GROUP TAKECARE INSURANCE

PART II OF THE POLICY

GENERAL DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this Policy or related Extensions/Endorsements:

Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

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

Age means the completed years of the Insured Person on his/her last birthday as per the English calendar.

Ambulance Services means procedures that are used to provide immediate care and support to transfer the patient from the pick-up point/location to the nearest Hospital where necessary treatment/care can be initiated depending on the nature of Illness or disorder, presence, severity and cause.

ALS Ambulance means an ambulance which is equipped with Advanced Life Support (ALS) mechanism and is provided in situations where the patient/Insured Person being transported is in a more critical condition. Certified Emergency Medical Technicians (EMTs) and paramedics required to assist in the treatment of the patient/Insured Person before and/or during transport to the emergency facility.

Alternative treatments means forms of treatments other than treatment “Allopathy” or “modern medicine” and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.

AYUSH Treatment refers to the medical and / or Hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

BLS Ambulance means an ambulance which is equipped with Basic Life Support (BLS) mechanism and is provided to transport the patient/Insured Person to the emergency facility. Certified Emergency Medical Technicians (EMTs) or/and Paramedic is required to assist in the treatment of the patient/Insured Person before and/or during transport to the emergency facility.

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 is approved.

Claim means a demand made by You or on Your behalf for payment of Medical Expenses or any other expenses or benefits, as covered under the Policy.

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

a) **Internal Congenital Anomaly** – means Congenital Anomaly which is not in the visible and accessible parts of the body.
b) **External Congenital Anomaly** – means Congenital Anomaly which is in the visible and accessible parts of the body.

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

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

Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Deductible shall be applicable per year, per life or per event as stated in the Policy Certificate and specific deductible to be applied shall be as per the Policy Certificate.

Disclosure to information norm means 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.

Extension means an additional insurance cover available under the Policy. An Extension will be in force for the Insured Person only if the due additional premium for the Extension has been received and the Policy Certificate states that the Extension is in force.

Emergency Care means management for an 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.

Franchise means a minimum amount of loss that must be incurred before insurance coverage applies. Once the Deductible is met, the entire benefit amount is paid, subject to the Policy terms and conditions.

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.

Health Service Provider means any person or entity providing healthcare and medical services in individual capacity, or through aggregation under "Health Service Provider Agreement", and shall include but not be limited to any clinic, diagnostic centre, pharmacy, associated facility for diagnosis, treatment or wellness services, and health care providers empanelled with Us to provide services specified under the Benefits (including Extensions) to the Insured Person on cashless /reimbursement basis for OPD Treatment or otherwise. The list of the Health Service Providers is available at our website (https://www.icicilombard.com) and is subject to amendment from time to time.

Healthcare Professional means a qualified/certified individual/counsellor/medical practitioner who provides/creates awareness for preventive, curative, rehabilitative healthcare services.

Health Service Provider Agreement means an agreement prescribing the terms and conditions of the services which may be rendered to the Insured Persons under this Policy, and may be entered into between
a) Health Service Provider and Us; or
b) Health Service Provider, a TPA and Us.

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 Regulations) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR comply 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 will make these accessible to the Insurance Company's authorized personnel.

Hospitalization means admission in a Hospital for a minimum period of 24 consecutive 'In-Patient Care' 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 disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

a) **Acute condition** is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
b) **Chronic condition** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests;
    2. it needs ongoing or long-term control or relief of symptoms;
    3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
    4. it continues indefinitely;
    5. it recurs or is likely to recur;

Immediate Family Member means the Insured Person's lawful spouse; children including stepchildren and children legally adopted by the Insured Person; siblings; parents; sister(s) in law, brother(s) in law; parents-in-law; legal guardian; ward; step-parents.

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

Insured Event means any event specifically mentioned as covered under this policy.

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

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.

Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

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 means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

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

Medical Practitioner – means a person who holds a valid registration from 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 his license. The term Medical Practitioner would include physician, specialist, anesthetist and surgeon but would exclude the insured and his/her Family Member. A Family Member means an Insured's lawful spouse; children including stepchildren and children legally adopted by the Insured (below 18 years); siblings; parents; sister(s) in law, brother(s) in law; parents-in-law; legal guardian; ward; step-parents.

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, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

Nominee means the person(s) nominated by You to receive the benefits under this Policy payable on Your death. For the purpose of avoidance of doubt it is clarified that if You are a minor, Your legal guardian shall appoint the Nominee.

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

Out-patient means the Insured Person who is not Hospitalized but who visits a clinic/ Hospital / or any associated facility like a consultation room for diagnosis or treatment (encompassing

but not limited to consultation, diagnostic tests & services, medicines/drugs, vaccination, Medical Procedure, external medical aid). However, any Insured Person undergoing any specified Day Care Treatment will not be considered as an Out-patient.

OPD Treatment means the 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.

Period of Cover means the period specified in the Policy Certificate during which the Insured Person is covered under the Policy.

Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or Benefits attaching to or forming part thereof. The Policy contains details of the extent of cover available to the insured, what is excluded from the cover and the terms & conditions on which the Policy is issued to the insured.

Policy Period means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Certificate.

Policy Schedule means the Policy Schedule attached to and forming part of the Policy.

Policy Year means a period of twelve months beginning from the Policy Start Date and ending on the last day of such twelve- month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy End Date, as specified in the Policy Certificate.

Portability means the right accorded to an individual health insurance policyholder (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.

Pre-existing Disease 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 its 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.

Proposal and Declaration Form means any initial or subsequent declaration made by the policyholder and is deemed to be attached and which forms a part of this Policy.

Renewal – means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time bound exclusions and for all waiting periods.

Sum Insured means:

(a) If the Policy Certificate specifies that the Policy has been issued on an individual basis: the amount specified in the Policy Certificate against a Benefit or set of Benefits that represents Our maximum, total and cumulative liability for any and all claims made in respect of that Insured Person during the Policy Year under that Benefit/set of

Benefits. Any Sum Insured which is not utilized in a particular Policy Year will not be carried over to any subsequent Policy Year in the Period of Cover**.**

(b) If the Policy Certificate specifies that the Policy has been issued on a family floater basis: the amount specified in the Policy Certificate against a Benefit or set of Benefits that represents Our maximum, total and cumulative liability for any and all claims made in respect of all Insured Persons named in the Policy Certificate during the Policy Year under that Benefit/set of Benefits. Any Sum Insured which is not utilized in a particular Policy Year will not be carried over to any subsequent Policy Year in the Period of Cover.

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 from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Third Party Administrators (TPA) means any person who is registered under the IRDAI (Third
Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those Regulations.

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

You / Your means the person named as the policyholder in the Policy Certificate and who is responsible for payment of premium

Waiting Period means a time-bound exclusion period related to condition(s) specified in the Policy Certificate which shall be served before a claim related to such condition becomes admissible.

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

SCOPE OF COVER

This Policy is a contract of insurance between the Policyholder and Us which is subject to the receipt of premium against each Benefit/Cover in respect of the Insured Persons and the terms, conditions and exclusions of this Policy.

Section A: HOSPIFUND BENEFIT

The Policy Certificate will specify which of the following Base Benefits and Extensions are applicable and in force for the Insured Person. Claims made in respect of an Insured Person for any Base Benefit or Extension applicable to the Insured Person shall be subject to the availability of the Sum Insured for the Base Benefit/Extension, and the terms, conditions and exclusions of this Policy.

All Claims shall be made in accordance with the procedures set out in this Policy. Admitted Claims will be payable to the Insured Person or the Nominee (as applicable).

Section A.1: Base Benefits

1. **Hospitalization Cash Benefit:** If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Base Benefit for each continuous and completed day of Hospitalization of the Insured Person.

