Universal Sompo General Insurance Company Limited

Complete Healthcare Insurance

Policy Wordings

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We are very pleased to introduce *You* to the Universal Sompo's ***Complete Healthcare Insurance*** and thank *You* for insuring with *Us*.

Please read this *Policy* carefully to ensure that it provides the cover *You* require. If the *Schedule* details do not agree with the details completed on *Your* Proposal Form then please return it to *Us* immediately with a note of the changes that should be made.

This *Policy* (which includes and shall be read as one document with the *Schedule*, Endorsements and Proposal Form) evidences a contract of insurance between *You* and *Us*.

We will, subject to the terms, conditions, limitations and exclusions of this *Policy*, indemnify *You* in respect of the medical contingencies covered which occur during the *Policy Period* for which *You* have paid the premium.

This *Policy* is a legal document and should be kept in a safe place.

On behalf of
For Universal Sompo General Insurance *Company* Limited

Mr. Sharad Mathur
Managing Director & CEO

Definations

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

Accident means a sudden unforeseen and involuntary event caused by external, visible and violent means.

Any one illness means continuous Period of *illness* and it includes relapse within 45 days from the date of last consultation with the *Hospital*/Nursing Home where treatment may have been taken.

Adventure Sports means participation in sports activities such as bungee jumping, sky diving, white water canoeing/rafting and engaging in racing, hunting, mountaineering, ice hockey, winter sports and the like.

a. ***Alternative Treatment*** means forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

Break in Policy occurs at the end of the existing *Policy* term, when the premium due for *Renewal* on a given *Policy* is not paid on or before the premium *Renewal* date or within 30 days thereof.

Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the *Policy* terms and conditions, are directly made to the *Network Provider* by the insurer to the extent pre-authorization approved.

Company means “Universal Sompo General Insurance *Company* Limited.”

Condition Precedent means a *Policy* term or condition upon which the Insurer's liability under the *Policy* is conditional upon.

Congenital Anomaly means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a) ***Internal Congenital Anomaly***: means which is not in the visible and accessible parts of the body

b) ***External Congenital Anomaly***: means which is in the visible and accessible parts of the body

Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of *Sum Insured*. This clause shall not apply to any Benefit offered on fixed benefit basis.

Co-pay means a cost sharing requirement under a health insurance *Policy* that provides that the *Policy* holder/Insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the *Sum Insured*.

Cumulative Bonus means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Day Care Treatment/Procedures means any institution established for *Day Care Treatment* of *Illness* and/or I*njuries* or a medical setup within a *Hospital* and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified *Medical Practitioner* AND must comply with all minimum criteria as under

- has qualified nursing staff under its employment;
- has qualified *Medical Practitioner*/s in charge;
- has a fully equipped operation theatre of its own where *Surgical Procedures* are carried out;
- maintains daily records of patients and will make these accessible to the insurance *Company*'s authorized personnel

Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and *Surgery* excluding any form of cosmetic *Surgery*/ implants.

Domiciliary Treatment means medical treatment for an *Illness*/disease/*Injury* which in the normal course would require care and treatment at a *Hospital* but is actually taken while confined at home under any of the following circumstances:

- the condition of the patient is such that he/she is not in a condition to be removed to a *Hospital*, or
- the patient takes treatment at home on account of non-availability of room in a *Hospital*.

Disclosure to information norm means the *Policy* shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Emergency Care means management for a severe *illness* or *injury* which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *Medical Practitioner* to prevent death or serious long term impairment of the *Insured Person*'s health.

Family Member

For the purpose of Family discount includes two or more persons of *Your* family who are named in the Schedule as *Insured Person* and is/ are related to *You* in the following manner

- Legally married spouse as long as he or she continues to be married to *You*;
- Son, Daughter-in-law, Daughter, Father, Mother, Brother(s) or Sister(s)
- Father-in-law, Mother-in-law as long as *Your* spouse continues to be married to *You*;
- Grandfather, Grandmother, Grandson, Granddaughter

For the purpose of family floater cover shall include two or more persons of *Your* family who are named in the Schedule as *Insured Person* and is/ are related to *You* in the following manner

- Legally married spouse as long as he or she continues to be married to *You*;
- Son and Daughter
- Father and Mother

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a *Policy* in force without loss of continuity benefits such as waiting periods and coverage of *Pre-Existing Diseases*. Coverage is not available for the period for which no premium is received.

Hospitalization means admission in a *Hospital* for a minimum period of 24 *In-patient Care* consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Hospital means any institution established for in-patient care and *Day Care Treatment* of *Illness* and/or *Injuries* and which has been registered as a *Hospital* with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the *Schedule* of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- has qualified *Medical Practitioner*(s) in charge round the clock;
- has a fully equipped operation theatre of its own where *Surgical Procedures* are carried out;
- maintains daily records of patients and makes these accessible to the insurance *Company*'s authorized personnel.

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the *Policy Period* and requires medical treatment.

a) ***Acute Condition*** is a disease, *Illness* or *Injury* that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/*Illness/Injury* which leads to full recovery.

b) ***Chronic condition*** is defined as a disease, *Illness*, or *Injury* that has one or more of the following characteristics

   - it needs on-going or long-term monitoring through consultations, examinations, check-ups, and/or tests
   - it needs on-going or long-term control or relief of symptoms
   - it requires *Your* rehabilitation or for *You* to be specially trained to cope with it
   - it continues indefinitely
   - it comes back or is likely to come back.

Injury means accidental physical bodily harm excluding *Illness* or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a *Medical Practitioner*.

In-patient Care means treatment for which the *Insured Person* has to stay in a *Hospital* for more than 24 hours for a covered event.

