Annexure IV

INTERNATIONAL HEALTH POLICY

ICICI Lombard General Insurance Company Limited ("*the Company*"), having received a Proposal and the premium from the Proposer named in the Schedule referred to herein below, 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 the Company and the Proposer as the basis of this Policy do, by this Policy agree, in consideration of and subject to the due receipt of the subsequent premiums, as set out in the Schedule with all its Parts, and further, subject to the terms and conditions contained in this Policy, as set out in the Schedule with all its Parts that on proof to the satisfaction of the Company of the compensation having become payable as set out in Part I of the 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 Sum Insured/ appropriate benefit will be paid by the Company.

PART I OF THE SCHEDULE

Policy No. *Issued at* *Stamp Duty*

1. Details of the Proposer/ Policyholder:
   a. Name
   b. Mailing address
   c. Contact no.
   d. Email id

2. Policy Details:
   a. Policy Period
      Start Date & Hour
      End Date & Hour:
   b. Period of Insurance
      Start Date & Hour:
      End Date & Hour:

3. Details of the Insured under the Policy:

	IInsured 1	Insured 2	Insured 3	Insured 4	Insured 5
Name of the Insured					
Residential Address • City/ Town • State • Country • Postal code • Contact Number • Mobile Number • e-mail id • Fax					

Relationship with the Proposer					
Date of Birth MM/DD/YY					
Sex	▫ M / ▫ F	▫ M/▫ F	▫ M / ▫ F	▫ M / ▫ F	▫ M / ▫ F
Nationality					
Height (Ft. In					
Weight (Lbs/ Kg)					
Residency(Residency is defined as a country where customer normally resides for more than 180 days of a year)					
Personal Identification No. (Passport,/Driver's License/ Social Security)					
Name of the Nominee					
Relation of the Nominee with the Insured					
Occupation					
Annual Salary					
Name of Medical Practitioner					
Pre-existing conditions (if any)					

4. Details of Previous International Health Policy:
   a. Insurance Company
   b. Previous Policy No.
   c. Previous Policy Period
   d. Cover Period
   e. Sum Insured
   f. Claims (if any)

Note: The details mentioned above including the information relating to the Pre-Existing Condition as also the history of the past Illness / Injury as supplied by the Insured have been taken as the basis of this Policy. In case of any variation, Insured shall approach the Company immediately. Failure on the Insured's part to supply all particulars material to assumption of risk or suppression and/or misrepresentation of such material facts by the Insured may render the Policy void.

5. Maximum Limit of Indemnity details:

	Sum Insured
Lifetime Sum Insured	USD_______
Policy Period Sum Insured :	USD_______

6. Benefits available under this Policy:

S.No.	Benefits
1.	Inpatient and Hospitalisation Benefits
2.	Outpatient Benefits
3.	Maternity and New born infant care Benefits
4.	Human Organ Transplant
5.	Mental Health Benefits
6.	Durable Medical Equipment
7.	Extended Care/Inpatient Rehabilitation
8.	Emergency Ambulance • Emergency Ground Ambulance Services • Emergency Air Ambulance Services
9.	Wellness and Preventative Benefit • Child Wellness • Adult Female Wellness • Adult Male Wellness • Wellness Diabetic Education

7. Endorsement: Premium Installment Clause

8. Waiting Period, applicable to the following benefits/ conditions:

Benefit/ Condition	**Waiting Period**
Human Organ Transplant	24 months
Maternity and New born infant care Benefits	24 months

9. Policy Period Deductible and Copayment
   a. Policy Period Deductible: _____ USD
   b. Copayment: 20 %
   c. Aggregate Maximum Co-payment Limit: 2000 USD per Policy Period

10. Third party Administrator (TPA) details, if any:

Name	Country	Contact Nos.

11. Territorial Scope:

Company Contact Information:

a) *Toll-free number*: 1800-209-8888

b) *Postal Address:*

ICICI Lombard General Insurance Company Limited
Zenith House, Keshavrao Khadye Marg,
Mahalaxmi, Mumbai-400 034

c) *E-mail*: customersupport@icicilombard.com

11. Special Conditions

a. Any physical, medical or mental condition or treatment or service which is specifically excluded under the Policy:

Name of the condition/treatment/Illness/procedure

b. Disclosed Pre-existing Conditions, covered under the Policy:

Name of the condition/treatment/Illness/procedure

12. Premium Details:

Premium Payment Type Annual/ Installments

a. Basic Premium ☐☐☐☐☐

b. Premium for Extension cover/ add-ons (if any) ☐☐☐☐☐

c. Gross Premium ☐☐☐☐☐

d. Add Service Tax, Education Cess (as applicable) ☐☐☐☐☐

e. Net Premium Payable ☐☐☐☐☐

Schedule of Policy Premiums Installments, if applicable, and due dates:

First Premium Payable ☐☐☐☐☐

Installments	Due date	Premium amount (Rs.) (*)
Second Installment		

Third Installment		
Fourth Installment		

(*) service tax and applicable cess extra

Signed for and on behalf of the ICICI Lombard General Insurance Company Limited, at ___________ on this date [| | | | | | | |]

Authorised Signatory

*Premium Certificate for the purpose of Deduction u/s 80D of Income Tax Act, 1961 **

To
-Name of Proposer/ Policyholder-

This is to certify that an amount of Rs ________ has been received by the Company towards premium for the International Health Policy no: ______________ issued to Mr/Ms/Mrs.___________________________ for a period from ________ to _______

Basic Premium: *Service Tax & Cess:* *Total Premium:*

Collection No.____

Collection Date of Issue____ For ICICI Lombard General Insurance Company Ltd

Place of Issue____ Authorized Signatory
Date of Issue____

<u>* Note</u>

- This is subject to the provisions of section 80D of Income Tax Act , 1961 and amendments made thereafter
- Details of the Policy as per the Part II and III of Schedule attached to this Policy.
- This certificate must be surrendered to the Company in case of cancellation of the Policy. In the event of incorrect representation of this declaration the liability shall be upon the Policyholder.
- In case you find any variations against your proposal or any discrepancy in the Policy please contact us immediately on the numbers available on our website www.icicilombard.com.
  You may also write to us at the following address:
  ICICI Lombard General Insurance Company Limited
  Zenith House
  Keshav Rao Khadye Marg
  Mahalaxmi
  Mumbai 400 034.

PART II OF THE SCHEDULE

1. DEFINITIONS

For the purposes of this Policy, the following words shall have the meanings as set forth below:

Accident	means a sudden, unforeseen and involuntary event caused by external and visible means.
Admission	means the stay of the Insured in a Hospital, or other approved health care facility as an Inpatient.
Air Ambulance	means an aircraft specially equipped with the necessary medical personnel, supplies and Hospital equipment to treat life-threatening Illnesses and/or Injuries of an Insured whose condition cannot be treated locally and who must be transported by air to the nearest medical center that can adequately treat his/her conditions. A commercial passenger airplane shall not fall within the meaning of an Air Ambulance
Allowable Charges	means the Reasonable and Customary Charges incurred by the Insured, for the services rendered by the Provider and as described in the relevant sections of the Policy. Allowable charges shall not include any Medical Charges.
Alternative Treatments	are forms of treatments other than treatment “Allopathy” or modern medicine” and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
Any one illness	means continuous Period of illness and it includes 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.
Break in Policy	occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
Cashless Facility	means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.
Confinement	means an Insured’s stay as an Inpatient at an approved Extended Care Facility for necessary skilled treatment or rehabilitation in accordance with the Policy
Claim	means a demand by the Insured for payment of Medical Charges or Allowable Charges as covered under the Policy

Copayment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible costs. A co-payment does not reduce the sum insured. The *Aggregate Maximum Copayment Limit* is the maximum amount, as specified in Part I of the Schedule, that the Insured will pay as "Copayment" during the Policy Period post which Copayment will cease to apply on further Claim amounts.

Company means ICICI Lombard General Insurance Company Limited.

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

Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion.

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

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

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

Day Care Treatment refers to medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital /day care centre in because of technological advancement, and

ii. which would have otherwise required a hospitalization of more than 24 hours.

Day care centre means any institution established for Day Care Treatment of sickness and / or injuries or a medical set-up with in a hospital and which has been registered with the local authorities, whenever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:- has qualified nursing staff under its employment; has qualified medical practitioner (s) in charge; has a fully equipped operation theatre of its own where surgical procedures are carried out- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

Deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured

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

Dependent Child refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

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:-

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

Durable medical equipment means equipments customarily and generally useful to a person only during an Illness or Injury and determined by the Company as Medically Necessary.

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

Extended Care Facility means a nursing and/ or rehabilitation centre approved by the Company that provides skilled and rehabilitation services to the Insured during Confinement. It does not include rest home, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of drug addicts or alcoholics, or similar institutions.

Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre existing diseases. Coverage is not available for the period for which no premium is received.

Hospital means any institution established for in patient care and day care treatment of sickness and/or injuries and which has been registered as a hospital with the local authorities, wherever

applicable, and is under the supervision of a registered and qualified Medical Practitioner and must comply with all minimum criteria as under:

1. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;

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

3. has qualified Medical Practitioner (s) in charge round the clock

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

5. Maintains daily records of patients and will make these accessible to then Insurance company's authorized personnel

For the purpose of this definition, the term "Hospital" shall not include an establishment, which is a place of rest or recreation, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or any other like place.

Hospitalisation shall mean admission in a Hospital for a minimum period of 24 consecutive hours except for specified Day Care Procedures/Treatments, where such admission could be for a period of less than 24consecutive hours

Inpatient Care means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event

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

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

a **Acute condition** - Acute condition is a medical condition that can be cured by Treatment

b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

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

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Injury means any accidental physical bodily harm occurring during the Policy Period, excluding illness or disease soley and directly cased by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

Insured means the individual whose name is specifically appearing as such in Part I of the Schedule to this Policy.

Lifetime Sum Insured means and denotes the maximum amount of cover available, over the Period of Insurance, as stated in Part I of the Schedule or any revisions thereof based on Claims settled under this Policy and, where appropriate, as more particularly described and limited in the Table of sub-limits under the relevant sections of the Policy.

Maternity expenses It shall include the following Medical treatment Expenses:

i. Medical Expenses for a delivery (including complicated deliveries and caesarean sections) incurred during Hospitalization;
ii. The lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person;
iii. Pre-natal and post-natal Medical Expenses for delivery or termination.

Maximum Limit of Indemnity means the Policy Period Sum Insured or the Lifetime Sum Insured, whichever is lower, during the Policy Period.

Medical Advice any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription

Medical **Expenses** */Charges* 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.

Medical Emergency Services

Means medical or surgical services provided in connection with an Emergency

Medical Practitioner

a person who holds a valid degree of a recognised institute and is registered or licensed by recognised medical council and acting within the scope of the license or registration granted to him/herand is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude the Insured and members of his/ her immediate family. Immediate family would comprise of Insured's legal spouse, children, brother(s), sister(s) and parent(s). The definition excludes practitioners in non-allopathic fields.

Medically Necessary

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

a) Is required for the medical management of the Illness or Injury suffered by the Insured
b) Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
c) Must have been prescribed by Medical Practitioner;
d) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India .

Nominee

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

Network Provider

means the Hospitals, health care providers, day care centers or other providers which have been empanelled by Us or Our appointed TPA to provide services like cashless access to the Insured Person, for the provision of medical treatment. The list of the Network Hospitals is available with Us/ TPA and is subject to amendment from time to time.

New Born baby

means those babies born to you and your spouse during the policy period Age between 1 day and 90 days.

Non- Network any hospital, Day Care Centre or other provider that is not part of the network.

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

Outpatient means the Insured Person who is not hospitalized for more than 24 consecutive hours but who visits a Hospital, clinic, or associated facility for diagnosis or treatment. However any Insured Person undergoing any specified "specified day care procedures/treatment" will not be considered as an Out-patient.

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

Policy means the Policy booklet, the Schedule, any Extension and applicable endorsements under the Policy. The Policy contains details of the extent of cover available to the Insured, the exclusions under the cover and the terms and conditions of the issue of the Policy.

Policy Period means the period commencing from Policy Period Start Date and Hour as specified in Part I of the Schedule to this Policy and terminating on the Policy Period End Date and Hour as specified in Part I of the Schedule to this Policy.

Policy Period Deductible is a cost sharing requirement under the Policy that provides that the Company will not be liable for a specified amount of the covered Medical Charges as stated in the Part I of the Schedule, which will apply before any benefits are payable by the Company during the Policy Period. It does not reduce the Sum Insured.

Policy Period Sum Insured means and denotes the maximum amount of cover available, during the Policy Period, as stated in Part I of the Schedule or any revisions thereof based on Claim settled under the Policy and, where appropriate, as more particularly described and limited in the Table of sub-limits under the relevant sections of the Policy. This is the maximum compensation that the Company will pay for each and every Claim and in aggregate of all Claims under the Policy.

Policyholder means the person named in Part I of the Schedule to this Policy who executed the Policy Schedule and is responsible for payment of premium.