   This Base Benefit shall be payable subject to the following:

   i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

   ii. We shall not be liable to pay the daily amount for more than the maximum number of days as specified in the Policy Certificate for each Insured Person, during the Policy Year.

   iii. Our liability to make any payment under this Base Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.

   iv. We shall not be liable to make any payment under this Base Benefit, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

   If We have admitted a Claim under this Base Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Base Benefit is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

2. **Accidental Hospitalization Cash Benefit:** If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Base Benefit for each continuous and completed day of Hospitalization of the Insured Person.

   This Base Benefit shall be payable subject to the following:

   i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

   ii. We shall not be liable to pay the daily amount for more than the maximum number of days as specified in the Policy Certificate for each Insured Person, during the Policy Year.

   iii. Our liability to make any payment under this Base Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.

   iv. We shall not be liable to make any payment under this Base Benefit, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

   v. If We have admitted a Claim under this Base Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment

due under this Base Benefit is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

Section A.2 Extensions To The Base Benefit –

1. **Intensive Care Cash Benefit:** If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized in an Intensive Care Unit, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of confinement of the Insured Person in the Intensive Care Unit.

   This Extension shall be payable subject to the following:

   i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same Illness/Injury in respect of which the Insured Person was Hospitalized in the Intensive Care Unit.

   ii. The Hospitalization in the Intensive Care Unit is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

   iii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person, during the Policy Year.

   iv. Our liability to make any payment under this Extension Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable. However, the Deductible/Franchise will not apply to the extent of days in respect of which the Insured Person has already been admitted in the Hospital in a non- ICU room.

   v. We shall not be liable to make any payment under this Extension, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

   vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

2. **Cancer Hospitalization Cash Benefit:** If an Insured Person contracts 'Cancer of Specified Severity' during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Cancer of Specified Severity.

   For the purpose of this Extension, Cancer of Specified Severity means-

   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 asT1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible / per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate.

vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

3. **Brain & Stroke Hospitalization Cash Benefit:** If an Insured Person contracts any of the Brain Ailment or Stroke listed below during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount, specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Brain Ailment or Stroke.
For the purpose of this Extension, Brain Ailment and Stroke shall mean the following:

I. BENIGN BRAIN TUMOR:
   I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies like CT Scan or MRI.
   II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist

a. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
b. Undergone surgical resection or radiation therapy to treat the brain tumor

The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of spinal cord.

II. STROKE RESULTING IN PERMANENT SYMPTOMS

I. 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.

II. The following are excluded:
   a. Transient ischemic attacks (TIA)
   b. Traumatic injury of the brain
   c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

III. PERMANENT PARALYSIS OF LIMBS

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

IV. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

Motor neuron 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.

V. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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.

Other causes of neurological damage such as SLE and HIV are excluded.

VI. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This

diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3)of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons.
For the purpose of this Benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:
   a. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   d. Mobility: the ability to move indoors from room to room on level surfaces;
   e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   f. Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

I. Spinal cord injury.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for a Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension Benefit shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee’s advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

4. **Organ Transplant Hospitalization Cash Benefit:** If an Insured Person undergoes Organ Transplant during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized for the procedure for transplantation, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for transplantation of the organ.

   For the purpose of this Extension, Organ Transplant shall mean the following:

The actual undergoing of transplant of:

a. One of the following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end stage failure of the relevant organ;
b. 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:

a. Other stem cell transplants;
b. Where only islets of langerhans are transplanted.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. We shall not be liable to make any payment under this Extension in respect of any organ transplantation that is not carried out in accordance with the Transplantation of Human Organs Act 1994, as amended.

iv. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

v. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

vi. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate, unless due to an Accident.

vii. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

5. **Heart Ailment Hospitalization Cash Benefit:** If an Insured Person contracts any of the Heart Ailments listed below during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of that Heart Ailment.

   For the purpose of this Extension, Heart Ailments mean the following:

   I. MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

   I. 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.

II. OPEN CHEST CABG

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

III. 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.

IV. ANGIOPLASTY

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).
II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.
III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

V. PRIMARY (IDIOPATHIC) 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.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate.

vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

6. **Fracture & Burns Cash Benefit:** If an Insured Person suffers a Fracture and/or Second Degree Burns and/or Third Degree Burns during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of that Fracture, Second Degree Burns or Third Degree Burns.

   For the purpose of this Extension the following definitions will apply:

   Fracture means a medical condition in which there is a damage in the continuity of the bone. A bone fracture may be the result of high force impact or stress, or a minimal trauma Injury as a result of certain medical conditions that weaken the bone, such as Osteoporosis, bone cancer, or osteogenesis imperfect, where the fracture is then properly termed a pathologic fracture.

   Second Degree (partial thickness) Burns means burns which involves the epidermis and part of the dermis layer of skin.
   Third Degree (full thickness) Burns means burns which affects and destroys the epidermis and the dermis.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise as stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless such Fracture is due to an Accident).

If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

7. **Day Care Treatment Cash Benefit:** If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to undergo a Day Care Treatment during the Period of Cover We will pay the per event amount specified in the Policy Certificate against this Extension.

For the purpose of this Extension, Day Care Treatment and Day Care Centre may be defined as under:

Day Care Treatment means medical treatment, and/or surgical procedure which is:
- undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
- 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 with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner/s in charge;
iii. has 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.

This Extension shall be payable subject to the following:

i. The Day Care Treatment is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

ii. We shall not be liable to pay the event amount for more than 5 times for each Insured Person during the Policy Year.

iii. We shall not be liable to make any payment under this Extension, if the Day Care Treatment was taken prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

i. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

8. Convalescence Benefit: If an Insured Person contracts an Illness or suffers an Injury due to Accident during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized for a continuous period of at least 10 consecutive days, then We will pay the event amount specified in the Policy Certificate against this Extension towards convalescence of the Insured Person.

This Extension is payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization. If a Claim is not admitted under the Base Benefit in respect of the Insured Person for the same period of Hospitalization, then no Claim will be admitted under this Extension even if the period of Hospitalization of the Insured Person exceeds 10 days.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. We shall not be liable to pay the event amount for more than 5 times specified in the Policy Certificate for each Insured Person during the Policy Year.

iv. We shall be liable to pay the Benefit amount under this extension, only once per hospitalization event.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

9. **Ambulance Cover Benefit:** If an Insured Person contracts an Illness or suffers an Injury that occurs due to an Accident during the Period of Cover and that Illness or Injury solely and directly requires the Insured Person to be transported to a Hospital for Medically Necessary Treatment, We will pay the event amount specified against this Extension in the Policy Certificate in respect of any Ambulance Services used for transportation of the Insured Person from the site of the Accident/ Illness to the nearest Hospital or from the site of first treatment to a higher centre of care.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The transportation in case of movement from the site of first treatment to a centre of higher care is recommended in writing by the treating Medical Practitioner.

iii. We shall not be liable to pay the event amount for more than 5 times for each Insured Person during the Policy Year.

iv. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

10. **Child Care Cash Benefit:** If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified against this Extension for the purpose of providing care to the Insured Person's Dependent Child/Children.

    For the purpose of this Extension, Dependent Child/Children means:

    Child/Children (including step child/children) of the Insured Person up to the age of 18 years who are dependent on the Insured Person for maintenance and financial support.

