CUSTOMER INFORMATION SHEET –ICICI Lombard Criti Shield Plus

Description is illustrative and not exhaustive

<table>
<tr><th>S.NO</th><th>Title</th><th>Description</th><th>Policy Clause No.</th></tr>
<tr><td>1</td><td>Product Name</td><td>ICICI Lombard Criti Shield Plus</td><td></td></tr>
<tr><td rowspan="3">2</td><td rowspan="3">What am I covered for?</td><td colspan="2">Section A : Critical Illness</td></tr>
<tr><td>Benefit 1 : Comprehensive Critical Illness
This cover has been broadly divided into five critical illness buckets.
<table>
<tr><td>Name of the bucket</td><td>No. of illnesses covered</td></tr>
<tr><td>Bucket 1 - Cancer and blood disorders</td><td>4 Major/1 Minor</td></tr>
<tr><td>Bucket 2 -Heart and Blood Vessel</td><td>10 Major/11 Minor</td></tr>
<tr><td>Bucket 3 -Major Organs</td><td>14 Major /12 Minor</td></tr>
<tr><td>Bucket 4 -Nervous System</td><td>24 Major/8 Minor</td></tr>
<tr><td>Bucket 5 -Other Illness</td><td>3 Major/5Minor</td></tr>
</table>

In the event of any minor illness the company shall pay 25% of the Sum Insured subject to a maximum of 12.50lac specified in the Policy Schedule against that bucket and for any major critical illness the company shall pay 100 % of the Sum Insured specified in the Policy Schedule against that bucket. If a major illness is followed by a minor illness from the same bucket the company shall only pay the remaining 75% of the sum insured as specified against that bucket in the Policy Schedule.
The amount payable will be on the First Diagnosis of any one of the Critical Illnesses listed in the policy wordings.
There is a survival period and waiting period applicable to this cover as specified on the policy schedule.

Illustration 1
Insured can opt for any of the Critical Illness bucket as per plan available at inception. The SI payable will be independent for each bucket if more than one bucket is selected.

e.g At policy inception if Mr. XYZ opts for all buckets Cancer and blood disorders, Heart and Blood Vessel, Major Organs, Nervous System, Other Illness, he can intimate a claim under all these buckets independently/simultaneously.

Incase Mr. XYZ is diagnosed with Stroke resulting in permanent symptoms (Nervous System -Major) in 5th month, if the claim is payable as per policy Terms and conditions we will pay 100% of SI allocated for Nervous System bucket.
The Nervous System bucket will be exhausted and no renewal of this bucket will be allowed to the customer.
In the 7th month Mr. XYZ is diagnosed with Pulmonary Embolism (Heart and Blood Vessel-Minor),he can claim for 25% of SI from Heart and Blood Vessel bucket.
Incase Mr. XYZ consequently suffers from a Myocardial Infarction (Heart and Blood Vessel -Major) we will pay balance 75% (since we have already paid minor claim of 25% under this bucket) once this claim has been paid the Heart and Blood Vessel bucket will be exhausted and no subsequent renewal will be done for this bucket

Illustration 2:
Mr. PQR a 33yr old has opted for plan which has “Heart and Blood Vessel” bucket for 1 year Policy Tenure and 3lac SI for a base premium of 270/- . After the waiting period of the policy is over Mr. PQR is diagnosed with Other Serious Coronary Artery Diseases in the 5th month. He is eligible to claim for 25% SI which is 75000/-. Now only 75% of the SI is remaining in “Heart and Blood Vessel bucket. At the time of renewal, we will be collecting the premium for 100% of SI however our liability will be only towards the balance Sum Insured which is 75% of SI(in this example 225000).</td>
<td>Part III of Wordings

Under Section A
1.1</td></tr>
<tr><td>Benefit 2: ICU Benefit (Add On)</td><td>Part III of Wordings</td></tr>
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		In the event of a hospital admission if an insured is admitted in ICU on account of any surgery or infection for a minimum of 5 or 7 days as specified in Policy Schedule, the company shall pay the Sum Insured as specified in the Policy Schedule against this benefit, in consideration of payment of additional premium. The surgery or infection and stay in the ICU must be directly due to the same cause and confirmed as necessary medical treatment. Add on cover will not be renewed incase base bucket is exhausted	Under Section A 2.1
		Benefit 3: Cancer Restore Benefit (Add On)	Part III of Wordings
		In consideration of payment of additional premium this cover pays the sum insured specified against this Benefit on account of a re diagnosed or recurred major cancer once a Major cancer (Cancer of Specified Severity) claim has already been considered and paid under this policy. A Waiting period of 3 years will be applicable from the date of diagnosis of the first Major Cancer (Cancer of Specified Severity) claim admitted under this policy for this Benefit to be triggered This Benefit 3 cannot be opted at the time of renewal or during the policy period. **Illustration 3:** Mr. RST a 40yr old male has opted for plan which has 'Cancer and blood disorders' bucket and add on 'Cancer Restore Benefit' for 1 year tenure for 5lac SI with base premium as 970/- & 340/- for 'Cancer and blood disorders Bucket' and 'Cancer Restore Cover' respectively. After the initial waiting period Mr. RST is diagnosed with Major Cancer (Cancer of Specified severity),after evaluation of required documents we pay the major claim with 100% payout of 5 lac sum insured. Since the customer has opted for cancer restore benefit he will be eligible to claim under this benefit provided the customer renews this policy subject to having received the premium for the 'Cancer and blood disorders' bucket under benefit 1 and cancer restore benefit as per the original Sum Insured and age at the time of renewal. Mr. RST is diagnosed with Cancer relapse after the 3 years waiting period he will be eligible to claim for 'Cancer Restore' Benefit.	Under Section A 3.1
		Section B : Add on Cover	
		Benefit: 4: Major Surgical Procedures	Part III of Wordings
		In the event an Insured Person is Hospitalized on the written advice of the treating Medical Practitioner due to an Illness contracted or any Injury sustained during the Period of Cover, and is advised by a Medical Practitioner qualified as a Surgeon to undergo a Surgical Procedure specified in Annexure 2 of this Policy and has undergone the surgery, we will pay the percentage of the Sum Insured as a lumpsum specified in the Policy Schedule in the manner specified in the Annexure 2 for each of the listed surgeries. This cover can only be availed with benefit 1. Add on cover will not be renewed incase base bucket is exhausted **Illustration 4**: Ms. PQR has opted for plan which has Cancer and blood disorders bucket and add on Section B: Major Surgical Procedures. After the initial waiting period she undergoes Pericardectomy. She is eligible to claim for 50% payout under Major Surgical Procedures(Add on Cover). Subsequently she has to undergo Amputation of Leg she will be eligible to claim for 100% payout under Major Surgical Procedure, however as we have already honoured a 50% claim on	Under Section B 4.1

		account of Pericardiactomy now she will be eligible to claim for balance 50% only. Hence we will be honouring 50% payout here subject to policy terms and conditions	
		Section C: PERSONAL ACCIDENT(Add on)	
		Benefit 5: Accidental Death Benefit	Part III of Wordings
		We will pay the specified Sum Insured in the manner specified in the Policy Schedule, if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's death within 365 days from the date of the Accident. On the acceptance of a claim under this Benefit and any other applicable Benefit pertaining to the same event, all Benefit under this Policy shall immediately and automatically cease in respect of that Insured Person and no subsequent Renewals of the Policy will be allowed. Add on cover will not be renewed incase base bucket is exhausted	Under Section C 5.1.1
		Benefit 6: Permanent Total Disablement (PTD) Benefit:	Part III of Wordings
		We will pay the Sum Insured specified against this Benefit in the Policy Schedule in the manner specified in the Policy Schedule if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Total Disablement of the Insured Person within 365 days from the date of the Accident. Add on cover will not be renewed incase base bucket is exhausted	Under Section C 5.1.2
		Benefit 7 : Permanent Partial Disablement (PPD) Benefit:	Part III of Wordings
		We will pay the percentage of the specified Sum Insured in the manner specified in the policy wordings if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Partial Disablement of the Insured Person (which is of the nature specified in the table below) within 365 days from the date of the Accident. Add on cover will not be renewed incase base bucket is exhausted	Under Section C 5.1.3
		Section D : Value Added Services	
		1. **Tele-consultation:** We will arrange consultations and recommendations for any listed Critical illnesses under Annexure 1 by a qualified General Practitioner. For the purpose of this benefit Telephonic/Virtual consultation shall mean consultation provided by a qualified General Practitioner through various mode of communication like audio, chat or mobile app. The services provided under this Benefit will be made available subject to the terms and conditions, and in the manner prescribed below: • The General Practitioner may suggest /recommend /prescribe over the counter medications based on the information provided, if required on a case to case basis. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional*. • This service will be available 24 hours a day, and 365 days in a year.	Part III of Wordings Under Section D 6.1

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Toll free no : 1800 2666
Alternate no : 86552 22666 (chargeable)
E-mail : customersupport@icicilombard.com
Website : www.icicilombard.com

		• The General Practitioner may refer the Insured Person to a specialist or a general physician, if required**, and the charges for such specialist or a general physician will have to be borne by the Insured Person. • We shall not be liable for any discrepancy in the information provided under this Benefit. • Choosing the services under this Benefit is purely upon the customer's own discretion and at own risk. • You will be eligible to avail maximum of 4 tele-consultation per policy period. • The insured will be able to use this service only with respect to the listed Critical Illnesses under Annexure 1. • This benefit will lapse incase not used during the policy tenure *The proposer should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If the Insured person has any concerns about His/ her health, He/ She may consult His/ her general practitioner. **Consultations charges would be applicable. 2. **E-opinion (second opinion)** In the event of your diagnosis with any of the critical illness covered under your policy and during the policy period, we shall facilitate in arranging an E-Consultation second opinion from a super specialty medical practitioner within our Network with respect to that critical illness only, subject to the following condition. It will be based on the medical records submitted by the insured person which should include investigation reports citing the final diagnosis and relevant consultation papers. We will not be reimbursing/bearing the cost for E-opinion/consultation (second opinion). 3. **Health and Wellness Offers** **Health and Wellness Offers** on services/products provided by our network providers/ Health service providers – We shall only facilitate the Insured Person in availing offers and discounts on services/products offered by our network providers/ health service providers. Customer can avail **Health and Wellness Offers** on our app on various health, fitness and wellness products and other services available on the app. 4. **Health assistance:** We also provide Health Assistance as a part of Our Value added services, Our Health Assistance Team (HAT) will assist the Insured Person in understanding his/her health condition better by providing answers to any queries related to health and health care providers on Our dedicated helpline. To avail this service, the Insured Person may call Our helpline on 040-66274205 (please note that this number is subject to change). The services provided under this shall include: • Identifying a Physician/ Specialist • Scheduling an appointment with any Medical Practitioner empanelled with Us • Scheduling appointments for a second opinion	

		• Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable. • Providing preventive information on ailments • Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home. Please note that services provided under this Benefit are solely for assistance, and should not be construed to be a substitute for a visit/ consultation to an independent Medical Practitioner. This Benefit does not include the charges for any independent Medical Practitioner/nutritionist consulted on HAT's recommendation, and such charges are to be borne by the Insured Person. We do not accept any liability towards quality of the services made available by our network providers/ service providers and are not liable for any defects or deficiencies on their part While deciding to obtain such value-added service, You expressly note and agree that it is entirely for You to decide whether to obtain these services and also to decide the use (if any) to which these services is to be put for	
3	What are the major exclusions in the policy	**Please refer to the policy wordings for the complete list.** We shall not be liable under this Policy for payment for any claim in respect of an Insured person, caused by, arising from or in any way attributable to any of the following:	
		Section A: **Benefit 1 : Comprehensive Critical Illness**	Part III of Wordings
		1. Any Critical Illness where the symptoms indicative of such Critical Illness have first manifested or first occurred prior to the Risk Inception Date or arisen within the waiting period of 90/120/150 days as specified in the Policy Schedule at commencement of the Period of Cover. 2. Insured should survive for 0/3/7/14 days as mentioned in the Policy Schedule from the date of diagnosis and fulfilment of the critical illness definition(definitions mentioned in Annexure 1) before the claim benefit will be paid. 3. Any Critical Illness arising on account of or in connection with any Pre-Existing Disease(s). 4. Any Critical Illness or Surgery/Surgical Procedure arising out of any external Congenital Anomaly or internal Congenital Anomaly known at the commencement of the policy. 5. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under the head "Special Conditions". 6. Any claim made without a medical certificate from the treating Medical Practitioner evidencing the diagnosis of such Critical Illness. 7. Any Critical Illness traceable to pregnancy, childbirth, abortion, or related consequences.	Under Section A 1.2
		Section A: **Benefit 2: ICU Benefit (Add on)**	Part III of Wordings
		1. Any ICU hospitalization where the appearance of first (signs/symptom/diagnosis) of the infection or advice for surgery was done during or prior to the initial waiting period of 90/120/150 days (as specified on the Policy Schedule) shall not be considered payable under this Benefit. 2. We shall not consider any domiciliary/Home ICU care under this Benefit.	Under Section A 2.3

		3. We shall not consider ICU stay in an AYUSH hospital as payable for this Benefit 4. Any Critical Illness or Surgery/Surgical Procedure arising out of any external Congenital Anomaly or internal Congenital Anomaly known at the commencement of the policy. 5. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under the head "Special Conditions". 6. Any claim made without a medical certificate from the treating Medical Practitioner mandating the stay in ICU. 7. Any claim traceable to pregnancy, childbirth, abortion, or related consequences. 8. ICU admissions on account of Sterility/Infertility or any plastic surgery for cosmetic purpose. 9. ICU admission due 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. 10. ICU admission directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. 11. ICU admission on account of Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. 12. ICU admission on account of Intentional self-injury (whether arising from an attempt to commit suicide or otherwise) 13. Any ICU admission arising from or attributed to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority 14. Any ICU admission 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	
		Section A: **Benefit 3: Cancer Restore Benefit (Add On)**	Part III of Wordings
		• No claim shall be payable within the waiting period of 3 years from the date of diagnosis of first Major Cancer. • In the event of death of the insured during the 3 years waiting period, the claim shall not be payable.	Under Section A 3.2
		Section B: **Benefit: 4: Major Surgical Procedures (Add On)**	Part III of Wordings
		1. Any covered Surgery/Surgical Procedure arising out of an Illness diagnosed/contracted prior to Risk Inception Date or arising within the waiting period of 90/120/150 days as specified in policy schedule. However, no Waiting Period will be applicable in case of any Surgical Procedure arising out of/due to an Accident during the Period of Cover. 2. Any Surgery/Surgical Procedure arising out of an Accident which occurred prior to Risk Inception Date. 3. Any Pre-Existing Disease(s) or any disability arising out of a Pre-Existing Disease or any complication arising therefrom.	Under Section B 4.2

