and all type of Dysenteries including Gastroenteritis,
   5. Epilepsy,
   6. Pyrexia of unknown Origin.

2. Ambulance Expenses

The company will pay the ambulance expenses incurred for Road Ambulance Expenses, Special Cardiac Ambulance expenses, Air Ambulance up to the maximum amount as specified in Policy Schedule, per valid

hospitalization claim for transferring the Insured member(s) to the nearest Hospital with adequate facilities, If a claim is accepted under In-patient hospitalization,

3. Maternity & New Born Care Cover:

The Company will pay for

3.1. **Maternity Cover:**

The Company shall pay the Medical Expenses incurred as an inpatient for a delivery (including caesarean section) or lawful medical termination of pregnancy during the policy period limited to two deliveries or terminations or either, during the lifetime of the Insured Person.

3.2. **Pre and Post natal expenses:**

The cost of pre-natal and post-natal expenses per delivery limited up to the amount stated in the Schedule under maternity coverage.

3.3. **New Born Care**

Medical Expenses incurred by Insured member(s)'s 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. The maximum liability for new born care will be subject to the amount specified in the schedule to cover Maternity & new Born Care, Provided that, When the New Born Baby is older than 91 days, then Insured member(s) will have to take an individual policy for the New Born or wait till your next renewal to cover the baby under a regular family floater plan.

Provided that,

- Maximum liability per delivery will be subject to the amount specified in the Schedule.
- This benefit is available only to the Insured or his spouse provided that this policy has been in force for a continuous period of minimum 9 months in respect of both the Insured and his/her spouse.
- Pre-natal and post-natal expenses are not covered unless admitted in Hospital and treatment is taken there. Prenatal is the medical care given to a pregnant woman and for the purpose of this policy it starts from the date of conception up-to the childbirth. Post natal is the medical care given to a woman after her baby is born and coverage is for a period of six weeks from the date of childbirth.
- Subject to the terms & conditions, the policy covers New Born Baby beyond 90 days only on payment of requisite premium.

4. Automatic Restoration

(this benefit is available for the plans with deductible limit 2 Lakh and above)

The Company will provide a 100% restoration of Base Annual Sum Insured opted by the Insured once in a policy year, if the opted Base Sum Insured and the Cumulative Bonus (if any) is insufficient as a result of previous claims in that policy year, provided that:

a) Restoration of Sum Insured will be in addition to opted Base Annual Sum Insured.
b) The restored Base Annual Sum Insured can only be used for all future claims within the same policy year, not related to the illness/disease/injury for which a claim has been paid in that policy year for the same Insured member(s)
c) The claim will be admissible under the restored Base Annual Sum Insured only if the claim is admissible under "Medical Expenses section"
d) Restore will not trigger for the first claim
e) No Cumulative Bonus will apply on the restored Base Annual Sum Insured;
f) For individual policies, restore Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis
g) Any unutilized restored Base Annual Sum Insured will not be carried forward to subsequent policy year
h) Automatic restoration of Base Annual Sum Insured will be available only once during a Policy year to each insured in case of individual policy and can be utilized by insured persons who stand covered under the Policy before the Sum Insured was exhausted.
i) For any single claim during a policy year, the maximum claim amount payable shall not exceed the sum of Base Sum Insured as mentioned in schedule, and Cumulative Bonus

j) During a Policy Year, the aggregate claim amount payable, shall not exceed the sum of: The Base Sum Insured, Cumulative bonus and Restored Sum Insured (100% of Base Sum Insured)

5. Bariatric Surgery Cover

The Company will pay for reasonable and customary expenses for Bariatric Surgery if the insured fulfils the following conditions:

- Surgery to be conducted is upon the advice of the Doctor
- The member has to be 18 years of age or older and
- Body Mass Index (BMI) greater than or equal to 40
- BMI greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
    a) Obesity-related cardiomyopathy
    b) Coronary heart disease
    c) Severe sleep apnea
    d) Uncontrolled Type 2 Diabetes

6. Emergency Assistance Services:

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.

i. **Medical Consultation, Evaluation and Referral-** In case of any emergency situation, The Company/our Service Provider will evaluate, troubleshoot and make immediate recommendations including referrals to qualified doctors and/or hospitals.
ii. **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.
iii. **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.
iv. **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.
v. **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.

VALUE ADDED BENEFIT

The policyholder can avail the benefits through Mobile application or web portal without any additional cost, subject to terms and conditions of the policy.

The Wellness Services and Activities Are Categorized As Below:

The Company covers below listed benefits to help the Insured person(s) maintain his/her health and wellness by offering services and incentivizing with rewards.

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.