Insured means the individual whose name is specifically appearing in the *Schedule* herein after referred as "*You*"/"*Your*"/"*Yours*"/"*Yourself*".

Insured Persons means the individual(s) whose name is/are appearing in the *Schedule* and shall include his/her spouse, dependent children and/ or parents.

Intensive Care Unit means an identified section, ward or wing of a *Hospital* which is under the constant supervision of a dedicated *Medical Practitioner*(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Maternity Expenses shall include:

- Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during *Hospitalization*).
- Expenses towards lawful medical termination of pregnancy during the *Policy Period*.

Medical Expenses means those expenses that an *Insured Person* has necessarily and actually incurred for medical treatment on account of *Illness* or *Accident* on the advice of a *Medical Practitioner*, as long as these are no more than would have been payable if the *Insured Person* had not been insured and no more than other *Hospitals* or doctors in the same locality would have charged for the same medical treatment.

Medically Necessary means any treatment, tests, medication, or stay in *Hospital* or part of a stay in *Hospital* which

- is required for the medical management of the *Illness* or *Injury* suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a *Medical Practitioner*,
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence and is not a member of the *Insured Person*'s Family.

Network Provider means *Hospitals* or health care providers enlisted by an insurer or by a *TPA* and insurer together to provide medical services to an insured on payment by a cashless facility.

New Born Baby means baby born during the *Policy Period* and is aged between 1 day and 90 days, both days inclusive.

Nominee means the person(s) nominated by the *Insured Person* to receive the insurance benefits under this *Policy* payable on his/her death.

Non- Network means any *Hospital*, day care centre or other provider that is not part of the network.

Notification of Claim is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

OPD Treatment is one in which the Insured visits a clinic / *Hospital* or associated facility like a consultation room for diagnosis and treatment based on the advice of a *Medical Practitioner*. The Insured is not admitted as a day care or in-patient.

Policy means *Our* contract of insurance with the *Insured* providing cover as detailed in this document.

Policy Period means the *Policy Period* as set out in the *Schedule* for which the insurance cover will remain valid.

Policy Year means a year following *Policy Period* Start Date and its subsequent annual anniversary.

a) ***Pre- Existing Diseases*** means any condition, ailment or *Injury* or related condition(s) for which *You* had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first *Policy* issued by the insurer.

Pre- Hospitalization Medical Expenses means the *Medical Expenses* incurred immediately before the *Insured Person* is hospitalised, provided that:

- Such *Medical Expenses* are incurred for the same condition for which the *Insured Person's Hospitalisation* was required, and
- The In-patient *Hospitalization* claim for such *Hospitalization* is admissible by the Insurance *Company*.

Post Hospitalization Medical Expenses means the *Medical Expenses* incurred immediately after the *Insured Person* is discharged from the *Hospital* provided that:

- Such *Medical Expenses* are incurred for the same condition for which the *Insured Person's Hospitalization* was required and
- The inpatient *Hospitalization* claim for such *Hospitalization* is admissible by the insurance *Company.*

Portability means transfer by an individual health insurance *Policy Holder* (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the

geographical area for identical or similar services, taking into account the nature of the *Illness* / *Injury* involved .

Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of *Grace Period* for treating the *Renewal* continuous for the purpose of all waiting periods.

Room Rent means the amount charged by a *Hospital* for the occupancy of a bed on per day (24 hours) basis and shall include associated *Medical Expenses*.

Service Providers means any person, institution or organisation that has been empanelled by the *Company* to provide services to the *Insured Person* specified in the *Policy*.

Schedule means *Schedule* attached to and forming part of this *Policy* mentioning the details of the Insured/*Insured Persons*, the *Sum Insured*, the period and the limits to which benefits under the *Policy* would be payable.

Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an *Illness* or *Injury*, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a *Hospital* or day care centre by a *Medical Practitioner.*

Subrogation means the right of the insurer to assume the rights of the *Insured Person* to recover expenses paid out under the *Policy* that may be recovered from any other source.

TPA means the third party administrator that *the Company* appoints from time to time as specified in the *Schedule*.

Unproven/Experimental Treatment means a treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

You/Your/Yours/Yourself means the person(s) that *We* insure and is/are specifically named as Insured in the *Schedule*.

We/Our/Ours/Us mean Universal Sompo General Insurance *Company* Limited.

War means *War*, whether declared or not, or any warlike activities, including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

Critical Illness

It means the following major diseases, which *You* have been diagnosed during the *Policy Period* to have suffered from and which requires *Hospitalisation* and are specifically defined as below:

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

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

- a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

- new characteristic electrocardiogram changes
- elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

Exclusions

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

2. ***Permanent Paralysis Of Limbs***

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

3. ***Cancer of specified severity***

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

Exclusions

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma.
- All tumours of the prostate unless histological classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2NOMO
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumours in the presence of HIV infection.