		4. Any Critical Illness or Surgery/Surgical Procedure arising out of any external Congenital Anomaly or internal Congenital Anomaly known at the commencement of the policy. 5. Any of the covered Surgery/Surgical Procedure performed which was otherwise deemed unnecessary, or against standard health practices. 6. Any Unproven/Experimental treatment. 7. Any Surgery/Surgical Procedure performed solely due to cosmetic or aesthetic reasons. 8. Any claim made without a medical certificate from the treating Medical Practitioner evidencing the diagnosis of such Illness or Injury or the undergoing of the medical / Surgical Procedure.	
		Section C: Personal Accident (Add On) **Benefit 5: Accidental Death Benefit** **Benefit 6: Permanent Total Disablement (PTD) Benefit:** **Benefit 7 : Permanent Partial Disablement (PPD) Benefit:**	Part III of Wordings
		1. War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft. 2. Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution, except to the extent it is expressly covered under any Benefit 3. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world. 4. Breach of law/ statutory provisions or while being involved in any unlawful activity. 5. Any Injury / Illness arising from full-time involvement in professional sports for livelihood and remuneration, except to the extent it is expressly covered under any Benefit. 6. Any Injury / Illness arising from intentional self- Injury, suicide or attempted suicide. 7. Any Injury / Illness arising from a failure to take reasonable precautions to avoid a claim under the Policy. 8. Any Injury / Illness arising whilst under the influence of alcohol or intoxicating drugs or substance abuse of any kind. 9. Any Injury / Illness occurring whilst working in underground mines or explosives magazines, or involving electrical installation with high tension supply, or as jockeys or circus personnel or any other high risk occupations. 10. Any Injury that has occurred prior to the commencement of Policy of Benefit whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought. 11. Any Illness, complication or ailment not arising out of or connected to Injury. 12. Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization of the Insured Person resulting directly from, or indirectly caused by, or contributed to or aggravated or prolonged by, childbirth or pregnancy or in consequence thereof. 13. Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization of Insured Person due to an insect or mosquito bite. 14. Death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization arising from or caused by ionizing radiation or contamination by radioactivity	Under Section C 5.2

		from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.	
		GENERAL EXCLUSIONS 1. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under the head "Special Conditions". 2. Any breach of the law by the Insured Person with a criminal intent. 3. War, invasion, act of foreign enemy, hostilities (whether war be declared or not) civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainment of citizens of whatever nation, riots or civil commotion. 4. Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution, except to the extent it is expressly covered under any Benefit. 5. Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from nuclear weapon materials or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission. 6. Use or misuse of intoxicating drugs and/or alcohol. 7. Participation (aggravation) in any kind of strike, processions, riots etc. 8. Any act of self-destruction or self-inflicted injury, attempted suicide or suicide and deliberate participation of the Insured in an illegal or criminal act with criminal intent. 9. Any Injury / Illness occurring whilst working in underground mines or explosives magazines, or involving electrical installation with high tension supply, or as jockeys or circus personnel 10. Any consequential or indirect losses or expenses related to any Insured Event. 11. Any tests and treatment relating to infertility and in vitro fertilization. 12. Any Injury / Illness occurring whilst engaging in any Adventure Sports, either as an instructor/ trainer, or as a participant. 13. Any natural peril (including but not limited to storm, tempest, avalanche, earthquake, volcanic eruptions, hurricane, or any other kind of natural hazard).	Part IV of Wordings
4	Waiting Period	Following Waiting Periods shall be applicable under the Policy, unless specified otherwise in the Policy Certificate. • Section A: Benefit 1 – 90/120/150 Days Benefit 2 – 90/120/150 Days Benefit 3 – There is a 3 Year waiting period from the date of first diagnosis of a major cancer • Section B: Benefit 4 – 90/120/150 Days • Section C: Benefit 5,6,7 – No Waiting Period	Part III of Wordings Section A Section B Section C & Policy Certificate
5	Payment Basis	• We shall make payment of an admissible claim to the Insured Person's nominee/assignee, as the case may be, or in the absence of an 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.	Part V of Wordings "Specific Terms and Conditions" Clause No.1 "Payments"

		• Any payment we make in this manner will be a complete and final discharge of our obligations under this Policy and Our liability towards the claim.	
6	Loss Sharing	NA	
7	Renewal Conditions	1. The Policy may be renewed by mutual consent under the then prevailing (ICICI Lombard Criti Shield Plus) Policy or its nearest substitute product (in case of product withdrawal) approved by the IRDAI, 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 Insured Event that occurs during the Grace Period. 2. Once the Sum Insured under any of the Benefits opted and available to the insured is exhausted any future renewal under that Benefit shall not be allowed. 3. 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. 4. Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts. We may, revise the Renewal premium payable under the Policy or the terms of Benefit, provided that all such changes are approved in accordance with the IRDAI rules and regulations as applicable from time to time. We will intimate You of any such changes at least 3 months prior to date of such revision or modification. 5. We shall not be bound to give any notice to You/ Insured Person that the premium for the Renewal is due. 6. Policyholder will not be allowed to make any changes in his/her policy coverage's, terms and conditions and Sum Insured at the time of renewal in case a claim has already been settled 7. Policyholder will not be allowed to make any changes in his/her policy coverage's, terms and conditions at the time of renewal, unless decided by Us on exceptional call or case to case basis 8. In the event where the base cover(s) has been exhausted the insured shall not be allowed to renew the add on cover(s) 9. The above conditions for Renewal are to be read in unison, and not standalone.	Part V of Wordings "Specific Terms and Conditions" Clause No. 2 "Terms of Renewal"
8	Renewal Benefits	No Waiting Periods shall be applicable in case of subsequent Renewals, subject to no Break In Policy.	Part I of Wordings "General Definitions" Definition No. 23 "Waiting Period"
9	Cancellation	1. 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. 2. We shall from the date of receipt of the notice cancel the Policy, retain the premium for the period this Policy has been in force, and refund at Our short period scales as per the Refund Grid provided below, provided that no refund of premium shall be made if any claim has been made under the Policy by or on behalf of the Insured Person. 3. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Insured Person where any Claim has been admitted by Us or has been lodged with Us or any Benefit has been availed by the Insured Person under the Policy. 4. In case of a cancellation request by You/ Insured Person, the Policy will be cancelled in its entirety, and any selected Benefits or Sections under the Policy cannot be cancelled. 5. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the	Part V of Wordings "General Terms and Conditions" Clause No. 6 "Cancellation/ Termination"

		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. 6. For any cancellation initiated by Us, due to any other reason the company may choose to refund the premium on pro-rata basis.	
10	Claims	• 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, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document. • 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. • 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 email us at customersupport@icicilombard.com • Along with the completed and signed Claim form, provide all the relevant documents, specified within the relevant Section of the Policy for the Benefit being claimed, must be submitted in full 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. • Customer to send documents to Us at :- ICICI Lombard General Insurance Company Limited ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, Andhra Pradesh- 500032 • 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. • 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-limits, if any, and as specifically defined in Policy Schedule. • The role of the TPA (if any) would be limited to facilitate the flow of information between Us and the Insured Person.	Part V of Wordings "Standard General Terms and Clauses" Clause No. 3 :Claim Settlement" & "Specific Terms and Conditions" Clause No. 3 "Claim Procedure"
11	Policy Servicing/ Grievances/Complaints	• Call Us at toll free number: 1800 2666 or email us at customersupport@icicilombard.com If You are not satisfied with the resolution then You may successively write to 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	Part V of Wordings "General Terms and Conditions" Clause No. 15 "Redressal of Grievances"

		• If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance. • Please refer to the policy wordings for the details of Insurance Ombudsman.	
12	Insured's Rights	The insured person shall be allowed free look period of fifteen days (30 days when policy is sourced 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. • If the insured has not made any claim during the Free Look Period, the insured shall be entitled to • 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 • 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 • Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period • The Policy can be cancelled only if no claims have been made under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. • In case the request for cancellation comes 15 days after the receipt of Policy by the Insured Person, We would refund the premium paid as per the applicable refund grid provided in the Cancellation clause of the Policy. • 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, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document. • 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. • 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. • 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-limits, if any, and as specifically defined in Policy Schedule.	Part V of Wordings "General Terms and Conditions" & Clause No. 14 "Free look period" "Standard General Terms and Clauses" Clause No. 3 :Claim Settlement" & "Specific Terms and Conditions" Clause No. 3 "Claim Procedure"
13	Insured's Obligations	• Please disclose all material information (Including Pre-existing illnesses) before buying the Policy. • The Policy shall be null and void and no Benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or on non-disclosure in any material particular in the proposal form, personal statement,	Part V of Wordings "General Terms and Conditions" "Standard General Terms and Clauses"

		declaration and connected documents, or any material information having been withheld. • Cooperation from the Insured/ Person claimant is solicited in providing all or sufficient documents as per the claims procedure in support of claim.	Clause No. 1 "Disclosure of Information"

Mailing Address:
601 & 602, 6th Floor, Interface 16,
New Linking Road, Malad (West)
Mumbai - 400 064
Registered Office Address:
ICICI Lombard House, 414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple, Prabhadevi,
Mumbai 400 025
Toll free no : 1800 2666
Alternate no : 86552 22666 (chargeable)
E-mail : customersupport@icicilombard.com
Website : www.icicilombard.com

Benefit Illustration in respect of policies offered individual basis or family floater basis										
	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
Age of the members insured	Premium(Rs)	Sum Insured(Rs)	Premium(Rs)	Discount if any	Premium(After Discount)(Rs)	Sum Insured(Rs)	Premium or consolidated premium for all members of family(Rs)	Floater discount if any	Premium after discount(Rs)	Sum Insured(Rs)
3mon-20yrs	214	5,00,000	214	11	204	5,00,000	NA	NA	NA	NA
21 - 25 yrs	254	5,00,000	254	13	241	5,00,000	NA	NA	NA	NA
26 - 30 yrs	299	5,00,000	299	15	284	5,00,000	NA	NA	NA	NA
31 - 35 yrs	452	5,00,000	452	23	429	5,00,000	NA	NA	NA	NA
36 - 40 yrs	1,112	5,00,000	1,112	56	1,056	5,00,000	NA	NA	NA	NA
41 - 45 yrs	2,105	5,00,000	2,105	105	2,000	5,00,000	NA	NA	NA	NA
46 - 50 yrs	3,572	5,00,000	3,572	179	3,394	5,00,000	NA	NA	NA	NA
51 - 55 yrs	6,174	5,00,000	6,174	309	5,866	5,00,000	NA	NA	NA	NA
56 - 60 yrs	9,566	5,00,000	9,566	478	9,088	5,00,000	NA	NA	NA	NA
61 - 65 yrs	12,552	5,00,000	12,552	628	11,924	5,00,000	NA	NA	NA	NA
>65 yrs*	14,431	5,00,000	14,431	722	13,710	5,00,000	NA	NA	NA	NA
Total Premium for all members of the family is Rs. 965/-, when each member is covered separately. Sum Insured available for each individual is 500000/-**			Total Premium for all members of the family is Rs. 917/-, when each member is covered separately. Sum Insured available for each individual is 500000/-**				NA			
Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. The premium rates are exclusive of taxes applicable										
Plan considered above is Cancer Shield plan without any Add on cover for 1 year policy tenure has been opted. Waiting period considered here is 90 days and 0 days Survival period										
1. The above Illustration is considering primary applicant to be 35yrs of age, spouse 30yrs of age and child 10yrs of age. If they opt for individual policies the total base premium would be 965/-. Incase Multi Life option is chosen 917/-. 2.**The above illustration is considering an equal Sum Insured for entire family, however the Sum Insured offered to spouse/child will be as per the company's UW guidelines. 3. *Premium rates are for renewal only. 4. Please refer rate chart for more details										

ICICI Lombard Criti Shield Plus

PREAMBLE

ICICI Lombard General Insurance Company Limited (“We / Us”), having received a Proposal and the premium from the Proposer named in Part I of the Policy (hereinafter referred to as the “Policy Schedule”) and the said Proposal and Declaration together with any statement, report or other document leading to the issue of this Policy and referred to therein having been accepted and agreed to by Us and the Proposer as the basis of this contract do, by this Policy agree, in consideration of and subject to the due receipt of the subsequent premiums, as set out in the Policy Schedule, and further, subject to the terms and conditions contained in this Policy that on proof to Our satisfaction of the compensation having become payable as set out in the Policy Schedule to the title of the said person or persons claiming payment or upon the happening of an event upon which one or more benefits become payable under this Policy, the Annual Sum Insured / appropriate benefit amount will be paid by Us.

Part II of Schedule: Policy Wordings

I GENERAL DEFINTIONS

Standard Definitions

1. Accident: An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. Any one illness: Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

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

   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company’s authorized representative.

4. Cashless 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.

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

6. Congenital Anomaly: 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 Congenital anomaly which is not in the visible and accessible parts of the body.
   b) External Congenital Anomaly Congenital anomaly which is in the visible and accessible parts of the body

7. Day Care Centre: A 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.

8. Day Care Treatment: Day care treatment means medical treatment, and/or surgical procedure which is:
   i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
   ii. which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

9. Disclosure to information norm: 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.
10. Domiciliary Hospitalization: Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

11. Emergency Care: 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.

12. Grace Period: 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.

13. Hospital: A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under: i) has qualified nursing staff under its employment round the clock; ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places; iii) has qualified medical practitioner(s) in charge round the clock; iv) has a fully equipped operation theatre of its own where surgical procedures are carried out; v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

14. Hospitalization: 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.

15. Illness: Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
    (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    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

16. Injury: 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.

17. Inpatient Care: Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

18. Intensive Care Unit: 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.

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

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

21. Medical Expenses: 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.

22. Medical Practitioner: Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The registered practitioner should not be the insured or close member of the family.

23. Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i) is required for the medical management of the illness or injury suffered by the insured;
    ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii) must have been prescribed by a medical practitioner;
    iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

24. Migration: Migration means, the right accorded to individual health insurance policyholders (including all member under family cover and members of group health insurance

policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with same insurer.

25. Network Provider: 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.

26. New Born Baby: Newborn baby means baby born during the Policy Period and is aged upto90 days.

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

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

29. OPD treatment: 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.

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

31. Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that: i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

32. Pre-Existing Disease: 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
    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.

33. Pre-hospitalization Medical Expenses Pre-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

35. Reasonable and Customary Charges: Reasonable and Customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

36. Renewal: 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.

37. Room Rent: Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

38. Surgery or Surgical Procedure: 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.

39. Unproven/Experimental treatment: 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

Specific Definitions:

1. Admission means admission of the Insured Person in a Hospital as an in-patient for the purpose of medical treatment of an Injury and/or Illness, for a minimum duration of 24 hours.

2. Adventure Sport means sports/activities including but not limited to Sky Diving, Bungee Jumping, Bungee swoop, Bungee slingshot, Dune sliding, Hot air ballooning, Bridge Swinging, Zip Lining, Zip Trekking, Rock Climbing, Bicycle Polo, Bamboo rafting, Rock Scrambling, Rappelling, Via Ferrata, Fell Running, Fell Walking, Gorge Walking, Indoor Rock Climbing, Mountain Biking, Mountaineering, Body Boarding, Sailing, Ski boarding, Scuba Diving, Snorkeling, Shark Diving, Sky Diving, Swimming with Dolphins, Banana boating/donuts/inflatable's behind power boat Diving with Whales, Wakeboarding, Surfing, Auto (car) racing, Motor rallying, Motorcycle racing, Air racing, Kart racing, Boat racing, Hovercraft racing, Lawn mower racing, Snowmobile racing, Zorbing, and Truck racing.

