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b. PREAMBLE:

The insurance cover provided under this Policy to the Insured / Insured Person up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium and (c) Disclosure to Information Norm (including by way of the Proposal) and (d) Schedule of Benefits.

c. SECTION 1 - DEFINITIONS:

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meaning set forth:

i. Standard Definitions (Definitions whose wordings are specified by IRDAI)

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

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

"AYUSH Day Care Centre" means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

"AYUSH Hospital" An AYUSH Hospital is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central

c. Government/Central Council of Indian Medicine / Central Council for Homeopathy ; or

d. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped

iv. operation theatre where surgical procedures are to be carried out;

v. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

"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.

"Condition Precedent" shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

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

Internal Congenital Anomaly - Congenital Anomaly which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly.

External Congenital Anomaly - Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly.

"Cumulative Bonus" shall mean any increase in the Sum Insured granted by the Insurer without an associated increase in the premium.

"Co Payment" shall mean a cost sharing requirement under a health Insurance policy that provides the policy holder/insured will bear a specified percentage of the admissible claims amount. A co payment does not reduce the Sum Insured

"Day Care treatment" means medical treatment, and / or surgical procedure which is:

i. undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and

ii. which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

"Day care Centre" means any institution established for day care treatment of Illness and / or injuries 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:

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i. has qualified nursing staff under its employment

ii. has qualified medical practitioner/s in charge;

iii. has a fully equipped operation theatre of its own where surgical procedures are carried out

iv. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

"Deductible" is a cost-sharing requirement applicable per event/claim under a health insurance Policy that provides, the Insurer will not be liable for a specified rupee amount in case of indemnity policies and/or for a specified number of days/hours in case of hospital cash benefit which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured.

"Dental Treatment:" Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

"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.

"Domiciliary hospitalization" 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:

i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

ii. the patient takes treatment at home on account of non-availability of room in a hospital.

"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.

"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.

"Hospital" - A 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:

i. has qualified nursing staff under its employment round the clock;

ii. 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;

iii. has qualified medical practitioner(s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;

v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

"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.

"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 - 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 - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:

   i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests;

   ii. it needs ongoing or long-term control or relief of symptoms;

   iii. it requires your/Insured person's rehabilitation or for you/Insured member to be specially trained to cope with it;

   iv. it continues indefinitely;

   v. it recurs or is likely to recur

"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.

"Inpatient care" means treatment for which the Insured person has to stay in a hospital for more than 24 hours for a covered event.

"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.

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ICU (intensive Care Unit) Charges:- means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

"Maternity expense" shall include

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

b. Expenses towards lawful medical termination of pregnancy during the Policy period.

"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 license. The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured/ Insured Person's family who includes Father, Mother, Father-in-law, Mother-in-law, Son, Daughter, Son-in-law, Daughter-in-law, Brother or Sister.

"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" treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

i. is required for the medical management of the Illness or Injury suffered by the Insured;

ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii. must have been prescribed by a medical practitioner,

iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

"Medical Advise" means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

"Migration" means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

"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.

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

"Notification of claim" means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

"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.

"Portability" means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

"Post-hospitalization Medical Expenses" means Medical Expenses incurred immediately after the Insured Person is discharged from the hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

"Pre-Existing Disease" (PED) means any condition, ailment, injury or disease:

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or it's reinstatement OR

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

"Pre-hospitalization Medical Expenses" means medical expenses incurred immediately before the Insured Person is Hospitalized, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

"Renewal" defines 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.

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"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.

"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.

"Subrogation" mean 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.

"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.

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

ii. Specific definitions (Definitions other than those mentioned under c (I) above)

"Ayush Treatment" refers to the medical and / o r hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

"Company" means ICICI Lombard General Insurance Company Limited.

"Dependent Child" means a child (natural or legally adopted), who is unmarried, aged between 91 days and 25 years, financially dependent on the Insured and does not have his / her independent sources of income.

"Disease" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner.

"Diagnostic Tests" Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

"Family" means a family described as such in the Schedule where Insured and Insured's Dependents named in the Schedule are insured under this Policy

"Family Floater Policy" means a Policy in terms of which, two or more persons of a Family are named in the Schedule as Insured Persons.

"Insured" / "Insured Person" means the individual(s) whose name(s) is/are specifically appearing as such in the Policy Schedule and is/are hereinafter referred as "You"/"Your"/ "Yours"/ "Yourself"

"New Born Baby" baby born during the Policy Period and is aged upto 90 days.

"Policy period" means the period between the inception date and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier.

"Policy" means this document of Policy describing the terms and conditions of this contract of insurance (basis the statements in the Proposal Form) , any annexure thereto, including the company's covering letter to the Insured / Insured person if any, the Schedule attached to and forming part of this Policy and any applicable endorsement thereon. The Policy contains details of the scope and extent of cover available to the Insured/Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.

"Policy Year" means the period of one year commencing on the date of commencement specified in the Schedule of Insurance Certificate or any anniversary thereof.

" Restore Benefit" means re-instatement of hundred percent of the Sum Insured.

"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 are subject to.

"Schedule of Benefits" means the Product Benefits Table issued by the Company and accompanying this Policy and annexures thereto.

"Service provider" means any person, organization, institution, or company that has been empanelled with Us to provide services specified under the Benefits (including add-ons) to The Insured person. These shall also include all healthcare providers empanelled to form a part of network other than hospitals. The list of the Service Providers is available at our website (https://www.icicilombard.com/content/ilom-en/serviceprovider/search.asp)and is subject to amendment from time to time

"Sum Insured" or **"Annual Sum Insured"** means the sum as specified in the Schedule to this Policy against the name of Insured / each Insured Person at the inception of a Policy Year and in the event of Policy is upgraded or downgraded on any continuous Renewal, then exclusive of Cumulative Bonus, if any, the Sum Insured for which premium is paid at the commencement of the Policy Year for which the prevalent upgrade or downgrade is sought.

"Terrorism/Terrorist Incident" means any actual or threatened use of force or violence directed at or causing damage, Injury, harm or disruption, or the commission of an act dangerous to human life or

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property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism.

"Third Party Administrator (TPA)" means any organization or institution that is licensed by the IRDA as a TPA and is engaged by the Company for a fee or remuneration for providing Policy and claims facilitation services to the Insured/ Insured Person as well as to the Company for an insurable event.

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

"We / Our / Ours / Us" means the ICICI Lombard General Insurance Company Limited

d. Benefits covered under the Policy

The coverage mentioned below differs between the various plan offerings and the wordings of only the relevant covers opted by the Insured Person and as mentioned in the Policy schedule will be applicable.

SECTION 2 - SALIENT FEATURES & BENEFITS:

Basic cover:

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy.

The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken during the Policy Period for an Illness, Accident or condition described below if this is contracted or sustained by an Insured / Insured Person during the Policy Period and subject always to the Sum Insured, any subsidiary limit specified in the schedule of Benefits, the terms, conditions, limitations and exclusions mentioned in the Policy and eligibility as per the insurance plan opted by insured and stated in as stated in the Schedule

Section 2.1) In-patient Treatment:

This benefit provides cover for reimbursement / payment of cashless hospitalization expenses which are reasonably and necessarily incurred by the Insured / Insured Person for treatment of Disease, Illness contracted or Injury sustained by the Insured / Insured Person during the Policy period as specified in the Schedule to this Policy, in a Hospital in India for in- patient care which among other things, includes, Hospital room rent or boarding expenses, nursing, Intensive Care Unit Charges, Operation Theatre charges, Medical Practitioner's charges, fees of Surgeon, Anesthetist, Qualified Nurse, Specialists, the cost of diagnostic tests, medicines, drugs, blood, oxygen, the cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure.

The Insured/Insured Person should have been hospitalized as an in-patient care for a minimum period of 24 consecutive hours. The benefit under this Section is limited to the Sum Insured specified for this Section in the Schedule of Benefits to this Policy.

Eligibility of room category as per the plan opted

For Insured / Insured Person opting for sum insured options 2Lacs/ 3Lacs / 4Lacs, the coverage for hospital room and / or boarding and nursing shall be subject to maximum per day capping of 1 % of the Sum Insured and in case of the coverage for Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses shall be subject to maximum per day capping of 2 % of the Sum Insured.

