**PROSPECTUS**

**SUPREME HEALTHCARE POLICY**

Universal Sompo brings to you Supreme Healthcare Policy which comes with most comprehensive health coverages at an affordable price. It covers cost of an insured member's medical and surgical expenses. 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.

## 1. Eligibility

| | |
|---|---|
| Entry Age – Minimum | Adult– 18 years<br>Child – 90 Days |
| Entry Age – Maximum | Adult: Lifelong<br>Child: 24 Years (last birthday) |
| Exit Age | Adult: Lifelong<br>Child: 25 Years |
| Age of Proposer | 18 Years or above |
| Policy Term | 1/2/3 Years |
| Premium Payment Term | Single/Monthly/Quarterly/Half-yearly |
| Cover Type | Individual: max up to 6 persons<br>Floater: max up to 2A2C |
| Who are covered (Relationship with respect to the Proposer) | Self, Spouse/live-in partner/same sex partner, Son, Daughter, Father, Mother, Mother-in-law, Father-in law, Grand - Father, Grand – Mother |
| Pricing | Zone 1: Delhi NCR, Mumbai Metropolis Area (including Mumbai suburban, Thane, Palghar , Raigad , any other city defined by Government ), Gujarat State, Aligarh, Mathura<br>(Delhi NCR includes Delhi, Baghpat, Bulandshahr, Gautam Buddh Nagar, Ghaziabad, Hapur, Meerut, Muzaffarnagar, Shamli, Charkhi Dadri, Faridabad, Gurugram, Jhajjar, Jind, Karnal, Mahendragarh, Nuh, Palwal, Panipat, Rewari, Bhiwani, Alwar, Bharatpur, Rohtak , Sonipat , any other city defined by Government)<br><br>Zone 2: ROI |

All the Age calculations are as per “Age Last Birthday” as on the date of first issue of Policy and / or at the time of Renewal.
Option of Mid-term inclusion of a Person in the Policy will be only upon marriage or childbirth; Additional differential premium will be calculated on a pro rata basis.

## 2. Discounts

| Sr. No | Description | Parameters | Rates |
|---|---|---|---|
| 1. | Discount for Employees and / or their dependents of :<br>Universal Sompo General Insurance Co Ltd | - | 15.00% |

<table>
<tr><td></td><td>Universal Sompo Promoters & Promoters Employees</td><td colspan="2"></td></tr>
<tr><td>2.</td><td>Tenure Discount</td><td colspan="2">7.5% on the second year premium if you pay for 2 year policy term in advance and additional 10% on the third year premium if you pay for 3 year policy term in advance.</td></tr>
<tr><td>3.</td><td>Family Discount</td><td colspan="2">This discount shall be applicable on each additional member covered (other than eldest member) in the same Policy having Sum Insured on individual basis.<br><table><tr><th>No. of Persons</th><th>Discount</th></tr><tr><td>2,3 members</td><td>5%</td></tr><tr><td>4 and above members</td><td>10%</td></tr></table></td></tr>
<tr><td>4.</td><td>Direct Discounts</td><td>Fresh Policy issuance<br><br>Renewal through Direct channel</td><td>5%<br><br>2.5%</td></tr>
<tr><td>5.</td><td>Discount in lieu of commission</td><td>Fresh Policy issuance & Renewal</td><td>5%</td></tr>
<tr><td>6.</td><td>Cross Sell Discount</td><td>If Insured person has existing health indemnity policy<br><br>If Insured person has existing Benefit/Travel policy</td><td>5%<br><br>2.5%</td></tr>
</table>

**Notes: –** Any other discount offered, other than mentioned above, is due to product features (e.g. offering deductible, Co-payment etc. ) or pricing related considerations (e.g. adding additional Insured Person). They are adequately explained in the premium rates annexed hereto with the prospectus.

All discounts mentioned in the Schedule above, are multiplicative in nature, subject to aggregate maximum discount (which will not exceed 50% of the Premium)

## 3.1 BASE COVERAGE

### 3.1.1 Hospitalization Expenses:

**(i)** **Benefit: In-patient Care:** Hospitalization for at least 24 hours - If You are admitted to a hospital for in-patient care due to Illness or Injury , which should be Medically Necessary, for a minimum period of 24 consecutive hours, We will pay for the medical expenses, through Cashless or Reimbursement Facility maximum up to Sum Insured, incurred by You at the hospital - from room charges, nursing expenses and intensive care unit charges to Surgeon's fee, Doctor's fee, Anesthesia, blood, oxygen, Operation theater charges etc. which forms a part of Hospitalization.

**(ii)** **Benefit: Day Care Treatment:** Hospitalization involving less than 24 hours – Some surgeries doesn't require or need not necessarily require Hospitalization Stay for minimum 24 Hours. It may be for your convenience or it may happen that the surgery underwent is minor or of intermediate complexity. We will pay through Cashless or Reimbursement Facility for all such day care treatments, maximum up to Sum Insured.

**(iii)** **Benefit : Advance Technology Methods:**

We will indemnify you for expenses incurred under In-patient Care and/or Day Care Treatment for treatment taken through following advance technology methods:

A. Uterine Artery Embolization and HIFU
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy- Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchical Thermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

**(iv)** **Benefit : Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses :**

1. **Pre-Hospitalization Medical Expenses:**

   Examination, tests and medication - Sometimes the procedures that finally lead You to hospital, such as Investigative tests, Consultation Fees and medication, can be quite financially draining. We cover the medically necessary expenses (Up to Sum Insured) incurred by You for a period of 60 days immediately before the date of Your admissible Hospitalization, provided that We shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were not incurred during the Policy Year.

2. **Post-Hospitalization Medical Expenses:**
   Back home and till You are back on Your feet - The expenses don't end once You are discharged. There might be follow-up visits to Your medical practitioner, medication that is required and sometimes even further confirmatory tests. We also cover the medically necessary expenses (Up to Sum Insured) incurred by You for a period of 180 days immediately after the date of Discharge from Hospital and claim documents to be submitted within 30 days after completion of 180 days from the date of discharge from Hospital.

   **Note:** Payment under this benefit will only be on re-imbursement basis

**(v)** **Benefit : AYUSH Treatments:**

It has been observed at times that a combination of conventional medical treatment and AYUSH therapies quicken & aid the process of recovery. Therefore, we will pay You up to Sum Insured for medical expenses incurred by You towards Your in-patient admission at any AYUSH Hospitals or health care facilities, which administers treatment related to the disciplines of medicine namely Ayurveda, Unani, Sidha and Homeopathy. Clause 4.2 (12) under Specific Exclusions, is superseded to the extent covered under this Benefit.