4. ***Open Chest CABG***

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

Exclusions

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

5. ***Open Heart Replacement Or Repair Of Heart Valves***

The actual undergoing of open-heart valve *Surgery* is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the

realization of *Surgery* has to be confirmed by a specialist *Medical Practitioner*. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

6. ***Coma Of Specified Severity***

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

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

Exclusions

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

7. ***Kidney Failure requiring regular dialysis***

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

8. ***Major Organ /Bone Marrow Transplant***

The actual undergoing of a transplant of:

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

Exclusion

- Other stem-cell transplants
- Where only islets of langerhans are transplanted

9. ***Stroke resulting in permanent symptoms***

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

Exclusion

- Transient ischemic attacks (TIA)
- Traumatic *Injury* of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions

10. ***Multiple Sclerosis with persisting symptoms***

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

11. ***Motor Neurone Disease With Permanent Symptoms***

Motor neurone disease diagnosed by a specialist *Medical Practitioner* as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

Section 1- Coverage

We will provide benefits for the following subject to the level of *Sum Insured* chosen and the benefits detailed in *Your Policy Schedule*. All costs incurred must be *Medically Necessary* and subject to *Reasonable and Customary Charges.*

If *You* suffer an *Illness* or *Accident* during the *Policy Period* that requires *Hospitalization* as an inpatient, then *We* will pay:

a) In-patient Treatment

The *Medical Expenses* for:

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

b) Day Care Procedures

The *Medical Expenses* for any *Day Care Procedure* where the procedure or *Surgery* is taken by *You* as an inpatient for less than 24 hours in a *Hospital* or standalone day care center but not in the outpatient department of a *Hospital* or standalone day care center.
We will pay *Medical Expenses* for 141 Day Care Procedures enlisted in the Annexure to this Policy Wordings

c) *Pre-Hospitalization*

The *Medical Expenses* incurred in the 30 days immediately prior before the date *You* were Hospitalized, provided that:

- Such *Medical Expenses* were in fact incurred for the same condition for which *Your* subsequent *Hospitalization* was required, and
- *We* have accepted an inpatient *Hospitalization* claim under benefit (a)In-patient treatment
- *We* will pay the *Medical Expenses* incurred within the 60 days prior to the date of *Hospitalization*, if *We* are provided with the following at least 5 days before the *Hospitalization*:
    1. medical documents with all details about the *Illness*; and
    2. the date and the place of the proposed *Hospitalization*.

d) *Post-Hospitalization*

The *Medical Expenses* incurred in the 60 days immediately after *Your* date of discharge from *Hospital* provided that:

- Such costs are incurred in respect of the same condition for which *Your* earlier *Hospitalization* was required, and
- *We* have accepted an inpatient *Hospitalization* claim under Benefit (a) In-patient treatment
- *We* will pay the *Medical Expenses* in the 90 days immediately after *You* were discharged if *We* were provided with the following at least 5 days before the *Hospitalization*:
    1. Medical documents with all details about the *Illness*; and
    2. The date and the place of the proposed *Hospitalization*

e) *Domiciliary Treatment*

The *Medical Expenses* incurred by *You* for medical treatment taken at home which would otherwise have required *Hospitalization*, provided that:

- The condition for which the medical treatment is required continues for at least 3 days, in which case *We* will pay the reasonable charge of any necessary medical treatment for the entire period, and
- If *We* accept a claim under this Benefit *We* will not make any payment for *Post- Hospitalization Expenses* but *We* will pay Pre-*Hospitalization* expenses for up to 60 days in accordance with (c) above, and
- No payment will be made if the condition for which *You* require medical treatment is:
    - Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza
    - Arthritis, Gout and Rheumatism
    - Chronic Nephritis and Nephritic Syndrome
    - Diarrhoea and all type of Dysenteries including Gastroenteritis,
    - Epilepsy,

- Pyrexia of unknown Origin.

f) Organ Donor

The *Medical Expenses* for an organ donor's treatment for the harvesting of the organ donated, provided that

- The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 and the organ donated is for *Your* use, and
- *We* will not pay the donor's *Pre and Post Hospitalization expenses* or any other medical treatment for the donor consequent on the harvesting, and
- *We* have accepted an inpatient *Hospitalization* claim under benefit (a) In-patient treatment

g) Ambulance

The expenses incurred on an ambulance offered by a healthcare or ambulance service provider used to transfer *You* to the nearest *Hospital* with adequate emergency facilities for the provision of health services following an Emergency, provided that:

- *Our* maximum liability shall be restricted to the amount as mentioned in the *Summary of Benefits* per *Hospitalization*, and
- *We* have accepted an inpatient *Hospitalization* claim under benefit (a) In-patient treatment
- The coverage includes *Your* cost of the transportation from a *Hospital* to the nearest *Hospital* which is prepared to admit *You* and provide the necessary medical services if such medical services cannot satisfactorily be provided at a *Hospital* where *You* are situated, provided that transportation has been prescribed by a *Medical Practitioner* and is *Medically Necessary.*

h) Dental Treatment (In case of Accident)

The *Medical Expenses* of any necessary *Dental Treatment* from a dentist provided that the *Dental Treatment* is required as a result of an *Accident*.

i) AYUSH Benefit

The *Medical Expenses* incurred for In-patient treatment taken under Ayurveda, Unani, Sidha or Homeopathy provided that:

- *Our* maximum liability will be limited to the amounts specified in the *Summary of Benefits*
- If *We* accept any claim under this benefit, then *We* will not make any payment under allopathic treatment for the same *Insured Person* and the same *Illness* or *Accident* under this *Policy*.