    This Extension shall be payable subject to the following:

    i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

    ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

    iii. Our liability under this Extension shall not increase if the Insured Person has more than one Dependent Child.

    iv. We shall not be liable to make any payment under this Extension if the Insured Person has no Dependent Children on the date of the Insured Event giving rise to the Claim under this Extension.

    v. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/Franchise as stated in the Policy Certificate, if applicable.

    vi. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

    vii. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

11. **Hospital Attendant Cash Benefit:** If an Insured Person contracts an Illness or suffers an Injury due to Accident during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Extension in respect of each continuous and completed day of Hospitalization of the Insured Person which requires a Hospital Attendant to be present.

    For the purpose of this Extension, Hospital Attendant means the Insured Person's family member / relative / acquaintance / any other registered third party service provider who would be available to take care of the Insured Person during his/ her Hospitalization.

    This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

12. **Compassionate Visit Cash Benefit:**

If an Insured Person contracts an Illness or suffers an Injury that occurs during the Period of Cover that Illness or Injury solely and directly requires the Insured Person to be Hospitalized for at least 3 continuous days at a location outside the Insured Person's city of residence, We will pay the event amount specified against this Extension in the Policy Certificate towards the expenses incurred on the travel of the Insured Person's Immediate Family Member(s) to the place of Hospitalization.

For the purpose of this Extension, Immediate Family Member means:

The Insured Person's lawful spouse; children including stepchildren and children legally adopted by the Insured Person; siblings; parents; sister(s) in law, brother(s) in law; parents-in-law; legal guardian; ward; step-parents.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. The Insured Person is Hospitalized at a distance of at least 100 kilometres from his place of residence.

iv. The Medical Practitioner treating the Insured Person recommends in writing the personal attendance of an Immediate Family Member.

v. The Insured Person has not be Hospitalized for any planned treatment or Surgery.

vi. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

vii. We shall not be liable to pay the event amount for more than 5 times for each Insured Person within the Policy Year.

viii. We shall be liable to pay the Benefit amount under this extension, only once per Hospitalization event.

ix. Our liability under this Extension shall not increase if more than one Immediate Family Member of the Insured Person travels to the Insured Person's place of Hospitalization.

x. We shall not be liable to make payment of the event amount under this Extension more than once for any period of Hospitalization of the Insured Person.

xi. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION A:

We shall not be liable to make any payment for any Claim under Section A of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. **Pre-existing Diseases (Code – Excl 01)** - (Unless specifically covered and mentioned in the policy certificate)

   i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.

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

   iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage

   iv. Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. **30 day waiting period (Code – Excl 03)** - Any hospitalization falling within the initial waiting period as specified in the policy certificate subject to a maximum of 30 days-

   i. Expenses related to the treatment of any illness within the initial waiting period shall be excluded except claims arising due to an accident, provided the same are covered.

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

iii. The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

3. **Specified disease/procedure waiting period (Code – Excl 02) -Two Years Exclusions** –(Unless the waiting period is specifically waived off and mentioned in the policy certificate)
   a. Expenses related to the treatment of the below listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 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.
   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 disease/procedures -

i. Deviated Nasal Septum, CSOM-Chronic Suppurative Otitis Media

ii. Stapedectomy, Mastoidectomy, any treatment for conditions related to tonsils, adenoids, sinuses, turbinates/ concha

iii. Fibroids (fibromyoma), Endometriosis, Uterine Prolapse, Polycysyic Ovarian Syndrome(PCOS)

iv. Dilatation and curettage (D&C), Myomectomy, Hysterectomy

v. Arthritis, Gout and Rheumatism, Intervertebral disc disorders , Arthroscopy, Spinal and Vertebral Disorders including diagnosis as low back ache, Surgeries for joint replacements

vi. Stones in gall bladder and biliary system; Cholecystitis, Fissure/fistula in anus, hemorrhoids, pilonidal sinus, piles, Esophageal Varices and Gastric Varices, Gastritis, Duodenitis & Pancreatitis

vii. Gastric and Duodenal ulcers, Gastro Esophageal Reflux Disorder (GERD)/Acid Peptic Disease, Ulcerative colitis, Crohn's disease, Irritable Bowel Syndrome, Inflammatory Bowel disease

viii. All forms of cirrhosis, rectal prolapse, Perineal Abscesses, Perianal Abscesses

ix. Cholecystectomy, Endoscopy

x. Stones in urinary system, all prostate diseases, chronic renal failure or end stage renal failure or chronic kidney disease, dialysis

xi. Dysfunctional uterine bleeding, pelvic inflammatory diseases, stress incontinence, Hydrocele, varicocele/ rectocele/ spermatocele

xii. Cataract, Glaucoma, Diseases of the vitreous and retina

xiii. Unless malignant, all internal/ external tumors, cysts, nodules, polyps, sinus, fistula, adenoma, lumps including teratoma, breast lumps, dermoid cyst, ovarian cyst, desmoid tumour, umblical granuloma, mucous cyst of lip/cheek

. xiv. Diseases related to thyroid

xv. All skin ailments

xvi. Ulcers of any kind (whether internal or external) including decubitus ulcers

xvii. Varicose veins and varicose ulcers

xviii. All hernias

4. Permanent Exclusions:

1. Any dental treatment or dental surgery of any kind unless necessitated due to an Accident or specifically covered and specified in the Policy Schedule/Policy Schedule.
2. Vaccination and inoculation of any kind.
3. Any alternative treatments not covered under AYUSH as instituted in a government hospital or any institutes recognised Board by the government and/or acreddited by Quality Council of India / National Accreditation of Health.
4. Any treatment received outside India unless specifically covered and specified in the Policy Schedule.
5. Circumcision unless necessary for treatment of an underlying Illness.
6. Hormone replacement therapy.
7. Alopecia, baldness, wigs, or toupees and hair fall treatment.
8. Routine medical, eye and ear examinations unless specifically covered and specified in the Policy Schedule.
9. **Cosmetic or plastic surgery (Code - Excl 08)** - 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.
10. **Refractive Error (Code – Excl 15)** - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres
11. Any medical examination or diagnostics or Hospitalization for the purpose of employment or travel.
12. Treatment of general debility, sterility, venereal disease.
13. **Obesity/Weight Control (Code – Excl 06)** - Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
    1. Surgery to be conducted is upon the advice of the Doctor
    2. The surgery/Procedure conducted should be supported by clinical protocols
    3. The member has to be 18 years of age or older and
    4. Body Mass Index (BMI);
        a. greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

14. **Rest Cure, rehabilitation and respite care (Code – Excl 05**) - 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.

15. Intentional self-Injury, suicide or attempt to suicide.

16. First Degree Burns where First Degree (superficial) Burns are those which affects only the epidermis, or outer layer of skin.

17. Any External Congenital Anomalies unless specifically covered and specified in the Policy Schedule.

18. **Change of Gender Treatments (Code – Excl 07)** - Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex

19. Any sexually transmitted diseases..

20. Treatment by a Family Member and self-medication or any treatment that is not scientifically recognized.

21. **Breach of Law (Code – Excl 10)** - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

22. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code – Excl 12)**

23. Illness or Injury whilst performing duties as a serving member of a military or a police force or any other forces of similar nature.

24. **Investigation & Evaluation (Code – Excl 04)** -

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.

25. **Unproven Treatments (Code – Excl 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.

26. Expenses related to donor screening related to donation of an organ(s).
27. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
28. Domiciliary Hospitalization.
29. Engaging in professional sports unless specifically covered and specified in the Policy Schedule.
30. War, invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion.
31. Nuclear weapon materials or ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission or nuclear fusion.
32. **Hazardous or Adventure Sport (Code – Excl 09)** - 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.
33. Whilst mounting or dismounting into an aircraft or flying or taking part in aerial activities (including airline crew or cabin crew) except as a fare-paying passenger in a regular scheduled airline or air charter company.
34. Treatment of any sexual problem including but not limited to impotence and Erectile Dysfunction irrespective of the cause; Venereal diseases or any sexually transmitted diseases.
35. **Sterility and Infertility (Code – Excl 17)** - Expenses related to Sterility and infertility. This includes:
    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization.
36. Hospitalization primarily for evaluative and diagnostic purpose for which treatment which is possible in outpatient department is given; Admission only for Holter monitoring/Sleep study.