In case of admission to a room at rates exceeding the above limits, the reimbursement/payment of all other expenses incurred at the Hospital, be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. However, cost of pharmacy and consumables; cost of implants and medical devices and cost of diagnostics shall be reimbursed at actuals. Proportionate deductions are not applicable on ICU charges and on hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on room category.

If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula, this is not applicable if the hospital does not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

Associated Medical Expenses shall include Room Rent excluding ICU charges, nursing charges for Hospitalization as an Inpatient, Medical Practitioners' fees , operation theatre charges and other supply of bill excluding Cost of pharmacy and consumables; Cost of implants and medical devices, Cost of diagnostics

Illustration:

Sum Insured – INR 400,000

Eligible Room Rent – INR 4,000

Room Rent actually incurred – INR 8,000

Associated Medical Expenses Incurred – INR 50,000

Associated Medical Expenses Payable – INR 25,000

Basis of Calculation:

4,000/8,000 * 50,000 = INR 25,000

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Section 2.2) Pre-hospitalization:

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule of benefits forming part of this Policy, prior to hospitalization or day care treatment for treatment of Disease, Illness contracted or Injury sustained for which the Insured / Insured Person was hospitalized, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. Pre-hospitalization Medical Expenses can be claimed as reimbursement only.

Section 2.3) Post-hospitalization:

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule of benefits forming part of this Policy, after discharge from Hospital / day care treatment for continuous and follow up treatment of the Disease, Illness contracted or Injury sustained for which the Insured/Insured Person was hospitalized, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. Post-hospitalization Medical Expenses can be claimed as reimbursement only.

Section 2.4) Organ Donor:

Where the Insured/Insured Person contracts any of the Illness or Injury requiring major Organ Transplantation surgery and undergoes surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible, the hospitalization expenses incurred for harvesting the organ donated for the Insured / Insured Person for this treatment is covered under this benefit, provided the donation conforms to The Transplantation of Human Organs Act 1994. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. This part of benefit is applicable throughout the policy period

This benefit also covers screening expenses of the donor if he/she is accepted as a donor. Post donation fitness test is also covered under this. Any medical expenses as a result of complications arising because of harvesting from the donor is also covered. However, this benefit does not cover costs directly or indirectly associated with the acquisition of the donor's organ. This part of the benefit is applicable for a period of six months or the policy end date whichever is earlier from the date of organ harvesting from the donor.

Section 2.5) Day Care Treatment:

This benefit covers hospitalization expenses towards medical treatment, and/or all day care procedures incurred by the Insured / Insured Person which is undertaken under General or Local Anesthesia in a Hospital/day care centre (where 24 hours of hospitalization is not required due to technologically advanced treatment) which shall be payable. The benefit under this Section is limited to the available Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

Section 2.6) Ayush Treatment:

This benefit provides reimbursement to the Insured/ Insured Person of Medical Expenses incurred for In-patient treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems provided that:

The treatment is undertaken in lines with definition of Ayush Day Care and Ayush Hospital

Note:

a) The reimbursement under Ayush benefit will be applicable for inpatient hospitalization claims only;

b) The Insured/ Insured person will not be entitled for Domiciliary Hospitalization;

c) Cashless facility is not available.

The benefit under this Section is available upto the Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

SECTION 3 – OTHER BENEFITS:

Benefits under this Section are payable as additional benefits / in-built benefits upto the limits specified in the Schedule to this Policy. However, the amount under this shall be part of the overall Sum Insured

Section 3.1 Restore Benefit

In case of a situation where the Sum Insured and Guaranteed Cumulative Bonus (GCB) are exhausted due to claims made and paid during the Policy Year, and the Insured/Insured Persons have to, incur any hospitalization expenses due to any Accident/ Disease/ Illness / Injury for which a valid claim is admissible under the Policy, then the Sum Insured shall be regained and called Regained Sum Insured which is equal to 100% of SI for the particular Policy year for all members in the Policy, provided that;

I. The Regained Sum Insured will be enforceable only after the first claim during the policy year. The regain benefit will be triggered upon partial or full utilization of Sum Insured. The Regained Sum Insured can be used for claims made by the Insured / Insured Person in respect of the benefits stated in Section 2. Hence making the total Sum Insured available as SI+GCB+Regain – (minus) 1st Claim

II. The Regained Sum Insured shall be available for any Accident / Disease / Illness / Injury or any related Accident / Disease / Illness/ Injury for which a Claim has already been admitted partially or fully for that Insured / Insured person during that Policy Year.

III. The Regain Sum Insured will only be allowed once during a Policy Year;

IV. Regain of Sum Insured is not applicable for Optional benefits.

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If the Regain Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

Sample Illustration 1

Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	300000	NA	250000	NA	300000	250000	50000
2	50000	NA	250000	300000	50000 - Main Sum Insured 300000 - Regain Sum Insured	250000	100000

Sample Illustration 2

Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	500000	NA	250000	NA	500000	250000	250000
2	250000	NA	1000000	500000	250000 - Main Sum Insured 500000 - Regain Sum Insured	750000	0

In case of renewal

Sample Illustration 3

Year	Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	No Claim	500000	NA	NA	NA	500000	NA	NA
2	1	500000	100000	500000	NA	500000 - Main Sum Insured 100000 - Cumulative Bonus	500000	100000
	2	NA	100000	300000	500000	0 - Main Sum Insured 100000 - GCB 500000 - Regain Sum Insured	300000	300000

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Sample Illustration 4

Year	Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	No Claim	500000	NA	NA	NA	500000	NA	NA
2	1	500000	100000	500000	NA	500000 - Main Sum Insured 100000 - Cumulative Bonus	500000	100000
	2	0	100000	300000	500000	0 - Main Sum Insured 100000 - GCB 500000 - Regain Sum Insured	300000	300000
3	1	500000	100000	500000	NA	500000 - Main Sum Insured 100000 - Cumulative Bonus	500000	100000
	2	0	100000	300000	500000	0 - Main Sum Insured 100000 - GCB 500000 - Regain Sum Insured	300000	300000

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3.2 Animal Bite (Vaccination)

The Company will cover Medical Expenses of OPD Treatment for vaccinations or immunizations for treatment post an animal bite, up to the limit provided in the Schedule of Benefits. This benefit is available only on reimbursement basis.

3.3 Guaranteed Cumulative Bonus (GCB):

If no claim has been made in a Policy Year by any Insured / Insured Person, then for each such Policy year, the Company will offer a GCB of 20% of Sum Insured maximum uptill 100% of expiring or renewed Policy Sum Insured, whichever is lower

Guaranteed Cumulative Bonus will be provided on the expiring/ renewed Policy Sum Insured, whichever is lower, provided that the Policy is renewed continuously.

The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the increase in Guaranteed Cumulative Bonus.

This will not affect the Sum Insured of the Policy.

Guaranteed Cumulative Bonus will be available only for base cover benefits

Once accrued shall remain guaranteed for the life (i.e. will not get reduced on subsequent renewals) and shall not get reduced in case of a claim irrespective of value of GCB accrued / Maximum value of GCB that can be accrued is 100% of expiring or renewed policy sum insured, whichever is lower.

Illustration Let us assume that an individual has opted for a Sum Insured of INR 500,000 and has continuously renewed the policy for next 4 years. The Guaranteed cumulative bonus is as illustrated below:

Year	Sum Insured Available	Guaranteed Cumulative Bonus Available (20% of Sum Insured)	Total Sum Insured Available (Base + GCB)	Claim / No Claim
Year 0	500000	NA	500000	No Claim
Year 1	500000	100000	600000	No Claim
Year 2	500000	200000 (100000 + 100000)	700000	Claim
Year 3	500000	200000 (100000+ 100000 + 0)	700000	Claim
Year 4	500000	200000 (100000+ 100000 +0 +0)	700000	

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3.4 Surface Ambulance Charges:

This benefit provides for cashless / reimbursement to the Insured/Insured Person of expenses incurred for his/her surface transport by ambulance to hospital or between hospitals and/or diagnostic center for treatment of Disease, Illness or Injury in a Hospital as an in-patient for which a valid claim under this Policy is admissible.

This benefit is subject to sub limits (per hospitalization claim) as mentioned in Schedule of benefit but within overall limit of the Sum Insured as specified in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to the overall Sum Insured.

3.5 Health Check-up:

The Company will cover the cost of health checkup on cashless basis as per plan eligibility as defined in the Policy schedule provided that Insured / Insured Person is covered within overall SI limit under section 2.1. Only that Insured / Insured Person who has attained minimum age of 18 years at the time of first policy/Renewal shall be eligible for a health check-up.