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

4. Break In Policy means the period that occurs at the end of the existing policy term, when the premium due for Renewal on a given Policy is not paid on or before the

premium Renewal date, or within 30 days thereof. In case of Premium collected on Installment basis the grace period is 7 days.

5. Common Carrier shall mean to include any commercial public airline, railway, bus, or water borne vessel carrying fare paying passengers and licensed by the appropriate authority for transportation of passengers

6. Family means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

   i. Legally wedded spouse.
   ii. Dependent Children (i.e. natural or legally adopted) between 3months of age to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage.

7. Financial Institution shall have the same meaning assigned to the term under Section 45-I of the Reserve Bank of India Act, 1934, and shall include a Non-Banking Financial Company as defined under Section 45-I of the Reserve Bank of India Act, 1934.

8. First Diagnosis shall mean the point in time at which the requirements of any Critical Illness under this Policy were first satisfied with respect to the Insured Person, including the availability of the test reports and medical reports evidencing such diagnosis and confirmed by a medical practitioner

9. Infection: means an invasion of human body by pathogenic microorganisms including bacteria, viruses, parasites and fungi.

10. Income means and includes the amount that the Insured Person earns each month from his/her Primary Occupation.

    For Salaried Individuals, this would mean salary including regular bonuses, regular commissions, superannuation contributions or any other allowances, any Benefits explicitly mentioned in CTC (Cost to Company) or any compensation structure provided to the Insured Person by his/her employer for the financial year, or as declared in the previous ITR (Income Tax Return) filed by the Insured Person. For self-employed individuals having an ownership in a business, or operating as a sole trader or under a partnership, company or trust, Income will be considered as the gross annual income (before tax) filed before the relevant tax authorities in the previous assessment year.

11. Insured Event means any event or occurrence specifically mentioned as covered under this Policy for which applicable premium has been received by Us.

12. Insured Person means the individual(s) whose name(s) are specifically appearing under the heading “Insured name” in the Policy Schedule to the Policy, and for whom the Insured Events are covered in lieu of the applicable premium received by Us under the Policy.

13. Loan means the sum of money lent at interest or otherwise to the Insured Person by any Financial Institution, as identified by a Loan Account Number. .

14. Nominee means the person(s) nominated by the Insured Person to receive the applicable Benefits under this Policy payable in the event of death of the Insured Person caused by any Critical Illness or Surgical Procedure defined and specified under the Policy. For the purpose of avoidance of doubt it is clarified that if the Nominee is a minor, the legal guardian appointed by the Insured Person will take care of any relevant proceedings.

15. Permanent Total Disablement means any of the following:

    i. Total and irrevocable loss of sight in both eyes, and
    ii. Total and irrevocable physical separation of two entire hands or two entire feet, or
    iii. Total and irrevocable loss of one entire hand and one entire foot, or
    iv. Total and irrevocable loss of sight of one eye and physical separation of one entire hand or physical separation of one entire foot, or Total and irrevocable loss of use of two hands or two feet, or
    v. Total and irrevocable loss of use of one hand and one foot, or
    vi. Total and irrevocable of loss of sight of one eye and loss of use of one hand or one foot. For the purpose of this definition:
      i. Physical separation of a hand or foot means separation of the hand at or above the wrist, and of the foot at or above the ankle.
      ii. Loss of use or Loss of sight means total paralysis of one or more limb, or loss of vision respectively, which is certified in writing by a Medical Practitioner to be permanent, complete and irreversible and substantiated by physical examination and investigation to be permanent, complete and irreversible.

16. Policy Period means the period commencing from the Policy Start Date and ending at the Policy End Date as specifically appearing in the Policy Schedule, inclusive of both dates. It is the duration in which the policy is valid and the Insured Person is liable to get a claim subject to any applicable waiting Periods and the terms and conditions under this Policy.

17. Public Authority means any governmental or quasi-governmental organization, statutory body, or duly authorized organization which exercises autonomous authority in a regulatory or supervisory capacity.

18. Risk Inception Date means the date of commencement of the Period of cover, as specified in the Policy Schedule for the Insured Person.

19. Salaried Individuals means those Insured Persons who work as an employee or a worker, with government or private organization, whether confirmed or on probation as on the Risk Inception Date, and earn a fixed amount of compensation at a fixed frequency as salary.

20. Sum Insured means the amount specified in the Policy Schedule 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 Period of cover under that Benefit/set of Benefits.

21. Surgeon means a specialist Medical Practitioner who is fully qualified as per applicable law to practice Surgery/carry out Surgical Procedures in India.

22. Survival period- refers to the period from the diagnosis and fulfilment of the critical illness definition which the life assured or Insured Person must survive before the claim benefit will be paid

23. Waiting Period means a time-bound exclusion period related to condition(s) specified in the Policy Schedule which shall be served before a claim related to such condition becomes admissible. No Waiting Periods shall be applicable in case of subsequent Renewals, subject to no Break In Policy.

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

25. You/Your/Yours/Yourself means the person or the entity named as the policyholder in the Policy Schedule and who is responsible for payment of premium.

II. 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 in full (or first instalment, where the Premium payment in Instalment Clause is opted) in respect of the Insured Persons, and the terms, conditions and exclusions of this Policy.

The Policy Schedule will specify which of the following Benefits and Endorsements are applicable and in force for the Insured Person. Claims made in respect of an Insured Person for any Benefit applicable to the Insured Person shall be subject to the occurrence of the Insured Event during the Period of cover, availability of the Sum Insured specified against the Benefit claimed, applicable sublimits for such Benefit as may be specified in the Policy Schedule 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 coverage under each Benefit terminates in relation to an Insured Person(s) in the event of one or more claim(s) in respect of that Insured Person becoming admissible and accepted by Us to the extent of the Sum Insured specified against each Benefit in the Policy Schedule. Admitted claims will be payable to the Insured Person or the Nominee (as applicable).

III Benefits under Product

Section A: Critical Illness

1.1 Base Cover: Benefit 1: Comprehensive Critical Illness

This Benefit has been bucketed under 5 Critical Illness buckets. Each Bucket has further been divided into major and minor Critical Illness. If an Insured Person(s) is First Diagnosed with any of the Critical Illnesses from the bucket, based on the categorization We will pay the Sum Insured specified in the Policy Schedule against that bucket in the manner as described below.

In the event of any minor illness listed in Annexure 1 the company shall pay 25% of the Sum Insured subject to a maximum of 12.50lac, as specified in the Policy Schedule against that bucket. In the event of any major critical illness listed in Annexure 1 the company shall pay 100 % of the Sum Insured specified in the Policy Schedule against that bucket. In any scenario if a major illness is followed by a minor illness from the same bucket the company shall only pay the remaining 75% of the sum insured as specified against that bucket in the Policy Schedule .

The company shall only allow an insured to make one major critical illness claim and one minor Critical Illness claim from each of the buckets opted upto the exhaustion of the sum insured against that bucket.

Once the sum Insured has been exhausted against a bucket, it will cease and the policyholder shall not be allowed to renew that bucket in any subsequent renewals and only the remaining buckets if not exhausted up to their respective Sum Insured can be renewed in subsequent renewals

The policy holder cannot opt for any new bucket at the time of renewal

The Insured can claim independently from each of the critical illness bucket opted and specified in the Policy Schedule upto the Sum Insured specified against each of these buckets in the Policy Schedule subject to due receipt of premium(or premium instalment, incase premium payment in instalment clause is opted) as the case may be.

The list of minor and major conditions under each bucket and their definitions have been stated in **Annexure 1** of these wordings

Note:

The maximum payout against any minor Critical Illness under any Critical illness bucket is restricted to 25% of the base cover Sum Insured upto a maximum of 12.5lacs however for “Cardiac Arrhythmia with surgical intervention” and “Angioplasty ” the Sum Insured is further restricted to a maximum of 5lac

Illustration 1

Insured can opt for any of the Critical Illness bucket as per plans available at inception. The SI payable will be independent for each bucket if more than one bucket is selected.

e.g At policy inception if Mr. XYZ opts for all buckets-Cancer and blood disorders, Heart and Blood Vessel, Major Organs, Nervous System, Other Illness he can intimate a claim under all these buckets independently/simultaneously.

- Incase Mr. XYZ is diagnosed with Stroke resulting in permanent symptoms (Nervous System -Major) in 5th month, if the claim is payable as per policy Terms and Conditions we will pay 100% of SI allocated for Nervous System bucket.

- The Nervous System bucket will be exhausted and no renewal of this bucket will be allowed to the customer.
- In the 7th month Mr. XYZ is diagnosed with Pulmonary embolism (Heart and Blood Vessel -Minor)he can claim for 25% of SI from Heart and Blood Vessel bucket.
- Incase Mr. XYZ consequently suffers from a Myocardial Infarction (Heart and Blood Vessel -Major) we will pay balance 75% (since we have already paid minor claim of 25% under this bucket) once this claim has been paid the Heart and Blood Vessel bucket will be exhausted and no subsequent renewal will be done for this bucket.

Illustration 2:

Mr. PQR a 33yr old has opted for plan which has Heart and Blood Vessel bucket for 1 year Policy Tenure and 3lac SI for a base premium of 270/- . After the waiting period of the policy is over Mr. PQR is diagnosed with Other Serious Coronary Artery Diseases in the 5th month.

He is eligible to claim for 25% SI which is 75000/-. Now only 75% of the SI is remaining in Heart and Blood Vessel bucket.

At the time of renewal, we will be collecting the premium as per the original 100% of SI however our liability will be only towards the balance Sum Insured which is 75% of SI(in this example 225000).

1.2 Exclusions applicable to Section A: Benefit 1:

We shall not be liable to make any payment for any claim under Benefit 1 of 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:

a) Any Critical Illness where the symptoms indicative of such Critical Illness have first manifested or first occurred prior to the Risk Inception Date or arisen within the waiting period of 90/120/150 days as specified in the Policy Schedule at commencement of the Period of Cover.
b) Insured should survive for 0/3/ 7/14 days as mentioned in the Policy Schedule from the date of diagnosis and fulfilment of the critical illness definition (definitions mentioned in Annexure 1) before the claim benefit will be paid.
c) Any Critical Illness arising on account of or in connection with any Pre-Existing Disease(s).
d) Any Critical Illness or Surgery/Surgical Procedure arising out of any external Congenital Anomaly or internal Congenital Anomaly known at the commencement of the policy.
e) Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under the head “Special Conditions”.
f) Any claim made without a medical certificate from the treating Medical Practitioner evidencing the diagnosis of such Critical Illness.
g) Any Critical Illness traceable to pregnancy, childbirth, abortion, or related consequences.

1.3 Claim Documents for Section A: Benefit 1:

On the occurrence of an Insured Event which may give rise to a claim under this Benefit, We shall be provided with the necessary and mandatory information specified in A: Common documents required for all claims under this Benefit for all claims, within 30 days of occurrence of the Insured Event:

A: Common documents required for all claims under this Benefit:	
	Claim Form duly filled and signed by Insured Person/Nominee/claimant
	EMS Paper
	Discharge Card/Summary papers
	Indoor Case papers
	Hospital Bills
	All Investigation Reports – blood, pathology, radiology, etc.
	Certificate by treating Medical Practitioner confirming diagnosis
	Current and past consultation papers
	Certificate of Medical Cause of Death issued by last attending Medical Practitioner (wherever applicable)
	Certificate from last attending Medical Practitioner /medical authority for underlying medical condition/s leading to death of the Insured Person
	Post Mortem Report, FSL Report, Viscera and Chemical Analysis Report, Histopathoilogy Report (wherever applicable)
	Any other specific investigation / document to support the diagnosis of such Critical Illness, as may be reasonably required by Us in addition to the documents specified under this Section.
	Income Proof(ITR/Salary Slip,etc)

The Company shall seek for specific investigation reports depending on the nature of ailment. The list of the specific requirements will be shared with the insured/ nominee at the time of claim

2.1 Add on cover: Benefit 2: ICU Benefit

In the event of a hospital admission if an insured is admitted in ICU on account of any surgery or infection for a minimum of 5 or 7 days as specified in Policy Schedule the company shall pay the Sum Insured as specified against this Benefit on the Policy Schedule in consideration of payment of additional premium

The surgery or infection and the stay in the ICU must be directly due to the same cause and confirmed as necessary medical treatment.

2.2 Terms and conditions applicable to Benefit 2

- This Benefit is paid only once during the entire Policy Period.
- Once a claim has been paid under this Benefit the Benefit shall stand terminated and no subsequent renewals of this Benefit will be allowed.
- This Benefit shall be paid as a lump sum to the extent of Sum Insured specified in the Policy Schedule against this Benefit.
- This Benefit shall not reimburse any expenses incurred during the stay of the insured in the hospital(ICU) or any

expenses incurred prior or post hospitalization/ICU stay. We shall be liable to only pay the Sum Insured irrespective of the expenses incurred during the stay in the hospital.