The company ensures that there is no sub-limit by way of percentage to SI or in term of amount for AYUSH

j) Daily Cash for Accompanying an Insured Child

A daily cash amount for one accompanying adult for each complete period of 24 hours if *Hospitalization* exceeds 72 hours provided that:

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

k) Vaccination

The *Medical Expenses* incurred for vaccination including inoculation and immunizations in case of post-bite treatment. *Our* maximum liability shall be limited to the amount specified in the *Summary of Benefits.*

l) Out-patient treatment

The below mentioned expenses to the extent of 50% of the *Reasonable and Customary Charges* incurred by *You* as an *Out-patient* when treatment is taken from a *Network Medical Practitioner*

i) ***Out-patient* Consultation**

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

ii) **Diagnostic Tests**

Out-patient diagnostic tests taken by *You* from a diagnostic centre

iii) ***Out-patient Dental Treatment***

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

iv) **Spectacles, Contact lenses, Hearing Aids**

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

Provided that,

- *Our* maximum liability shall be restricted to the amount mentioned in the *Summary of Benefits* and
- *You* have continuously renewed the *Policy* with *Us* without break for a period of 36 months

- For Floater Policies, the benefit under this Section shall be available on floater basis and for spectacles, contact lenses or hearing aids, Our liability shall be limited to either one pair of spectacles or hearing aid per family.

m) Convalescence Benefit:

A lump sum amount as shown in the *Summary of Benefits* if *You* are hospitalised for a minimum period of 10 consecutive days, provided that

- *We* have accepted claim under benefit (a) In-patient treatment
- This benefit is payable only once to an *Insured Person* during each *Policy* Year of the *Policy Period.*

n) Mother and Child Care Benefit

i. ***Routine Pregnancy:***

- *Medical Expenses* associated with the delivery of a child (including complicated deliveries and caesarean costs) while hospitalized

ii. ***Pre and Post-natal expenses:***

- The cost of pre-natal and post-natal expenses per delivery limited up to the amount stated in the *Summary of Benefits*.

Provided that,

- *Our* maximum liability per delivery will be subject to the amount specified in the *Summary of Benefits.*
- This benefit is not available for dependents other than *Your* spouse.
- This benefit will be available only after 36 months of continuous coverage have elapsed since the inception of the first *Policy* withed *Us.*
- This benefit will be available for a maximum of 2 deliveries or lawful termination of pregnancy once during the *Policy Period.*

iii. ***New Born Care***

- *Medical Expenses* incurred by *Your New Born Baby* as an In-Patient from the first day till expiry of the *Policy* or the child is 91 days old whichever is earlier.

Provided that,

When the New Born Baby is older than 91 days, then You will have a take an individual policy for the New Born or wait till your next renewal to cover the baby under a regular family floater plan.

Section 2- Additional Benefits

a) Restore Benefit:

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

Provided that,

- The Restore *Sum Insured* will be enforceable only after the basic *Sum Insured* inclusive of the *No Claim Bonus* have been completely exhausted in that year; and
- The Restore *Sum Insured* can be used for claims made by *You* in respect of Benefit (a) Inpatient Treatment
- The restored *Sum Insured* can be used to bear the expenses of any other *Illness*, that is dissimilar to the one for which claim has been made earlier. This restriction will not be applicable if the claim is made under a floater *Policy* for another *Family Member*'s treatment.
- The Restore *Sum Insured* shall not be considered for calculating *No Claim Bonus* under the *Policy*
- Any unutilised Restore *Sum Insured* shall not be carried forward to the next year
- The Restore *Sum Insured* shall be applied once for *You* during a *Policy Year*
- If the *Policy* is issued on floater basis, then the Restore *Sum Insured* shall also be available on floater basis. The Restore *Sum Insured* for these policies will be only available in respect of claims made by *Insured Persons* who were *Insured Persons* before the *Sum Insured* exhausted

b) Cover for People Living with HIV/ AIDS (PLHA)

If *You* have been diagnosed with HIV/ AIDS and *You* require *Hospitalization* as an Inpatient, then *We* will pay:

- *Medical Expenses* which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses and including Acquired Immune Deficiency Syndrome (AIDS) being maintained throughout or AIDS Related Complex (ARC) and/or any mutant the period, derivative or variations thereof, provided that
- The benefit is covered as mentioned in the *Summary of Benefits*
- The *Medical Expenses* are related to Diagnostic Procedures, *Room Rent* and boarding Expenses, *Medical Practitioner* and *Nursing* Fees, medicines, drugs and consumables.
- *Your Medical Expenses* would be covered up to 20% of the *Sum Insured.*
- *Your* CD4count is more than 400Mircolitr

Note: Even if the Insured purchases the Policy for a term of 2/3 years, the benefits will be payable as entitled per Policy year basis and not in cumulative basis.

Section 3- Renewal Benefits

We shall provide the following benefits as an incentive to *You* for staying healthy

a. Cumulative Bonus

- If no claim has been made under the *Policy*, including for the optional benefits, and the *Policy* is renewed with *Us* without any break, *We* will apply a *Cumulative Bonus* to the next *Policy Year* by automatically increasing the *Sum Insured* by 10% of the *Sum Insured* this year. The maximum *Cumulative Bonus* shall not exceed 50% of the Inpatient *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 Persons* who were *Insured Persons* in the claim free *Policy Year* and continue to be *Insured Persons* 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 10% of the increased *Sum Insured* in that following *Policy Year.* There will be no impact on the *Inpatient Sum Insured*, only the accrued *Cumulative Bonus* will be decreased.

- *Portability* benefit will be offered to the extent of sum of previous *Sum Insured* and accrued *Cumulative Bonus, Portability* shall not apply to any additional increased *Sum Insured.*

b. Health Check Up

- If no claim has been made under this *Policy*, including for the optional benefits, and *You* have maintained this *Policy* with *Us* without any break, then *We* will issue *You* a health Check-up coupon provided that *You* complete a continuous number of claims-free *Policy Years* as mentioned in the *Summary of Benefits* which will cover health check-ups arranged by *Us* through *Our* empanelled *Service Providers.*

- In case of family floater, two such health check-up coupons will be issued to the entire family, if, however, any of the members have made a claim under this *Policy*, the health check-up benefit will not be offered to the whole family.

Section 4- Value Added Benefits

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

1. Dial-a-Doctor

You may seek medical advice from a *Medical Practitioner* through the telephonic or online mode by contacting the helpline details specified on *Our* website.