3.6 Convalescence Benefit:

In case the Insured / Insured Person is hospitalized for a continuous period of 10 days or more for treatment of any Accident / Disease/ Illness /Injury for which a valid claim is admissible under the Policy, this benefit provides for payment to the Insured / Insured Person of a fixed allowance as mentioned in the Schedule of benefit attached to this Policy.

This benefit is subject to sub limits as mentioned in Schedule of benefits payable only once during the Policy year.

If an insured is taking a coverage for 1 year he is eligible for convalescence benefit only once (i.e. one per policy year), while if he is taking the policy coverage for 3 years, he is then eligible for this benefit once in each and every year (i.e. one per policy year).

3.7: Bariatric Surgery Cover:

If the insured is hospitalized on the advice of a Doctor because of Conditions mentioned below which required insured to undergo Bariatric Surgery during the Policy year, then We will pay the insured, Reasonable and Customary Expenses related to Bariatric Surgery according to the policy schedule and waiting period mentioned in this document. There is no limit on the number of time this cover can be used in a policy year subject to the Sum Insured of the cover as specified in policy schedule.

Eligibility:

For adults aged 18 years or older, presence of severe obesity documented in contemporaneous clinical records defined as any of the following:

BMI greater than and equal to 40 in conjunctions with any of the following severe comorbidities:

1. Coronary heart disease; or
2. Medically refractory hypertension (blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes); or
3. Type 2 diabetes mellitus

Special Conditions applicable to Bariatric Surgery Cover

- Bariatric surgery performed for any other reason not listed above shall not be covered.
- The indication for the procedure should be found appropriate by two qualified surgeons and the insured person shall obtain prior approval of the company for cashless treatment. This optional benefit helps insured in availing bariatric treatment if suggested by attending doctor

3.8 Domiciliary Hospitalization:

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:

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

However, this does not cover

1. Treatment of less than 3 days. (Coverage will be provided for expenses incurred in first three days however this benefit will be applicable if treatment period is greater than 3 days);
2. The following medical conditions:
   a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,
   b. Arthritis, Gout and Rheumatism,
   c. Chronic Nephritis and Nephritic Syndrome,
   d. Diarrhoea and all type of Dysenteries including Gastroenteritis,
   e. Diabetes Mellitus and Insupidus,
   f. Epilepsy,
   g. Hypertension,
   h. Pyrexia of unknown origin.

   Domiciliary hospitalization benefits also cover expenses on Qualified nurses engaged on the recommendation of the attending Medical Practitioner.

   The benefit under this Section is limited to the available Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

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3.9 Zonal Pricing

For the purpose of calculating premium below zones are available:-

Zone 1:-NCR, Mumbai, Thane district, Raigad District (Maharashtra), Navi Mumbai, Gujrat, Kolkata.

Zone 2:-Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Raigad District (Maharashtra), Navi Mumbai)

Zone 3:-Rest of India (excluding as mentioned in Zone 1 and Zone 2).

Cities included in the zone	Discount on Premium	Co-pay on claim
Zone 1 – NCR, Mumbai, Thane district, Raigad District (Maharashtra), Navi Mumbai, Gujrat , Kolkata	No Discount	No co-pay on claim anywhere in India
Zone 2 – Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Raigad District (Maharashtra), Navi Mumbai)	Discount on premium – 12.50%	Treatment taken at locations included in Zone 1: 12.5% co-pay Treatment taken at locations included in Zone 2 & 3 – no co-pay
Zone 3 – Rest of India	Discount on premium – 15%	Treatment taken at locations included in Zone 1: 15% co-pay Treatment taken at locations included in Zone 2 – 12.5% co-pay Treatment taken at locations included in Zone 3 – no co-pay

NCR*	Name of the Districts
Haryana	Faridabad, Gurugram, Nuh, Rohtak, Sonepat, Rewari, Jhajjhar, Gurugram, Panipat, Palwal, Bhiwani,Charkhi Dadri, Mahendragarh, Jind and Karnal
Uttar Pradesh	Meerut, Ghaziabad, Noida/ Gautam Budh Nagar, Bulandshahr, Baghpat, Hapur,Shamli and Muzaffarnagar
Rajasthan	Alwar and Bharatpur
Delhi	Whole of NCT Delhi.

If you select Zone 1 during proposal inward and if treatment is taken in zone 1 then no copay will be applicable.

If you select Zone 2 during proposal inward and if treatment is taken in zone 1 then 12.5% copay will be applicable.

If you select Zone 3 during proposal inward and if treatment is taken in zone 2 then 12.5% copay will be applicable.

If you select Zone 3 during proposal inward and if treatment is taken in zone 1 then 15% copay will be applicable

3.10 Incentives associated with Vaccination against pneumococcal disease

We will provide an additional 1.5% discount on premium (fresh or renewal) for Insured Person who have taken the conjugate Pneumococcal vaccine which helps prevent pneumococcal disease. All the adult members covered under the policy should have been vaccinated in the past one year (1 year) from policy start date to avail this discount. i.e. if policy start date is 1st January 2022, all adult members under the policy should have been vaccinated against Pneumococcal disease in the period from 1st January 2021 to 31st December 2021. This discount shall be provided lifetime as long as the Insured person continues to renew this policy

SECTION 4 – OPTIONAL BENEFIT:

Benefits under this Section are payable as optional benefits on payment of additional premium, up to the limits specified in the Schedule to this Policy unless specified otherwise.

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4.1: Domestic Air Ambulance:

In consideration of the payment of additional premium to Us, We will cover the expenses incurred on air ambulance services in respect of an Insured Person which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

i. Our maximum liability under this Benefit for any and all claims arising during the Policy Year will be restricted to the Sum insured as stated in the Policy Schedule;

ii. It is for a life threatening emergency health condition/s of the Insured Person which requires immediate and rapid ambulance transportation from the place where the Insured Person is situated at the time of requiring Emergency Care to a hospital provided that the transportation is for Medically Necessary Treatment, is certified in writing by a Medical Practitioner, and road ambulance services cannot be provided.

iii. Such air ambulance providing the services, should be duly licensed to operate as such by a competent government Authority.

iv. This cover is limited to transportation from the area of emergency to the nearest Hospital only;

v. We will not cover:

a) Any transportation from one Hospital to another;

b) Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital

c) Any transportation or air ambulance expenses incurred outside the geographical scope of India.

vi. We have accepted a claim under Section In patient treatment in respect of the Insured Person for the same Accident/Illness for which air ambulance services were availed.

vii. We shall not be liable if Medically Necessary Treatment can be provided at the Hospital where the Insured Person is situated at the time of requiring Emergency Care.

4.2: Maternity Cover:

This optional benefit covers the medical expenses including up to limits specified in the schedule (over and above Sum Insured mentioned in the Schedule) for the delivery of a baby and / or expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner, limited to maximum of three deliveries or terminations as said herein during the lifetime of an female Insured/Insured Person as the case may be between the ages of 18 years to 45 years in the Policy.

The benefit will have a waiting period of 9 months from the time this cover is opted for

This optional benefit is applicable to all or any female Insured / Insured person who has opted for 3 years Policy term between age 18 to 45 years as selected by proposer.

In case, insured has taken three year policy without maternity optional benefit and would like to opt for maternity optional benefit, then this can be availed only at the time of renewal

Ectopic Pregnancy is not covered under this section. In case the maternity benefit is not claimed, next 3 years maternity premium is waived off. Exclusion No, **'R. Maternity: Code Excl18' will not be applicable to this section**

4.3: New Born Baby Cover:

Medical Expenses for any medically necessary treatment described at 2.1 while the Insured Person (the Newborn baby) is hospitalized during the Policy Period within first 90 days of birth, as an inpatient under this benefit. The coverage is subject to the Policy exclusions, terms and conditions. This Benefit is applicable if Maternity benefit is opted and the Company has accepted a maternity claim under this Policy.

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Maternity sum insured mentioned in the Schedule.

4.4: Vaccinations for new born baby in the first year:

Vaccinations for new born baby till one year of age during the policy period - Option of covering vaccination for the new born baby which is upto 1% of Sum Insured or upto Rs.10,000 whichever is lesser. This Benefit is applicable if Maternity benefit is opted and the Company has accepted a maternity claim under this Policy.