Period of Insurance means the period commencing from the Policy Period Start Date & Hour of the first International Health Policy of the Insured with the Company and then, subject to the Insured continuously renewing such International Health Policy with the Company, terminating at midnight on the Period of Insurance End Date & Hour as specified in Part I of the Schedule to this Policy.

Portability means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for Pre-existing Conditions and time bound exclusions, from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

Pre-existing Disease/Condition means any condition, ailment or injury or related condition(s) for which You had signs or symptoms, and / or were diagnosed, and / or received Medical Advice/ treatment, within 48 months prior to the first policy issued by the insurer.

Preferred Provider Organization means a participating Provider, such as Hospital, clinic or Medical Practitioner that has entered into an agreement with the Company to provide health services to the Insured.

Prescription Drugs means any product which may be marketed as medicine on the strength of local regulations and are used in the cure or treatment of an Illness or Injury, obtained upon the Medical Practitioner's prescription and are approved by the Company as Prescription Drugs.

Provider means the organization or person performing or supplying treatment, services, supplies or drugs, and shall mean to include any Hospital, Extended Care Facility or any other approved health care facility.

Qualified Nurse is a person who holds a valid registration from the local authorities.

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

identical or similar services, taking into account the nature of the illness / injury involved

Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

Room rent mean the amount charged by a hospital for the deductibles occupying of a bed and associated medical expenses. Deductibles is a cost sharing requirement that provides that We will not be liable for the amount of covered Medical Expenses, as specifically mentioned in the policy Schedule, which has to be borne by You for each and every claim during the Policy Period, before it becomes payable by US under the Policy. This is to clarify that a deductible does not reduce the sum insured.

Senior Citizen means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

Subrogation shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

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

Table of Benefits Means a list of benefits as set out in point number 6 of Part I of the Schedule to this Policy.

Third Party Administrator (TPA)
means any person or entity that, for the time being, is licensed by the Insurance Regulatory and Development Authority as a Third Party Administrator in India and is engaged for a fee or remuneration by the Company for the provision of health services under this Policy.
An international TPA means any person or entity that is licensed by an international authorised body as a TPA outside India and is engaged for a fee or remuneration by the Company for the provision of health services outside India, under this Policy.

Unproven/ Experimental treatment is treatment, including drug Experimental therapy, which is based on established medical practice in India, is treatment experimental or unproven.

Waiting Period	Means the period commencing from the Period of Insurance Start Date & Hour during which no Claim shall be payable in respect of the Insured under this Policy for specific benefits as specified in Part I of the Schedule. After completion of the Waiting Period, benefits for those services become available in accordance with terms and conditions of the Policy.
You/Your/ Yours/ Yourself	means the person(s) that We insure and is/are specifically named as Insured / Insured Person(s) in the Policy Schedule.
We/ Our/ Ours/ Us	means the ICICI Lombard General Insurance Company Limited

2. BENEFITS UNDER THE POLICY

SECTION 1: *Inpatient and Hospitalisation Benefits*

2.1.1 *Scope of Cover*: The Company will indemnify the Insured against Medical Charges, as per section 2.1.2 of Part II of the Schedule, incurred by the Insured upon Hospitalisation as an Inpatient, during the Policy Period, as a result of any Illness contracted or Injury sustained or for undergoing Medically Necessary surgical procedure, upon the advice of a Medical Practitioner, subject to the Maximum Limit of Indemnity under the Policy.

2.1.2 *Medical Charges reimbursable under Section 1*:
Medical Charges incurred for the following services are covered under Section I: Inpatient and Hospitalisation Benefit. Sub-limits for these charges are provided under clause 2.1.3

(a) *Accommodation*: Coverage is provided for a private room and board, meals and special diets. In case the elected place of treatment is in US or Europe then coverage will be provided for semi-private room and board, meals and special diets

(b) *Intensive Care Services*: Coverage is provided for Medically Necessary intensive care services

(c) *Inpatient Surgery*: Coverage is provided for surgical and related surgical procedures and dressings, use of operating room, recovery room and related facilities, use of intensive care and cardiac units and related services to include x-ray, laboratory and other diagnostic tests, prescription drugs and medicines, biological anesthesia and oxygen services

(d) *Medical Treatment & tests*: Coverage is provided for diagnostic and therapeutic services, including but not limited to, radiation therapy, inhalation therapy, respiration therapy, chemotherapy, physical and occupational therapy, a Medically Necessary video laryngoscopy for the diagnosis of a swallowing dysfunction if done by a registered speech therapist

(e) *Inpatient Surgeon* – Coverage is provided for availing the services of the operating surgeon in respect of the surgeries and other related surgical procedures.