37. **Excluded Providers (Code – Excl 11)** - Expenses incurred towards treatment in any hospital or by an 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.

38. **Maternity (Code – Excl 18)** –

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;

39. 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 – Excl 13)**

40. 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 – Excl 14)**

CLAIM DOCUMENTS AND PROCEDURE APPLICABLE TO SECTION A

On the occurrence of an Insured Event which may give rise to a claim under the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Base Benefit/Extension being claimed within 30 days of the occurrence of the Insured Event:

1. Claim form duly completed and signed by the claimant/Insured Person. The claim form can be downloaded from our website www.icicilombard.com

2. Indoor case papers from the Hospital mentioning the diagnosis, date and time of admission and discharge, past medical and surgical history with duration.

3. Hospital discharge summary filled and attested by Hospital.

4. First Information Report (F.I.R.) copy / medico-legal case papers - notarized/ attested by a gazetted officer in case of an Injury.

5. Payment receipt in case an Ambulance Service has been availed, if applicable.

6. KYC Documents of the Insured Person and claimant

7. Age proof of child in case of Child Care Cash Benefit

8. Travel Ticket of the Immediate Family Member in case of Compassionate Visit Cash Benefit

9. Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque)

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

Cashless Facility

Cashless Facility is only available at specific Network Providers (The list of Network Providers is available at Our website). In order to avail of Cashless facility, the following procedure must be followed:

a) Insured Person/claimant must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Insured Person's name, relationship with Insured Person, 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/ Hospitalization.

b) The request must be made at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization.

c)In case, the amount payable under a Benefit/Extension is more than the actual expenses incurred by the Insured Person at the Network Provider, there will be a part payment upto the actual expenses to the Network Provider, and remaining claim payment will be made to the Insured Person.

d)To avail of Cashless facility, the Insured Person/claimant is required to produce the health card (physical or online), as provided with this Policy, subject to the terms and conditions for the usage of the said health card

Where reimbursement is available:

The Insured Person shall tender to Us all reasonable information, assistance and proofs in connection with any Claim hereunder

(i) In case, Insured Person does not avail Cashless facility, reimbursement, if applicable, may be provided.

(ii) The Insured Person/claimant shall give notice to the TPA in writing or at Our address with particulars as below,:
   a) Policy number;
   b) Unique health identification number
   c) Name of the Insured Person;
   d) Relationship with the Insured Person;
   e) Nature of Illness or Injury;
   f) Name and address of the attending Medical Practitioner and the medical facility;
   g) Any other information/ claim related documents as specified, that may be relevant to the Illness/ Injury/ Hospitalization.

Section B : OUTPATIENT BENEFIT

The Policy Certificate will specify if the Base Benefit is applicable and in force for the Insured Person. Claims made in respect of an Insured Person for any Base Benefit and any underlying

Coverage(s) applicable to the Insured Person shall be subject to the availability of the Sum Insured for the Base Benefit, applicable sub-limits for the Coverage(s) under Base Benefit claimed as specified in the Policy Certificate and the terms, conditions and exclusions of this Policy.

All claims shall be made in accordance with the procedures set out in this Policy. The applicable Base Benefit and Coverage(s) specified under Base Benefit can be availed by the Insured Person on a Cashless facility basis only, unless the Policy Schedule/Policy Certificate specifies that the Base Benefit can also be availed on a reimbursement basis from Network Provider/ Health Service Provider / Non-Network Provider.

Health records in respect of the Insured Person may be made available to the Insured Person on request by digital modes.

Section B. Base Benefit

1. **Outpatient Cover**:

This Base Benefit can be availed by the Insured Person only during the Policy Year and subject to the terms, conditions and exclusions set out below.We will pay for the Medical Expenses incurred during the Period of Cover for consultations, pharmacy, diagnostics, minor procedures and travel expenses for medical treatment as specified in the Coverage(s) detailed below:

A. Consultation Cover

We will pay for the Medical Expenses incurred during the Period of Cover for any of the following consultations with or second opinions from a Medical Practitioner or Healthcare Professional empanelled with Our Health Service Providers / Network Provider in relation to any Illness contracted or Injury suffered by the Insured Person during the Period of Cover.

Based on the information provided by the Insured Person while availing any of the features under this Coverage, medicines including over the counter medicines or other suggestions may be prescribed or suggested. We shall not be liable or responsible or deemed to be liable or responsible for any discrepancy in the information provided, or Medical Advice provided by such Medical Practitioners/Healthcare Professionals.

Choosing to avail the features under this Coverage is purely on Insured Person’s discretion and at his/her own risk. The Insured Person is free to choose whether or not to obtain services under this Coverage, and, if obtained, then whether or not to act on the advice/suggestions received in whole or in part.

By seeking and availing services under this Coverage, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.

The Policy Certificate will specify whether there is any limit on the number of consultations which may be availed under this Coverage and whether any specific specialty consultations are covered/excluded.

1. GP Consult

Consultation with a general Medical Practitioner, who for the purpose of this Base Benefit, is a Medical Practitioner who typically manages the types of Illnesses that manifest in an undifferentiated way at an early stage of development but may require a Medical Practitioner's intervention.

2. Specialist Consult

   Consultation with a specialist/super specialist Medical Practitioner, i.e. a Medical Practitioner having additional expertise in any one or more types of medicine, including but not limited to, cardiology, diabetology, endocrinology, ENT, gastroenterology, general surgery, gynecology /obstetrics, internal medicine, nephrology, neurology, ophthalmology, orthopedics, pediatrics, psychiatry, urology, dietitian, nutritionist, dermatology and pulmonology.

3. Physiotherapy Consult

   Consultation with a Medical Practitioner/healthcare professional qualified to treat any Illness, Injury, or deformity by physical methods such as but not limited massage, heat treatment, and exercise.

4. AYUSH Consult

   Consultation with a Medical Practitioner/Healthcare Professional specializing in providing AYUSH treatment in any particular mode.

5. Dental Consult

   Consultation with a Medical Practitioner who is qualified to treat Illnesses and other conditions that affect the teeth and gums, particularly the repair and extraction of teeth and the insertion of artificial teeth.

6. Counseling

   Session with a Medical Practitioner/Healthcare Professional for providing assistance with dealing with issues such as but not limited to personal and lifestyle imbalance, speech impairment, and problems related to psychological/mental illness.

7. Tele Consult

   Consultation with a Medical Practitioner through Our Health Service Providers' helpline for assessing the medical records or routine health issues of the Insured Person over the phone.

8. Home Consult

   Consultation given by a Medical Practitioner/ Healthcare Professional at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request for availing this Base Benefit.

9. Online / Digital Consult

   Consultation given by a Medical Practitioner/Healthcare Professional or a panel of such Medical Practitioners/Healthcare Professionals through a virtual mode of communication such as via chat, email, video, online portal, or mobile application.

B. Pharmacy Cover

We will pay the Medical Expenses incurred on purchase during the Period of Cover of medicines (including over the counter medicines), drugs, medical consumables, prosthetics, medically necessary spectacles or cochlear implants, external medical aids, vaccinations, vitamins, tonics or other related products as specified in the Policy Certificate from a Network Provider/Health Service Provider that are prescribed by a Medical Practitioner for any Illness contracted or Injury suffered by the Insured Person during the Period of Cover.