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Maternity sum insured mentioned in the Schedule

4.5: OPD for Medical and Dental:

This optional cover help you in getting your bill reimbursed upto the limit specified in the schedule. The OPD benefit will cover the following on reimbursement basis

- In-network Doctor Consultation on submission of consultation papers
- In-network Pharmacy on submission of prescription.
- In-network diagnostics on submission of diagnostic reports
- In-network Physiotherapy on submission of consultation papers

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Sum Insured mentioned in the Schedule. Exclusion No, 'U' will not be applicable to this section.

Illustration

SI	OPD SI Eligibility
1000000	5000
10000000	50000
30000000	100000

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4.6: Hospital Cash Benefit:

Daily cash amount will be payable per day up to the specified limits as mentioned in the Schedule to this Policy if the Insured Person is Hospitalized for treatment of any Disease / Illness / Injury for which a valid claim is admissible under the Policy for each continuous and completed period of 24 hours and if the Hospitalization exceeds for more than 24 hours. First continuous and completed period of 48hours will act as deferment which means minimum hospitalization of 48 hours is required for claims to be payable from the time of hospitalization.

This is paid up to a maximum of 45 days for all Insured Persons.

This benefit is subject to the specified limits as mentioned in Schedule over and above the Sum Insured as mentioned in the Schedule.to this policy.

4.7: Personal Accident Cover:

This optional benefit helps insured in getting additional coverage of following benefits upto the Sum Insured opted for:

a. Accidental Death

We shall pay 100% of the coverage amount of the Insured / Insured Person, in the event of his / her Death on account of an Accident / Injury, during the Policy Period or within twelve calendar months from the date of occurrence of such Accident / Injury which occurred during Policy Period.

b. Permanent Total Disablement

We shall pay up to the coverage amount of the Insured Person as specified below in case of his / her permanent total disablement on account of any Accident / Injury, during the Policy Period or within twelve calendar months from the date of occurrence of such Accident / Injury which occurred during Policy Period. The payout of the Sum Insured shall be as per table below:

S.No	Insured Events	Amount payable = % of the Sum Insured specified in the policy schedule
I	Total and irrecoverable loss of sight of both the eyes or the actual loss by physical separation of two entire hands or feet, or one entire hand and one entire foot, or the total and irrecoverable loss of sight of one eye and loss by physical separation of one entire hand or one entire foot.	100%
II	Total and irrecoverable loss	100%
	(a) use of two hands or two feet	
	(b) one hand and one foot	
	(c) sight of one eye and use of one hand or one foot	
III	Total and irrecoverable loss of sight of one eye or the actual loss by physical separation of one entire hand or one entire foot	50%
IV	Total and irrecoverable loss of use of one entire hand or one entire foot without physical separation	50%
V	Paraplegia or Quadriplegia or Hemiplegia	100%

NOTE: For the purpose of Sr. No. I to IV in the table above, physical separation of a hand or foot shall mean separation of the hand at or above the wrist, and of the foot at or above the ankle.

For the purpose of this Benefit only:

(I) "Hemiplegia" means complete and irrecoverable paralysis of the arm, leg, and trunk on the same side of the body;

(II) "Paraplegia" means complete and irrecoverable paralysis of the whole of the lower half of the body (below waist) including both the legs;

(III) "Quadriplegia" means complete and irrecoverable paralysis of all four limbs.

c. Permanent Partial Disablement

We shall pay up to the coverage amount of the Insured Person as specified below in case of his / her permanent partial disablement on account of any Accident / Injury, during the Policy Period or within twelve calendar months from the date of occurrence of such Accident / Injury which occurred during Policy Period. The payout of the Sum Insured shall be as per table below:

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S.No	Insured Events	Amount payable = % of the Sun Insured specified in the policy schedule
I	Total and irrecoverable loss of hearing in: -	
	a) Both ears	75%
	b) One ear	30%
II	Loss of toes	
	a) All	20%
	b) Both phalanges of great toes bilateral	5%
	c) Both phalanges of one great toe	2%
	d) Both phalanges of other than great than great toes for each	1%
III	III Loss of four fingers and thumb of one hand	40%
IV	Loss of four fingers of one hand	35%
V	Loss of thumb	
	a) Both phalanges	25%
	b) One phalanx	10%
VI	Loss of index finger	
	a) Three phalanges	10%
	b) Two phalanges	8%
	c) One phalanx	4%
VII	Loss of middle finger	
	a) Three phalanges	6%
	b) Two phalanges	4%
	c) One phalanx	2%
VIII	Loss of ring finger	
	a) Three phalanges	5%
	b) Two phalanges	3%
	c) One phalanx	2%
IX	Loss of ring finger	
	a) Three phalanges	4%
	b) Two phalanges	3%
	c) One phalanx	2%
X	Loss of metacarpus	
	a) First or second	2%
	b) Third, fourth or fifth	2%

S.No	Insured Events	Amount payable = % of the Sum Insured specified in the policy schedule
XI	Permanent partial disablement not otherwise provided for under serial no. I to X	Such % of the Sum Insured as determined in accordance with the medical assessment carried out by the Company's Network Hospital that the %age under Insured event Sr. No. XI shall not exceed 50% of the Sum Insured

4.8: Critical Illness:

After waiting period as specified in the policy schedule (mentioned as Waiting Period), if the Insured is at any time during the Policy period, being diagnosed contracted by any Critical Illness as specified below and surviving for more than such period mentioned in Schedule mentioned as Critical Illness Survival Period, post such diagnosis, (over and above the Sum Insured mentioned in the Schedule), Insured shall be paid Lump Sum amount upto the specified limits as mentioned in Schedule.

After availing the benefit under section Critical Illness, if the Insured / Insured Person takes treatment for the Critical Illness in a Hospital, the hospitalization expenses incurred for the same would be payable/reimbursed, subject to the terms and conditions of the Policy, out of the Sum Insured available for Hospitalization Benefit cover under Section In patient Treatment of this Policy. However, in case of diagnosis of multiple illnesses qualified as Critical Illness under the Policy, the payment of compensation under critical illness benefit shall be limited to the limit specified in the schedule and shall be payable only once in the lifetime of Insured/Insured person. Critical Illness benefit will lapse after reporting of and payment of one claim for the claiming Insured/Insured person. Critical Illness limit opted cannot be more than Sum Insured opted for Section In patient Treatment The illnesses qualified as Critical Illnesses and covered in this section are as follows:

1. Cancer of Specified Severity
2. Myocardial Infarction (First Heart Attack of Specified Severity)
3. Coronary Artery Disease
4. Open Chest CABG
5. Open Heart Replacement or Repair of Heart Valves
6. Surgery to Aorta
7. Stroke resulting in Permanent Symptoms
8. Kidney Failure requiring Regular Dialysis
9. Aplastic Anaemia

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10. End Stage Lung Disease
11. End Stage Liver Failure
12. Coma of Specified Severity
13. Third Degree Burns
14. Major organ /bone marrow transplant
15. Multiple Sclerosis with Persisting Symptoms
16. Fulminant Hepatitis
17. Motor Neurone Disease with Permanent Symptoms
18. Primary Pulmonary Hypertension
19. Terminal Illness
20. Bacterial Meningitis

1. Cancer of Specified Severity

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

The following are excluded –

i. All tumors which are histologically described as carcinoma in situ,benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not

limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction (First Heart Attack of specified severity)

The first occurrence of heart attack or 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 Myocardial Infarction should be evidenced by all of the following criteria:

I. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial Infarction (for e.g. typical chest pain)

II. New characteristic electrocardiogram changes

III. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded

I. Other acute Coronary Syndromes

II. Any type of angina pectoris

III. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Coronary Artery Disease

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery.

4. Open Chest CABG (Coronary Artery By-pass Graft) surgery

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

I. Angioplasty and/ or any other intra-arterial procedures

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. Surgery to Aorta

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures are excluded.

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7. **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 embolisation from an extracranial 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.

The following are excluded:

I. Transient ischemic attacks (TIA)

II. Traumatic Injury of the brain

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

8. **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.

9. **Aplastic Anaemia**

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

I. Blood product transfusion;

II. Marrow stimulating agents;

III. Immunosuppressive agents; or

IV. Bone marrow transplantation

The diagnosis must be confirmed by a haematologist.

10. **End Stage Lung Disease**

End Stage Lung Disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and

iv. Dyspnea at rest.