**(vi) Benefit : Domiciliary Hospitalization:**

Despite suffering from an Illness /Injury (which would normally require care and treatment at a Hospital), Hospitalization may not be possible - perhaps Your state of health is such that You are not in a condition to be moved to a Hospital or a Hospital room may not be available when you need the medical treatment the most.
Under Our Domiciliary Hospitalization Benefit, We will pay you maximum up to Sum Insured, for the Medical Expenses incurred during your treatment at home, as long as it involves medical treatment for a period exceeding 3 consecutive days. 'Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses' shall be payable in respect of a claim made under this Benefit.
Any Medical Expenses incurred for the treatment in relation to any of the following diseases shall not be payable under this Benefit:

- **(i)** Asthma;
- **(ii)** Bronchitis;
- **(iii)** Chronic Nephritis and Chronic Nephritic Syndrome;
- **(iv)** Diarrhoea and all types of Dysenteries including Gastro-enteritis;
- **(v)** Diabetes Mellitus and Diabetes Insipidus ;
- **(vi)** Epilepsy;
- **(vii)** Hypertension;
- **(viii)** Influenza, cough or cold;
- **(ix)** All Psychiatric or Psychosomatic Disorders;
- **(x)** Pyrexia of unknown origin;
- **(xi)** Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
- **(xii)** Arthritis, Gout and Rheumatism.

**(vii) Organ Donor Cover:**

We care about those who help you as much as we care for you. So, beyond ensuring that your medical needs are met, we will pay you up to Sum Insured for medical expenses that are incurred by you towards your organ donor, while undergoing the organ transplant surgery, if the donation confirms to the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules.

'Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses' shall not be payable in respect to the donor.

### 3.1.2 Road Ambulance Cover:

It is one of our utmost concerns that you get the medical attention which you require as soon as possible, especially in an emergency. Towards that end, we will pay you up to a specified amount/limit per Policy Year, for expenses that you incur on an ambulance service offered by the hospital or any service provider, in an emergency situation. Through this cover, we will also pay your necessary transportation fares from one Hospital to another Hospital, for advanced/better equipped medical support/aid required for your health condition, provided medically necessary.

### 3.1.3 Cumulative Bonus :

For every year that you enjoy un-interrupted good health, your bonus keeps building up! It's just our way to tell you that we're there with you in good times and in bad.

Sum Insured (excluding Cumulative Bonus) shall be increased by 50%, provided the policy is renewed without a break subject to maximum 100% of the sum Insured.

### 3.1.4 Unlimited Automatic Recharge

A refill is always welcome! So your sum insured is reinstated just when you need it the most.
If, due to claims made, you ever utilize the maximum limit of Sum Insured and thereby run out of/exhaust your health cover, we reinstate the entire base sum insured immediately, for unlimited times in the policy year.
In case of a floater policy, all Insured Person will be eligible to utilize the Recharged amount for any illness or injury pertaining to that Policy Year.
- Any unutilized Recharge cannot be carried forward to any subsequent Policy Year.
- Please note that the applicable 'Cumulative Bonus', 'Optional Benefit: Cumulative Bonus Super', Optional Benefit: Plus Benefit shall not be considered while calculating 'Unlimited Automatic Recharge'.
- Recharge amount can be utilized for same illness as well as different Illnesses.
- A Claim will be admissible under the Recharge only if the Claim is admissible under Benefit: Hospitalization Expenses;
- The Sum insured available under Unlimited Automatic Recharge can only be utilized for Benefits under 'Hospitalization Expenses' and Benefit 'Road Ambulance Cover' under the Policy.

### 3.1.4 Unlimited E-Consultation

We shall offer unlimited e-consultations with qualified General Physicians at our network during the Policy Year through any mode of communication (Voice/Video Call /Chat /Email Chat/etc.).

### 3.1.5 Health Services

**Health Portal:** You may access health related information and services such as Doctor on chat, Healthy tips reminder, Digital locker for medical records etc. as available on Company's website.
**Discount Connect:** You may access to Special rates for OPD, Diagnostics, and Pharmacy etc. through Network as available on our website.

## 3.2 OPTIONAL BENEFITS:

The Policy provides the following Optional Benefits which can be opted either at the inception of the policy or at the time of renewal. The Policy Schedule will specify the Optional Benefits that are in force for the Insured Persons.

### 3.2.1 Smart Select

This Optional Benefit provides you a reduction in the premium you pay!
By choosing this Optional Benefit and thereby getting a reduction on the total premium ( which includes premium of Base Benefits, Optional Benefits- Room Rent Modification, PED Wait Period Modification, Named Ailment Wait Period Modification, Instant Cover, Deductible, Co-payment, New Born Cover, Plus Benefit, Cumulative Bonus Super, Air Ambulance cover) payable as specified, you can avail Medical Treatment at any hospital listed under Annexure – III to the Prospectus.

However, if you avail Medical Treatment in hospitals other than those mentioned under Annexure – III to the Prospectus, then you shall bear a Co-Payment of 20% on each and every Claim arising in such regard, which will be in addition to any other Co-payment (if any) applicable in the Policy.

NOTE: For an updated list of Hospitals mentioned under Annexure – III to the Prospectus, please refer to our Website. *https://www.universalsompo.com*

### 3.2.2 Room Rent Modification

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit, we agree to modify the Room Rent / Room Category as per the following:

| Sr. No. | Room Category | Eligibility |
|---|---|---|
| 1. | **Single Private AC Room** | It means your maximum eligible Room Category in case of Hospitalization payable by Us is limited for stay in a Single Private AC Room. |
| 2. | **Twin Sharing Room** | It means your maximum eligible Room Category in case of Hospitalization payable by Us is limited for stay in a Twin Sharing Room. |

Notes:
**-** The nomenclature of Room categories may vary from one hospital to the other. The final consideration shall be as per definition of the Rooms mentioned in the Policy.
- No limit on ICU charges applicable

### 3.2.3 PED Wait Period Modification

Choosing this Optional Benefit modifies the applicable waiting period of 36 months for Claims related to Pre-existing diseases, to specific time period as specified.
Hence all the provisions stated under Clause 4.1 (a) (i) holds good for this Benefit as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Pre-existing Disease after specific time period of continuous coverage has elapsed as specified, since the inception of the first Policy with us.

### 3.2.4 Named Ailment Wait Period Modification

Choosing this Optional Benefit modifies the applicable waiting period of 24 months for Claims related to Named Ailments, to specific time period as specified.
Hence all the provisions stated under Clause 4.1 (a) (ii) holds good for this Benefit as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Named Ailment Disease after specific time period of continuous coverage has elapsed as specified, since the inception of the first Policy with us.