- The 5 or 7 day stay in ICU(as specified in policy schedule) should form part of single hospitalization stay relating to insured peril.
- For ICU benefit cover: No Waiting Period will be applicable in case of ICU stay on account of any Surgery/infection arising out of/due to an Accident during the Period of Cover.
- The surgery or infection and the stay in the ICU must be directly due to the same cause and confirmed as necessary medical treatment.
- We will not consider a stay in ICU as necessary medical treatment if the insured can be safely and adequately treated in any other facility.
- This Benefit shall be payable subject to providing proof of Surgery or Infection to the satisfaction of the Company.
- All Procedures claimed should be confirmed as Medically Necessary, by a qualified Physician or Surgeon, to the satisfaction of the Company.
- The Stay in an ICU shall only be considered subject to the definition of ICU being met as defined above in the Policy Wordings and subject to the satisfaction of the Company.
- In the event of death in ICU the claim shall be considered payable subject to the insured having survived for minimum 3 days of continuous stay in ICU
- In the event where the base cover(s) has been exhausted the insured shall not be allowed to renew the add on cover(s)

2.3 Exclusions applicable to Section A: Benefit 2:

a) Any ICU hospitalization where the appearance of first (signs/symptom/diagnosis) of the infection or advice for surgery was done during or prior to the initial waiting period of 90/120/150 days (as specified on the Policy Schedule) shall not be considered payable under this Benefit.

b) We shall not consider any domiciliary/Home ICU care under this Benefit.

c) We shall not consider ICU stay in an AYUSH hospital as payable for this Benefit

d) Any Critical Illness or Surgery/Surgical Procedure arising out of any external Congenital Anomaly or internal Congenital Anomaly known at the commencement of the policy.

e) Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under the head “Special Conditions”.

f) Any claim made without a medical certificate from the treating Medical Practitioner mandating the stay in ICU.

g) Any claim traceable to pregnancy, childbirth, abortion, or related consequences.

h) ICU admissions on account of Sterility/Infertility or any plastic surgery for cosmetic purpose.

i) ICU admission due to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

j) ICU admission directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

k) ICU admission on account of Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

l) ICU admission on account of Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)

m) Any ICU admission arising from or attributed to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority

n) Any ICU admission 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

2.4 Claim Documents for Section A: Benefit 2:

	Documents required for claims under this Benefit:
	Claim Form duly filled and signed by Insured Person/Nominee/claimant
	EMS Paper
	Discharge Card/Summary papers
	Indoor Case papers
	Hospital Bills
	All Investigation Reports – blood, pathology, radiology, etc.
	Certificate by treating Medical Practitioner confirming diagnosis
	Current and past consultation papers
	Certificate of Medical Cause of Death issued by last attending Medical Practitioner (wherever applicable)
	Certificate from last attending Medical Practitioner /medical authority for underlying medical condition/s leading to death of the Insured Person
	Post Mortem Report, FSL Report, Viscera and Chemical Analysis Report, Histopathoilogy Report (wherever applicable)
	Any other specific investigation / document to support the diagnosis of such Critical Illness, as may be reasonably required by Us in addition to the documents specified under this Section.
	ICU admission papers
	Proof for advice on ICU admission by Medical practitioner
	Income Proof(ITR/Salary Slip,etc)

The Company shall seek for specific investigation reports depending on the nature of ailment. The list of the specific requirements will be shared with the insured/ nominee at the time of claim

3.1 Add on cover: Benefit 3: Cancer Restore Benefit

In consideration of payment of additional premium this cover pays the sum insured specified against this Benefit on account of a re diagnosed or recurred major cancer once a Major cancer (Cancer of Specified Severity) claim has already been considered and paid under this policy. A Waiting period of 3 years will be applicable from the date of diagnosis of the first Major Cancer (Cancer of Specified Severity) claim admitted under this policy.

The insured can claim under this Benefit only if he has opted for this Benefit 3 along with the Cancer Bucket under Benefit 1 at the time of first purchase of this policy subject to due receipt of premium by the company.

This Benefit 3 cannot be opted at the time of renewal or during the policy period

"Re-diagnosed Major Cancer" (Cancer of Specified Severity) means cancer for which any of the following conditions are met after the stipulated waiting period of 3 years from the date of diagnosis of the last Major Cancer(Cancer of Specified Severity) claim admitted under this policy.

- The Major Cancer(Cancer of Specified Severity) persists since first diagnosis;
- The Major Cancer(Cancer of Specified Severity) relapses, that is, though recovered temporarily (in remission), the same Major Cancer(Cancer of Specified Severity) recurs at the same organ as the preceding Major Cancer(Cancer of Specified Severity);
- Metastasis of the preceding Major Cancer (Cancer of Specified Severity) to other parts of the body; or
- The new Major Cancer (Cancer of Specified Severity) is unrelated to the preceding Major Cancer(Cancer of Specified Severity).

Re-diagnosed Major Cancer(Cancer of Specified Severity) must be confirmed by an oncologist on the basis of histopathological diagnosis. Clinical re-diagnosis of Cancer can only be adopted if histopathological diagnosis is medically not possible; in which case, the Insured must have medical documentary proof or record from a certificated oncologist of ongoing cancer therapy (including but not limited to radiotherapy or chemotherapy or surgery).

Ongoing preventive cancer therapy (including but not limited to Tamoxifen or Raloxifene) will not be accepted as a basis of clinical re-diagnosis.

The date of diagnosis of Re-diagnosed Major Cancer (Cancer of Specified Severity) refers to the date of the histopathological report.

If histopathological diagnosis is medically not possible; the date of diagnosis of Re-diagnosed Major Cancer(Cancer of Specified Severity) refers to the date of documentary proof or record from a certificated oncologist of ongoing cancer therapy (including but not limited to radiotherapy or chemotherapy or surgery).

The rediagnosed cancer must meet the definition of "Cancer of specified severity" as stated in the policy wordings

This feature is only applicable only once during the entire policy period Once the Cancer restore Benefit feature has been utilised and exhausted, this Benefit terminates and no subsequent renewal of Cancer Bucket under Benefit 1 and of this Benefit 3 will be allowed

3.2 Exclusions applicable to Section A: Benefit 3:

a) No claim shall be payable within the waiting period of 3 years from the date of diagnosis of first Major Cancer(Cancer of Specified Severity).
b) In the event of death of the insured during the 3 years waiting period the claim shall not be payable.

3.3 Claim Documents for Section A: Benefit 3:

Claim Form duly filled and signed by Insured Person/Nominee/claimant
EMS Paper
Discharge Card/Summary papers
Indoor Case papers
Hospital Bills
All Investigation Reports – blood, pathology, radiology, etc.
Certificate by treating Medical Practitioner confirming diagnosis
Current and past consultation papers
Certificate of Medical Cause of Death issued by last attending Medical Practitioner (wherever applicable)
Certificate from last attending Medical Practitioner /medical authority for underlying medical condition/s leading to death of the Insured Person
Post Mortem Report, FSL Report, Viscera and Chemical Analysis Report, Histopathoilogy Report (wherever applicable)
Any other specific investigation / document to support the diagnosis of such Critical Illness, as may be reasonably required by Us in addition to the documents specified under this Section.
All histology/cytology/FNAC/Biopsy/Immuno-chemistry reports, X-ray, CT Scan, MRI, PET Scan, Bone Marrow Test, Cancer Markers, all other pathological tests

Income Proof(ITR/Salary Slip,etc)

The Company shall seek for specific investigation reports depending on the nature of ailment. The list of the specific requirements will be shared with the insured/ nominee at the time of claim

Illustration 3:

Mr. RST a 40yr old male has opted for plan which has 'Cancer and blood disorders' bucket and add on 'Cancer Restore Benefit' for 1 year tenure for 5lac SI with base premium as 970/- & 340/- for 'Cancer and blood disorders Bucket' and 'Cancer Restore Cover' respectively. After the initial waiting period Mr. RST is diagnosed with Major Cancer (Cancer of Specified severity),after evaluation of required documents we pay the major claim with 100% payout of 5 lac sum insured. Since the customer has opted for cancer restore benefit he will be eligible to claim under this benefit provided the customer renews this policy subject to having received the premium for the 'Cancer and blood disorders' bucket under benefit 1 and cancer restore benefit as per the original Sum Insured and age at the time of renewal. Mr. RST is diagnosed with Cancer relapse after the 3 years waiting period he will be eligible to claim for 'Cancer Restore' Benefit.

4.1 Section B: Add on cover : Benefit: 4: Major Surgical Procedures

In consideration of payment of additional premium if the Insured Person is Hospitalized on the written advice of the treating Medical Practitioner due to an Illness contracted or any Injury sustained during the Period of Cover, and is advised by a Medical Practitioner qualified as a Surgeon to undergo a Surgical Procedure specified in Annexure 2 of this Policy and has undergone the surgery, then We will pay the percentage of the Sum Insured as a lumpsum (specified against this Benefit in the Policy Schedule) in the manner specified in the Annexure 2 for each of the listed surgeries.

This Benefit shall be payable subject to the following:

1. We will consider more than one claim in respect of the Insured Person under Section B Major Surgical Procedure of the Policy), subject to the availability of the Sum Insured as specified in the Policy Schedule against Section B, and provided that the Illness/Accident causing the Injury is distinct and unrelated for each such claim. On exhaustion of the Sum Insured, the Benefit under this Benefit will terminate in relation to the Insured Person.
2. Once a claim has been considered admissible and payable by Us under this Benefit and Sum Insured has been exhausted no subsequent Renewal of this Cover will be allowed
3. In case of multiple Surgeries/Surgical Procedures performed in a single Admission to a Hospital, or arising out of the same Illness/Injury, We will pay the amount specified against only one such Surgical Procedure, having the higher payout
4. 24 hours of continuous and completed Hospitalization is mandatory for any claim to be admissible.
5. In case the customer has opted for both Comprehensive Critical Illness and Major Surgical Procedures Benefit, in a scenario where the customer is covered for a surgical procedure under both these Benefits the company, shall be liable to pay under either of the Benefits whichever is having a higher payout and the Insured shall not be eligible to claim for it in the future.
6. Add on cover will not be renewed incase all Critical Illness buckets under base cover are exhausted

4.2 Exclusions applicable to Section B: Benefit 4 :

We shall not be liable to make any payment for any claim under Benefit 4 of 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:

a) Any covered Surgery/Surgical Procedure arising out of an Illness diagnosed/contracted prior to Risk Inception Date or arising within the 90/120/150 days waiting period as specified in policy schedule. However, no Waiting Period will be applicable in case of any Surgical Procedure arising out of/due to an Accident during the Period of Cover
b) Any Surgery/Surgical Procedure arising out of an Accident which occurred prior to Risk Inception Date.
c) Any Pre-Existing Disease(s) or any disability arising out of a Pre- Existing Disease or any complication arising therefrom.
d) Any Critical Illness or Surgery/Surgical Procedure arising out of any external Congenital Anomaly or internal Congenital Anomaly known at the commencement of the policy.
e) Any of the covered Surgery/Surgical Procedure performed which was otherwise deemed unnecessary, or against standard health practices.
f) Any Unproven/Experimental treatment.
g) Any Surgery/Surgical Procedure performed solely due to cosmetic or aesthetic reasons.
h) Any claim made without a medical certificate from the treating Medical Practitioner evidencing the diagnosis of such Illness or Injury or the undergoing of the medical / Surgical Procedure.

Illustration 4:

Ms. PQR has opted for plan which has Cancer bucket and add on Section B: Major Surgical Procedures. After the initial waiting period she undergoes Pericardectomy.
She is eligible to claim for 50% payout under Major Surgical Procedures(Add on Cover).

Subsequently she has to undergo Amputation of Leg she will be eligible to claim for 100% payout under Major Surgical Procedure, however as we have already honoured a 50% claim on account of Pericardiactomy now she will be eligible to claim for balance 50% only.

Hence we will be honouring 50% payout here subject to policy terms and conditions

4.3 Claim Documents for Section B:Benefit 4:

Claim Documents On the occurrence of an Insured Event which may give rise to a claim under this Benefit, We shall be provided with the following necessary and mandatory information and

documentation specified in relation to the Benefit being claimed within 30 days of occurrence of the Insured Event:

1. Duly filled claim form and signed by the Insured Person or claimant
2. Scan copy of original Hospital discharge summary
3. All pre and post-Surgery investigation reports/scans
4. Scan copy of original Policy copy
5. Consultation papers of the surgeon advising for the Surgical Procedure
6. If the claim amount is more than ₹1 lakh, AML Documents - Pan Card Copy, Residence Proof, and 2 passport sized color photos of Insured Person/claimant
7. Cancelled cheque and NEFT mandate form - duly filled in by the Insured Person/claimant
8. All post Hospitalisation, consultation or treatment details and documents.
9. Copies of Indoor case papers from the Hospital
10. Income Proof(ITR/Salary Slip,etc)

5.1 Section C: Add on Cover: PERSONAL ACCIDENT

Our maximum, total and cumulative liability for claims arising in respect of the Insured Person during the Period of Cover under Benefit 5, Benefit 6, and Benefit 7 under Section C, shall be the Sum Insured as specified against this set of Benefits in the Policy Schedule.

5.1.1 Benefit 5: Accidental Death Benefit:

We will pay the Sum Insured specified against this Benefit in the Policy Schedule in the manner specified in the Policy Schedule if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's death within 365 days from the date of the Accident. On the acceptance of a claim under this Benefit and any other applicable Benefit pertaining to the same event, all Benefit under this Policy shall immediately and automatically cease in respect of that Insured Person and no subsequent Renewals of the Policy will be allowed.

Add on cover will not be renewed incase base bucket is exhausted

5.1.2 Benefit 6: Permanent Total Disablement (PTD) Benefit:

We will pay the Sum Insured specified against this Benefit in the Policy Schedule in the manner specified in the Policy Schedule if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Total Disablement of the Insured Person within 365 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. If the Insured Person dies inconsequence to the accident event before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be considered under Benefit 5, if in force for the Insured Person.

ii. If the Insured Person suffers Injuries resulting in more than one of the Permanent Total Disablements, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.

iii. If We have admitted a claim for Permanent Total Disablement in accordance with this Benefit, then We shall not be liable to make any payment under the Policy under Benefit 5 on the death of the Insured Person, if the Insured Person subsequently dies.

iv. We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all Benefit under this Benefit in respect of the Insured Person shall immediately and automatically cease.

v. On the acceptance of a claim under this Benefit, this Benefit will terminate and no subsequent renewal of this Benefit will be allowed

vi. Add on cover will not be renewed incase base bucket is exhausted

vii. This benefit has been capped at flat 1lac Sum Insured for less than 10 yrs of age

5.1.3 Benefit 7: Permanent Partial Disablement (PPD) Benefit:

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Schedule) in the manner specified in the table below if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Partial Disablement of the Insured Person (which is of the nature specified in the table below) within 365 days from the date of the Accident.

For the purpose of this Benefit, Permanent Partial Disablement means total and/or partial irreversible loss of use or the actual loss by physical separation of the body parts as specified in the table below

PPD Table:

Sr No.	LOSSES COVERED	% OF SUM INSURED payable
1	Loss of one entire hand	70
2	Loss of one entire foot	70
3	Loss of use of one eye	50
4	Loss of all toes	20
5	Loss of great toe - both phalanges	5
6	Loss of great toe - one phalanx	2
7	Other than great toe if more than one toe lost each	5
8	Loss of use of both ears	75
9	Loss of use of one ear	30
10	Loss of four fingers and thumb of one hand	40
11	Loss of four fingers	35
12	Loss of thumb - both phalanges	25
13	Loss of thumb - one phalanx	10
14	Loss of index finger - three phalanges	10
15	Loss of index finger - two phalanges	8

16	Loss of index finger - one phalanx	4
17	Loss of middle finger - three phalanges	6
18	Loss of middle finger - two phalanges	4
19	Loss of middle finger - one phalanx	2
20	Loss of ring finger - three phalanges	5
21	Loss of ring finger - two phalanges	4
22	Loss of ring finger - one phalanx	2
23	Loss of little finger - three phalanges	4
24	Loss of little finger - two phalanges	3
25	Loss of little finger - one phalanx	2
26	Loss of metacarpus - first or second (additional)	3
27	Loss of metacarpus - third, fourth or fifth (additional)	2

This Benefit shall be payable subject to the following:

i. If the Insured Person dies in consequence to the accident event before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be considered under Benefit 5, if in force for the Insured Person.
ii. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.
iii. On exhaustion of Sum Insured, this Benefit shall terminate and cease to operate in relation to such Insured Person.
iv. Once a claim has been considered admissible and payable by Us under this Benefit, any subsequent Renewal of this this Benefit will be solely as per Our discretion, on a case to case basis.
v. Add on cover will not be renewed incase base bucket is exhausted
vi. This benefit has been capped at flat 1lac Sum Insured for less than 10 yrs of age, however claim will be payable in accordance to the above PPD table.