11. **End Stage Liver Failure**

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

12. **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:

I. no response to external stimuli continuously for at least 96 hours;

II. life support measures are necessary to sustain life; and

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

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

13. **Third Degree Burns**

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

14. **Major organ /bone marrow transplant**

The actual undergoing of a transplant of:

I. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

II. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

I. Other stem-cell transplants

II. Where only islets of langerhans are transplanted

15. **Multiple Sclerosis with persistent symptoms**

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

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

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

I. Other causes of neurological damage such as SLE are excluded.

16. **Fulminant Hepatitis**

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure.

This diagnosis must be supported by all of the following:

I. Rapid decreasing of liver size;

II. Necrosis involving entire lobules, leaving only a collapsed reticular framework;

III. Rapid deterioration of liver function tests;

IV. Deepening jaundice; and

V. Hepatic encephalopathy.

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17. 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

18. Primary Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort.Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation,pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

19. Terminal Illness

The conclusive diagnosis of an Illness that is expected to result in the death of the insured person within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed Doctor.

20. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

I. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and

II. A consultant neurologist.

4.9 Worldwide Cover:

In consideration of the payment of additional premium to Us, We will cover the Insured person for hospitalization expenses including planned hospitalisation incurred outside India and anywhere across the world including USA and Canada, up to the amount specified under against this benefit in the policy schedule subject to the terms & conditions specified hereunder:

I. A co-pay of 10% will be applied to every admissible claim over and above to any other co-pay charged

II. The benefit is available for 45 consecutive days from the date of travel in a single trip and 90 days in a cumulative bases as a whole in a Policy year

III. The expenses covered under this benefit will be limited to inpatient hospitalization expenses and days care treatment/ procedure expenses. Expenses incurred for pre and post hospitalization will not be covered under this benefit.

IV. The payment of any claim under this benefit will be based on the rate of exchange as on Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian rupees for payment of claims. If on the insured person's date of loss, if the RBI rates are not published, the exchange rates published next shall be considered for conversion

V. In case of planned hospitalization, prior intimation of the claim and due approval from Us will be necessary

4.10 Tele Consultation(s):

We will arrange consultations and recommendations for routine health issues by a qualified Medical Practitioner or health care professional. For the purpose of this benefit Telephonic/Virtual consultation shall mean consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile application. The services provided under this Benefit will be made available subject to the terms and conditions, and in the manner prescribed below:

- The Medical Practitioner may suggest /recommend / prescribe over the counter medications based on the information provided, if required on a case to case basis. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional*.
- There shall be no maximum limit on the count of tele-consultations that can be availed by the Insured Person in a policy year
- This service will be available 24 hours a day, and 365 days in a year.
- We/Medical Practitioner/Healthcare professional may refer the Insured Person to another specialist or a general physician (outside of our empanelled network), if required and the charges for such specialist or a general physician will have to be borne by the Insured Person.
- We will provide Emergency assistance information such as nearest ambulance / hospital / blood bank etc.
- We shall not be liable for any discrepancy in the information provided under this Benefit.

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- Choosing the services under this Benefit is purely upon the customer's own discretion and at own risk.
- *The proposer should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If the Insured person has any concerns about His/ her health, He/ She may consult His/ her general practitioner. We shall not hold any responsibility towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner/ Healthcare professional

4.11 Home Care Treatment:

We will cover the medical expenses incurred by the Insured Person on home care treatment maximum up to 5% of Sum Insured subject to a limit of Rs. 25,000 provided that:

a. The Medical Practitioner advices the Insured Person to undergo treatment at home
b. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
c. Daily monitoring chart including records of the treatment duly signed by the treating doctor is maintained
d. The condition of the Insured Person is expected to improve in a reasonable and foreseeable period of time.
e. Treatment that can be availed on outpatient basis will not be qualified to be covered under this clause.
f. Prior approval from Us has been taken. The Home care treatment is availed only on a cashless basis, subject to availability of our empanelled service provider(s). Kindly visit our website for cities/locations where such services are available.
g. Treatment availed is not categorized under "AYUSH" or any form of non- allopathic treatment

However in case of unavailability of our empanelled service provider in the insured person's location, in case the insured person intends to avail the services of non-network provider and claims for reimbursement, a prior approval from Us needs to be taken before availing such services.

In case the insured person breaches the conditions of approval or fails to take the prior written approval from Us, we are not liable to settle any claim under this section.

For the purpose of this benefit, Home care treatment shall include:

a. Diagnostic tests underwent at home as advised by medical practitioner
b. Medicines prescribed in writing by a medical practitioner
c. Consultation charges of the medical practitioner
d. Nursing charges if advised by the medical practitioner

Any expenses payable during the Policy period shall not in aggregate exceed the Annual Sum Insured and Guaranteed Cumulative Bonus (if any) as specified in the Policy Schedule against this Benefit.

4.12 Sum Insured Protector:

In consideration of payment of additional premium to Us, the insured person can avail the benefit under sum insured protector. The Sum Insured protector is designed to protect the Sum Insured against rising inflation by linking the Sum Insured under the base plan to the Consumer Price index (CPI).

The Sum Insured will be increased on cumulative basis at each renewal on the basis of inflation rate in previous\ year. Inflation rate would be computed as the average CPI of the entire calendar year published by the Central Statistical Organisation (CSO).

The % increase will be applicable only on Annual Sum Insured under the Policy and not on guaranteed cumulative bonus or any other benefit which leads to increase in Sum Insured.

4.13 Claim Protector:

In consideration of payment of additional premium to Us, the insured can avail the benefit as mentioned under claim protector. If a claim has been accepted under the inpatient hospitalization cover, then the items which are not payable under the claim as per the List of Excluded items released by IRDAI that is related to the particular claim will become payable. The maximum claim payout under this benefit shall be limited to Annual Sum Insured under your policy.

SECTION 5 – Waiting Periods and Survival Periods:

5.1: Waiting Period for PED:

This optional benefit allows the Insured / Insured Person to opt for 24/36/48 months of waiting period.

5.2: Waiting Period for Named Ailments:

This optional benefit allows the Insured / Insured Person to opt for 24/12 months of waiting period. This named ailments are listed in SECTION 7 - EXCLUSIONS: B. Exclusion Name: Specified disease/procedure waiting period- Code- Excl02

5.3: Waiting period for Bariatric Surgery:

This benefit can be availed after a waiting period of 3 years as per advice of Medical Practitioner

5.4: Waiting period for Critical illness:

This optional benefit allows the Insured / Insured Person to opt for 60 / 90 days of waiting period.

5.5: Survival period for Critical illness:

This optional benefit allows the Insured / Insured Person to opt for 30 days of survival period.

5.6: Co payment:

Co payment will be applicable as chosen by the Insured. This optional benefit allows the Insured to opt for 10% or 20% co-payment.

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5.7 Waiting period for below illnesses:

Internal Congenital Anomalies, Genetic Disorders and Mental Illness specifically for the following ICD codes:

Schizophrenia (ICD - F20; F21; F25)

Bipolar Affective Disorders (ICD - F31; F34)

Depression (ICD - F32; F33)

Obsessive Compulsive Disorders (ICD - F42; F60.5)

Psychosis (ICD - F 22; F23; F28; F29)

The waiting period chosen for Pre-existing Diseases will by default apply to this section.

SECTION 6 – Wellness and Value Added Services:

This services will be available to all Insured / Insured persons and this will have no premium and / or Sum Insured impact.

6.1 Health Rewards

Insured can accumulate rewards by opting for an array of wellness programs listed below, that will help assess his/her health status and aid in improving the overall well-being.