### 3.2.5 Instant Cover

Notwithstanding anything to the contrary in the Policy, by choosing this Optional Benefit we shall waive off the applicable PED waiting period on Diabetes/ Hypertension/ Hyperlipidemia / Asthma at the time of issuance of first Policy with us.

**Note:** The above Optional Benefit can be opted only if this policy is issued for the first time with us.

### 3.2.6 Deductible

We give you an option of choosing a deductible along with your Plan, which will help you reduce the amount of Premium to be paid.

Deductible is the claim amount (as specified) which is to be borne by You under this Policy. Deductible would apply on an aggregate basis in a Policy Year. We shall be liable only once the aggregate amount of all the claims exceed the Deductible.

Illustration for applicability of Deductible in the same Policy Year:

*(Amount in Rs.)*

| Case | Sum Insured | Deductible | Claim 1 | Claim 2 | Claim 3 | Payable 1 | Payable 2 | Payable 3 |
|---|---|---|---|---|---|---|---|---|
| 1 | 25,00,000 | 10,00,000 | 750,000 | 12,50,000 | 10,00,000 | - | 10,00,000 | 10,00,000 |
| 2 | 25,00,000 | 10,00,000 | 750,000 | 15,00,000 | 30,00,000 | - | 12,50,000 | 12,50,000 |
| 3 | 25,00,000 | 10,00,000 | 12,50,000 | 40,00,000 | 40,00,000 | 2,50,000 | 22,50,000 | Claim not payable as SI is exhausted |

### 3.2.7 Co-Payment

By choosing this Optional Benefit, you will have an option to bear a Co-payment on per claim basis (over & above any other co-pay, if any) and Our liability shall be restricted to the balance amount payable.

### 3.2.8 New – Born Cover

By choosing this Optional Benefit, We will allow the addition of New Born baby **from day 1**.

Note: All the applicable waiting period shall stand valid for this Benefit. Premium of this Optional Benefit shall be payable only at the time of addition of new born and will be pro-rated for the exposure period.

### 3.2.9 Plus Benefit

An additional amount as opted, will be available to the Insured Person for all claims (admissible under Base Benefits) during the Policy Year, subject to the following conditions:

a. This Plus Benefit would be applied on the base Sum Insured only.
b. Any unutilized amount will not be carried forward to the subsequent Policy Year.
c. The Plus Benefit can be utilized for any number of claims admissible under the Policy during the Policy Year.
d. The Plus Benefit will be applicable only after exhaustion of Base Sum Insured. 'Cumulative Bonus', 'Optional Benefit: Plus Benefit', 'Optional Benefit: Cumulative Bonus Super' shall not be considered while calculating amount under this Benefit.

### 3.2.10 Cumulative Bonus Super

For every year that you enjoy un-interrupted good health, your Cumulative Bonus Super keeps building up!

This Optional Benefit serves as an extension to Benefit: Cumulative Bonus. In a particular year, if this option is chosen by you, we raise a cheer to your good health in the form of a Cumulative Bonus Super for you. You receive an increase of 100 percent flat in your Sum insured, which is over & above the Sum Insured accrued under Benefit: Cumulative Bonus, for the next Policy year. In any case the Cumulative Bonus Super will not exceed 500% of the Sum insured and In the event of a Claim there is no impact on the accrual of Cumulative Bonus Super. 'Unlimited Automatic Recharge' and 'Optional Benefit: Plus Benefit' shall not be considered while calculating 'Cumulative Bonus Super'. Accrued 'Cumulative Bonus Super' can only be utilized for Benefits under 'Hospitalization Expenses' and Benefit 'Road Ambulance Cover' under the Policy.
At the time of Policy renewal if You choose not to renew this Optional Benefit, then the Cumulative Bonus Super under the expiring Policy shall be forfeited.

### 3.2.11 Annual Health Check –Up :

Our prime concern is your good health! For this we are providing you preventive care, over and above the amount of Sum Insured!!

To pre-empt your ever having to visit a hospital, as a preventive measure, we provide an annual health check-up at our Network to provide the services, in India, for all the Insured Persons who is covered under the Policy, on a Cashless basis. This Benefit shall be available only once during a Policy Year per Insured Person.

i) Medical Tests covered in the Annual Health Check-up, applicable for Insured Persons who are of Age 18 years or above on the Policy Period Start Date, are as follows :-

| Set No. | List of Medical Tests covered as a part of Annual Health Check-up | Sum Insured |
|---|---|---|
| 1 | COMPLETE BLOOD COUNT(CBC), URINE ROUTINE, ESR, ABO GROUP & RH TYPE, BLOOD SUGAR FASTING, CHOLESTEROL, CHOLESTEROL DIRECT LDL, CHOLESTEROL-HDL, TRIGLYCERIDES, TOTAL CHOLESTEROL/HDL RATIO, CREATININE, BLOOD UREA NITROGEN, BUN/ CREATININE RATIO, URIC ACID | 5Lakhs-10Lakhs |
| 2 | COMPLETE BLOOD COUNT(CBC), URINE ROUTINE, ESR, ABO GROUP & RH TYPE, BLOOD SUGAR FASTING, CHOLESTEROL, CHOLESTEROL DIRECT LDL, CHOLESTEROL-HDL, TRIGLYCERIDES, TOTAL CHOLESTEROL/HDL RATIO, CREATININE, BLOOD UREA NITROGEN, BUN/ CREATININE RATIO, URIC ACID, TREADMILL TEST | Above 10 Lakhs |

ii) Medical Tests covered in the Annual Health Check-up, applicable for Insured Persons who are of Age below 18 years on the Policy Period Start Date

| List of Medical Tests covered as a part of Annual Health Check-up |
|---|
| Physical Examination (Height, Weight and Body Mass Index (BMI), Eye Examination, Dental Examination and Scoring, Growth Charting, Doctor Consultation, Urine Examination (Routine and Microscopic) |

### 3.2.12 Be-Fit Benefit :

If you're above 12 years of age, covered under this Benefit - You may avail unlimited visits to the Fitness Centers in a Policy year at the Company's network!

Note: The services availed would be subject to the following conditions:

- The services will be provided through an empanelled Fitness center only. Choice of the Insured Person in utilizing the services of Fitness Center will be entirely his/ her own and We will have no liability towards the quality of services provided by the Fitness Centers.
- We shall not be responsible for any disputes or loss in account of availing the services or arising between the Insured Person and the Fitness center.

### 3.2.13 Wellness Benefit :

a. Insured Person who is covered as Adult (aged 18 years and above) in the Policy can avail following, provided this benefit is opted for –

Discount on renewal Premium by accumulating Healthy days as per table given below. One Healthy day can be accumulated by recording 10,000 steps or more in single day through tracking apps, devices, etc.