5.2 EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION C

We shall not be liable to make any payment for any claim under Section C 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:

a) War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.
b) Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution, except to the extent it is expressly covered under any Benefit
c) Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world.
d) Breach of law/ statutory provisions or while being involved in any unlawful activity.
e) Any Injury / Illness arising from full-time involvement in professional sports for livelihood and remuneration, except to the extent it is expressly covered under any Benefit.
f) Any Injury / Illness arising from intentional self- Injury, suicide or attempted suicide.
g) Any Injury / Illness arising from a failure to take reasonable precautions to avoid a claim under the Policy.
h) Any Injury / Illness arising whilst under the influence of alcohol or intoxicating drugs or substance abuse of any kind.
i) Any Injury / Illness occurring whilst working in underground mines or explosives magazines, or involving electrical installation with high tension supply, or as jockeys or circus personnel or any other high risk occupations.
j) Any Injury that has occurred prior to the commencement of Policy of Benefit whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought.
k) Any Illness, complication or ailment not arising out of or connected to Injury.
l) Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization of the Insured Person resulting directly from, or indirectly caused by, or contributed to or aggravated or prolonged by, childbirth or pregnancy or in consequence thereof.
m) Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization of Insured Person due to an insect or mosquito bite.
n) Death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

5.3 Claim documents applicable to Section C:

On the occurrence of an Insured Event which may give rise to a claim under this Section, We shall be provided with the following

necessary and mandatory information and documentation as specified in relation to the particular Benefit being claimed within 30 days of occurrence of the Insured Event:

Benefit 5 – Accidental Death Benefit

1	Duly filled claim form by the claimant
2	Scan of original policy report
3	MLC / FIR
4	Cause of Death Certificate
5	Death Certificate issued by the Government Authority
6	Post Mortem Report
7	Viscera / Chemical Analysis / Forensic Report
8	Police Final Charge sheet / Court Final Order
9	Spot Inquest / Panchnama
10	RACT award in case of rail accident
11	Indoor Case Papers
12	If the claim amount is more than ₹1 lakh, AML Documents - Pan Card Copy, Residence Proof, and 2 passport sized color photos of Insured Person/claimant
13	Cancelled cheque and NEFT mandate form - duly filled in by the Insured Person/claimant
14	Income Proof(ITR/Salary Slip,etc)

Benefit 6 – Permanent Total Disablement (PTD) Benefit

1	Duly filled claim form by the claimant
2	Scan of original policy report
3	MLC or FIR
4	Police Final Charge sheet / Court Final Order
5	Spot Inquest / Panchnama
6	Indoor Case Papers
7	Disability Certificate by Civil Surgeon / Government Hospital
8	Certificate from treating Medical Practitioner
9	RACT award in case of rail accident
10	Hospitalisation records and Discharge summary(wherever applicable)
11	If the claim amount is more than ₹1 lakh, AML Documents - Pan Card Copy, Residence Proof, and 2 passport sized color photos of Insured Person/claimant
12	Cancelled cheque and NEFT mandate form - duly filled in by the Insured Person/claimant
13	Income Proof(ITR/Salary Slip,etc)

Benefit 7 - Permanent Partial Disablement (PPD) Benefit

1	Duly filled claim form by the claimant
2	Scan of original policy report
3	MLC or FIR
4	Police Final Charge sheet / Court Final Order
5	Spot Inquest / Panchnama
6	Indoor Case Papers
7	Disability Certificate by Civil Surgeon / Government Hospital
8	Certificate from treating Medical Practitioner
9	If the claim amount is more than ₹1 lakh, AML Documents - Pan Card Copy, Residence Proof, and 2 passport sized color photos of Insured Person/claimant
10	Cancelled cheque and NEFT mandate form - duly filled in by the Insured Person/claimant
11	Income Proof(ITR/Salary Slip,etc)

Section D: Value Added Services

1. **Tele-consultation:**

We will arrange consultations and recommendations for any listed Critical illnesses under Annexure 1 by a qualified General Practitioner. For the purpose of this benefit Telephonic/Virtual consultation shall mean consultation provided by a qualified General Practitioner through various mode of communication like audio, chat or mobile app. The services provided under this Benefit will be made available subject to the terms and conditions, and in the manner prescribed below:

- The General Practitioner may suggest/recommend/prescribe over the counter medications based on the information provided, if required on a case to case basis. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional*.
- This service will be available 24 hours a day, and 365 days in a year.
- The General Practitioner may refer the Insured Person to a specialist or a general physician, if required**, and the charges for such specialist or a general physician will have to be borne by the Insured Person.
- We shall not be liable for any discrepancy in the information provided under this Benefit.
- Choosing the services under this Benefit is purely upon the customer's own discretion and at own risk.
- You will be eligible to avail maximum of 4 tele-consultation per policy period
- The insured will be able to use this service only with respect to the listed Critical Illnesses under Annexure 1.
- This benefit will lapse incase not used during the policy tenure

**The proposer should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If the Insured person has any concerns about His/ her health, He/ She may consult His/ her general practitioner.*

***Consultations charges would be applicable.*

2. **E-opinion (second opinion)**

In the event of your diagnosis with any of the critical illness covered under your policy and during the policy period, we shall facilitate in arranging an E-Consultation second opinion from a super specialty medical practitioner within our Network with respect to that critical illness only, subject to the following condition. It will be based on the medical records submitted by the insured person which should include investigation reports citing the final diagnosis and relevant consultation papers. We will not be reimbursing/bearing the cost for second E-opinion/consultation.

3. **Health and Wellness Offers:**

Health and Wellness Offers on services/products provided by our network providers/ Health service providers – We shall only facilitate the Insured Person in availing offers and discounts on services/products offered by our network providers/ health service providers. Customer can avail **Health and Wellness Offers** on our app on various health, fitness and wellness products and other services available on the app.

4. **Health assistance:**

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

The services provided under this shall include:

- Identifying a Physician/ Specialist
- Scheduling an appointment with any Medical Practitioner empanelled with Us
- Scheduling appointments for a second opinion
- Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.

Please note that services provided under this Benefit are solely for assistance, and should not be construed to be a substitute for a visit/ consultation to an independent Medical Practitioner. This Benefit does not include the charges for any independent Medical Practitioner/nutritionist consulted on HAT's recommendation, and such charges are to be borne by the Insured Person. We do not accept any liability towards quality of the services made available by our network providers/ service providers and are not liable for any defects or deficiencies on their part

While deciding to obtain such value-added service, You expressly note and agree that it is entirely for You to decide whether to obtain these services and also to decide the use (if any) to which these services is to be put for

IV GENERAL EXCLUSIONS:

We shall not be liable to make any payment for any claim under 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. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under the head "Special Conditions".

2. Any breach of the law by the Insured Person with a criminal intent.

3. War, invasion, act of foreign enemy, hostilities (whether war be declared or not) civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainment of citizens of whatever nation, riots or civil commotion.

4. Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution, except to the extent it is expressly covered under any Benefit.

5. Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from nuclear weapon materials or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission.

6. Use or misuse of intoxicating drugs and/or alcohol.

7. Participation (aggravation) in any kind of strike, processions, riots etc.

8. Any act of self-destruction or self-inflicted injury, attempted suicide or suicide and deliberate participation of the Insured in an illegal or criminal act with criminal intent.

9. Any Injury / Illness occurring whilst working in underground mines or explosives magazines, or involving electrical installation with high tension supply, or as jockeys or circus personnel

10. Any consequential or indirect losses or expenses related to any Insured Event.

11. Any tests and treatment relating to infertility and in vitro fertilization.

12. Any Injury / Illness occurring whilst engaging in any Adventure Sports, either as an instructor/ trainer, or as a participant.

13. Any natural peril (including but not limited to storm, tempest, avalanche, earthquake, volcanic eruptions, hurricane, or any other kind of natural hazard).

V. GENERAL TERMS AND CONDITIONS

i. Standard General Terms and Clauses

1. **Disclosure of Information**

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

"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**
   i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
   ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
   iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
   iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

4. **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 party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

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

6. **Cancellation/ Termination**

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

   ii. We shall from the date of receipt of the notice cancel the Policy, retain the premium for the period this Policy has been in force, and refund at Our short period scales as per the Cancellation Grid provided below, provided that no refund of premium shall be made if any claim has been made under the Policy by or on behalf of the Insured Person.

   iii. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Insured Person where any Claim has been admitted by Us or has been lodged with Us or any Benefit has been availed by the Insured Person under the Policy.

   iv. In case of a cancellation request by You/Insured Person, the Policy will be cancelled in its entirety, and any selected Benefits or Sections under the Policy cannot be cancelled.

   v. 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.

   vi. For any cancellation initiated by Us, due to any other reason the company may choose to refund the premium on prorata basis.

   vii. Cancellation Grid:

Time of cancellation	Policy Duration		
	1Yr	2Yrs	3Yrs
15 days - 30 days	77%	80%	82%
31 days - 90 days	62%	72%	77%
91 days - 180 days	42%	62%	70%
181 days - 270 days	20%	52%	62%
271 days - 365 days	0%	42%	55%
366 days - 455 days		30%	47%
456 days - 545 days		20%	42%
546 days - 635 days		10%	35%
636 days - 730 days		0%	27%
731 days - 820 days			20%
821 days - 910 days			12%
911 days - 1000 days			5%
Above 1000 days			0%

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 policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
   Migration benefit will be offered to the extent of sum of previous sum insured, this benefit shall not apply to any additional sum insured.

   For Detailed Guidelines on migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3986andflag=1

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987andflag=1

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=PageNo3986andflag=1
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987andflag=1

9. **Renewal of Policy**: The policy shall ordinarily be renewable except on misrepresentation by the insured person

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

   ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
   iii. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days
   iv. 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 installments**
If 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 Insurance, 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 If the instalment premium is not paid on due date

v. In case of instalment premium due not received within the grace period, the policy will get cancelled. We shall not be liable under this Policy for any loss occurring thereafter, including the intervening period, nor shall any refund of premium become due under the Policy. We shall not be bound to give any notice that such Premium Installment is due.

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

vii. We shall not be obligated to give any notice to the Insured Person/Policyholder for payment of premium installment, and will recover and deduct any or all the pending premium installments from the claim amount falling due under the Policy.

13. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

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(30days when policy is sourced 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.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

The Policy can be cancelled only if no claims have been made under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy.

In case the request for cancellation comes 15 days after the receipt of Policy by the Insured Person, We would refund the premium paid as per the applicable refund grid provided in the Cancellation clause of the Policy.

15. Redressal of Grievances:

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

Website: www. icicilombard.com (Customer Support section).
Toll free: 1800 2666
E-mail: customersupport@icicilombard.com
Fax : ……..

Courier: **ICICI Lombard General Insurance Company Ltd.**

ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai- 400025

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...

As per the IRDAI's guidelines on special provision for senior citizens, We will provide a separate channel for addressing grievances of Insured Persons who are senior citizens. You may avail the service by contacting the above mentioned toll free no and selecting suitable option provided on the Interactive Voice Response System (IVRS)

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.

If You are not satisfied with Our response or do not receive a response from Us within 15 days, You may approach the Grievance Cell of the Authority at:
Insurance Regulatory and Development Authority of India; Grievance Call Centre (IGCC) Toll Free No:155255 Email ID: complaints@irda.gov.in
Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/igms. irda.qov. in

You can also register Your complaint through fax/letter by submitting Your complaint to:
Consumer Affairs Department Insurance Regulatory and Development Authority of India; Sy No. 115/1 Financial

District Nanakramguda Gachibowli -500032 If the issue still remains unresolved,

You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.

The details of Insurance Ombudsman are available below:

S no .	Name of office of insurance Ombudsman	Territorial Area of jurisdiction
1	AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra and Nagar Haveli, Daman and Diu.
2	BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27- N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
3	BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
4	BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
5	CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 and 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana, Himachal Pradesh, Jammu and Kashmir, Chandigarh.
6	CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
7	DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi
8	ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
9	GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
10	HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 – 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
11	JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor,	Rajasthan.

	Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	
12	KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman and Nicobar Islands.
13	LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
14	MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai and Thane.
15	NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur
16	PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
17	PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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.

ii. Specific Terms and Clauses:

1. PAYMENTS

We shall make payment of an admissible claim to the Insured Person's Nominee/assignee, as the case may be, or in the absence of an 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 obligations under this Policy and Our liability towards the claim.

2. TERMS OF RENEWAL

- The Policy may be renewed by mutual consent under the then prevailing (ICICI Lombard Criti Shield Plus)Policy or its nearest substitute product (in case of product withdrawal) approved by the IRDAI, 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 Insured Event that occurs during the Grace Period.
- Once the Sum Insured under any of the Benefits opted and available to the insured is exhausted any future renewal under that Benefit shall not be allowed.
- 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.
- Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts. We may, revise the Renewal premium payable under the Policy or the terms of Benefit, provided that all such changes are approved in accordance with the IRDAI rules and regulations as applicable from time to time. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.
- We shall not be bound to give any notice to You/Insured Person that the premium for the Renewal is due.
- Policyholder will not be allowed to make any changes in his/her policy coverages, terms and conditions and Sum Insured at the time of renewal in case a claim has already been settled
- Policyholder will not be allowed to make any changes in his/her policy coverages, terms and conditions at the time of renewal, unless decided by Us on exceptional call or case to case basis and subject to fresh proposal form
- In the event where the base cover(s) has been exhausted the insured shall not be allowed to renew the add on cover(s)
- The above conditions for Renewal are to be read in unison, and not standalone.

3. CLAIM PROCEDURE:

- The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by 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 Benefit 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 Schedule or email us at customersupport@icicilombard.com
    - Along with the completed and signed Claim form, provide all the relevant documents, specified within the relevant Section of the Policy for the Benefit being claimed, must be submitted in full 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.
- 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.
- 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-limits, if any, and as specifically defined in Policy Schedule.
- The role of the TPA (if any) would be limited to facilitate the flow of information between Us and the Insured Person.

4. Incontestability and Duty of Disclosure :

The Policy shall be null and void and no Benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis description or on non-disclosure in any material particular in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or devices being used by the Insured Person or any one acting on his/her behalf to obtain any Benefit under this Policy.

5. Observance of terms and conditions

The due observance and fulfilment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by the Insured Person, shall be a condition precedent to Our liability to make any payment under this Policy.

6. Records to be maintained

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

7. No constructive Notice

Any knowledge or information of any circumstances or condition in relation to the Insured Person, or in connection with which a claim may be made under this Policy coming to the knowledge or possession of any of Our officials shall not be construed as notice to or be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

8. 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.

9. Special Provisions

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

10. Overriding effect of Part II of the Schedule

The terms and conditions contained herein and in Policy Schedule(Policy certificate or Certificate of Insurance) 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 Benefit contained in Policy Schedule, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of Benefit/terms and conditions contained in Policy Schedule and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

11. Electronic Transactions

The Insured Person agrees to adhere to and comply with all such terms and conditions as We may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, the world wide web, electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on Our behalf, for and in respect of the Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time. The Insured Person agrees that We may exchange, share or part with any information with any government institution or statutory body, as may be determined by Us and shall not hold Us liable for such use/application.