2. Health Educational Library for People (HELP)

We will provide *You* access to *Our* Health Education Library for People, dedicated online medical knowledgebase which provides many features such Ask a health expert, Live Chat and Online health Guides and Videos

3. Second Opinion

We shall arrange for a second opinion when *Your* first *Medical Practitioner* recommends *You* a *Surgery* to diagnose or treat a health problem that is not an emergency. The benefit can be availed by *You* once during a *Policy Year.*

4. Specialist Consultation with Two follow up session

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

5. Wellness Package

We offer vouchers, in either electronic or physical form, for availing certain health services and products. *You* or any *Insured Person* may avail of such services and products within next 3 *Policy Years* if all of the following requirements are met:

- The vouchers are used for health services and benefits communicated from time to time.
- The conditions or limitations specified in the vouchers are adhered to.
- The vouchers are used (and will only be valid) at empanelled service provider(s)

The details of these discounts and offerings on health and wellness products and services are listed on *Our* website

6. 24x7 Customer Service

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

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

7. Newsletter

You shall get a monthly newsletter with dieting tips, nutritional information and similar other health related articles to help *You* reach *Your* optimum state of health.

You have access to these tools and resources via *Our* website www.universalsompo.com

Please note: *We* assume no responsibility for and will not be responsible for any actual or alleged errors, adequacy or accuracy of any medical opinion provided, omissions or representations made

by any *Medical Practitioner* or for any consequences of any action taken or not taken by *You* in reliance thereon for the above mentioned services.

Section 5- Product Options

The following endorsements only apply if they are specifically noted in *Your Policy Schedule*

Opt 1: Personal Accident

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

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

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

Opt 2: Critical Illness

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

Provided that,

- *We* will not make any payment if *You* are diagnosed as suffering from *Critical Illness* within 90 days of taking the *Policy*
- No claim under this option shall be admissible if the *Critical Illness* or the *Surgical Procedure* is a consequence of or arising out of any pre-existing conditions/ diseases.
- *Cover* under this *Policy* shall cease upon payment of the compensation on the happening of a Critical *Illness* and/ or *Surgical Procedure* and no further payment will be made for any consequent disease or any dependent diseases

Opt 3: Hospital Daily Cash

If *You* avail this option by paying an additional premium to *Us*, a daily cash amount will be payable per day if *You* receive treatment as an In-patient for an eligible medical condition

Provided that,

- *We* have accepted a claim under Inpatient Treatment Benefit
- *You* are hospitalized for more than 3 days.

- *Our* maximum liability shall be restricted to the amount mentioned in the *Summary of Benefits*, and
- This benefit shall not apply to time spent by *You* in an *Intensive Care Unit*.

Opt 4: Sub limits

If *You* avail this option, *You* agree that in lieu of the discount offered as mentioned in the *Summary of Benefits*, the *Medical Expenses* incurred during *Hospitalization* (including its related *Pre and Post Hospitalization expenses*, if applicable) due to the below mentioned *Surgeries / Medical Procedures* or any medical treatment pertaining to an *Illness/ Injury* upon admissibility would become payable by *Us* subject to limits as per the table below:

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

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

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

Opt 5: Treatment in Tiered Network

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

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

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

Section 6- Waiting Periods

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

1. Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

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 12/36 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:

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

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

***4. Maternity (and Childcare Benefit) Waiting Period (Code Excl.18*):**
(Applicable for Essential & Privilege Plan)
(Excluded until the expiry of 36 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.

5. Out-patient Treatment Waiting Period of 3 years
(Excluded until the expiry of 36 months after the date of inception of the first policy with us)

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

6. Critical Illness

Any critical *Illness*, which incepts or manifests during first 90 days of commencement of this cover.

Section 7 - 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:

A. 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

B. 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.

C. Obesity/ Weight Control (Code- Excl06)

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

- **1)** Surgery to be conducted is upon the advice of the Doctor
- **2)** The surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and
4) Body Mass Index (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

D. Change-of-Gender Treatments: (Code- Excl07)

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

E. 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.

F. 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.

G. 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.

H. 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.

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

J. 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)**

K. 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)**

L. Refractive Error:(Code- Excl15)

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

M. 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.

N. 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

O. Maternity Expenses (Code – Excl 18): (Applicable only for Basic 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.

P. 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.

Q. 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.

R. Treatment taken outside the geographical limits of India

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

Section 8- Claim Procedure:

1. Procedure for Cashless claims:

- **i** Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.
- **ii** Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
- **iii** The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.
- **iv** At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
- **v** The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
- **vi** In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

2. Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

SI No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

3. Notification of Claim

Notice with full particulars shall be sent to the Company as under:

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

4. Documents to be submitted:

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

- **i** Duly Completed claim form
- **ii** Photo Identity proof of the patient

iii Medical practitioner's prescription advising admission
iv Original bills with itemized break-up
v Payment receipts
vi Discharge summary including complete medical history of the patient along with other details.
vii Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix Sticker/Invoice of the Implants, wherever applicable.
x MLR(Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.
xi NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
xiii Legal heir/succession certificate , wherever applicable
xiv Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. 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
3. 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

Payment of Claim

All claims under the policy shall be payable in Indian currency only.

Section 9 - General Terms & Conditions

i. ***Disclosure of Information***

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

ii. ***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.

iii. ***Claim Settlement (provision for Penal Interest)***

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

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

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

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

iv. 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.

v. 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.

vi. 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.

vii. Cancellation

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

	Cancellation Period					
Cover Period	Within 1 month	From 1 month to 3 months	From 3 month to 6 months	From 6 months to 1 year	During 2nd Year	During 3rd Year
1 year	75%	50%	25%	0%	NA	NA
2 year	75%	65%	50%	25%	0%	NA
3 year	75%	70%	60%	45%	11%	0%

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.