Healthy Days discount

| No. of Healthy days in a year | Discount on Renewal Premium |
|---|---|
| 270 | 30% |
| 240 | 20% |
| 180 | 15% |
| 120 | 10% |
| Less than 120 | 0% |

**Note:**

- The above benefit will be applicable on Individual basis. In case of floater, average of number of Healthy days earned by Insured Members shall be considered for calculating renewal discount. For example,' A' has attained 260 Healthy days and ' B' has attained 230 Healthy days, average of the Healthy days is 245 and accordingly the discount calculated is 20%.In case of multi tenure, average of number of Healthy days earned over the policy tenure shall be considered for discount.
- The above section of benefit is available only for Insured covered as Adults aged 18 and above in the Policy and discount calculated shall be applicable on total premium of Policy.
- Responsibility of mapping device with CHIL system is of the insured/customer
- Number of days completing 10,000 steps or more that are accumulated in last 2 months of the Policy Period would not be considered for discount on renewal premium. The same shall carry forward and will be considered in next policy period.
- In case of installment premium mode is opted, then discount shall be considered only post payment of first 6 month of premium.
- Vouchers of value equivalent to renewal discount amount can also be provided to Insured in case he/she does not wish for discount on renewal premium.

b. Access to Digital Fitness Coaching
c. Access to Artificial Intelligence Fitness Coaching
d. Access to Nutritionist/Wellness Coach

**Note:** The above services (b, c, d) shall be available at Our Network and available to Insured Members aged above 12 years subject to the following conditions:

a. The services will be provided through an empanelled Provider only. Choice of the Insured Person in utilizing the services of Provider will be entirely his/ her own and We will have no liability towards the quality of services provided by the Provider.

b. We shall not be responsible for any disputes arising between the Insured Person and the empanelled Provider.

c. The network under this benefit, does not constitute medical advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition.

### 3.2.14 Air Ambulance Cover :

Through this Optional Benefit, we will pay you up to the specified amount for availing Air Ambulance services in India, offered by a Hospital or by an Ambulance service provider, for your necessary transportation from the place of occurrence of Medical Emergency, to the nearest Hospital. Through this cover, we will also pay your necessary transportation fares from one Hospital to another Hospital, for advanced/better equipped medical support/aid required for rescuing your health condition, following an Emergency.

However, the treating Medical Practitioner should certify in writing that the severity or the nature of your Illness or Injury warrants your requirement for the Air Ambulance.

### 3.2.15 Women Care

If you're Female aged 18 years & above and have opted for this Optional Benefit, you will be covered on cashless basis, up to the amount specified, for following diagnostic services:

a) Mammography
b) Cervical Cancer screening
c) PCOS/PCOD diagnostic tests

### 3.2.16 Mental Health wellbeing :

Mental Health often taken less seriously!

In order to keep up with good mental health, we provide you out-patient coverage for specified mental conditions through this optional Benefit.

You can avail Consultation, Counseling and Rehabilitation, up to the specified amount, on cashless basis.

The conditions included are –

a) Acute depression

b) Obsessive compulsive disorder

c) Anxiety

d) Post traumatic stress disorder

### 3.2.17 Claim Shield

If a claim has been accepted under this benefit, then We shall indemnify for the items which are otherwise not payable, as per List-I under Annexure I. The maximum claim payout under this benefit shall be limited to applicable Sum Insured under the Policy.

Note: Coverage for any item as per List-I under Annexure I, shall be available only if the same is not covered under any Base Benefit or Optional Benefit.

### 3.2.18 Inflation Shield

The Inflation Shield benefit is designed to provide additional increase in Sum Insured under Base Policy on the basis of inflation rate in previous calendar year.

The Inflation would be computed as the change in average CPI of the entire calendar year published by the National Statistical Office (NSO), Ministry of Statistics and Programme Implementation. In case inflation rate of previous year is not available at renewal, then the inflation rate available for penultimate calendar year shall be considered.

The % increase will be applicable only on Sum Insured under the Base Policy and not on No Claim Bonus or any other benefit which leads to increase in Sum Insured.
In case of Sum Insured is changed at the time of renewal, any accumulated sum Insured due to Inflation Shield Benefit will be added to the applicable new Sum Insured opted by Insured at the time of renewal.

Please Note that all the accumulated Inflation Shield benefit will lapse and your Sum Insured under Policy will roll back to the Sum Insured opted under the Policy if this benefit is not continued.

### 3.2.19. Additional Sum Insured for Defined Critical Illnesses

In case any Claim is made due to 15 listed Critical illnesses during the Policy Year, the Company shall provide an additional Sum Insured for In-patient Care for that Insured Person who is hospitalized, as specified in Policy Schedule, provided that:
I. This Benefit shall be utilized only after the base Sum Insured has been completely exhausted and shall be applied only once during the Policy Year
II. The total amount payable under this Benefit shall not exceed the sum total of the Sum Insured, Cumulative Bonus, Cumulative Bonus Super, 'Additional Sum Insured for CI'
III. This Benefit is applicable only if Claim is admissible under Benefit: Hospitalization expenses.

| S.No | CI Conditions |
|---|---|
| 1 | Cancer |
| 2 | Myocardial Infarction |
| 3 | Open Chest CABG |
| 4 | Stroke |
| 5 | Open Heart Replacement Or Repair Of Heart Valves |
| 6 | Multiple Sclerosis |
| 7 | Major Organ /Bone Marrow Transplant |
| 8 | Permanent Paralysis Of Limbs |
| 9 | Kidney Failure Requiring Regular Dialysis |

| | |
|---|---|
| 10 | Benign Brain Tumour |
| 11 | Blindness |
| 12 | Motor Neurone Disease |
| 13 | End Stage Lung Failure |
| 14 | Third Degree Burns |
| 15 | Coma |

**3.2.20. Home Modification**

The Company shall indemnify the relevant expenses incurred during the Policy Year, as specified in the Policy Schedule, for the reasonable and necessary modification of the Insured Person's place of residence, if Insured Person is hospitalized for a medically necessary treatment and post discharge from the hospital requires mobility support to facilitate the Insured Person's movement at his/her place of residence , subject to admissible Hospitalization, provided that such modification is carried out within 30 days from the date of discharge from the hospital.

1.1.1. **Nursing Care**

The Company shall indemnify the Insured Person for the expenses incurred up to the limit per day as specified in Policy Schedule incurred towards the hiring of a qualified nurse. If Insured Person requires to be attended by a qualified nurse at home after the discharge from the hospital to avail post-operative care at home during the Policy Year subject to admissible Hospitalization, provided that:

i. Nursing care must be recommended and certified by attending Medical Practitioner in writing.

ii. The Company shall not be liable to make payment under this Benefit for more than 7 days per Policy Year per Insured Person.

iii. This Benefit does not apply to terminally ill, Palliative Care and coma patients

## 2. EXCLUSIONS

**4.1 Standard Exclusions:**

**(a) Waiting Periods:**

**(i) 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 insurer.
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 Insurer.