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	150/quarter	500

	Laboratory		
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 Application		150	150
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

OPTIONAL COVER

1. Global Care

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

RENEWAL

The Insured will have an option to opt from:

1. Cumulative Bonus

a) Enhancement in Sum Insured:

The company will increase the Base Annual Sum Insured by 20% at the end of the Policy Year if the Policy is renewed with Us provided that:

- No claim has been made under the Policy, including for the optional benefits, and the Policy is renewed with the Company without any break. The maximum Cumulative Bonus shall not exceed 100% of the Base Annual Sum Insured under the Policy.
- In case of a Family floater the Cumulative Bonus so applied will only be available in respect of claims made by those Insured Members(s)who were Insured Member(s)in the immediate preceding claim free Policy Year and continue to be Insured Member(s) in the subsequent Policy Year.
- If a Cumulative Bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the Cumulative Bonus by 20% of the Base Annual Sum Insured in that following Policy Year. There will be no impact on the Base Annual Sum Insured.

- If the Policy Period is more than one year, then any Cumulative Bonus that has accrued for the Policy Year will be credited at the end of the Policy Year and shall be available for any claims made in the subsequent Policy Year.

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 mentioned below for every renewal 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.

2. Free Health Check-Ups

The company will provide free medical check-ups to the insured on every renewal, through the empanelled Service Provider. This free health check-up is offered irrespective of the claim history of policyholder. Provided that, the Insured Member(s) have to renew the Policy with the company without any break.

EXCLUSIONS

E.1. Standard Exclusions:

a) Waiting Period:

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 36/24/12 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 36/24/12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. **Specific Waiting Period: (Code- Excl02)**

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 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.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre- existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break under the policy, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures:

S.No.	Organ/Organ System	Illness	Treatment/Procedure

1.	ENT	• Sinusitis • Deviated Nasal Septum	Treatment for conditions related to Tonsils, adenoids, sinuses
2	Gynaecological	• Fibroids(fibromyoma) • Endometriosis • Prolapsed uterus • Polycystic ovarian disorder (PCOD)	• Dilatation and (D&C) • Myomectomy • Hysterectomy
3	Orthopaedic	• Arthritis • Gout and Rheumatism • Osteoarthritis • Osteoporosis • Spinal or Vertebral Disorders	• Surgery for inter vertebral disc • Joint replacement surgeries
4	Gastrointestinal	• Calculus Diseases Of Gall • Bladder Including Cholecystitis • Esophageal varices • Pancreatitis • Fissure/ fistula In Anus, Hemorrhoids, pilonidal sinus, Piles • Ulcer and erosion • Gastro Esophageal • Reflux Disorder (GERD) • Perianal abscesses	• Cholecystectomy • Procedures for Biliary stones
5	Uro-genital	• Calculus diseases of Urogenital • systemExample: Kidney stone, • Urinary bladder stone etc. Benign enlargement of Prostate Chronic Kidney Disease	• Surgery on prostate • Surgery for Hydrocele/ Rectocele • Dialysis
6	Eye	• Cataract	• PHACO emulcification • Any other cataract surgery
7	Other General conditions (Applicable to all organ systems/ organs/ disciplines)	• Internal tumours, cysts, Nodules, polyps, skin tumours, Lumps, All types of Internal Congenital Anomalies/ illnesses/ defects	• Surgery and varicose ulcers • Varicocele • Surgery for any Hernia

In case the above illnesses are Pre-existing disease at the commencement of this Policy, then the Illnesses shall be covered after the specified period mentioned in summary of benefit of continuous coverage, since Period of Insurance Start Date.
This waiting period will be reduced by number of continuous preceding years of coverage of the Insured person under previous health insurance policy in case of portability.

3. **First Thirty Days Waiting Period (Code- Excl03)**

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.
This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4. **Maternity (and Childcare Benefit) Waiting Period (Code Excl18):**

(Applicable for Top up: Plan 2, Plan 3, Super Top-up: Diamond, Platinum Plan)
(Excluded until the expiry of 9 months after the date of inception of the first policy with us):

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

b) Exclusions:

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

1. **Investigation & Evaluation (Code- Excl04)**
   a) Expenses related to any admission primarily for diagnostics and evaluation purposes.
   b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.
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.

3. **Obesity/ Weight Control (Code- Excl06) (Not Applicable for Super Top-up: Diamond & Platinum)**
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   i. Surgery to be conducted is upon the advice of the Doctor
   ii. The surgery/Procedure conducted should be supported by clinical protocols
   iii. The member has to be 18 years of age or older and
   iv. Body Mass Index (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
4. **Change-of-Gender Treatments: (Code- Excl07)**
   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
5. **Cosmetic or plastic Surgery: (Code- Excl08**)
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment 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.
6. **Hazardous or Adventure sports: (Code- Excl09)**
   Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
7. **Breach of law: (Code- Excl10)**
   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. **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.
9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof**.(Code- Excl12)**
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)**
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)**
12. **Refractive Error:(Code- Excl15)**
    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
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.
14. **Birth Control, 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
15. **Maternity (Code – Excl 18): (Applicable only for Top- up : Plan 1 Super Top-up : Gold Plan)**
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

E.2. Specific Exclusions:

a. Exclusions:

1. Treatment taken outside the geographical limits of India (Not applicable if 'Global Cover' is opted.)

2. 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.

3. 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.

4. 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:

5. 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.

a) 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.

b) 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.

4. Deductible:

The Company shall not be liable for the deductible amount as specifically defined in the Schedule. The Company is not liable for any payment unless the medical expenses exceed the deductible.