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

viii. 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 policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link www.universalsompo.com

ix. Portability

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

For Detailed Guidelines on portability, kindly refer the link www.universalsompo.com

x. Renewal of Policy

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

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 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.

xi. 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.

xii. *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.

xiii. *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.

xiv. *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 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;

xv. *Redressal of Grievance*

In case of any grievance the insured person may contact the company through
Universal Sompo General Insurance Co. Ltd.
Express IT Park, Plot No. EL - 94, T.T.C. Industrial Area, M.I.D.C., Mahape,
Navi Mumbai-400710
Website: www.universalsompo.com
Toll free: 1800-200-5142
E-mail: contactus@universalsompo.com
Fax : (022) 39171419

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 www.universalsompo.com

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://igms.irda.gov.in/

xvi. ***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.

Section 10 - Summary of Benefits

S.No	Benefits	Basic	Essential	Privilege
	Sum Insured (in ₹ Lakhs)	1, 2	3, 4, 5	6,7, 8, 9, 10
A	Inpatient Treatment	Covered	Covered	Covered
B	Day Care Procedures	Covered	Covered	Covered
C	Post-Hospitalisation	Covered	Covered	Covered
D	Pre-Hospitalisation	Covered	Covered	Covered
E	Domiciliary Treatment	Covered	Covered	Covered
F	Organ Donor	Covered	Covered	Covered
G	Ambulance	Up to 1% of SI or Rs 1,000 or actuals whichever is less.	Up to 1% of SI or Rs 2,000 or actuals whichever is less.	Up to 1% of SI or Rs 3,000 or actuals whichever is less.

H	Dental Treatment in case of Accidents	Inpatient *Dental Treatment*-Upto 100% of In-patient Treatment Sum Insured.	Inpatient *Dental Treatment*-Upto 100% of In-patient Treatment Sum Insured.	Inpatient *Dental Treatment*-Upto 100% of In-patient Treatment Sum Insured.
I	AYUSH Benefit	Upto SI	Upto SI	Upto SI
J	Daily Cash for accompanying an Insured child	Not covered	Rs 300 per day subject to maximum of Rs 9,000.	Rs 500 per day subject to maximum of Rs 15,000.
K	Vaccination (in case of Post Bite Treatment)	Inpatient treatment- Upto 100% of In-patient Treatment Sum Insured or actuals whichever is less.	Inpatient treatment- Upto 100% of In-patient Treatment Sum Insured or actuals whichever is less.	Inpatient treatment- Upto 100% of In-patient Treatment Sum Insured or actuals whichever is less.
L	Out-Patient Treatment Cover after waiting period of 3 years a) Out-patient Consultation b) Diagnostic Tests c) Dental Treatment d)Spectacles, Contact Lens, Hearing Aids	Covered up to 1% of SI or actuals whichever is less subject to maximum of Rs 2,500.	Covered up to 1% of SI or actuals whichever is less subject to maximum of Rs 5,000.	Covered up to 1% of SI or actuals whichever is less subject to maximum of Rs 7,500.
M	Convalescence Benefit	Flat Rs. 10,000 per member when *Hospitalisation* exceeds 10 days.	Flat Rs. 10,000 per member when *Hospitalisation* exceeds 10 days.	Flat Rs. 10,000 per member when *Hospitalisation* exceeds 10 days.
	Mother and Child Care Benefits			
N	Maternity Expenses with waiting period of 3 years	Not covered	Normal Delivery: up to Rs 15,000 or actuals whichever is less Caesarean Delivery: up to Rs 25,000 (including pre and post natal expenses up to Rs 2,000) or actuals whichever is less	Normal Delivery: Up to Rs 25,000 or actuals whichever is less Caesarean Delivery: Up to Rs 50,000 (including pre and post natal expenses up to Rs 2,000) or actuals whichever is less
	New Born Baby Cover	Not Covered	Up to Basic SI from 1st Day till expiry of *Policy* or the child is 91 days old whichever is earlier.	Up to Basic SI from 1st Day till expiry of *Policy* or the child is 91 days old whichever is earlier.

S.No	Benefits	Basic	Essential	Privilege
Additional Benefits				
a	Restore Benefit	Covered	Covered	Covered