12. Right to inspect

In case of any loss or occurrence to the Insured Person that has given or may give rise to a claim under the Policy, If required by Us, Our agent/representative, including any loss assessor or surveyor/investigator or any individual or entity appointed on Our behalf shall be permitted at all reasonable times to examine the circumstances of such loss or occurrence. The Insured Person shall on being required to do so by Us, produce all books of accounts, receipts, documents relating to or containing entries relating to the loss or such circumstance in his/her possession and furnish copies of or extracts from such of them as may be required by Us so far as they relate to such claim(s), or may in any way assist Us to ascertain the correctness thereof or Our liability under the Policy.

13. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured Person and Us to be subject to Indian Law. Each party agrees to submit to the jurisdiction of the Courts in India and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

14. Arbitration clause

i. If any dispute or difference shall arise as to the quantum of claim to be paid under this Policy (liability/claim being otherwise admitted by the Insurer), such difference shall independently of all other question be referred to the decision of a sole arbitrator to be appointed mutually in writing by the Insurer and the Insured who has made claim under this Policy or if they cannot agree upon a single arbitrator within 30 days of any party [the Insurer or the and the Insured who has made claim under this Policy] invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators one to be appointed by the Insured who has made claim under this Policy and the Insurer, respectively, who are the parties to the dispute/ difference and the third arbitrator to be appointed by such two appointed arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation

Act, 1996 as amended from time to time. The law of the arbitration will be Indian law.

ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided if the Insurer has disputed or not accepted/admitted the liability/claim under the Policy.

iii. It is hereby expressly stipulated and declared that it shall be a Condition Precedent to any right of action or suit read with this Policy that the award by such arbitrator/ arbitrators of the amount of the benefits shall be first obtained

iv. It is also hereby further expressly agreed and declared that if the Insurers shall disclaim/repudiate the liability to the Insured for any claim under the Policy, and such claim shall not, within 12 calendar months from the date of such disclaimer/repudiation have been made the subject matter of a suit in a court of law, then all benefits under the Policy shall be forfeited and the rights of Insured shall stand extinguished and the liability of the Insurer shall also stand discharged.

15. 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 You, at the address specified in Policy Schedule, and in case of the Insured Person, at the Insured Person's address specified in the Policy Schedule.
In case of Us:
ICICI Lombard General Insurance Company Limited, ICICI Lombard House,
414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi,
Mumbai 400025, Toll-free number: 1800-2666
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.

16. 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.

You could also call us on Toll free No: 1800 2666 or E-mail: customersupport@icicilombard.com.

- 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).

VI OTHER TERMS AND CONDITIONS

1. **AGE LIMIT**
   The age of proposer: minimum and maximum age of entry for proposer into the Policy is 18 years and 65 years respectively
   Age of insured: minimum and maximum age of entry for an insured into the Policy is 3 months and 65 years respectively
2. In case You choose to pay the premium in instalments, then You shall not be able to change the frequency of payments within the Period of Cover
3. In case You have opted for auto renewal, the Policy shall be Renewed with the same terms and conditions including but not limited to the Sum Insured, coverage, premium paying terms and claim payment terms.
4. The scope of Benefit shall be worldwide unless specified otherwise.
5. Any change in the policy terms and conditions including but not limited to Sum Insured and/or coverage shall not be permitted within the policy period
6. Nationality: The policy can only be opted by Indian Nationality citizens or Non Residents of India holding an Indian Passport & account

VII ADDITIONAL CLAUSES AVAILABLE UNDER THIS POLICY

1. **Assignment clause**

It is hereby declared and agreed that upon due written consent granted by the Proposer as stated under the head of "Proposer name" in the Policy Schedule to the Policy:

i. Any amount becoming payable to the Insured Person in accordance with policy terms and conditions) including all rights, title, benefits and interest of the Insured Person under this Policy stand assigned in favour of the Financial Institution (assignee) specified in the Policy Schedule of the Policy with respect to only that Loan Account Number, as specified in the Policy Schedule.

ii. The receipt of such amount in the manner aforesaid by the Financial Institution (assignee) specified in the Policy Schedule of this Policy, shall completely discharge Us from all Our liability under the Policy in respect of such payable amount, and this shall be binding on the Insured Persons and their legal heirs, executors, administrators, and successors.

iii. This is to clarify that such assignment shall be subject to the condition that in the event of the Insured Person's death during the Period of Cover, the amounts payable as per the Policy terms and conditions will be paid to the said Financial Institution (assignee) only to the extent of the Loan amount outstanding, if any, and any amount in

excess after such payment shall be paid to the Insured Person's Nominee.

2. **Auto Renewal Clause**

a. On due consent by the Proposer We will automatically renew the Policy for the Period of Cover as opted by the Insured Person. However, after completing an 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.

b. Every Renewal premium shall be paid and accepted as per the terms of Renewal specified under this Policy and upon the distinct understanding that no alteration has taken place in the facts contained in the Proposal and Declaration Form herein before mentioned and that nothing is known to the Insured Person that may result to enhance the risk of We under the guarantee hereby given. Any change in the risk will be intimated to Us by the Policyholder/ Insured Person. Nothing herein or otherwise shall affect Our right to impose any additional terms and conditions on Renewal or restrict any Renewal terms as to premium or otherwise.

No Renewal receipt shall be valid unless it is on the printed form of Our and signed by Our authorized official.

3. **Increase/decrease in sum insured:**

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company subject to revised proposal form. For any increase in Sum Insurance, the waiting period and survival period if any shall start afresh only for the enhanced portion of the sum insured.

Annexure 1:

	Major(55)	**Minor(37)**
Cancer and blood disorders(4/1)		
	Cancer of Specified severity(Major Cancer)	Early stage cancer/Carcinoma-in- Situ
	Bone Marrow Transplant	
	Aplastic Anaemia	
	Primary Myelofibrosis	
Heart and Blood Vessel (10/11)		
	Takayasu Arteritis	Pulmonary Artery Graft Surgery
	Refractory Heart Failure	Cardiac Arrhythmia with surgical intervention(Sum Insured capped at 5 lacs)
	Eisenmenger's Syndrome	Other Serious Coronary Artery Diseases
	Myocardial Infarction (First Heart Attack - Of Specified Severity	Insertion of a Permanent Cardiac Defibrillator
	Cardiomyopathy of specified severity	Complete Heart Block or Third Degree Heart Block with pacemaker
	Open Chest CABG	Pericardectomy
	Open Heart Replacement Or Repair Of Heart Valves	Balloon Valvotomy or Valvuloplasty
	Surgery Of Aorta	Angioplasty (Sum Insured capped at 5 lacs)
	Primary (Idiopathic) Pulmonary Hypertension	Minimally Invasive Surgery to Aorta
	Infective Endocarditis	Pulmonary embolism
		Moderately Severe Cardiomyopathy
Major Organs(14/12)		
	Systemic Lupus Erythematous With Renal Involvement	Severe Acquired Or Secondary Pulmonary Alveolar Proteinosis (Pap)
	Rheumatoid Arthritis	Glomerulonephiritis with Nephrotic Syndrome
	Scleroderma	Moderately Severe Kidney Disease
	Good Pastures Syndrome With Lung or Renal Involvement	Moderately Severe Systemic Lupus Erythematous With Lupus Nephritis
	Myasthenia Gravis	Intestinal Gangrene
	End Stage Lung Failure	Portal Vein Thrombosis
	Kidney Failure Requiring Regular Dialysis	Surgical Removal of One Lung
	Medullary Cystic Kidney Disease	Moderately Severe Crohn's Disease
	Fulminant Hepatitis	Moderterly Severe Ulcerative Colitis.
	End Stage Liver Failure	Small bowel transplant
	Major Organ transplant	Ankylosing Spondylytis
	Severe Crohn's Disease	Surgical Removal of one kidney
	Severe Ulcerative Colitis	
	Chronic Relapsing Pancreatitis	
Nervous System(24/8)		

	Stroke Resulting in Permanent Symptoms	Loss of Hearing of One Ear
	Permanent Paralysis of Limbs	Loss Of Sight In One Eye
	Motor Neuron Disease With Permanent Symptoms	Dissolution of the nerve roots of Brachial Plexus
	Parkinson's Disease	Syringomelia or Syringobulbia Requiring Surgery
	Benign Brain Tumor	Carotid Artery Surgery
	Alzheimer's Disease	Loss of Use of One Limb
	Progressive Supranuclear Palsy	Idiopathic Scoliosis
	Multiple Sclerosis with Persisting Symptoms	Coma 72 Hours
	Creutzfeldt-Jakob Disease	
	Muscular Dystrophy	
	Coma of Specified Severity	
	Apallic Syndrome	
	Major Head Trauma	
	Guillain-Barre Syndrome	
	Deafness	
	Loss Of Speech	
	Blindness	
	Spinal Stroke	
	Benign Spinal Cord Tumour with Neurological Deficit	
	Poliomyelitis	
	Bacterial Meningitis	
	Encephalitis	
	Tuberculousis Meningitis	
	Severe Progressive Bulbar Palsy	
Other Illness(3/5)		
	Third Degree Burns	Elephantiasis
	Necrotising Fasciitis	Adrenalectomy for Adrenocortical Adenoma
	Pheochromocytoma	Wilson's Disease
		Optic Neuropathy
		Facial Reconstructive Surgery due to accident

Note:

The maximum payout against any minor Critical Illness under any Critical illness bucket is restricted to 25% of the base cover Sum Insured upto a maximum of 12.5lacs however for "Cardiac Arrhythmia with surgical intervention" and "Angioplasty" the Sum Insured is further restricted to a maximum of 5lac

Definitions:

1. Cardiomyopathy of specified severity

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association Classification Class IV, or its equivalent, based on the following classification criteria:

Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echocardiographic findings of compromised ventricular performance.

Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

2. Surgery of Aorta :

The actual undergoing of medically necessary major surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

Traumatic injury of the aorta is excluded.

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

3. Complete Heart Block or Third Degree Heart Block with pacemaker:

A specific kind of abnormality of heart beat (arrhythmia) characterized by complete cessation of transmission of electrical impulses to the ventricles (lower chambers) of the heart. The diagnosis of Complete Heart Block or Third Degree Heart Block must be made by a cardiologist and substantiated by findings in ECG suggestive of Complete Heart Block or Third Degree Heart Block .The insured must have undergone pacemaker insertion for treating Complete Heart Block.

4. Eisenmenger's Syndrome

Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a registered Medical Practitioner who is a specialist with echocardiography and cardiac catheterisation resulting in permanent physical impairment to the degree of New York Heart Association Classification Class IV, or its equivalent, based on the following classification criteria:

Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced.

5. Infective Endocarditis

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

• Positive result of the blood culture proving presence of the infectious organism(s);
• Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and
• The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a registered Medical Practitioner who is a cardiologist

6. Pulmonary Embolism

The medically necessary surgical insertion of a veno-caval filter after there has been documented proof of recurrent pulmonary emboli. The need for the insertion of a veno-caval filter must be certified to be absolutely necessary by a specialist in the relevant field.

7. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more
Activities of Daily Living.
This diagnosis must be confirmed by:
a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b. A consultant neurologist certifying the diagnosis of bacterial meningitis.

Activities of Daily Living are defined as :

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.

8. Encephalitis

Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 6 weeks, certified by a specialist Medical Practitioner (Neurologist)
The permanent deficit must result in permanent inability to perform three or more Activities of Daily Living.

Activities of Daily Living are defined as :

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.

9. Tuberculosis Meningitis

Meningitis caused by tubercle bacilli. Such a diagnosis must be supported by:
1) Findings in the cerebrospinal fluid (csf) report
2) Presence of acid fast bacilli in the cerebrospinal fluid or growth of M. Tuberculosis demonstrated in the culture report or Nucleic acid amplification tests like PCR
3) Certification by a registered doctor who is a specialist in neurology, or a physician with a degree of MD
The condition must have resulted in irreversible and permanent neurological deficit which persist for at least 6 weeks and resulting in permanent inability to perform three or more Activities of Daily Living.

Activities of Daily Living are defined as :

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.

10. Progressive Supranuclear Palsy

Confirmed by a registered doctor who is a specialist in neurology of a definite diagnosis of progressive supranuclear palsy.
The condition must have resulted in irreversible and permanent neurological deficit which persist for at least 6 weeks and resulting in permanent inability to perform three or more Activities of Daily Living.

Activities of Daily Living are defined as :

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.

11. Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

a. Rapid decreasing of liver size;
b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
c. Rapid deterioration of liver function tests;
d. Deepening jaundice; and
e. Hepatic encephalopathy.

Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

12. Pheochromocytoma

Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.

The Diagnosis of Pheochromocytoma must be supported by plasma metanephrine levels and / or urine catecholamines and metanephrines and confirmed by a registered doctor who is an endocrinologist.

13. Guillain Barre Syndrome:

It is a disorder in which the immune system of a person attacks the person's peripheral nervous system resulting in irreversible and permanent neurological deficit which persist for at least 6 weeks and resulting in permanent inability to perform three or more Activities of Daily Living. The diagnosis has to be confirmed by a neurologist and substantiated by typical findings in CSF, EMG and NC studies.

Activities of Daily Living are defined as :

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.

14. Takayasu's Arteritis:

It is a specific kind of arteritis and the inflammation damages the aorta and its main branches resulting in the medically necessary bypass surgery or aortic valve surgery. The diagnosis has to be confirmed by a specialist medical practitioner and substantiated by typical findings in angiography.

15. Rheumatoid Arthritis

Widespread chronic progressive joint destruction with major deformity, where all of the following criteria are met:

- Unequivocal diagnosis of Rheumatoid Arthritis made based on the American College of Rheumatology criteria;
- Damage and deformity of at least 3 (three) of the following joints: hand (metaphalangeal joints), wrist, elbow, knee, hip, or feet (metatarsophalangeal joints). Such deformity must be confirmed by imaging studies showing such changes; and Disability resulting in the inability of the Insured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 months.

Activities of Daily Living are defined as:

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.

16. Ankylosing spondylitis:

It is a type of arthritis that causes inflammation between the vertebrae and in the joints between the spine and pelvis. The condition must have progressed to the extent of irreversible and permanent neurological deficit which persist for at least 6 weeks and resulting in permanent inability to perform three or more Activities of Daily Living. The diagnosis must be made by a specialist medical practitioner and substantiated by typical findings in MRI.

Activities of Daily Living are defined as :

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.

17. Intestinal Gangrene:
Death of a part or whole of the intestine due to lack of blood flow and superimposed infection. The diagnosis must be made by a specialist medical practitioner and substantiated by typical findings in MRI and histopathology report.

18. Severe Crohn's Disease
Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:
- Stricture formation causing intestinal obstruction requiring admission to Hospital, and
- Fistula formation between loops of bowel, and
- At least one bowel segment resection.

The diagnosis must be made by a registered Medical Practitioner who is a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.