There will be no limitation to the number of programs one can enroll however maximum rewards that all the insured person(s) in a single policy period can earn, will be limited to 5% in a year and of the policy premium for the opted tenure on renewal. The Wellness Rewards will get accrued in the following manner

Wellness Grid HRA GRID		
Services	**Points**	**Limits**
Completes Health Risk Assessment	100	1 HRA
Does 2 Health Risk Assessment in a Year	200	Additional points
Basis Investigation Report (upload into our portal)		
Services	**Points**	**Limits**
Comprehensive health report (Routine Urine Analysis (RUA), Lipid profile, Compete Blood Count (CBC), Kidney Function Test (KFT), Liver Function Test (LFT), Hepatitis B Surface Antigen Test (HBsAg,)	1000	Max 1
2D Echocardiogram	300	Max 1
Magnetic Resonance Imaging (MRI Scan)	300	Max 1
Glycosylated Hemoglobin (Hb1Ac Report)	200	Max 1
Prostate Specific Antigen (PSA)	200	Max 1
Mammography	1000	Max 1
Bone Scan	1000	Max 1
Bone Densitometry test	1000	Max 1

Healthy Initiaitves		
Services	**Points**	**Limits**
Membership (Gym, Fitness Club, Yoga) for a year	3000	Max. 2
Participation in Walkathon, Marathon, Fitness League, Cycling, Swimming Competition	1000	Max 4
Claim		
Services	**Points**	**Limits**
Enrollment within 30 Days with our wellness portal for this additional points will be offered	1000	Max 1
Invoices should be uploaded within 60 days from the Date of Invoice date for points redemption Per Point Value-INR 0.30 Paise		

Any member in the policy can avail these facilities and accumulate the above reward points for both individual and floater policies.

The accrual shall happen on continuous coverage basis and if the insured fails to continue these activities in subsequent years or fails to redeem these discounts in the subsequent year/subsequent renewals, the accrual shall fall to zero and the insured will have to start the process again to achieve the maximum discount benefit.

Policy Premium means the premium paid by the proposer to the Company for the renewal policy period, post application of all discounts & loadings excluding any applicable taxes.

- The Total Accrual rewards earned as reward scale as percentage of the premium paid during the renewal year shall be converted to and accumulated as reward points as mentioned in the Wellness and Value Added Services.
- In case of Multi-year policies, the insured needs to perform all or any of the activities at least once during the tenure of the insurance.
- Rewards can be redeemed in the following manner

  Adjustment of renewal year premium, when the insured purchases selected health insurance products from the company post accrual of the wellness rewards points under this policy. However, the total rewards points that can be utilized in a policy tenure shall not exceed 5% of the policy premium for such health policy.
- Rewards Points earned by an insured cannot be transferred to anyone or rewards points earned under multiple such programs cannot be clubbed together for redemption in any single policy.

  HRA to be availed by login in on company's portal. All Invoices and reports to be uploaded on company's wellness portal to be elgible for redemption.

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6.2 Medical Condition Management Program

The insured will have a choice to avail various wellness benefits/services under this benefit head provided by the Company through the network of specialists/service providers. The assistance in arranging consultation will be provided on best effort basis. The cost of the services shall be borne by Insured / Insured Person.

1. Health Coach to monitor your day to day well being - The Insured Person will have the facility to connect with a personal coach to motivate the Insured person to achieve his/her personal health goals.
2. Chronic Condition Screening – Customized Health Checks including gene screening to understand the potential health risks the insured(s) may encounter in future or to avail regular screenings for chronic conditions to stay abreast about their on-going health and corrective/precautionary measures can be taken.
3. Condition Specific Care
   a. Orthopedics Program (Rehabilitation and mobilization, Nursing attendant, Physiotherapist and medical equipments, etc.).
   b. Oncology Program (Palliative care support, Stroma care, Colostomy, Tube feeding, Supportive care, etc.).
   c. Pulmonary Program (Services/programs related to Improving breathing ability. Improving overall strength and exercise tolerance, programs to increase participation in daily physical and social activities)..
   d. Diabetes Management Program (Services such as Personal Health Coach, Personal Nutritionist, Hypo/Hyper Alerts Management, etc may be availed on the basis of need or as recommended by the treating medical practitioner).
   e. Internal Medicine Program (Services such as Doctor visits at home, Triage nursing, Medicine delivery, etc. may be availed on the basis of need or as recommended by the treating medical practitioner).

6.3 Video / Tele Consultation

Assistance in arranging consultation with a medical practitioner through Network Service Providers for assessing the medical records or routine health issues of the Insured Person over the phone or Video Chat on best effort basis. The cost of the services shall be borne by Insured / Insured Person.

6.4 Tele medicine

Assistance in arranging consultation with a medical practitioner through Network Service Providers to evaluate, diagnose and treat patients at a distance using telecommunications technology on best effort basis. Telemedicine involves the use of electronic communications and software to provide clinical services to patients without an in-person visit. The cost of the services shall be borne by Insured / Insured Person.

6.5 Pharmacy and Diagnostic Services

You may purchase medicines and diagnostic services from our Network Service Provider on best effort basis. The cost for the purchase of the medicines or diagnostic services shall be borne by Insured / Insured Person. Assistance in arranging delivery of purchased medicine on best effort basis

6.6 Online Chat with Doctor

The Insured / Insured person can get answers to their health problems by consulting a physician online via an online chat from our panel of doctors available through our network service provider. The cost of the services rendered by the medical practitioner shall be borne by Insured / Insured Person.

6.7 Doctor on Call

The insured can avail the benefit of doctor on call according to the policy schedule. The insured can avail doctor consultation for any ailment or illness over call upto the limit specified in the schedule to the policy.

6.8 Health Assistance

We also provide Health Assistance as a part of Our Value added services, Our Health Assistance Team (HAT) will assist the Insured Person in understanding his/her health condition better by providing answers to any queries related to health and health care providers on Our dedicated helpline. To avail this service, the Insured Person may call Our helpline on 040-66274205 (please note that this number is subject to change).The services provided under this shall include:

- Identifying a Physician/ Specialist
- Scheduling an appointment with any Medical Practitioner empanelled with Us
- Scheduling appointments for a second opinion
- Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.
- The list of the Service Providers is available at our website (https://www.icicilombard.com/content/ilom-en/serviceprovider/search.asp) and is subject to amendment from time to time.

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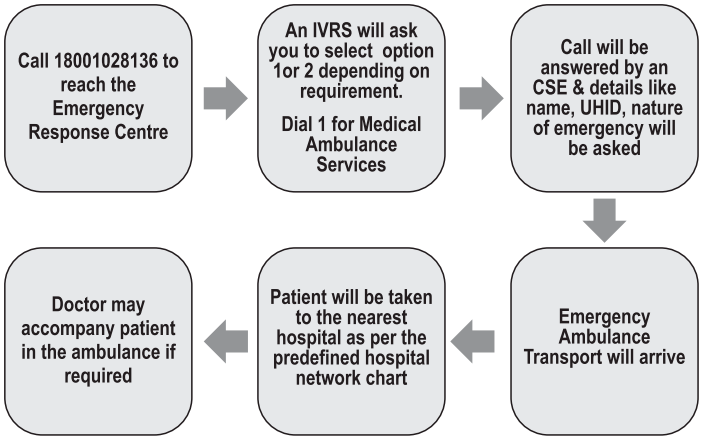
6.9 Ambulance Assistance

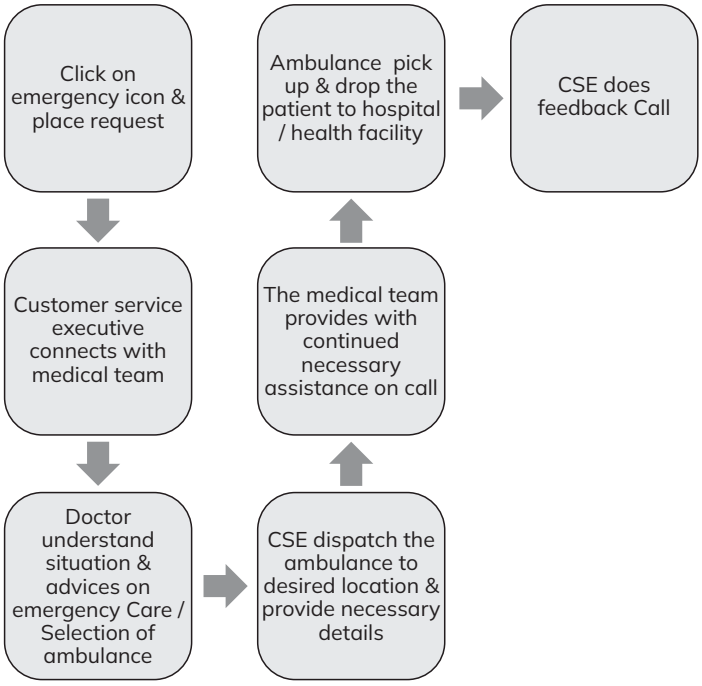
We will facilitate ground medical transportation by a Service provider to transport the Insured Person to the nearest Hospital or any clinic or nursing home for medically necessary treatment subject to availability of services in that particular city/location. Kindly visit our website for updated list of cities/locations where the services are provided.