(f) *Assistant Surgeon*– Coverage is provided for availing the services of the assistant surgeon.

(g) *Anesthesiologist*– Coverage is provided for availing the services of an anesthesiologist, other than the operating surgeon or his/ her assistant, who administers anesthesia for a covered surgical or obstetrical procedure.

(h) *Blood transfusion*: Coverage is provided for blood transfusion, blood plasma, blood plasma expanders and all related testing components and equipment

(i) *Prescription Drugs*: Coverage is provided for Prescription Drugs based upon written recommendation of Medical Practitioner required by the Insured during the period of Hospitalisation

(j) *Inpatient Medical Practitioner Consultation*: Coverage is provided for upto one Medical Practitioner visit per day while the Insured is an Inpatient in a Hospital or approved Health Care Facility. If Medically Necessary, the Company, at its sole discretion, may elect to pay for more than one visit of different Medical Practitioners on the same day, of different specialties. When lengthy, prolonged or repeated Inpatient visits by the Medical Practitioners are necessary because of a critical condition, payment for such intensive medical services will be based on the merits of each individual case. The Company will require submission of records and other documentation of the medical necessity for payment of charges for the intensive services.

2.1.3 Sub-limits on Medical Charges reimbursable under Section 1:

Treatment or Service	Age 1-49	Age 50+
Accommodation (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	USD850 per day for maximum of 250 consecutive days
Intensive Care Services (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	USD 2600 per day for maximum of 250 consecutive days
Medical Treatment & Tests (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Inpatient Medical Practitioner Consultation (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Inpatient surgery (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Inpatient Surgeon (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity

Assistant Surgeon (Policy Period Sum Insured)	Upto 20% of allowable Surgeon's fee	Upto 20% of allowable Surgeon's fee
Anesthesiologist (Policy Period Sum Insured)	Upto 30% of allowable Surgeon's fee	Upto 30% of allowable Surgeon's fee
Blood Transfusion (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Prescription Drugs (including injectibles) (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity

2.1.4 Special Conditions applicable to Section 1

a) Pre-certification by Third Party Administrator and use of Preferred Provider Organization for Hospitalisation, CAT scans, PET scans, MRI procedure, chemotherapy and radiation therapy is necessary prerequisite for a Claim to be admissible under this cover. Failure to pre-certify a Preferred Provider Organization will result in a reimbursement reduction to the extent of 75% of covered charges, approved by the Company, for the entire episode of care.

2.1.5 Exclusions applicable to Section 1

Charges incurred on account of the following shall not be payable under Section 1 - Inpatient and Hospitalisation Benefit

1. Any charges not specifically covered under Section 1 - Inpatient and Hospitalisation Benefit, or which are covered under any other section of this Policy.

2. Vitamins and tonics, treatment of obesity (including morbid obesity) , and any other weight control programs, photodynamic therapy, ozone therapy, chelation therapy, services or supplies, general debility, convalescence (convalescent home, convalescent hospital), or treatment received at health spa, hydro clinic, nature care clinics or similar establishments, run-down condition and rest cure, Hospitalisation for the purpose of physiotherapy, occupational therapy.

3. Self-medication or any treatment that is not scientifically recognized.

4. Any treatment/surgery for change of sex or treatment/surgery /complications/illness arising as a consequence thereof.
5. Alternative treatment
6. Any expenses arising out of dental treatment
7. Personal care items purchased during Hospitalization.

SECTION 2: Outpatient Benefits

2.2.1 *Scope of Cover:* The Company will indemnify the Insured against Medical Charges, as per section 2.2.2 of Part II of the Schedule, incurred by the Insured for medical treatment taken as an Outpatient of a Hospital or other approved health care facility (which are

empanelled and listed by the company or TPA), during the Policy Period, as a result of any Illness or Injury or as a consequence of Medically Necessary surgical procedure, subject to the Maximum Limit of Indemnity under this Policy.

2.2.2 Medical Charges reimbursable under Section 2:

Medical Charges incurred for the following services are covered under Section 2: Outpatient Benefits. Sub-limits for these charges are provided under clause 2.2.3

1. *Medical Emergency Services:* Treatment for Injury within twenty four (24) hours of the Accident.