**(ii) Named Ailment Waiting Period: Code- Excl02**

a. Expenses related to the treatment of the 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 the Company. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures:
    1. Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders , Joint Replacement Surgery , Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
    2. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty ), Nasal Septum Deviation, Sinusitis and related disorders
    3. Benign Prostatic Hypertrophy
    4. Cataract
    5. Dilatation and Curettage
    6. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
    7. Surgery of Genito-urinary system unless necessitated by malignancy
    8. All types of Hernia & Hydrocele
    9. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
    10. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
    11. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
    12. Myomectomy for fibroids
    13. Varicose veins and varicose ulcers
    14. Parkinson's or Alzheimer's disease or Dementia

**(iii) 30-day waiting period- Code- Excl03**

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

**Notes:**

**(i)** The Waiting Periods as defined above shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

**(ii)** If Coverage for Optional Benefits (if applicable) are added afresh at the time of renewal of this Policy, the Waiting Periods as defined above shall be applicable afresh to the newly added Optional Benefits (if applicable), from the time of such renewal.

**(b) Permanent Exclusions:**

Any Claim of an Insured Person arising due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy Terms and conditions.

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

2. **Rest Cure, rehabilitation and respite care: (Code- Excl05)**
   a) 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)**
   Expenses related to the surgical treatment of obesity that does not fulfill 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 (BMI);
      a) greater than or equal to 40 or
      b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy
         ii. Coronary heart disease
         iii. Severe Sleep 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.
Note: Refer Annexure – II of Prospectus for list of excluded hospitals.

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. **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 Excl18)**
    a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

**4.2 <u>Specific Exclusions:</u>**

Any Claim of an Insured Person arising due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy Terms and conditions.

1. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – I to Prospectus).
2. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi-professional nature.
3. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
4. Charges incurred in connection with routine eye examinations and ear examinations, dentures, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment

5. Any expenses incurred on external prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, glucometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.
6. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.
7. Screening, counseling or treatment of any external Congenital Anomaly, Illness or defects or anomalies or treatment relating to external birth defects.
8. Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability.
9. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.
10. All preventive care (except eligible and entitled for Benefit: 'Annual Health Check-up'), Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics.
11. Expenses incurred for Artificial life maintenance, including life support machine use, post confirmation of vegetative state or brain dead by treating medical practitioner where such treatment will not result in recovery or restoration of the previous state of health under any circumstances.
12. Non-Allopathic Treatment, Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or treatment related to any unrecognized systems of medicine.
13. 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.
14. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs, alcohol or hallucinogens.
15. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness.
16. Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to cosmetics, hygiene articles, body care products and bath additives, as well as similar incidental services and supplies.
17. Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the hospital under whatever head or transportation charges by visiting consultant.
18. 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.
19. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a medical practitioner.
20. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, remodeling clinic or similar institutions.
21. Remicade, Avastin or similar injectable treatment which is undergone other than as a part of In-Patient Care Hospitalisation or Day Care Hospitalisation is excluded.
22. Expenses related to any kind of Advance Technology Methods other than mentioned in the Clause 3.1.1(iii).
23. Hormone replacement therapy.
24. Any other exclusion as specified in the Policy Schedule.

Note: In addition to the foregoing, any loss, claim or expense of whatsoever nature arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above Permanent Exclusions shall also be excluded.

## 5. GENERAL TERMS AND CLAUSES

### 5.1. 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.

Note:

a. "Material facts" for the purpose of this clause policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

b. In continuation to the above clause the Company may also adjust the scope of cover and / or the premium paid or payable /reject the claim, accordingly.

### 5.2. 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.

### 5.3. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate .

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.

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

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.

### 5.4. 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 valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

### 5.5. Multiple Policies

a. In case of multiple policies taken by an insured during a period from the same or 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.

b. 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.
c. If the amount to be claimed exceeds the sum insured under a single policy, the Insured Person shall have the right to choose insurers from whom he/she wants to claim the balance amount.
d. Where an Insured has policies from more than one insurer to cover the same risk on indemnity basis, the Insured shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

**5.6. 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 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:-

(b) The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
(c) The active concealment of a fact by the Insured Person having knowledge or belief of the fact;
(d) Any other act fitted to deceive; and
(e) 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.

**5.7. Cancellation / Termination**

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

Refund % to be applied on premium received

| Cancellation date from Policy Period Start Date | Policy Tenure – 1 Year | Policy Tenure – 2 Years | Policy Tenure – 3 Years |
|---|---|---|---|
| Up to 1 month | **75.00%** | **87.50%** | **91.70%** |
| 1 month to 3 months | **50.00%** | **75.00%** | **83.30%** |
| 3 months to 6 months | **25.00%** | **62.50%** | **75.00%** |
| 6 months to 12 months | **0.00%** | **50.00%** | **66.70%** |
| 12 months to 15 months | **N.A.** | **25.00%** | **50.00%** |
| 15 months to 18 months | **N.A.** | **12.50%** | **41.70%** |
| 18 months to 24 months | **N.A.** | **0.00%** | **33.30%** |
| 24 months to 30 months | **N.A.** | **N.A.** | **8.30%** |
| Beyond 30 months | **N.A.** | **N.A.** | **0.00%** |

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

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

**Notes:**

**In case of demise of the Policyholder,**

**(i)** Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder. The premium would be refunded for the unexpired period of this Policy at the short period scales subject to no claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

**(ii)** Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period for the other Insured Persons. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a policyholder provided that:

I. Written notice in this regard is given to the Company before the Policy Period End Date; and

II. A person of Age 18 years or above, who satisfies the Company's criteria applies to become the Policyholder.

**In case Premium Installment mode is opted for, then:**

**(i)** If Policyholder cancels the Policy after the Free look period or demise of Policyholder where he/she is the only Insured in the Policy, then the Company will refund 50% of the installment premium for the unexpired installment period, provided no Claim has been made under the Policy

## 5.8. Migration

The Insured Person will have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration

For Detailed Guidelines on Migration, kindly refer Guidelines issued by IRDAI (Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof.

## 5.9. Portability

The Insured Person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer Guidelines issued IRDAI (Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof

## 5.10. Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period
v. No loading shall apply on renewals based on individual claims experience

**5.11. 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 etc as per IRDAI guidelines, provided the policy has been maintained without a break.

**5.12. Moratorium Period**

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from 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.