1. **The services under this Benefit are subject to the following conditions:**
   - The medical transportation is for a life threatening health condition of the Insured Person which requires immediate and rapid transportation to the Hospital; as certified in writing by the Medical practitioner
   - The Insured Person is in India and the treatment is in India only;
   - The ambulance service is availed within the same city
   - This is an assistance service and the expenses for the same will have to be borne by the insured person or can be claimed under surface ambulance cover(if inpatient treatment claim is found to be admissible)
2. **Process to avail Ambulance Assistance:**
   a. On calling Our helpline number provided below, Our trained customer service executive (CSE) will ask the Insured person relevant questions to assess the situation.
   b. The call may be redirected to a qualified Medical Practitioner in order to evaluate the requirement for an ambulance with Advanced Life Support based on the Insured Person's condition.
   c. The below mentioned details are to be made available for availing the services:
      1. UHID of Insured Person, as provided on the Health Card.
      2. Contact number of the Insured Person
      3. Location of Insured Person

How to Call an Ambulance?



How to Call an Ambulance? (Via Mobile Application)



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6.10 Discounts on services/products

We shall only facilitate the Insured Person in availing discounts on services/products including but not limited to investigations/diagnostic tests / laboratory tests / health supplements / /medical equipment/homecare services/virtual health & wellness sessions / AYUSH products/Fitness & wellness related activities & products etc. at our empanelled diagnostic centres, drugs/medicines ordered from pharmacies etc. offered by our network providers/ health service providers. These discounts can be viewed on our mobile application and one can redeem the wellness points earned from Health rewards for availing discounts as per product terms and conditions and subject to availability.

The above benefits will be subject to following conditions:

- For services that are availed over phone or through online/digital mode, the Insured / Insured Person will be required to provide the details as sought by our Service Provider in order to establish authenticity and validity prior to availing such services.
- It is entirely for the Insured / Insured Person to decide whether to obtain these services, the extent to which he/she wishes to avail these services and further to decide whether to use any of these services and if so to which extent.
- The services are intended to provide support information to the Insured Person to improve well-being and habits through working towards personalized health goals. These services are not medical advice and are not meant to substitute the Insured / Insured Person's visit/ consultation to an independent Medical Practitioner.
- The information services provided under these benefits, including information provided through personalized health coaching services, does not constitute medical advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical condition.
- The Insured Person shall be free to consider or not consider the suggestions of the health coach and make any lifestyle changes based on information provided through these services. For any change the Insured Person makes to his lifestyle whether or not on the advice of the health coach, we shall in no manner be liable for any harm or injury, whether bodily or otherwise that may occur as a result of such lifestyle changes. The Insured Person must seek immediate medical advice if there is any adverse effect or discomfort on making any lifestyle changes.
- The company shall not be liable for any damages sustained by the Insured Person on such information or suggestions provided by Health Coach or any of the service rendered by our service provider.
- The company is not responsible for any medical or mental health problems the Insured Person may face as a result of accessing or using these services.
- The Insured Person is solely responsible for all information, data, text, music, sound, photographs, graphics, video, messages or other materials that the Insured Person uploads, transmits, posts, publishes or displays on any platform used by the service providers
- The Insured Person expressly understands and agrees that we will not be liable for any damages related to services provided by the network service provider
- The cost of the services rendered by the medical practitioner shall be borne by Insured / Insured Person.

e. SECTION 7 - EXCLUSIONS:

i. Standard Exclusions (Exclusions for which standard wordings are specified by IRDAI)

A. 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 48/36/24 months of continuous coverage after the date of inception of the first policy with insurer as selected by the Insurer.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability / migration 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 48/36/24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. Specified disease/procedure waiting period- Code- Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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.

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d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis
7. Stones in the urinary and biliary systems
8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
9. Cataracts,
10. Hernia of all types and Hydrocele
11. Fistulae in anus
12. Fissure in anus
13. Fibromyoma
14. Hysterectomy
15. Surgery for any skin ailment
16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
17. Dialysis required for Chronic Renal Failure.
18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.
19. Dilatation and curettage
20. Varicose Veins and Varicose Ulcers
21. Non Infective Arthritis and other form arthritis
22. Gout and Rheumatism
23. Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis / spondylosis unless arising from Accident

C. 30-day waiting period- Code- Excl03

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

D. Investigation & Evaluation- Code- Excl04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

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

E. Rest Cure, rehabilitation and respite care- Code- Excl05

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

F. Obesity/ Weight Control: Code- Excl06

1. Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
2. Surgery to be conducted is upon the advice of the Doctor
3. The surgery/Procedure conducted should be supported by clinical protocols
4. The member has to be 18 years of age or older and
5. 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

G. 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.

H. 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.

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I. 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.

J. 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.

K. Excluded providers: Code- Excl 11

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.

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

M. 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**

N. 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**

O. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

P. Unproven Treatments: Code- Exel 16

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.

Q. Sterility and Infertility: Code- Excl 17

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy

d. Reversal of sterilization

R. Maternity: Code Excl18

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.

This exclusion will stand modified to the effect to cover **4.2:Maternity Cover**

ii. **Specific Exclusions (Exclusions other than those specified under e. I. above)**

S. 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.

T. 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.

U. Any expenses incurred on OPD treatment. This exclusion will stand modified to the effect to cover **Section 4.5: OPD for Medical and Dental**

V. Treatment taken outside the geographical limits of India (unless worldwide cover is opted for)

W. Any ailment/ illness/ injury/ condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.

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f. SECTION 8- GENERAL CONDITIONS:

I. Standard General Terms and clauses (General terms and clauses whose wordings are specified by IRDAI)

1. Disclosure of Information:

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

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability:

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

3. 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.

4. 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 deceivee; 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.

5. Multiple policies:

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

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

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

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

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6. **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;

7. **Cancellation:**

The policyholder may cancel this policy by giving l5days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

1 year Policy

Months Expired	Premium Retained
0-3	25%
3-6	50.0%
6-9	75.0%
9-12	100.0

2 year Policy

Months Expired	Premium Retained
0-3	15%
3-6	25%
6-9	50%
9-12	65%
12-15	75%
15-18	85%
18-24	100%

3 year Policy

Months Expired	Premium Retained
0-3	15%
3-6	25%
6-9	35%
9-12	40%
12-15	50%
15-18	60%
18-21	70%
21-24	80%
24-27	85%
27-30	90%
31-36	100%

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.

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.

8. **Renewal of Policy:**

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

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

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

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

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

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POLICY WORDINGS - HEALTH ADVANTEDGE

9. **Premium payment in instalments:**

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

   i. For Yearly and single payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.

   ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

   iii. The insured person will get the accrued continuity benefit in respect of the ' Waiting Periods' , 'Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period

   iv. No interest will be charged If the installment premium is not paid on due date.

   v. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

   vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable

   vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

10. **Portability:**

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

    For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

11. **Migration:**

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

    For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

12. **Withdrawal of Policy:**

    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.

    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.

13. **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.

14. **Possibility of Revision of Terms of the Policy Including the Premium Rates:**

    The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

15. **Nomination:**

    The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder. the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

16. **Grievance Redressal Procedure:**

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

    Website: www.icicilombard.com

    Toll Free: 1800 2666

    E-Mail: customersupport@icicilombard.com

    Courier: ICICI Lombard General Insurance Company Ltd.

    ICICI Lombard House,

    414, Veer Savarkar Marg,

    Near Siddhi Vinayak Temple,

    Prabhadevi, Mumbai- 400025

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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 Manager-Service Quality, Corporate Manager- Service Quality, National Manager- Operations & finally Director-services and Business development at the following address:

ICICI Lombard General Insurance Company Limited,

ICICI Lombard House,

414, Veer Savarkar Marg,

Near Siddhi Vinayak Temple,

Prabhadevi, Mumbai 400025

For updated details of grievance officer, kindly refer the link

https://www.icicilombard.com/grievance-redressal.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://www.irdai.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo225&mid=14.2

LIST OF INSURANCE OMBUDSMEN

The contact details of the Insurance Ombudsman offices are as below. These details can also be found at http://www.cioins.co.in/ombudsman.html.