We will arrange for delivery of the products purchased under this Coverage at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request for availing this Coverage and only if the Policy Certificate specifies that this option is in force for the Insured Person.

C. Diagnostic Cover

We will pay the Medical Expenses incurred on Outpatient diagnostics tests including but not limited to, biochemistry, hematology, immunology, microbiology, serology, pathology, x-ray, ultrasound and TMT for the Insured Person from a Network Provider/Health Service Provider the Period of Cover.

The Policy Certificate will specify whether there is any limit on the nature and type of diagnostic tests which may be availed under this Coverage and whether the Insured Person is required to have a written prescription from a Medical Practitioner in advance of carrying out the diagnostic tests.

We will arrange for diagnostic tests available under this Coverage to be carried out at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request for availing this Base Benefit and only if the Policy Certificate specifies that this option is in force for the Insured Person.

D. Minor Procedures: We will pay the Medical Expenses incurred on a Medical Procedure related to any specialties, including dental procedures, undergone at a Network Provider/Health Service Provider or at the location of the Insured Person for any Illness contracted or Injury suffered by the Insured Person during the Period of Cover.

For the purpose of this Coverage, Medical Procedure shall mean as following:

Medical Procedure means Surgical Procedure and/or non-Surgical Procedure(s) required for treatment of an Illness or Injury, including but not limited to, audiometry, application of cast, cast removal, injection administration, wound switching, retinoscopy, biopsy, drainage of abscess, and any other procedures which can be done on outpatient basis excluding the Day Care Treatment and not requiring any Hospitalization, performed in Health Service Provider or Insured Person’s premises by a Medical Practitioner.

The Policy Certificate will specify whether there is any limit on the nature and type of Medical Procedures which may be availed under this Coverage.

We will arrange for the Medical Procedures available under this Coverage to be carried out at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request for availing this Coverage and only if the Policy Certificate specifies that this option is in force for the Insured Person.

E. Travel Expenses for Medical Treatment: We will pay the travel costs incurred by an

Insured Person during the Period of Cover to purchase medicines prescribed by a Medical Practitioner from a pharmacy or to undergo diagnostic tests provided that We will pay for the costs incurred in such travel up to a maximum of one time for each prescription from a Medical Practitioner and one visit to Diagnostic center and/or pharmacy for each prescription even if the prescription/diagnostic tests are executed in parts, unless specified otherwise.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION B:

We shall not be liable to make any payment for any Claim under Section B of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following. Others specific policy related exclusions may be defined in Policy Certificate or any exclusions mentioned below may be covered if mentioned as inclusions in the Policy Certificate.

1. Expenses incurred due to contraction of any Illness necessitating Hospitalization.
2. Personal comfort, cosmetics convenience -
3. 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 – Excl 14)**
4. Alternative treatment except AYUSH treatment.
5. . **Unproven Treatments (Code – Excl 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
6. **30-day waiting period (Code – Excl 03)** - Any hospitalization falling within the initial waiting period as specified in the policy certificate subject to a maximum of 30 days-
    - Expenses related to the treatment of any illness within the initial waiting period shall be excluded except claims arising due to an accident, provided the same are covered.
    - This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
    - The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently
7. Illness, Accident or Injury directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not).
8. Defects or anomalies, venereal disease, intentional self-injury (whether arising from an attempt to suicide or otherwise)
9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code – Excl 12)**

10. **Sterility and Infertility (Code – Excl 17)** - Expenses related to Sterility and infertility. This includes:
    - Any type of contraception, sterilization
    - Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    - Gestational Surrogacy
    - Reversal of sterilization.
11. All expenses arising out of any condition directly or indirectly caused to or associated with, Human T-Cell Lymphotropic Virus Type III (HTLV -III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any syndrome or condition of a similar kind.
12. Illness, Accident or Injuries directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.
13. Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.
14. Any expenses incurred on instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.), oxygen concentrator for bronchial asthmatic condition,
15. Any sexually transmitted disease.
16. **Cosmetic or plastic Surgery (Code – Excl 08)** - 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.
17. **Change of Gender treatments (Code – Excl 07)** - Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
18. **Breach of law (Code – Excl 10)** - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
19. **Hazardous or Adventure Sports (Code – Excl 09)** - 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
20. 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 – Excl 13)**
21. Treatment received outside India

CLAIM DOCUMENTS, PROCEDURE, ADMINISTRATION APPLICABLE FOR SECTION B

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 Our liability under the Policy, the Insured Person shall undertake the following:

1. Claims Procedure

a. For Cashless Settlement

- Cashless treatment is only available at specific Network Providers/ Health Service Providers. The list of Network Providers/ Health Service Providers is available at www.icicilombard.com. In order to avail of Cashless facility, the following procedure must be followed:
- **Authorization**

  Prior to taking treatment and/or incurring Medical Expenses at a Network / Health Service Provider, the Insured person must contact the company or the TPA through online mode or otherwise, accompanied with full particulars namely,

  i. Policy Number,
  ii. Unique health identification number
  iii. Name of the Insured Person,
  iv. Relationship with the Insured Person,
  v. Nature of Illness or Injury;
  vi. Name and Address of the Medical Practitioner/ medical facility / Health Service Provider and any other information that may be relevant to the Illness/ Injury.
- To avail of Cashless facility, the Insured Person/claimant is required to produce the health card (physical or online), as provided with this Policy, subject to the terms and conditions for the usage of the said health card. The request shall be considered after having obtained accurate and complete information for the Illness or Injury, where applicable, for which Cashless facility is sought and We will confirm the request digitally or in writing.
- In case the services availed exceed the eligibility, the difference will have to be paid directly to the Hospital/Network Provider/Health Service Provider by the Insured person/claimant.

b. For Reimbursement Settlement

(i) For Outpatient cover, Reimbursement of medically necessary expenses incurred on outpatient basis would be done in cases where the member visits a Non-Network provider. In case, Insured person visits a Network / Health Service provider, reimbursement may be done on the basis of actual payment made or limited to the expenses consistent with the prevailing charges agreed between Network / Health Service provider and Us, whichever is lower.

(ii) The Insured Person shall give notice in writing at the Company's address with particulars as below:

h) Policy number;
i) Unique health identification number
j) Name of the Insured Person;
k) Relationship with the Insured Person;
l) Nature of Illness or Injury;

m) Name and address of the attending Medical Practitioner and the medical facility;

n) Any other information that may be relevant to the Illness/ Injury.

(iii) The procedure for lodging the Claim shall be as under:

Upon the happening of any event giving rise or likely to give rise to a Claim under this policy:

a) The Insured Person shall give immediate notice thereof in writing to Us.

b) The Insured Person shall submit the claim documents to Us, within 30 days from the date of completion of treatment, a detailed statement in writing as per the claim form together with bills, vouchers and any other material particular, relevant to the making of such Claim.

c) The Insured Person shall tender to Us all reasonable information, assistance and proofs in connection with any Claim hereunder

2. Basis of assessment of claims

a) The benefit payable shall be such expenses reasonably and necessarily incurred by or on behalf of the Insured Person under the following categories but not exceeding the Sum Insured in respect of such Insured Person as specified in Part I of the Policy.

Heads of compensation payable:

(i) Consultation Expenses,

(ii) Procedure Expenses,

(iii) Diagnostics Expenses,

(iv) Pharmacy Expenses

(v) Minor Procedure Expenses

(vi) Others

b) Claim documents :

The Insured shall be required to furnish the following for or in support of a Claim. The right to waive off as an exception or accept the document in any other format than specified below remains with Us.