19. Severe ulcerative colitis
Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.
All of the following criteria must be met:
- The entire colon is affected, with severe bloody diarrhoea; and
- The necessary treatment is total colectomy and ileostomy; and
- The diagnosis must be based on histopathological features and confirmed by a registered Medical Practitioner who is a specialist in gastroenterology

20. Chronic Relapsing Pancreatitis
More than three attacks of pancreatitis resulting in pancreatic dysfunction causing malabsorption needing enzyme replacement therapy.
The Diagnosis must be made by a gastroenterologist and confirmed by Endoscopic Retrograde Cholangio Pancreatography (ERCP).

21. Elephantiasis

The result and complication of filariasis, characterized by massive swelling in the tissues of the body as a result of obstructed circulation in lymphatic vessels. Unequivocal Diagnosis of elephantiasis must be clinically confirmed by a Specialist in the relevant medical field, including laboratory confirmation of microfilariae, and must be supported by our medical adviser.

The benefit does not cover Lymphoedema caused by infection with a sexually transmitted disease, trauma, postoperative scarring, congestive heart failure, or congenital lymphatic system abnormalities.

22. Primary Myelofibrosis

A disorder which can cause fibrous tissue to replace the normal bone marrow and results in severe anaemia below 10 g/dl, low platelet count below 100,000 microL and enlarged spleen. The condition must have progressed to the point that it is permanent, and the severity is such that the Insured
Person requires a blood transfusion at least monthly over at least six (6) consecutive months. The diagnosis of Primary Myelofibrosis must be supported by bone marrow biopsy and confirmed by a registered Medical Practitioner who is a specialist. Secondary Myelofibrosis is excluded.

23. Carcinoma-In-Situ(Cis) / Early Stage Cancer

Carcinoma -in-situ
Carcinoma-in-situ shall mean a histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma in any one of the following covered organ groups, and subject to any classification stated:
(a) breast, where the tumour is classified as Tis according to the TNM Staging method;
(b) corpus uteri, vagina, vulva or fallopian tubes where the tumour is classified as Tis according to the TNM Staging method ;
(c) cervix uteri, classified as Tis according to the TNM Staging method;
(d) ovary –include borderline ovarian tumours with intact capsule, no tumour on the ovarian surface, classified as T1aN0M0, T1bN0M0 (TMN Staging) or FIGO 1A, FIGO 1B
(e) Colon and rectum;
(f) Penis;
(g) Testis;
(h) Lung;
(i) Liver;
(j) Stomach and esophagus;
(k) Urinary tract, for the purpose of in-situ cancers of the bladder, stage Ta of papillary carcinoma is included
(l) Nasopharynx
For purposes of this Policy, Carcinoma-in-situ must be confirmed by a biopsy.
Pre-malignant lesions and Carcinoma-in-situ of any organ unless listed above are excluded.

Early Stage Cancer

Early Stage Cancer shall mean the presence of one of the following malignant conditions:
(i) Prostate tumour histologically described as TNM Classification T1a or T1b or T1c or of another equivalent or lesser classification.
(ii) Chronic lymphocytic leukaemia classified as RAI Stage I or II;
(iii) Any malignant tumor of the thyroid, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue, which is histologically classified as T1N0M0 according to the TNM classification system, or another equivalent classification.

This benefit will be payable only when total thyroidectomy is performed to treat this condition.
The Diagnosis must be based on histopathological features and confirmed by a Pathologist. Pre-malignantlesions and conditions, unless listed above, are excluded.

24. Necrotizing Fasciitis

The occurrence of necrotising fasciitis where the following conditions are met:

(i) the usual clinical criteria of necrotising fasciitis are met; and
(ii) the bacteria identified is a known cause of necrotising fasciitis; and
(iii) there is widespread destruction of muscle and other soft tissues that results in a total and permanent loss of function of the affected body part.

The Unequivocal Diagnosis must be made by a Specialist in the relevant medical field.

25. Idiopathic Scoliosis

Severe Idiopathic scoliosis with spinal curvature of more than 40 (forty) degrees Cobb angle where spinal surgery is necessitated to correct idiopathic scoliosis (of unknown cause) in order to restore the spinal cord to a normal vertical position.
Spinal deformity caused by congenital abnormalities and neuromusclar diseases are excluded.

26. Dissolution of the nerve roots of Brachial Plexus

Permanent loss of sensory function of the upper limb caused by the dissolution of 2 (two) or more brachial plexus nerve roots caused by an accident or injury. The diagnosis must be confirmed via electrodiagnostic tests performed by a consultant neurologist.

27. Optic Neuropathy

The Unequivocal Diagnosis of optic nerve atrophy affecting both eyes leading to a permanent best corrected visual acuity of 6/60 or less on the Snellen Chart in both eyes. The optic nerve atrophy and quantum of visual loss of sight must be certified by a Specialist in the relevant medical field.

Optic nerve atrophy resulting from alcohol or drug abuse will be excluded.

28. Wilson Disease

Wilson's disease is an inherited disorder that causes copper to accumulate in your liver, brain and other vital organs. Following criteria must be confirmed by a relevant specialist

1. Unequivocal diagnosis of Wilson’s Disease using relevant blood tests, eye examination and other imaging techniques
2. Treatment of Wilsons disease with a chelating agent documented for at least six(6) months
3. Diagnosis of liver cirrhosis based on abnormal liver biochemistry and findings of the liver biopsy or Fibroscan/USG liver

Liver disease secondary to alcohol and drug abuse is excluded.

29. Cardiac arrhythmia with surgical intervention

Procedures like Maze surgery, RF Ablation therapy or any relevant procedure/surgery deemed absolutely necessary by a cardiologist to treat life threatening arrhythmias. Diagnosis must be evidenced by monitoring through a Holter monitor, event monitor or loop recorder and should be confirmed by a consultant cardiologist.

The following are excluded:

- Cardio version and any other form of non-surgical treatments
- Claim arising due to Internal Congenital Anomalies within 1 year from the date of commencement of cover or revival of coverage, whichever occurs later.

30. Benign Spinal Cord Tumor with Neurological Deficit

Benign spinal cord tumor is defined as a life threatening, non-cancerous tumor of the spinal cord or its meninges. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
This spinal cord tumor must result in Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days and must be confirmed by the relevant medical specialist. The Neurological deficit must result in permanent inability to perform three or more Activities of Daily Living.

Activities of Daily Living are defined as :

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.

31. Facial Reconstructive Surgery due to accident

The actual undergoing of plastic or reconstructive surgery (restoration or reconstruction of the shape and appearance of facial structures above the neck which are defective, missing, damaged due to Accident happened during the policy period) which, in the opinion of a Specialist Medical Practitioner, is deemed Medically Necessary for the treatment of facial disfigurement due to Injury requiring in-patient treatment and subsequently the performance of such surgery. Surgery solely for cosmetic reasons, isolated dental restorations, isolated nasal fractures or isolated skin wounds are excluded.

32. Pulmonary Artery Graft Surgery

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

The following conditions are excluded:

o Pulmonary artery graft surgery necessitated as a result of Coronary Artery Bypass Grafting

o Pulmonary artery graft surgery necessitated as a result of Post trauma

33. Glomerulonephiritis with Nephrotic Syndrome

Primary or Secondary glomerulonephritis with Nephrotic Syndrome for a continuous period of six (6) months.

The nephrotic syndrome is defined by the presence of all of the below :

- heavy proteinuria (protein excretion greater than 3.5 g/24 hours),
- hypoalbuminemia (less than 3.0 g/dL),
- peripheral edema.

The nephrotic syndrome must have continued for a period of at least six (6) months with or without intervening periods of remission and the life assured must have received treatment regimen appropriate to the clinical presentation over the period of time. Other forms of kidney disease are not covered.

34. Severe Acquired Or Secondary Pulmonary Alveolar Proteinosis (PAP)

Pulmonary alveolar proteinosis (PAP)_ is a lung disorder characterized by an abnormal accumulation of surfactant derived lipoprotein compounds within the alveoli of the lung.

Only Secondary PAP is covered. The followings are excluded :

- Autoimmune PAP
- Genetic PAP / Congenital PAP

Secondary PAP must be confirmed by Certified Medical Practitioner with evidence of the underlying cause and diagnosis confirmed through any one of the following :

- bronchoalveolar lavage fluid (BALF) staining ,
- transbronchial lung biopsy
- video-assisted thoracoscopic lung biopsy

35. Moderately Severe Kidney Disease

It means chronic renal insufficiency which meets all of the following criteria :

(i) Creatinine Clearance corrected for body surface area (CCr- corrected) is lower than 30mL/min/1.73 m2 and this abnormality has been consistently documented for at least ninety (90) consecutive calendar days; and

(ii) Such Unequivocal Diagnosis must be confirmed by a Medical Practitioner who is an urologist or nephrologist.

36. Moderately Severe Systemic Lupus Erythematous With Lupus Nephritis

Means a multisystem autoimmune disorder, characterized by the development of auto-antibodies.

All of the following criteria must be met:

(i) Presence of at least three (3) of the below five (5) criteria;
  a. Arthritis: non-erosive arthritis, involving two (2) or more joints;
  b. Serositis: pleuritis or pericarditis;
  c. Renal Disorder: persistent proteinuria > 0.5 g per day or cellular casts;
  d. Hematologic disorder: hemolytic anemia, Leukopenia, Lymphopenia, or thrombocytopenia; or
  e. Positive anti-nuclear antibody, Anti-dsDNA or anti-Smith antibody.

(ii) Such Unequivocal Diagnosis must be confirmed by a Medical Practitioner who is a rheumatologist or immunologist.

37. Syringomyelia or Syringobulbia Requiring Surgery

The unequivocal diagnosis of Syringomyelia or Syringobulbia with evidence of a fluid-filled cavity or cyst found within the spinal cord or brainstem resulting in neurological deficit for continuous period of 3 months or more.

The insured must have undergone surgery for treatment of Syringomyelia or Syringobulbia and the surgery must be certified to be Medically Necessary by the relevant Medical Practitioner.

The following is excluded:

- Congenital syringomyelia

38. Surgical removal of one lung

Complete surgical removal of the entire right or entire left lung necessitated by an illness or an Accident of the Insured. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a pulmonologist or thoracic surgeon**.**

39. Moderately Severe Crohn's Disease

Crohn’s Disease is a chronic, transmural inflammatory disorder of the bowel. For the purposes of this benefit, the Unequivocal Diagnosis of Crohn's disease must be made by a Specialist in the relevant medical field on the basis of an endoscopy and bowel biopsy which confirms the Unequivocal Diagnosis of Crohn's disease. The condition must require continuous immunosuppressive treatment or continuous treatment with immunomodulating drugs/steriod under the direction of a Specialist in the relevant medical field for a period of at least six (6) consecutive months

40. Moderately Severe Ulcerative Colitis

Ulcerative Colitis shall mean acute ulcerative colitis with life threatening electrolyte disturbances usually associated with intestinal distention and a risk of intestinal rupture. For the purpose of Unequivocal Diagnosis, there must be biopsy

evidence which unequivocally confirms the presence of ulcerative colitis and there must be imaging or endoscopic evidence that the condition involves the entire colon.

For the purposes of this benefit, there must be a requirement for ongoing systemic immunosuppression therapy or immunomodulatory therapy for a period of at least six (6) consecutive months supervised by a Specialist in gastroenterology.

Other forms of inflammatory colitis are specifically excluded. Ulcerative colitis confined to the rectum is specifically excluded.

41. Small Bowel Transplant

The actual undergoing of surgery to replace a diseased or shortened small bowel (**intestine)** of the insured with a healthy bowel to treat intestinal failure.

The surgery must be certified to be Medically Necessary by a relevant Medical Practitioner.

42. Adrenalectomy for Adrenocortical Adenoma

Adrenalectomy for treatment of malignant systemic hypertension that was secondary to an aldosterone secreting adrenal adenoma. Malignant hypertension was uncontrolled by medical therapy. The adrenalectomy must be considered Medically Necessary for the management of poorly controlled hypertension by a Specialist in the relevant medical field

43. Spinal Stroke

Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal canal resulting in neurological deficit with persisting clinical symptoms.

Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.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.

44. Portal Vein Thrombosis

The unequivocal diagnosis of Portal Vein Thrombosis evidenced by the complete or partial obstruction of blood flow in the portal vein. The diagnosis must be made by a specialist through doppler ultrasonography, CT Scans , MRI or angiography requiring surgical thrombectomy on an inpatient basis.

The surgery must be certified to be Medically Necessary by a relevant Medical Practitioner.

45. Surgical Removal of One Kidney

The actual undergoing of surgical removal of one kidney due to diseases or trauma of the kidney. The surgery must be considered Medically Necessary by a Medical Practitioner who is a nephrologist.

Removal of kidney as a donor or due to congenital kidney condition including renal agenesis and non functioning kidney is excluded

46. Severe Progressive Bulbar Palsy

Neurological disorder with paralysis in the head region, difficulties in chewing and swallowing, problems in speaking, persistent signs of involvement of the spinal nerves and the motor centres in the brain and spastic weakness and atrophy of the muscles of the extremities. The disease must be Unequivocally Diagnosed by a Medical Practitioner who is a neurologist. The condition must result in the permanent inability to perform, without assistance, at least three (3) of the six (6) Activities of Daily Living. These conditions have to be medically documented for at least three (3) consecutive months.

The Activities of Daily Living are:

I. 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;
II. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
III. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
IV. Mobility: the ability to move indoors from room to room on level surfaces;
V. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
VI. Feeding: the ability to feed oneself once food has been prepared and made available.

47. Coma 72 hours

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

I. No response to external stimuli continuously for at least 72 hours;
II. Life support measures are necessary to sustain life; and
III. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

48. Moderately Severe Cardiomyopathy

The unequivocal Diagnosis of cardiomyopathy which has resulted in the presence of permanent physical impairments to at least Class III of the New York Heart Association (NYHA) classification of Cardiac Impairment.
The Diagnosis must be confirmed by a Specialist in the relevant field. Cardiomyopathy that is directly related to alcohol misuse is excluded.

The NYHA Classification of Cardiac Impairment:

Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or anginal pain.

Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.

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

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

49. Other Serious Coronary Artery Diseases

Severe coronary artery disease in which at least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only (non-invasive diagnostic procedures excluded).

For purposes of this definition, "major coronary artery" refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).

50. Insertion of a Permanent Cardiac Defibrillator

Insertion of a permanent cardiac defibrillator as a result of cardiac arrhythmia which cannot be treated via any other method. The surgical procedure must be certified to be medically necessary by a specialist in the relevant field.

Documentary evidence of cardiac arrhythmia must be provided.

51. Pericardiectomy

The undergoing of a pericardiectomy performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consultant cardiologist.

The following are excluded:

Other procedures on the pericardium including pericardial biopsies and pericardial drainage procedures by needle aspiration.

52. Balloon Valvotomy or Valvuloplasty

The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field and established by a cardiac echocardiogram or any other appropriate diagnostic test that is available.

The following are excluded:

Procedures done for treatment of Congenital Heart Disease within 4 years from the date of commencement of cover or revival of coverage, whichever occurs later.