**5.13. Premium payment Installment**

If the Insured Person has opted for Payment of Premium on an installment basis i.e. Half Yearly or Quarterly or Monthly, as mentioned in the Policy Schedule/ Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

1. Grace Period of 30 days would be given to pay the installment premium due for the policy
2. During such grace period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company
3. 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
4. No interest will be charged If the installment premium is not paid on due date.
5. In case of installment premium due not received within the grace period, the policy will get cancelled
6. In the event of a claim, all subsequent premium installments shall immediately become due and payable.(This clause will not apply to claims arising under ‘Unlimited E-consultations’ , ‘Health Services’ , ‘Annual Health Check-up’ , ‘Be-Fit ‘ , ‘Wellness Benefit’ , ‘Women Care and ‘Mental Health wellbeing’ )
7. The Company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

**Note:**

Tenure Discount will not be applicable if the Insured Person has opted for Premium Payment in Installments.

**5.14. Possibility of Revision of Terms of the Policy Including the Premium Rates**

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

**5.15. 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 fifteen days (Thirty days in case of distance marketing) 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;

**5.16. Grievances**

In case of any grievance the Insured Person may contact the Company through

Website/link: https://www.careinsurance.com/customer-grievance-redressal.html
Mobile App :
Toll free (whatsapp number):
Courier: Any of Company's Branch Office or corporate office

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at Branch Office or corporate office. For updated details of grievance officer, kindly refer the link

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI integrated Grievance Management System - https://bimabharosa.irdai.gov.in/

Note: The Contact details of the Insurance Ombudsman offices have been provided as Annexure IV.

**5.17. 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.

**Specific General Terms & Clauses**

**5.18. Material Change**

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business or current residing address at his own expense. The Company may adjust the scope of cover and / or the premium paid or payable/reject the claim, accordingly.

**5.19. Records to be maintained**

The Policyholder or Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period or Policy Year or until final adjustment (if any) and resolution of all Claims under this Policy.

**5.20. No constructive Notice**

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

**5.21. Policy Disputes**

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

**5.22. Limitation of liability**

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond his control.

**5.23. Communication**

a. Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule. Any communication meant for the Policyholder/ Insured Person will be sent by the Company to his last known address or the address as shown in the Policy Schedule.
b. All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule.Agents are not authorized to receive notices and declarations on the Company's behalf.
c. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

**5.24. Alterations in the Policy**

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy.

5.25. Out of all the details of the various Benefits provided in the Policy Terms and Conditions, only the details pertaining to Benefits chosen by policyholder as per Policy Schedule shall be considered relevant

**5.26. Electronic Transactions**

The Policyholder and /or Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Any terms and conditions related to electronic transactions shall be within the approved Policy Terms and Conditions

6. OTHER TERMS AND CLAUSES

**6.1. Claims procedure and management**

This section explains about procedures involved to file a valid Claim by the Insured Person and related processes involved to manage the Claim by the Company.

**6.2. Pre-requisite for admissibility of a Claim:**

Any claim being made by an Insured Person or attendant of Insured Person during Hospitalization on behalf of the Insured Person, should comply with the following conditions:

**(i)** The Condition Precedent Clause has to be fulfilled.

**(ii)** The health damage caused, Medical Expenses incurred, subsequently the Claim being made, should be with respect to the Insured Person only. The Company will not be liable to indemnify the Insured Person for any loss other than the covered Benefits and any other person who is not accepted by the Company as an Insured Person.

**(iii)** The holding Insurance Policy should be in force at the event of the Claim. All the Policy Terms and Conditions, wait periods and exclusions are to be fulfilled including the realization of Premium by their respective due dates.

**(iv)** All the required and supportive Claim related documents are to be furnished within the stipulated timelines. The Company may call for additional documents wherever required.

**6.3. Claim settlement - Facilities**

**(a) Cashless Facility**

The Company extends Cashless Facility as a mode to indemnify the medical expenses incurred by the Insured Person at a Network Provider. For this purpose, the Insured Person will be issued a "Health card" at the time of Policy purchase, which has to be preserved and produced at any of the Network Providers in the event of Claim being made, to avail Cashless Facility. The following is the process for availing Cashless Facility:-

**(i) Submission of Pre-authorization Form:** A Pre-authorization form which is available on the Company's Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted electronically by the Network Provider to the Company for approval. Only upon due approval from the Company, Cashless Facility can be availed at any Network Hospital.

(ii) **Identification Documents:** The "Health card" provided by the Company under this Policy, along with one Valid Photo Identification Proof of the Insured Person are to be produced at the Network Provider, photocopies of which shall be forwarded to the Company for authentication purposes. Valid Photo Identification Proof documents which will be accepted by the Company are Voter ID card, Driving License, Passport, PAN Card, Aadhar Card or any other identification proof as stated by the Company.

(iii) **Company's Approval:** The Company will confirm in writing, authorization or rejection of the request to avail Cashless Facility for the Insured Person's Hospitalization.

(iv) **Company's Authorization:**

a) If the request for availing Cashless Facility is authorized by the Company, then payment for the Medical Expenses incurred in respect of the Insured Person shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing Cashless Facility.
b) An Authorization letter will include details of Sanctioned Amount, any specific limitation on the Claim, and any other details specific to the Insured Person, if any, as applicable.
c) In the event that the cost of Hospitalization exceeds the authorized limit, the Network Provider shall request the Company for an enhancement of Authorization Limit stating details of specific circumstances which have led to the need for increase in the previously authorized limit. The Company will verify the eligibility and evaluate the request for enhancement on the availability of further limits.

(v) **Event of Discharge from Hospital:** All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Person and all other information and documentation specified under Clauses 6.1.4 and 6.1.5 shall be submitted by the Network Provider immediately and in any event before the Insured Person's discharge from Hospital.

(vi) **Company's Rejection:** If the Company does not authorize the Cashless Facility due to insufficient Sum Insured or insufficient information provided to the Company to determine the admissibility of the Claim, then payment for such treatment will have to be made by the Policyholder / Insured Person to the Network Provider, following which a Claim for reimbursement may be made to the Company which shall be considered subject to the Insured Person's Policy limits and relevant conditions. Please note that rejection of a Pre-authorization request is in no way construed as rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

(vii) **Network Provider related:** The Company may modify the list of Network Providers or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider. For an updated list of Network Providers and the extent of Cashless Facilities available at each Network Provider, the Insured Person may refer to the list of Network Providers available on the Company's website or at the call center.

(viii) **Claim Settlement:** For Claim settlement under Cashless Facility, the payment shall be made to the Network Provider whose discharge would be complete and final.