B	Cover for PLHA	Not covered	Not Covered	Covered
Renewal Benefits				
A	Cumulative Bonus	10% in increase in SI for every claims free year subject to maximum of 50%. The increased SI shall be decreased by 10% in event of claim but SI shall not be reduced	10% in increase in SI for every claims free year subject to maximum of 50%. The increased SI shall be decreased by 10% in event of claim but SI shall not be reduced	10% in increase in SI for every claims free year subject to maximum of 50%. The increased SI shall be decreased by 10% in event of claim but SI shall not be reduced
B	Health Check-up	1 coupon at the end of every claims two continuous claims free year 2 coupons in case of family floater	1 coupon at the end of every claim free year 2 coupons in case of family floater	1 coupon at the end of every claim free year 2 coupons in case of family floater
Value Added Benefits				
A	Dial a Doctor	Covered	Covered	Covered
B	Health Educational Library for People(HELP)	Covered	Covered	Covered
C	Second Option	Not Covered	Covered	Covered
D	Specialist Consultation with Two follow up session	Not Covered	Covered	Covered
E	Wellness Package	Covered	Covered	Covered
F	24x7 Customer Service	Covered	Covered	Covered
G	Newsletter	Covered	Covered	Covered
Product Options				
A	Personal Accident	Available	Available	Available
B	Critical Illness	Available	Available	Available
C	Hospital Daily Cash when Hospitalisation exceeds 3 days for a maximum number of 7 days	Rs 2,00 per day	Rs 5,00 per day	Rs 1,000 per day
D	Sub limits Applicability	No sublimit applicable under base *Policy*. Avail discount of 7.5% for choosing Sublimit A Avail discount of 5% for choosing Sublimit B	No sub limits applicable under base *Policy* Avail discount of 10% for choosing Sublimit A Avail discount of 7.5% for choosing Sublimit B Avail discount of 5% for choosing Sublimit C	No sub limits applicable under base *Policy*. Avail discount of 10% for choosing Sublimit A Avail discount of 7.5% for choosing Sublimit B Avail discount of 5% for choosing Sublimit C
E	Treatment only in tiered Network	5% discount if treatment is taken in tiered network and 10% co-pay shall be applicable for taking treatment in non-tiered network.	5% discount if treatment is taken in tiered network and 10% co-pay shall be applicable for taking treatment in non-tiered network.	5% discount if treatment is taken in tiered network and 10% co-pay shall be applicable for taking treatment in non-tiered network.
Discounts under the Policy				

A	***Family Discount*** **:** Avail discount for covering more than one *Family Member* under the *Policy* on individual sum insured basis
B	***E-Policy discount*** **:** Avail a discount of Rs 110 for opting to choose *Policy* in electronic form
C	***Long Term Policy discount:*** The following discounts will be offered if the *Policy* is taken by paying the appropriate premium for 2 years/ 3 years at once. No instalment facility is available for payment of premium under the *Policy*.

Number of Members	*Discounts*
2-3	5%
4-5	7%
More than 5	10%

Duration of *Policy*	Premium to be charged
2 years	2 year premium in advance less 5% discount
3 years	3 year premium in advance less 7.5% discount

d ***Lifestyle Discount:*** discount of 2.5% on Your premium under the Policy if You are employed in an occupation which doesn't fall into higher risks zones, You have maintained a healthy lifestyle and if You have already been covered under Group Health Insurance Policy of Your employer

S.N.	Health Indicators		Normal
1	Blood Sugar Levels		99 mg and lower
2	Blood Pressure	Systolic	Below 130
		Diastolic	Below 80
3	Cholesterol Level (mg/dL)		Below 200
4	Body Mass Index		18.5-24.9

The overall limit on discounts is 40%

Annexure-A

List I — Items for which coverage is not available in the policy

List of Expenses Generally excluded in Hospitalisation Policy		
S. No	**List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -**	**SUGGESTIONS**
Toiletries/ Cosmetics/ Personal Comfort Or Convenience Items		
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable

15	BELTS/ BRACES	Payable
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Payable
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	LACTOGEN/ INFANT FOOD	Not Payable
58	SLINGS	Reasonable cost will be payable for one sling in case of upper arm fractures.
Items Specifically Excluded In The Policies		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Excluded
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Excluded

61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Excluded
62	HORMONE REPLACEMENT THERAPY	Excluded
63	HOME VISIT CHARGES	Excluded
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Excluded
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT	Excluded
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Excluded
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Excluded
68	DONOR SCREENING CHARGES	Excluded
69	ADMISSION/REGISTRATION CHARGES	Excluded
70	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Excluded
71	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Excluded
Items Which Form Part Of Hospital Services Where Separate Consumables Are Not Payable But The Service Is		
72	WARD AND THEATRE BOOKING CHARGES	Payable under OT charges not payable separately
73	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by hospital payable. Purchase of instruments not payable
74	MICROSCOPE COVER	Payable under OT charges not payable separately
75	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT charges not payable separately
76	SURGICAL DRILL	Payable under OT charges not payable separately
78	EYE KIT	Payable under OT charges not payable separately
79	EYE DRAPE	Payable under OT charges not payable separately
80	X-RAY FILM	Payable under Radiology Charges not as consumable
81	SPUTUM CUP	Payable under Investigation Charges not as consumable
82	BOYLES APPARATUS CHARGES	Part of OT charges not payable separately
83	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
84	ANTISECPTIC OR DISINFECTANT LOTIONS	Not Payable-Part of Dressing Charges
85	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable-Part of Dressing Charges
86	COTTON	Not Payable-Part of Dressing Charges
87	COTTON BANDAGE	Not Payable-Part of Dressing Charges
88	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
89	BLADE	Not Payable
90	APRON	Not Payable -Part of Hospital Services/Disposable linen to be part of OT/ICU charges not covered under the policy

91	TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
92	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges/ Not Payable
93	URINE CONTAINER	Not Payable
Elements Of Room Charge		
94	LUXURY TAX	Actual tax levied by the government Is payable. Part of room charges for sub limits
95	HVAC	Part of room charge, not payable separately
96	HOUSE KEEPING CHARGES	Part of room charge, not payable separately
97	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge, not payable separately
98	TELEVISION & AIR CONDITIONER CHARGES	Payable under room category not if separately levied
99	SURCHARGES	Part of room charges, not payable separately
100	ATTENDANT CHARGES	Part of room charges, not payable separately
101	IM IV INJECTION CHARGES	Part of nursing charges, not payable
102	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
103	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
104	BLANKET/WARMER BLANKET	Not Payable- part of room charges
Administrative Or Non-Medical Charges		
105	ADMISSION KIT	Not Payable
106	BIRTH CERTIFICATE	Not Payable
107	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
108	CERTIFICATE CHARGES	Not Payable
109	COURIER CHARGES	Not Payable
110	CONVENYANCE CHARGES	Not Payable
111	DIABETIC CHART CHARGES	Not Payable
112	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
113	DISCHARGE PROCEDURE CHARGES	Not Payable
114	DAILY CHART CHARGES	Not Payable
115	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
116	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post hospitalisation where admissible
117	FILE OPENING CHARGES	Not Payable
118	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
119	MEDICAL CERTIFICATE	Not Payable
120	MAINTAINANCE CHARGES	Not Payable
121	MEDICAL RECORDS	Not Payable
122	PREPARATION CHARGES	Not Payable
123	PHOTOCOPIES CHARGES	Not Payable
124	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
125	WASHING CHARGES	Not Payable
126	MEDICINE BOX	Not Payable
127	MORTUARY CHARGES	Payable up to 24 Hrs, shifting charges not payable