53. Minimally Invasive Surgery to Aorta

The actual undergoing of minimally invasive surgical repair (i.e. via percutaneous intra-arterial route) of a diseased portion of an aorta to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

The following are excluded:

Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of cover or revival of coverage, whichever occurs later.

54. Loss of Hearing of One Ear

Total and irreversible loss of hearing in one ear as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist.
Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all
frequencies of hearing" in one ear.

55. Loss Of Sight In One Eye

Total, permanent and irreversible loss of all vision in one eye as a result of illness or accident.

The Blindness is evidenced by:

I. corrected visual acuity being 3/60 or less in one eye or;
II. the field of vision being less than 10 degrees in one eye.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

56. Carotid Artery Surgery

The actual undergoing of surgery to the Carotid Artery to treat carotid artery stenosis of fifty percent (50%) or above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met:

a) Either:
i). Actual undergoing of endarterectomy to alleviate the symptoms; or
ii). Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and
b) The Diagnosis and medical necessity of the treatment must be confirmed by a Registered Medical Practitioner who is a specialist in the relevant field.

57. Loss of Use of One Limb

Total and irreversible loss of use of one 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.

58. 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:

1. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
2. New characteristic electrocardiogram changes
3. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

1. Other acute Coronary Syndromes
2. Any type of angina pectoris
3. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

59. REFRACTORY HEART FAILURE

Refractory heart failure is defined as a systolic dysfunction that does not respond to optimal medical therapy ("triple therapy") and results in permanent physical impairment to the degree of New York Heart Association Classification Class IV, or its equivalent, for at least six months. The diagnosis of refractory heart failure has to be supported by echocardiographic findings of compromised ventricular performance. The diagnosis must be made by a cardiology specialist.

The following is excluded:

1. Reversible causes of heart failure such as hypocalcemia, alcohol abuse, thyroid, anaemia.

60. END STAGE LUNG FAILURE

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

1. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
2. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
3. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO_2 < 55mmHg); and
4. Dyspnoea at rest.

61. 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:

1. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
2. 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

62. END STAGE LIVER FAILURE

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

1. Permanent jaundice; and
2. Ascites; and
3. Hepatic encephalopathy.

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

63. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

1. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
2. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

64. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. 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.

65. 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.

66. 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:

1. Transient ischemic attacks (TIA)
2. Traumatic injury of the brain
3. Vascular disease affecting only the eye or optic nerve or vestibular functions.

67. COMA OF SPECIFIED SEVERITY

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

1. No response to external stimuli continuously for at least 96 hours;
2. Life support measures are necessary to sustain life; and
3. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

68. ALZEIMER'S DISEASE

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardised questionnaires and cerebral imaging.

The diagnosis of Alzheimer's Disease must be confirmed by an appropriate consultant and supported by a Medical Practitioner appointed by Us. There must be significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. There must also be an inability of the Insured Person to perform (whether aided or unaided) at least three of the Activities of Daily Living, for a continuous period of at least 3 months:

For the purpose of this clause, Activities of Daily Living are defined as:

1. 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;
2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding – the ability to feed oneself once food has been prepared and made available.
6. Mobility - the ability to move from room to room without requiring any physical assistance.

The following are excluded:

- Any other type of irreversible organic disorder/dementia
- Alcohol-related brain damage.

69. PARKINSON'S DISEASE

I. The occurrence of Parkinson's Disease where there is an associated Neurological Deficit that results in permanent inability to perform independently at least three of the Activities of Daily Living, for a continuous period of at least 3 months:

For the purpose of this clause, Activities of Daily Living are defined as:

1. 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
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

The following is excluded:

Parkinson's Disease accompanied with drug and/or alcohol abuse.

70. APALLIC SYNDROME

Universal non-functioning of the brain cortex, with the brain stem intact. Diagnosis of Apallic Syndrome must be definitely confirmed by a registered Medical Practitioner who is also a neurologist and substantiated by clinical and investigation findings. This condition must be documented for a continuous period of at least one month.

71. 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 such as 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.

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

III. 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 the spinal cord.

72. CREUTZFELDT-JAKOB DISEASE (CJD)

A diagnosis of Creutzfeldt Jakob Disease must be made by a specialist Medical Practitioner who is a neurologist and the diagnosis must be substantiated by CSF examination, EEG, CT Brain and MRI of the brain. There must be permanent clinical loss of the ability in mental, physical and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.

73. 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:

I. 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;
II. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
III. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
IV. Mobility: the ability to move indoors from room to room on level surfaces;
V. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
VI. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:

i. Spinal cord injury;

74. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

75. MEDULLARY CYSTIC DISEASE

I. Medullary Cystic Disease where the following criteria are met:

i. The presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
ii. Clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
iii. The diagnosis of Medullary Cystic Disease is confirmed by renal biopsy along with specialist Medical Practitioner opinion.

II. The following are excluded

i. Isolated or benign kidney cysts are specifically excluded from this Benefit
ii. Any condition is which cysts are absent

76. MUSCULAR DYSTROPHY

Diagnosis of muscular dystrophy by a registered Medical Practitioner who is a neurologist based on the presence of following conditions:

1. Clinical presentation including weakness and loss of muscle mass, absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
2. Characteristic electromyogram
3. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform (whether aided or unaided) at least three of the Activities of Daily Living, for a continuous period of at least 6 months.

For the purpose of this clause, Activities of Daily Living are defined as:

1. 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;

2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding – the ability to feed oneself once food has been prepared and made available.
6. Mobility - the ability to move from room to room without requiring any physical assistance

77. POLIOMYELITIS

The occurrence of Poliomyelitis, where the following conditions are met:

I. Poliovirus is identified as the cause through laboratory investigation
II. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

The diagnosis of Poliomyelitis must be confirmed by a registered Medical Practitioner who is a neurologist.

78. APLASTIC ANEMIA

Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

1. Blood product transfusion;
2. Marrow stimulating agents;
3. Immunosuppressive agents; or
4. Bone marrow transplantation.

The diagnosis of Aplastic anaemia must be confirmed by a bone marrow biopsy. Atleast two of the following values should be present:

1. Absolute Neutrophil count of 500 per cubic millimetre or less;
2. Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
3. Platelet count of 20,000 per cubic millimetre or less.

79. Systemic lupus erythematosus (SLE) with renal involvement

I. Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "SLE" under this policy is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Diagnosis by a nephrologist, supported by renal biopsy report is mandatory. There must be positive antinuclear antibody test

II. The following are excluded

i. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.
ii. Class I - Minimal mesangial lupus nephritis
iii. Class II - Mesangial proliferative lupus nephritis

80. MYASTHENIA GRAVIS

I. An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatigability, where all of the following criteria are met:

1. Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and
2. The diagnosis of Myasthenia Gravis and categorization are confirmed by a registered Medical Practitioner who is a neurologist.

Myasthenia Gravis Foundation of America Clinical Classification is as follows:

Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere.
Class II: Eye muscle weakness of any severity, mild weakness of other muscles.
Class III: Eye muscle weakness of any severity, moderate weakness of other muscles.
Class IV: Eye muscle weakness of any severity, severe weakness of other muscles.
Class V: Intubation needed to maintain airway.

II. The following are excluded:

1. Congenital myasthenic syndrome
2. Transient neonatal or juvenile myasthenia gravis

81. SCLERODERMA

A systemic collagen-vascular Illness causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following conditions are excluded:

1. Localised scleroderma (linear scleroderma or morphea);
2. Eosinophilic fascitis; and
3. CREST syndrome.

82. GOOD PASTURES SYNDROME with lung or renal involvement

Goodpastures Syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for continuous period of at least 30 days. The diagnosis must be proven by kidney biopsy and confirmed by a specialist Medical Practitioner who is a rheumatologist.

83. BLINDNESS

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:

1. Corrected visual acuity being 3/60 or less in both eyes or ;
2. The field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

84. DEAFNESS

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

85. CANCER OF SPECIFIED SEVERITY

I. 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.

II. The following are excluded –

1. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
3. Malignant melanoma that has not caused invasion beyond the epidermis;
4. 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
5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6. Chronic lymphocytic leukaemia less than RAI stage 3
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
8. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
9. All tumors in the presence of HIV infection.

86. THIRD DEGREE BURNS

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

87. LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, throat (ENT) specialist.

II. All psychiatric related causes are excluded.

88. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

I. 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.

89. Major Organ Transplant

I. The actual undergoing of a transplant of:

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

II. The following are excluded:.

i. Where only islets of Langerhans are transplanted.

90. BONE MARROW TRANSPLANT

The actual undergoing of a transplant of:

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

II. The following are excluded:

Other stem-cell transplants

91. OPEN CHEST CABG

I. 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.

II. The following are excluded:

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

92. 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.

Annexure 2

Final Major Surgical Procedures List	Payout
Open Heart Replacement Or Repair Of Heart Valves	100%
Valvotomy/Valvuloplasty	50%
CABG (Coronary Artery Bypass Grafting)	100%
Other vascular bypass grafts(eg. Femoral popliteal grafts)	50%
Clipping or repair of Aneurysm(including aortic, cerebral, femoral or iliac) with or without graft	50%
Coronary Angioplasty with Stent implantation	50% -inr 5lac which ever lower
Excision of benign mediastinal lesions (evidence of thoracotomy needs to be ascertained)	50%
Heart Proximal aortic aneurysm, Aortic root transplantation with coronary artery reimplantation	50%
Initial implantation of permanent pacemaker/ICD/VAD device in heart	50%
Major Surgery of Aorta	100%
Major vein repair with or without grafting for traumatic & non traumatic lesions	50%
Pericardiotomy / Pericardectomy	50%
Carotid endarterectomy/ Ext carotid Int. carotid bypass/Carotid tumour excision	50%
Closure Of Semilunar Valve	50%
Minimally Invasive Surgery to Aorta	50%
Pulmonary Artery Graft	50%
Cardiac Arrhythmia with Ablative Procedure	50%- capping of 5lac
Hemicolectomy	50%
Partial Gastrectomy	50%
Complete Gastrectomy	100%
Partial Eosophagectomy	50%
Complete Eosophagectomy	100%
Pancrepancreaticoduodenectomy- Whipples surgery	100%
Partial Hepatectomy	50%
Complete Hepatectomy	100%
Partial splenectomy	50%
Complete splenectomy	100%
small bowel transplant	50%
Resection/anastamosis for small intestine	50%
Partial Pancreatectomy	50%
Complete Pancreatectomy	100%
Amputation of arm	100%
Amputation of foot	100%
Amputation of hand	100%
Amputation of leg	100%
Excision reconstruction of joint(small joints-hand & feet)	50%-cap of 2lac
microvascular replantation of finger due to trauma	50%-cap of 2lac
Implantation of prosthesis for limb for amputees	100%
Open/closed Reduction and Internal fixation of fracture Long bone (Humerus, Radius, ulna, Femur, Tibia, Fibula, clavicle) with or without Bone grafting-	50%-cap 3lac
Osteomyelitis - Surgical Drainage and Curettage	50%-cap of 2lac
core decompression with graft for osteonecrosis of femoral head	50%
Replantation of lower limb	100%
Replantation of upper limb	100%
Spinal Fusion (arthrodesis of spine with bone graft/internal fixation)	50%
Therapeutic endoscopic operations on cavity of knee/hip joint	50%-cap of 2lac
Therapeutic endoscopic operations on cavity of Shoulder/elbow joint	50%-cap of 2lac
ACL/PCL repair/reconstruction	50%-cap of 2lac
Total replacement of hip/knee/shoulder/elbow/head of femur/head of humerus-unilateral	50%
reconstruction or arthroplasty of hip/knee/shoulder/elbow/head of femur/head of humerus(unilateral/bilateral)	50%

Total replacement of hip/knee/shoulder/elbow/head of femur/head of humerus-bilateral	100%
HIND QUARTER AMPUTATION	100%
Open Reduction And Internal Fixation Of Fracture Of Small Bones /patella With Or Without Graft	50%-cap to 1lac
Prosthetic Replacement of small joints	50%-cap to 2lac
Multiple (more than 2)Tendon Transfer - Sts Hand / Foot	50%
Surgery for Idiopathic Scoilosis	50%
Bur-hole Drainage of Extradural, subdural or intracerebral space	50%
Craniotomy for non malignant space occupying lesions	100%
Craniotomy for Drainage of Extradural, subdural or intracerebral space	100%
Craniotomy for malignant Brain tumors	100%
Decompression surgery for Entrapment Syndrome	100%
Embolectomy / Thrombectomy/ Endarterectomy with or without Graft	100%
Excision of deep seated peripheral nerve tumor	100%
Excision of pineal gland	100%
Fixation of fracture of spine	100%
Free Fascia Graft for Facial Nerve Paralysis	50%
Intracranial transection of Cranial nerve	100%
Laminectomy/Discectomy for Spinal nerve root decompression	100%
Microvascular decompression of cranial nerves/nervectomy	100%
Multiple Microsurgical Repair of digital nerve	100%
Operations on Subarachnoid space of brain	100%
Other operations on the meninges of the Brain	100%
Peripheral nerve Graft	100%
Repair of Cerebral or Spinal Arterio- Venous Malformations or aneurysms	100%
Total or Partial Excision of the pituitary gland - Any approach (Transforntal or Trans Sphenoid)	100%
Surgery for ACOUSTIC NEUROMA	50%
Brachial Plexus Surgery	50%
neuro endoscopy for removal of brain tumor/ foreign body	50%
STA MCA BYPASS SURGERY	50%
SYMPATHECTOMY CERVICAL/LUMBAR/THORACOLUMBAR	50%
Bone Marrow transplant (as recipient)	100%
Heart/Heart-Lung Transplant	100%
Liver Transplantation	100%
Lung Transplantation	100%
Renal transplant (recipient)	100%
Pancrease Transplant	100%
Major reconstructive oro-maxillafacial surgery due to trauma or burns and not for cosmetic purpose	100%

Osteotomy including segmental resection with bone grafting for Mandibular and maxillary lesions	100%
Commando Operation-for only cancer	100%
Total Larygectomy And Neck Dissection And Flap-only for cancer	100%
Excision and Major Flap Repair of skin and Subcutaneous tissue due to Major Burns	100%
Surgical treatment of cancer with removal of organ & excluding biopsy & other diagnostics	100%
Surgical removal of an eye ball	50%
Surgical treatment of cancer without removal of organ excluding biopsy & other diagnostics	50%
THYMECTOMY	50%
Amputation of penis	50%
Excision of ureter	50%
Total excision of bladder	50%
Partial nephrectomy due to medical advice (not as a transplant donor)	50%
Total nephrectomy due to medical advice (not as a transplant donor)	100%
Bilateral excision of testes	50%
Urinary diversion	50%
Adrenelectomy	50%
Pneumonectomy/Lobectomy/removal of 1 lung	50%
Pleurectomy/lung decortication	50%
Chronic bronchopleural fistula requiring a surgical procedure for closure of the fistula through an open thoracotomy	50%
pulmonary embolectomy/enderectomy	50%