Office Details	Jurisdiction of Office Union Territory, District)
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@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
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@cioins.co.in	Karnataka.
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@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: imalokpal.bhubaneswar@cioins.co.in	Orissa.
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@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh
CHENNAI 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@cioins.co.in	Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry)
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@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
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@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
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 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
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@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry

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POLICY WORDINGS - HEALTH ADVANTEDGE

Office Details	Jurisdiction of Office Union Territory, District)
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@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
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@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, 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, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
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@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
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.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.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
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
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@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

17. **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.

II. **Specific terms and clauses (terms and other clauses other than those mentioned under f.i above)**

18. **Floater Policy:**

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all other Insured Persons. However, the Sum Insured shall be the overall limit including Optional Sum Insured unless otherwise specified, if opted and guaranteed GCB, if any for the entire period of Insurance/Policy period including all members/Insured persons and all claims.

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POLICY WORDINGS - HEALTH ADVANTEDGE

19. **Material Change:**

The Insured / Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business, partial disclosure of the medical history at Insured / Insured person own expense. The Company may, adjust the scope of cover and / or the premium, if necessary, accordingly.

20. **No Constructive Notice:**

The Company shall not take notice of any information relating to the Insured person unless such information is submitted in writing by the Insured, even if such information was available with the Company.

21. **Notice of Charge:**

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to the Policy. However, any payment by the Company to Insured or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

22. **Special Provisions:**

Any special provisions subject to which this Policy has been entered into and endorsed on the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

23. **Electronic Transaction:**

The Insured / Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDA regulations for protection of Policy holder's interests.

24. **Duty of the Insured on occurrence of loss/event leading to claim:**

On the occurrence of loss/event/claim within the scope of cover under the Policy resulting in a claim, the Insured / Insured Person shall:

a. Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.
b. Allow the Medical Practitioner or any agent of the Company to inspect the medical and hospitalization records and to examine the Insured / Insured Person
c. Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties

In case the Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Insured / Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

25. **Right to Inspect:**

If required by the Company, an agent/representative of the Company including a physician appointed in that behalf in case of any loss/event/claim or any circumstances that have given rise to a claim to the Insured / Insured Person, be permitted at all reasonable times to examine into the circumstances of such loss/event leading to claim. The Insured / Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss/event or such circumstance in his/her possession including presenting himself/herself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or shall assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

The Company shall bear all cost of examination required under this section.

26. **Position after a claim:**

As from the day of receipt of the claim amount by the Insured / Insured Person, the Sum Insured for the remainder of the Policy year of insurance shall stand reduced by a corresponding amount.

27. **Forfeiture of claims:**

If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any rights whatsoever.

28. **Cause of action/Currency of payment:**

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India in Indian Rupees only.

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POLICY WORDINGS - HEALTH ADVANTEDGE

29. Policy Disputes:

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

30. Arbitration:

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 arbitrators, comprising of 2 arbitrators - 1 to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such 2 arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.

It is hereby agreed and understood that no dispute or difference shall be referred to arbitration, as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss shall be first obtained.

31. Sum Insured Enhancement:

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a duly filled fresh Proposal Form to the Company.

ii. The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured members, claim history and subject to acceptance by the Company post underwriting.

All waiting periods as defined in the Policy shall apply afresh for this enhanced Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy in respect of such increased Sum Insured.

32. Policy alignment:

Policy Alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy.

Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.

33. Endorsements (Changes in Policy):

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

ii. The proposer may be changed only at the time of renewal. The new proposer must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

iii. The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

iv. Mid- term endorsement of addition of member in the policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation

34. Notices:

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to

a. In case of the Insured, at the address given in the Schedule to the Policy.

b. In case of the Company, to the Policy issuing office/nearest office of the Company.

g. Other Terms and Conditions

Claim Administration

The fulfilment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by each of You shall be conditions precedent to admission of Our liability. You are requested to go through our list of de-listed/excluded providers which is available on our website. As the list is dynamic, please refer to the latest list.

Further, upon the discovery or happening of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admission of Our liability, You shall undertake the following

POLICY WORDINGS - HEALTH ADVANTEDGE

1.1 Claims Procedure

A. For Cashless Settlement

Cashless treatment is only available at a Network Provider (List of Network Providers is available at our website). In order to avail of cashless treatment, the following procedure must be followed by You:

Pre-authorization

Prior to taking treatment and/ or incurring Medical Expenses at a Network Provider, You must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request preauthorization at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization. To avail of Cashless Hospitalization facility, you are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card Or You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. We will consider Your request after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalization facility is sought by You and We will confirm Your request in writing.

B. For Reimbursement Settlement

You shall give notice to Us or Our in house claim processing team by calling the toll free number 1800 2666 or emailing us at customersupport@icicilombard.com as specified in the Policy provided to You and also in writing at Our address with particulars as below:

Policy number;

Your Name;

Your relationship with the Policyholder;

Nature of Illness or Injury;

Name and address of the attending Medical Practitioner and the Hospital;

Any other information that may be relevant to the Illness/ Injury/ Hospitalisation

The above information needs to be provided to Us or Our in house claim processing team immediately and in any event within 10 days of Hospitalization, failing which We will have the right to treat the Claim as inadmissible, as We may deem fit at Our sole discretion.

You must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.

You or someone claiming on Your behalf must promptly and in any event within 30 days of Your discharge from a Hospital (for post-hospitalization expenses, within 30 days from the completion of post-hospitalization period) deliver to Us the documentation (written details of the quantum of any Claim along with all original supporting documentation) as more particularly listed in Claim documents section. In case there is a delay beyond 30 days in submission of claim documents, we may condone the delay provided the insured person submits a valid reason justifying the delay to us in writing. However, in both the above cases i.e. g. 1.1.1(A) & (B), You must take reasonable steps or measure to minimise the quantum of any Claim that may be covered under the Policy If so requested by Us or Our in house claim processing team, You will have to undergo a medical examination from Our nominated Medical Practitioner, as and when We or Our in house claim processing team considers reasonable and necessary. The cost of such eexamination will be borne by Us

Claim falling in two Policy periods

If the claim event falls within two Policy periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy periods, including the Deductions for each Policy Period. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the Renewal/due date of premium of health insurance Policy, if not received earlier.

1.2 CLAIM DOCUMENTS

You shall be required to furnish the following documents for or in support of a Claim:

Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from our website www.icicilombard.com

Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner

Original bills from chemists supported by proper prescription.

Original investigation test reports and payment receipts.

Indoor case papers

Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.

Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

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POLICY WORDINGS - HEALTH ADVANTEDGE

1.3 Claim Service Guarantee

We provide You Claim Service Guarantee as follows

A. For Reimbursement Claims: We shall make the payment of admissible claim (as per terms & conditions of Policy) OR communicate non admissibility of claim within 14 days after You submit complete set of documents & information in respect of the claims. In case We fail to make the payment of admissible claims or to communicate non admissibility of claim within the time period, We shall pay 2% interest over and above the rate defined as per IRDAI (Protection of Policyholder's interest) Regulation 2017.

B. For Cashless Claims: If You notify pre authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will respond within 4 hours of the actual receipt of such pre authorization request with:

Approval, or

Rejection, or

Query seeking further information

In case the request is for enhancement, i.e. Request for increase in the amount already authorized, We will respond to it within 3 hours.

In case of delay in response by Us beyond the time period as stated above for cashless claims, We shall be liable to pay ₹1,000 to You. Our maximum liability in respect of a single hospitalization shall, at no time exceed ₹1,000. We will not be liable to make any payments under this Claim Service Guarantee in case of any force majeure, natural event or manmade disturbance which impedes Our inability to make a decision or to communicate such decisions to You.

The service guarantee shall not be applicable for any cases delayed on account of reasonable apprehension of fraud or fraudulent claims or cases referred to/by any adjudicative forum for necessary disposal.

You may lodge claim separately for the hospitalization claim, Pre-Post hospitalization. In such scenario, if delay happens beyond the time period as specified above, the interest amount calculated will be on the net sanctioned amount of respective transaction and not the total amount paid for the entire claim.

Any amounts paid towards interest under Claim Service Guarantee will not affect the Annual Sum Insured as specified in the Schedule.

If you are not eligible for 'Claim Service Guarantee' for the reasons stated above, We will inform the same to You, within 14 days in case of A. For Reimbursement claims and within 4 hours in case of B. For Cashless claims above.

Annexure II

List I- Items for which coverage is not available in the Policy.

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE

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Sl No	Item
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl 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	FLEX I 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	BLANKETS/VARMER 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

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

Sl. 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

Sl.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\SPIRITS 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

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