128	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
External Durable Devices		
129	WALKING AIDS CHARGES	Not Payable
130	BIPAP MACHINE	Not Payable
131	COMMODE	Not Payable
132	CPAP/ CAPD EQUIPMENTS	Device not payable
133	INFUSION PUMP - COST	Device not payable
134	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
135	PULSEOXYMETER CHARGES	Device not payable
136	SPACER	Not Payable
137	SPIROMETRE	Device not payable
138	SPO2 PROBE	Not Payable
139	NEBULIZER KIT	Not Payable
140	STEAM INHALER	Not Payable
141	ARMSLING	Not Payable
142	THERMOMETER	Not Payable (paid by patient)
143	CERVICAL COLLAR	Not Payable
144	SPLINT	Not Payable
145	DIABETIC FOOT WEAR	Not Payable
146	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
147	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
148	LUMBO SACRAL BELT	Payable for cases where insured patients have undergone surgery of lumbar spine
149	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/ quadriplegia, for any reason and at reasonable cost of Rs 200/ day.
150	AMBULANCE COLLAR	Not Payable
151	AMBULANCE EQUIPMENT	Not Payable
152	MICROSHEILD	Not Payable
153	ABDOMINAL BINDER	Payable in post-surgery insured patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy, for intestinal obstruction, liver transplant etc.
Items Payable If Supported By A Prescription		
154	BETADINE \ HYDROGEN PEROXIDE\ SPIRIT\DETTOL\ SAVLON\ DISINFECTANTS ETC	Payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
155	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalisation nursing charges not payable
156	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	Patient diet provided by hospital is payable
157	ALEX SUGAR FREE	Payable- Sugar free variants of admissible medicines are not excluded
158	CREAMS POWDERS LOTIONS (Toileteries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
159	DIGENE GEL/ ANTACID GEL	Payable when prescribed
160	ECG ELECTRODES	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, one set every second day shall be payable.

161	GLOVES	Sterilized gloves payable/ unsterilized gloves not payable
162	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
163	LOZENGES	Payable when prescribed
164	MOUTH PAINT	Payable when prescribed
165	NEBULISATION KIT	If used during hospitalisation is payable reasonably
166	NOVARAPID	Payable when prescribed
167	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
168	ZYTEE GEL	Payable when prescribed
169	VACCINATION CHARGES	Routine vaccination not payable/ post bite vaccination payable
Part Of Hospital's Own Costs And Not Payable		
170	AHD	Not Payable - Part of Hospital's internal Cost
171	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
172	SCRUB SOLUTION/STERILLIUM OTHERS	Not Payable - Part of Hospital's internal Cost
Others		
173	VACCINE CHARGES FOR BABY	Not Payable
174	AESTHETIC TREATMENT / SURGERY	Not Payable
175	TPA CHARGES	Not Payable
176	VISCO BELT CHARGES	Not Payable
177	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
178	EXAMINATION GLOVES	Not payable
179	KIDNEY TRAY	Not Payable
180	MASK	Not Payable
181	OUNCE GLASS	Not Payable
182	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable
183	OXYGEN MASK	Not Payable
184	PAPER GLOVES	Not Payable
185	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction as this is not generally re-used
186	REFERAL DOCTOR'S FEES	Not Payable
187	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitilasation or post hospitalisation / Reports and Charts required/ Device not payable
188	PAN CAN	Not Payable
189	SOFNET	Not Payable
190	TROLLY COVER	Not Payable
191	UROMETER, URINE JUG	Not Payable
192	AMBULANCE	Payable from home to hospital or inter hospital shifts
193	TEGADERM / VASOFIX SAFETY	Payable- maximum of 3 in 48 Hrs and 1 in 24 Hrs
194	URINE BAG	Payable when medically necessary till a reasonable cost-maximum 1 per 24 Hrs
195	SOFTOVAC	Not Payable
196	STOCKINGS	Essential for case like CABG etc, where it should be paid.

List II — Items that are to be subsumed into Room Charges

SI No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)

36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III — Items that are to be subsumed into Procedure Charges

SI No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV — Items that are to be subsumed into costs of treatment

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS

7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Annexure-B

The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu.	**AHMEDABAD** Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka.	**BENGALURU** Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh Chattisgarh.	**BHOPAL** Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Orissa.	**BHUBANESHWAR** Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.	**CHANDIGARH** Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu,	**CHENNAI**

Pondicherry Town and Karaikal (which are part of Pondicherry).	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi.	**DELHI** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**GUWAHATI** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(Assam). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.	**HYDERABAD** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan.	**JAIPUR** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala, Lakshadweep, Mahe-a part of Pondicherry.	**ERNAKULAM** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	**KOLKATA** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340, Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh,	**LUCKNOW** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331, Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in

Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	**MUMBAI** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	**NOIDA** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	**PATNA** Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.	**PUNE** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in

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