(i) Duly completed Outpatient claim form signed by the Insured person along with Aadhaar and PAN copy

(ii) Original bills, receipts and copy of prescription, clinical notes from the Medical Practitioner / medical facility

(iii) Original bills from pharmacy supported by proper prescription

(iv) Copy of investigation test reports and original bills, payment receipts

(v) Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque)

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

Section C: WELLNESS COVER

This Section can only be taken as an Extension to Section A (Hospifund Benefit) or Section B (Outpatient Benefit). This Section will be available and in force for the Insured Person only if either Section A or Section B or both are in force for that Insured Person.

The Insured Person can avail any of the following Benefits on a Cashless Facility basis only. The Policy Certificate will specify the scope of cover, limitations on the number of times or for what periods the Insured Person can avail a particular Benefit during the Period of Cover, sub-limits on any particular Benefit, demography, duration and exclusions applicable to the following Benefits against such Benefit.

Health records in respect of the Insured Person may be made available to the Insured Person on request by digital modes.

C.1. Routine Physical & Preventive Examinations: If the Insured Person undertakes any of the Routine Physical and Preventive Examinations specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred.

For the purpose of this Benefit, 'Routine Physical and Preventive Examinations' shall mean on-site or off-site health check-ups of all health parameters, including any consultations from relevant Medical Practitioners/Healthcare Professionals.

C.2. Onsite Health Services: If the Insured Person undertakes any Onsite Health Services, during the Period of Cover, then We shall pay the costs incurred.

For the purpose of this Benefit, "Onsite Health Consultation' shall mean any consultation, health audit, provided by a Medical Practitioner/Healthcare Professional through a clinic or otherwise within the place of work of the Insured Person or elsewhere, and shall include but not be limited to Medical Procedures, vaccinations, First Aid (prescribing and dispensing medicines onsite). The Medical Practitioner/Healthcare Professional will diagnosis, prescribe medications, advice further investigations or refer to a specialist if needed and also schedule follow up session to evaluate the progress. The clinic may be subjected to medical audits and, operational and maintenance services by Us at Our discretion.

C.3. Wellness Session: If the Insured Person attends any Wellness Sessions of the type specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred.

For the purpose of this Benefit, "Wellness Session" shall mean any off-site or on-site mode of providing awareness/ training/ education on complete wellbeing which includes physical fitness, diet and nutrition, spiritual, occupational, environmental, financial, social and mental wellbeing and safety related parameters by relevant Healthcare Professionals/Health Service Providers.

C.4. Health Risk Assessment (HRA): If the Insured Person undertakes Health Risk Assessment (HRA) during the Period of Cover, then We shall pay the costs incurred.

For the purpose of this Benefit, "HRA" shall mean any online or hard copy questionnaire tool, as specified in the Policy Certificate, for evaluation of the Insured Person's health and

quality of life by reviewing the current lifestyle practices, habits, diet, existing health issues, pathology, family history and others, affecting the Insured Person's health status. Online HRA shall be provided through Our platform. Awareness on health can be provided based on the health status of the Insured Person.

C.5. Wellness Event: If the Insured Person attends any Wellness Event of the type specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred.

For the purpose of this Benefit, "Wellness Event" shall mean any planned on-site or off-site camp focusing on health parameters such as but not limited to vaccination, eye screening, and dental screening.

C.6. Telephonic /Virtual Consultation: If the Insured Person avails any Telephonic/Virtual Consultation of the type or mode specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred.

For the purpose of this Benefit, "Telephonic/Virtual Consultation" shall mean any consultations provided by Medical Practitioners/Healthcare Professionals through a virtual mode of communication, such as via audio, video, online portal, chat or mobile application for routine health query or second opinion. This shall also include consulting a professional expert through a dedicated helpline number in relation to any social, mental, emotional, environmental or other issues faced by the Insured Person which affect his/her well being.

(i) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it;

(ii) Under this Benefit, We are only providing the Insured Person with access to consultations or opinion and We shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner

We will make available consultation with Medical Practitioners in case of need through Our service provider helpline for assessing the case situation or routine health issues over the phone. Based on the information provided by the Insured Person while availing any of the features under this Benefit, medicines including over the counter medicines or other suggestions may be prescribed or suggested. We shall not be liable or responsible or deemed to be liable or responsible for any discrepancy in the information provided.

C.7. Workplace Wellness Management Program: If the Insured Person attends any Workplace Wellness Management Program, of the nature specified in the Policy Certificate, during the Period of Cover, then We shall pay the costs incurred.

For the purpose of this Benefit, "Workplace Wellness Management Program" shall mean any of the following:

i. Lifestyle management program with a specific focus such as but not limited to smoking cessation, stress management to educate, empower and engage Insured Persons to become more aware of their health and proactively manage it, each Insured Person shall have access to wellness coach. These programs can be app /web/chat/call based with/without wearable devices.

ii. Pregnancy management care program: Customised pregnancy program, online app/web based and telephonic general tips and suggestions to expectant parents

on antenatal support, labour preparation and post-partum support. These services are to educate, empower and engage the expecting parents, which will include but are not limited to customised diet plan, fitness advice, emotional support, educating on changes in the body, caution signs, advises on tests and scans, labour pain management, lactation counselling and counselling on breathing exercises for the expectant mother, baby shoot, maternity shoot with discounts on pharmacy and necessary diagnostics. The services also provide counselling on emotional support and preparation for parenting to the father. These programs can be app /web based with/without wearable devices.

iii. Disease management program will cover customized program for Insured Persons with any chronic disease or borderline cases, to educate, empower and engage Insured Persons to become more aware of their health and proactively manage it, each Insured Person shall have access to wellness coach. This program can be app/web/call/chat based with/without wearable devices.

iv. Benefits may be earned by the Insured Person under this benefit which can be redeemed against any of the benefits available under the Policy, as notified from time to time and subject to our internal eligibility criteria provided on our website. There will be no cash reimbursement or redemption available against the benefits obtained under this benefit.

These services are in addition to and are not meant to be availed in replacement of the Medical Advice or treatment provided by a Medical Practitioner. These services are based on general tips and suggestions and may not be suitable for all pregnancies. The Insured Person must not avail or continue if they have received any express instructions from the treating/consulting Medical Practitioner.

C.8. Emergency Ambulance Service: If the Insured Person suffers an Illness or sustains an Injury during the Period of Cover which requires the Insured Person to be transported to a Hospital in an emergency for Medically Necessary Treatment to be rendered, We will pay for the charges incurred for ground medical transportation by an ambulance service provider.

This Benefit shall be payable subject to the following:

i. The medical condition of the Insured Person requires immediate on-ground transportation from the place where the Insured Person is Injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Illness or Injury for which the service is called upon.

ii. The ambulance service will be offered by Our Service Providers on a Cashless Facility basis provided that the request has been made by the Insured Person or his Family Members on the dedicated helpline 18001028136 (Toll free) and 01244498770 (Charges applicable helpline number). This number if changed will be updated on Our website.

iii. We will provide this Benefit only for a one way transfer from the place of Injury or Illness to the nearest Hospital where necessary treatment facility is available or from one Hospital to another Hospital having advanced facilities.

iv. We will provide this Benefit only for transportation within the same city.

v. We will not make any payment under this Benefit if the Insured Person is transferred

to any Hospital for evaluation purposes only or for any non-emergency services or if there is no active line of treatment.

vi. Ambulance coordination for emergency cases will be provided through the helpline of Our Service Provider on best effort basis from the communicated location by providing a valid identification for validation of coverage. A Medical Practitioner can accompany the ambulance, as and when required and as per availability.

vii. The ambulance coordination is available 24*7, 365 days a year and within the jurisdiction of major cities as listed. The list of cities where this facility will be provided shall be available on Our website.