(b) **Re-imbursement Facility**

(i) It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation specified in Clause 6.1.4 and Clause 6.1.5 shall be submitted to the Company at Policyholder's / Insured Person's own expense, immediately and in any event within 30 days of Insured Person's discharge from Hospital.

**(ii)** The Company shall give an acknowledgement of collected documents. However, in case of any delayed submission, the Company may examine and relax the time limits mentioned upon the merits of the case.

**(iii)** In case a reimbursement claim is received after a Pre-Authorization letter has been issued for the same case earlier, before processing such claim, a check will be made with the Network Provider whether the Pre-authorization has been utilized. Once such check and declaration is received from the Network Provider, the case will be processed.

**(iv)** For Claim settlement under reimbursement, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no 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.

**(v)** 'Date of Loss' under Reimbursement Facility is the 'Date of Admission' to Hospital in case of Hospitalization & actual Date of Loss for non-Hospitalization related Benefits.

### 6.4. Duties of a Claimant/ Insured Person in the event of Claim

It is agreed and understood that as a Condition Precedent for a Claim to be considered under this Policy:

**(i)** The Policyholder / Insured Person shall check the updated list of Network Provider before submission of a pre-authorization request for Cashless Facility.

**(ii)** All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.

**(iii)** Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 6.1 (Claims Procedure and Management) of the Policy.

**(iv)** The Insured Person will, at the request of the Company, submit himself / herself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.

**(v)** The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person.

**(vi)** The Company shall be provided with complete necessary documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

### 6.5. Claims Intimation

Upon the occurrence of any Illness or Injury that may result in a Claim under this Policy, then as a Condition Precedent to the Company's liability under the Policy, all of the following shall be undertaken:

**(i)** If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Company shall be notified with full particulars within 48 hours from the date of occurrence of event either at the Company's call center or in writing.

**(ii)** Claim must be filed within 30 days from the date of discharge from the hospital in case of hospitalization and actual date of loss in case of non-hospitalization Benefits.
**Note:** 6.1.4 (i) and 6.1.4 (ii) are precedent to admission of liability under the policy.

**(iii)** The following details are to be disclosed to the Company at the time of intimation of Claim:

1. Policy Number;
2. Name of the Policyholder;
3. Name and address of the Insured Person in respect of whom the Claim is being made;
4. Nature of Illness or Injury;
5. Name and address of the attending Medical Practitioner and Hospital;
6. Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
7. Any other necessary information, documentation or details requested by the Company.

**(iv)** In case of an Emergency Hospitalization, the Company shall be notified either at the Company's call center or in writing immediately and in any event within 48 hours of Hospitalization commencing or before the Insured Person's discharge from Hospital.

**(v)** In case of an Planned Hospitalization, the Company shall be notified either at the Company's call center or in writing at least 48 hours prior to planned date of admission to Hospital

### 6.6. Documents to be submitted for filing a valid Claim

The following information and documentation shall be submitted in accordance with the procedures and within the timeframes specified in Clause 6.1 in respect of all Claims:

1. Duly filled and signed Claim form by the Insured Person;
2. Copy of Photo ID of Insured Person;
3. Medical Practitioner's referral letter advising Hospitalization;
4. Medical Practitioner's prescription advising drugs or diagnostic tests or consultations;
5. Original bills, receipts and discharge summary from the Hospital/Medical Practitioner;
6. Original bills from pharmacy/chemists;
7. Original pathological/diagnostic test reports/radiology reports and payment receipts;
8. Operation Theatre Notes(if applicable);
9. Indoor case papers(if applicable);
10. Original investigation test reports and payment receipts supported by Doctor's reference slip;
11. MLC/FIR report, Post Mortem Report if applicable and conducted;
12. Ambulance Receipt;
13. Any other document as required by the Company to assess the Claim, in case fraud is suspected.

**Notes**:

- The Company may give a waiver to one or few of the above mentioned documents depending upon the case.
- Additional documents as specified against any Benefit shall be submitted to the company.
- The Company will accept bills/invoices which are made in the Insured Person's name only.
- The Company may seek any other document as required to assess the Claim.
- Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance Company, the Company will accept properly verified photocopies of such documents attested by such other insurance Company along with an original certificate of the extent of payment received from such insurance Company.

However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay.

### 6.7. Claim Assessment

a. The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.

b. All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:

**(i)** If a room accommodation has been opted for where the Room Rent or Room Category is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule, then, the Associate Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Clause 3.1.1(ix) and 3.2.2.

**(ii)** The Deductible (if applicable) shall be applied to the aggregate of all Claims that are either paid or payable under this Policy. The Company's liability to make payment shall commence only once the aggregate amount of all Claims payable or paid exceed the Deductible.

**(iii)** Co-payment (if applicable) shall be applicable on the admissible claim amount payable by the Company.

**(iv)** The balance amount, if any, subject to the applicability of sub-limits, Company's liability to make payment shall be limited to such extent as applicable and shall be the Claim payable

c. The Claim amount assessed in Clause 6.1.6 (b) above would be deducted from the following amounts in the following progressive order:
   **(i)** Sum Insured;
   **(ii)** Plus benefit , as applicable
   **(iii)** Cumulative Bonus
   **(iv)** Cumulative Bonus Super , as applicable
   **(v)** Unlimited Automatic Recharge

d. All claims incurred in India are serviced by the Company directly.

**6.8. Payment Terms**

**(a)** This Policy covers only medical treatment taken entirely within India. All payments under this Policy shall be made in Indian Rupees and within India.

**(b)** The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person during the Policy Period, once the Sum Insured for that Insured Person is exhausted.

**(c)** **The Company shall settle or reject any Claim within 30 days** of receipt of all the necessary documents / information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder / Insured Person an offer of settlement of Claim and upon acceptance of such offer by the Policyholder / Insured Person the Company shall make payment within 7 days from the date of receipt of such acceptance.

**(d)** The Claim shall be paid only for the Policy Year in which the Insured event which gives rise to a Claim under this Policy occurs.

**(e)** The Premium for the policy will remain the same for the policy period mentioned in the Policy Schedule.

## 7. PRE-POLICY ISSUANCE MEDICAL CHECK-UP

We may ask the Insured Person to undergo requisite pre-policy Medical Check-up based on the age and the Sum Insured selected. The result of these tests shall be valid for a period of 3 months from the date of tests.

You will be required to undergo Pre-Policy Medical Check-up with respect to the grid mentioned below. The cost of the medical tests would be borne by Us in case You opt for a 2 year or 3 year tenure and Your proposal is accepted. We shall bear 50% of the cost of medical tests in case You opt for a 1 year tenure and Your proposal is accepted.