GENERAL TERMS AND CLAUSES

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 by the policyholder.

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. 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.

4. 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.

5. 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.

6. Cancellation

The policyholder may cancel his/ her policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall

a. refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.
b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

7. 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. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration. The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

8. 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. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with any Indian General/ Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

9. Renewal of Policy

i. A health insurance policy is renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate to another product.
ii. An Insurer shall not deny the renewal on the ground that the policyholder had made a claim (s) in the preceding policy years.
iii. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.

10. 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.

11. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

12. 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.

13. Free look period

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This optio**n is available in case of policies with a term of one year or more.**

14. Redressal of Grievance

If Customer has a grievance about any matter relating to the Policy/Claim, and/or the decision of the Company on any matter he/she can address the grievance as follows:

Grievance Cell
Write 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
Email: grievance@universalsompo.com
with a cc to Melvin.dsouza@universalsompo.com

For More details, visit – www.universalsompo.com
Visit Branch Grievance Redressal Officer (GRO) - Walk into any of our nearest branches and request to meet the GRO.

Grievance Redressal Officer
In case, the customer is not satisfied with the decision/resolution of the above office or have not received any response, he/she may write or email/mail 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
Email ID: GRO@universalsompo.com / namita.singh@universalsompo.com

Insurance Ombudsman
Bima Bharosa Portal link: https://bimabharosa.irdai.gov.in/
The customer can approach the Insurance Ombudsman depending on the nature of grievance and financial implication, if any.

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.

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 Offices of the Company.

15. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. 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.

DISCOUNTS & LOADINGS

Discount:

1. **Family Discount**:

A Family discount of 10% will be given if 2 or more family members are covered on Individual Sum Insured basis and is available for each member under the policy

2. **Long Term Policy Discount:**

A discount will be applicable on purchase of long term policy as per below table

Duration of Policy	Discount
2 years	2 year annual premium in advance less 7.5% discount
3 years	3 year annual premium in advance less 10% discount

3. **Loyalty Discount:**

5% discount if the client already has our on-going retail health insurance policy.

4. **Employee Discount:**

15% discount if the client is an employee of the Company. The discount will be given to each member insured under the Policy.

Loading:
We may apply a risk loading up to a maximum 100% of normal slab premium per diagnosis/medical condition and not over 200% of normal slab premium per person, on the premium payable based on declarations on proposal form, on the basis of your health status.
Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be

no loadings based on individual claims experience.

CLAIMS 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 mentioned 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

1. **Method of Assessment and Payment of claim**

Any claim under this policy shall be payable by the Company only if:

i. It is in respect of Covered Expenses specified in this Policy
ii. The Company's liability to make payment shall commence once the claim amount exceed the Deductible under the policy. This means that all the claims, including those falling within the Deductible, will be assessed based on the terms and conditions of this policy for working out the admissible expenses. Expenses related to pre-hospitalisation and post-hospitalisation in respect of all previous claims would also be taken into consideration.
iii. **For Top Up - Plan 1, Plan 2 and Plan 3**, the Deductible (as mentioned in the Policy Schedule) shall be applicable per claim basis, incepting during each policy year under the policy. In case of more than one claim during the Policy period, each claim shall be separately assessed except in case of relapse within 45 (Forty-Five) days, as defined under Any One Illness, this will be applicable for Individual Policy as well as for Family Floater Policy.
iv. **For Super Top Up – Gold, Diamond and Platinum**, the Deductible (as mentioned in the Policy Schedule) shall be applied to aggregate of amount of all eligible claims as per policy terms and conditions that are related to hospitalisation/s of insured person in case of Individual Policy or all insured persons in case of Floater Policy, within the same policy year. For a Policy with Policy Period greater than one year, the

Sum Insured considered for assessment of claim shall be the Sum Insured mentioned against the Policy Year.

In the event that a claim becomes payable under the terms of the Policy, Company shall make such payment as incurred by You and accepted by Us by way of electronic fund transfer.

2. The steps for lodging the claim shall be as under:

Notify Us immediately on occurrence of a claim and in any case within 7 days giving full description of the medical treatment undertaken and the cause.

Submit the completed and signed claim form, provide all the relevant documents as mentioned below in support of Your claim not later than 30 days from the date of intimation.

3. Basis of payment:

a) Any claim under this Policy shall be payable by Us only if it is in respect of Expense specified, cover this Policy and
b) In no case Company shall be liable to pay any sum in excess of the Sum Insured in aggregate of all claims during the period of this Policy.
c) We shall make payment in Indian Rupees only.

4. **Fraudulent claims**

If any claim 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 You or anyone acting on Your behalf to obtain any benefit under this Policy, or if a claim is made and rejected for aforesaid reasons and no court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

5. Claim Administration:

For assisting you during claims related services, we have in-house Claim Administration Team and we have also tied-up hospitals all over India for securing you a cashless claims processing. The detailed list of network hospitals empanelled by us (the Network Providers) can be found at our website: **www.universalsompo.com**

6. 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.

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