The following covers will also be available with the Emergency Ambulance Service Benefit:

Tele consultation Benefit: We will make available consultation with Medical Practitioners in case of need through Our service provider helpline for assessing the case situation. Over the counter (OTC) medicines may be prescribed/ suggested on case to case basis. Features under this Benefit include:

a. 24*7, 365 days a year availability
b. Consultations by Medical Practitioners
c. Over the counter (OTC) medicines may be prescribed/ suggested on case to case basis
d. The Insured can reach the Medical Practitioner by calling on the dedicated helpline number: +91 124 4498757. Any change in this helpline number shall be updated on Our website www.icicilombard.com

Health Assistance Benefit: Health assistance will be provided through Our dedicated helpline. The health assistance team is dedicated to assist the Insured Person in:

a. Identifying specialist/ Hospital
b. Fixing an appointment with Medical Practitioners wherever applicable on best effort basis
c. Providing options on suitable Network Providers.
d. Providing information on ailments and possible lines of treatment

The facilitation for assistance would be free for the Insured Person. Any service availed by the Insured Person would be on a paid basis and to payment will be borne by the Insured Person and paid directly to the Medical Practitioner or Hospital.

Call Helpline no. 040 – 6627 4205 (9:30 am to 6 pm Mon to Fri, excluding public holidays) or write to healthassistance@icicilombard.com to avail this facility. Any change in this helpline number shall be updated on Our website www.icicilombard.com. Any information provided through assistance cannot be used as a substitute for physical examination by a Medical Practitioner.

GENERAL CONDITIONS APPLICABLE TO SECTION C:

1. Where any of the services provided under this Section are arranged by Us at Our Network Providers/Health Service Providers, We shall not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider/Health Service Provider in relation to the same. Communication around the Benefits, as well as awareness on general health, will be sent through various modes of communication.
2. The Insured Person is free to choose whether or not to obtain services under this Section, and, if obtained, then whether or not to act on the advice received in whole or in part.
3. Based on the information provided by the Insured Person while availing any of the features under this Section, medicines including over the counter medicines or other suggestions may be prescribed or suggested. We shall not be liable or responsible or deemed to be liable or responsible for any discrepancy in the information provided.
4. The Insured Person should seek assistance from a Medical Practitioner/Healthcare Professional when interpreting these material/suggestions received under this Section and applying them to his/her individual circumstances. If the Insured Person has any concerns about his/her health, he/she should consult their general practitioner immediately.
5. By seeking and availing services under this Section, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
6. The services obtained under this Section shall be provided on best effort basis and be limited to defined criteria and shall not be valid for any medico legal purposes.

EXCLUSIONS APPLICABLE FOR SECTION C

No exclusions applicable for Section C.

CLAIM PROCEDURE APPLICABLE TO SECTION C

Claims Procedure For Cashless Settlement

Cashless Facility is only available at specific Network Providers/ Health Service Providers. The updated list of Network Providers/ Health Service Providers is available at Our website. In order to avail of Cashless facility, the following procedure must be followed:

The Insured Person/ group administrator/claimant should notify Us before the usage of the any Benefits under this Section by writing a mail to ihealthcare@icicilombard.com. To avail Cashless facility, the Insured Person/claimant may be required to produce the health card (physical or online), as provided with this Policy, subject to the terms and conditions for the usage of the said health card.

In case the services availed exceed the eligibility, the difference will have to be paid directly to the Health Service Provider/ Network Provider by the Insured person/claimant.

CLAIM ADMINISTRATION APPLICABLE TO ALL SECTIONS

- The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Certificate) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the procedures and requirements in relation to claims, shall be Conditions Precedent to Our liability under this Policy**.**
- We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full and on time in respect of the Insured Person's cover under the Policy and all payments have been realised.
- On occurrence of an any event that may give rise to a Claim under this Policy, You shall-

    - Notify Us immediately on toll free number 1800 2666 or on our website www.icicilombard.com or also in writing at Our address specified in the Policy Certificate.
    - Along with the completed and signed Claim form, provide all the relevant documents in support of Your Claim within 30 days.
    - Wherever details pertaining to happening of Claim are conveyed by you to Us after reasonable period, You shall provide the reasons of such delay to Us.

- All claims documentation specified within the relevant Section of the Policy for the Base Benefit/Extension being claimed must be submitted in full. The final decision to waive the requirement for any specified claim documents rests with Us.
- If any Claim is not made within 30 days of the Insured Event, then We will condone such delay on merits only where the delay has been proved to be for reasons beyond the claimant's control.
- We/Our representatives must be given all reasonable co-operation in investigating the Claim in order to assess Our liability and quantum in respect of such Claim. If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's Injury/Illness and treatment and to investigate the facts surrounding the Claim.
- Our medical or other representative shall be allowed to examine the Insured Person on the occurrence of any alleged Injury or disablement when and as often as the same may reasonably be required on behalf of Us Such evidence as We may require from time to time shall be furnished The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed..
- All Claims will be investigated (as required) and settled in accordance with the applicable regulatory guidelines, including the IRDAI (Protection of Policyholders Interests) Regulations, 2017.
- The admissible Claim amount will be calculated post applicability of Deductible, Co-pay, Sub-limit if any and as specifically defined in Policy certificate.

TERMS OF RENEWAL

a. The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any Claim arising out of an Injury or Accident or Illness or Hospitalization that occurred during the Grace Period.

b. You shall on tendering any premium for the Renewal of this Policy give notice in writing to Us of any Illness, physical defect or infirmity with which any of the Insured Person(s) have become affected since the payment of the expiring Policy start date.

c. There will be life-long renewal without any age restriction for the cover.

PORTABILITY BENEFITS

Any Insured Person has the option to migrate to similar indemnity health insurance policy available with Us or any other non-life insurer, at the time of Renewal subject to underwriting with all the accrued continuity benefits such as waiver of Waiting Period provided the Policy has been maintained without a break as per the applicable IRDAI regulations on Portability.

If You were insured continuously and without a break under another Indian retail health insurance policy with any other Indian non-life Insurance company or stand alone health insurance company, it is understood and agreed that:

a) All health insurance policies are portable. These provisions will apply to You, if You wish to migrate from this Policy to any other health insurance policy on Renewals;

b) You should initiate action to approach another insurer, to take advantage of Portability, well before the renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer;

c)You should provide Us with Your application and completed portability form with complete documentation atleast 45 days before the expiry of the present period of insurance, in case you wish to avail Portability benefits;

d) Portability benefit is available only at the time of Renewal of the existing health insurance policy;

e) Portability benefits is available only up to the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, Waiting Periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

f) We should receive the database and claim history from the insurer for Your previous policy.

g) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions/Waiting Periods in accordance with the applicable IRDAI regulations on Portability.

POLICY RELATED TERMS AND CONDITIONS

- Please inform us immediately of any change in the address, occupation, state of health, or of any other changes affecting the Insured Person (or his Nominee/ legal heir, as the case may be)
- Any change in the policy terms and conditions including but not limited to Sum Insured and/or coverage shall not be permitted within the Period of Cover.

- In case the customer chooses to pay the premium in installments then he/she shall not be able to change the frequency of payments within the Period of Cover.
- In case the customer has opted for auto renewal, the policy shall be Renewed with the same policy terms & conditions including but not limited to the Sum Insured, coverage, premium paying terms and Claim payment terms and policy terms and conditions.
- We shall make payment to assignee/partial assignee/conditional assignee, as the case may be or in the absence of assignee to the Insured Person or the Insured Person's nominee. If there is no assignee or nominee and the Insured Person is incapacitated or deceased, We will pay to the Insured Person's heir, executor or validly appointed legal representative. Any payment We make in this manner will be a complete and final discharge of Our liability towards the Claim.
- The scope of cover shall be within the geographical boundaries on India unless specified otherwise.