Also, wherever any Pre-Existing Disease or any other adverse medical history is declared for any member, We may ask such Insured Person to undergo tele-underwriting which may include specific tests, as We may deem fit to evaluate such member, irrespective of the member's age. We shall bear the cost of such medical tests if your proposal is accepted.

| Age | Particular |
|---|---|
| **Up to 65 years** | No Medical Tests if no Pre-Existing declared, 61-65 years – Tele UW |
| **66 Years and above** | Medical Tests as follows- MER, CBC &ESR, HBA1C, T. Cholesterol, ECG, SGPT, S. Creatinine, RUA |

*Underwriting will redefine the Medical Tests as per proposal & Product experience.

## 8. SCHEDULE OF BENEFITS:

| | |
|---|---|
| Coverage | |
| Base Benefits | |

| | |
|---|---|
| Hospitalization Expenses | |
| - In-Patient Care | Up to SI |
| - Day Care Treatment | All Day Care Procedures |
| - Advance Technology Methods | Up to SI |
| - Pre-Hospitalization Medical Expenses | Up to SI, Pre-Hospitalization expense cover for 60 days prior to hospitalization |
| - Post Hospitalization Medical Expenses | Up to SI, Post -Hospitalization expense cover for 180 days prior to hospitalization |
| - AYUSH Treatment | Up to SI |
| - Domiciliary Hospitalization | Up to SI |
| - Organ Donor Cover | Up to SI |
| Road Ambulance Cover | For SI < 15 lac SI – up to Rs. 10,000<br>For 15 lac and above SI - Up to SI |
| Cumulative Bonus | 50% of SI per year, max up to 100% of SI;<br>Note: Shall not reduce in case of claim |
| Unlimited Automatic Recharge | Available for unlimited times for unrelated or same illness. |
| Unlimited E-Consultations | Available for Consultations with General Physicians |
| Health Services | Health Portal- Doctor on chat, Healthy tips reminder, etc.<br>Discount Connect – Discounts on services such as consultations, diagnostics, maternity etc at our network. |
| Optional Benefits | |
| Smart Select | For listed Smart Select Hospitals : Up to SI<br>Other than listed Smart Select Hospitals : Up to SI with an additional co-payment of 20% per claim |
| Room Rent Modification | Twin Sharing Room /Single Private Room |
| PED Wait Period Modification | PED wait period shall be modified to 1 year/2 years/3 years |
| Named Ailment Wait Period Modification | Named Ailment wait period shall be modified to 1 year |
| Instant Cover | No PED wait period (for Diabetes/ Hypertension/ Hyperlipidimia / Asthma) If Insured Person has these Pre-Existing Diseases at the time of issuance of first Policy with us, the applicable PED wait period shall be waived off on Diabetes/ Hypertension/ Hyperlipidemia/ Asthma. |
| Deductible | 10k, 25k, 50k, 1 Lac, 2 Lac, 5 Lac, 10 Lac |
| Co-payment | 5%, 10%, 20%, 30% & 50% |
| New Born cover | New born babies are allowed to get coverage from the day 1<br>All wait period will be applicable mandatorily |
| Plus benefit | Additional 20% SI, maximum up to 10 lacs from day 1 |
| Cumulative Bonus Super | Up to 100% of Base SI per year, Max up to 500% of Base SI<br>Note: Shall not reduce in case of claim |
| Annual Health check up | Once for all Insured every policy year |
| Be-Fit Benefit | Unlimited visits to Fitness centers can be availed by Insured members aged above 12 years |
| Wellness | • Recording 10,000 steps or more in a day through tracking apps, devices etc.<br>No. of days in a year Renewal Discount<br>270 - 30%<br>240 - 20%<br>180 - 15%<br>120 - 10%<br>Less than 120 - 0% |

| | |
|---|---|
| | • This benefit will be applicable on Individual basis. In case of floater, average of no. of healthy days as attained by the Insured shall be considered<br>• Responsibility of mapping device with CHIL system is of the Insured<br>• No. of days completing 10,000 steps or more that are accumulated in last 2 months of the Policy Period would not be considered for discount on renewal premium. The same shall carry forward and will be considered in next policy period.<br>• In case of multi tenure, average of no. of healthy days over policy tenure will be considered for discount<br>• In case of installment premium mode is opted, then discount shall be considered only post payment of first 6 month of premium.<br>• Vouchers of value equivalent to renewal discount amount can also be provided to Insured in case he/she does not wish for discount on renewal premium.<br><br>Note: The above section of benefit is available only for Insured covered as Adults aged 18 and above in the Policy and discount calculated shall be applicable on total premium of Policy.<br><br>• Access to Digital Fitness Coaching<br>• Access to AI Fitness Coaching<br>• Access to Nutritionist/Wellness Coach<br>Note: Benefit (b, c & d) shall be available for Insured members aged above 12 years |
| Air Ambulance Cover | Up to 5 Lacs per year |
| Women Care<br>- Mammography<br>- Cervical Cancer screening<br>- PCOS/PCOD Tests | Up to 10k/25k/50k per year (only on cashless)<br><br>Note: This benefit is available only for women Insured members aged 18 Years and above. |
| Mental Health well being | Up to 10k/25k/50k per year (only on cashless)<br>Covers consultations, counseling and rehab of listed mental illness:<br>Acute depression, Obsessive compulsive disorder, Anxiety , Post traumatic stress disorder |
| Claim Shield | Non Payable items covered up to Sum Insured. |
| Inflation Shield | inflation based |
| Additional Sum Insured for Defined Critical Illnesses | Additional SI of Up to 100% of SI or Rs.25L whichever is lower |
| Home Modification | upto 10,000 per policy year |
| Nursing Care | Up to 1000 per day, max. 7 days in a Policy Year |

**9. Grievance**

In case of any grievance the insured person may contact the company through;

**Universal Sompo General Insurance Co. Ltd.**

Unit No. 601 & 602, 6th Floor, Reliable Tech Park, Cloud City Campus; Gut No-31, Mouje Elthan, Thane-Belapur Road, Airoli, Navi Mumbai- 400708

- **Toll Free Numbers:** 1800-200-5142
- **Landline Numbers:** (022)- 41659800
- **E-mail Address:** contactus@universalsompo.com

Note: Please include Your Policy number for any communication with us.

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievance@universalsompo.com

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

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI integrated Grievance Management System - https://bimabharosa.irdai.gov.in/
Note: The Contact details of the Insurance Ombudsman offices have been provided as Annexure 4.

**Disclaimer:** This is only a summary of features of Product. The actual benefits available are as described in the Policy, and will be subject to the Policy terms, conditions and exclusions. Please seek the advice of Your insurance advisor if You require any further information or clarification.

Prohibition of Rebates (under Section 41 of Insurance Act, 1938):
No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.
Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.