PART III OF THE POLICY SCHEDULE

STANDARD TERMS AND CONDITIONS

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.
("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)**
- 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
- 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
- However, when 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.
- 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.
("Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

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

5. **Fraud**
- If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
- Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
- For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
- c) any other act fitted to deceive; and
- d) any such act or omission as the law specially declares to be fraudulent

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

6. Cancellation/ Termination

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

i) Refund Grid applicable to Policies having Policy Period lesser than or equal to one year:

PERIOD ON RISK	RATE OF PREMIUM REFUNDED
Up to 1 month	75% of premium
Up to 3 months	50% of premium
Up to 6 months	25% of premium
Exceeding six months	NIL

ii) Refund Grid Applicable to policies having Policy Period greater than 1year

% of Premium Refund				
	Policy period (years)			
Day of cancellation	**2**	**3**	**4**	**5**
Within 180 days	60%	65%	70%	75%
181 – 365 days	40%	52%	57%	61%
366 – 730 days	NIL	26%	38%	46%
731 – 1095 days		NIL	20%	30%
1096 – 1460 days			NIL	15%
> 1460 days	NIL			

Full refund may be given based on underwriter’s discretion.
For any cancellation initiated by the company, refund shall be done on a pro rata basis.

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.

b) 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.

7. **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 policyatleast3O 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 producuplan 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

8. **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

9. **Renewal of Policy**

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

- The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- 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.
- No loading shall apply on renewals based on individual claims experience

10. **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

11. **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

12. **Premium Payment in lnstalments**

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

i. Grace Period of 7 days would be given to pay the instalment premium due for the policy.

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 lf the instalment premium is not paid on due date

v. ln case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. ln 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.

13. **Possibility of Revision of Terms of the Policy lncluding the Premium Rates**

The Company, with prior approval of lRDAl, 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.

14. **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 (30 days if the Policy is sold through distance marketing) from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

lf 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;

15. **Redressal of Grievance**

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

Website: www. icicilombard.com (Customer Support section).
Toll Free: 1800 2666 (Senior citizen included)
E-mail: customersupport@icicilombard.com

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

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.

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.:- 079 - 25501201/02/05/06 Email:-**bimalokpal.ahmedabad@ecoi.co.in**	State of Gujarat and Union Territories of Dadra & Nagar Haveli and 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, 1st Phase, Bengaluru-560 078. Tel.:- 080-26652048 / 26652049 Email:- **bimalokpal.bengaluru@ecoi.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.	States of Madhya Pradesh and Chattisgarh.

Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email:- **bimalokpalbhopal@ecoi.co.in**	
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.:- 0674-2596461 / 2596455 Fax:- 0674-2596429 Email:-**bimalokpal.bhubaneswar@ecoi.co.in**	State of 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@ecoi.co.in**	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668 / 24335284 Fax:- 044-24333664 Email:- **bimalokpal.chennai@ecoi.co.in**	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 2323481/23213504 Email:- **bimalokpal.delhi@ecoi.co.in**	State of Delhi
ERNAKULAM Office of the Insurance Ombudsman, 2nd floor, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, Ernakulum - 682 015. Tel.:- 0484-2358759/2359338 Fax:- 0484-2359336 Email:- **bimalokpal.ernakulum@ecoi.co.in**	Kerala, Lakshadweep, Mahe-a part of Pondicherry
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361- 2132204 / 2132205 Fax:- 0361-2732937 Email:- **bimalokpal.guwahati@ecoi.co.in**	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman,	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of

6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040-65504123/23312122 Fax:- 040-23376599 Email:- **bimalokpal.hyderabad@ecoi.co.in**	the Union Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi-II Bldg., Ground Floor, Bhawani Singh Marg, Jaipur - 302005. Tel.:- 0141-2740363 Email:- **bimalokpal.jaipur@ecoi.co.in**	State of Rajasthan.
KOLKATA Office of the Insurance Ombudsman, Hindustan Building Annexe, 4th floor, 4, CR Avenue, Kolkata - 700 072. Tel.:- 033-22124339 / 22124340 Fax:- 033-22124341 Email:- **bimalokpal.kolkata@ecoi.co.in**	States of West Bengal, Bihar, Sikkim and Union Territories of Andaman and 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@ecoi.co.in**	District of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varansi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sulanpur, Maharajganj, Santkabirnagar, Azamgarh, Kaushinagar, Gorkhpur, Deoria, Mau, 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@ecoi.co.in**	States of 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, Gautam Budh Nagar, Noida U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email:- **bimalokpal.noida@ecoi.co.in**	States 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, Firozabad, Gautam Budh Nagar, 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@ecoi.co.in**	States of Bihar and Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Building, 3rd Floor, CTS Nos. 195 to 198, NC Kelkar Road, Narayan Peth, Pune - 411 030 Tel: 020 -41312555 Email:- **bimalokpal.pune@ecoi.co.in**	States of Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/ligms. irda.qov. in/
The updated details of Insurance Ombudsman are also available on IRDA website: www.irdaindia.org, on the website of Executive Council of Insurers (ECOI): http://www.gbic.co.in/ombudsman.html, Our website www.icicilombard.com or from any of Our offices.

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

17. **Material Change**

The Insured Person shall immediately notify Us in writing of any material change in the risk and cause at his own expense such additional precautions to be taken as circumstances may require to ensure safe operation, trade or business practices thereby containing the circumstances that may give rise to the Claim and We may, adjust the scope of cover and / or premium, if necessary, accordingly.

18. **Records to be Maintained**

The Insured Person shall keep an accurate record containing all relevant particulars and shall allow Us to inspect such record.

19. **Notice of Charge**

We shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by Us to the Insured

Person, Nominee, assignee or his legal heirs of any amount under the Policy shall in all cases be an effectual discharge to Us.

20. Overriding effect of Part II of the Schedule

The terms and conditions contained herein and in Part II of the Schedule to this Policy shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Schedule to this Policy, then the term(s) and condition(s) contained herein shall be read *mutatis mutandis* with the scope of cover/terms and conditions contained in Part II of the Schedule to this Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

21. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be adjudicated or interpreted in accordance with Indian Laws and only competent Indian courts shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

22. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to: In case of the Insured Person, at the address specified in the Policy Certificate.
In case of Us:
ICICI Lombard General Insurance Company Limited, ICICI Lombard House,
414, Veer Savarkar Marg, Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400 025

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

23. Customer Service

If at any time the Insured Person (or his Nominee/ legal heir, as the case may be) requires any clarification or assistance, they may contact Our offices at the address specified below, during normal business hours.
ICICI Lombard General Insurance Company Limited
ICICI Lombard House 414, Veer Savarkar Marg,
Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025.

ENDORSEMENTS AVAILABLE UNDER THIS POLICY

Endorsement I: Auto Renewal Clause

Under this Endorsement, We will automatically renew the Policy for the Policy Period as opted by the policyholder. However, after completing its entire auto Renewal period on expiry of the Policy on the Policy End Date, We shall not be bound to accept any Renewal premium nor give notice that such Renewal premium is due. Any change in the risk will be intimated to the Company by the Policyholder/ Insured Person.

Endorsement II: Premium Installment Clause

a. We will accept payment of the premium applicable taxes, charges, cess etc. in monthly/quarterly/semi-annual/annual installments as specified in the Policy Certificate provided that the Policyholder continues to perform and observe all their obligations hereunder.