2. *Emergency Medical Room:* Room, boarding and nursing expenses as charged by the Hospital or other approved health care facility

3. *Outpatient Surgery*: Minor surgical procedures inclusive of all invasive procedures including colonoscopy and endoscopy procedures. Shall also include charges for anesthesia, blood, oxygen charges; operation theatre charges; surgical consumables, diagnostic materials, X-ray, dialysis, chemotherapy, radiotherapy charges; cost of pacemaker, cost of artificial limbs, external medical aids, ambulance charges

4. *Outpatient Surgeon, Assistant Surgeon, Anesthesiologist, Consultants' Specialist Fee:* Fee paid by the Insured for availing the services of an outpatient surgeon, assistant surgeon, anesthesiologist, consultants and specialist.

5. *Prescription Drugs:* All Prescription Drugs must be used by the Insured while not being Confined in a Hospital, for a maximum period of three months, subject to the relevant sub limit. Prescribed Drugs related to organ transplants and subsequent treatment are governed by the benefits and limitations listed under the Human Organs Transplant section of this Policy. For Prescription Drugs used in the US and Canada, use of US Prescription Drug Pharmacy network or Canadian Mail Order Pharmacy network is mandatory

6. *Outpatient Medical Practitioner visits:* Medically Necessary visits to a Medical Practitioner in his office. Benefits are limited to one visit per day per Insured. If Medically Necessary, the Company may at its election reimburse the costs for more than one visit to different Medical Practitioners on the same day if they are of different specialties.

7. *Laboratory charges:* Laboratory charges and charges related to echocardiograph, ultrasound, CAT scan, MRI or PET scan, endoscopy, X ray and other laboratory tests.

8. *Blood Transfusion:* Blood transfusion and administration of blood products, durable medical equipment which do not require Hospitalisation.

9. *Physical or Occupational Therapy*: Radiation therapy, inhalation therapy, respiration therapy, chemotherapy, physical and occupational therapy, for which Hospitalisation is not required. Physical and occupational therapy shall be provided by a Medical Practitioner or a person authorized for rendering physical or occupational therapy. Services must be pursuant to a Medical Practitioner's written treatment plan, which contains short and long term treatment goals and is provided to the Company for review. **Video laryngoscopy (if Medically Necessary only)** may be performed by a person authorized for rendering speech therapy for the diagnosis of a swallowing dysfunction. All

other speech therapy services or treatments are excluded from coverage.

2.2.3 Sub-limits on Medical Charges reimbursable under Section 2

Treatment or service	Age 1-49	Age 50+
Emergency Medical Room (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Medical Emergency Services (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Outpatient Medical Practitioner Visit (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Consultation by Specialist (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Echocardiography, Ultrasound (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto USD 600 per exam
CAT SCAN (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto USD 800 per exam
MRI or PET Scan (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto USD 850 per exam
Endoscopy (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto USD 750 per exam
X Rays (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto USD 300 per exam
Laboratory Tests (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto USD 250 per exam
Physical or Occupational Therapy (Policy Period Sum Insured)	Upto USD 50 per visit subject to a maximum of 20 visits	Upto USD 65 per visit subject to a maximum of 40 visits
Outpatient Surgery (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Outpatient Surgeon (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Assistant Surgeon (Policy Period Sum Insured)	Upto 20% of allowable Surgeon's fee	Upto 20% of allowable Surgeon's fee
Anesthesiologist (Policy Period Sum Insured)	Upto 30% of allowable Surgeon's fee	Upto 30% of allowable Surgeon's fee
Prescription Drugs (including injectibles) (Policy Period Sum Insured)	Upto a maximum of USD 1,000	Upto a maximum of USD 1,000
Blood Transfusion, Plasma (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity

2.2.4 Exclusions applicable to section 2

Charges incurred on account of the following shall not be payable under Section 2: Outpatient Benefit

1. Any charges not specifically covered under Section 2 - Outpatient Benefit, or which are covered under any other section of this Policy.

2. Treatment received at health spa, hydro clinic, nature care clinics or similar establishments.

3. Massages, steam bathing, treatment related to run-down condition and rest cure, ozone therapy, chelation therapy and alike treatment.

4. Alternative treatment

5. Contraceptive drugs even if such drugs are prescribed for other than contraceptive purposes.

6. Weight reduction, smoking cessation, fertility/infertility, growth hormones or hair restoration drugs, even if prescribed by the Medical Practitioner.

2.2.5 Special Conditions applicable to Section 2

Pre-certification by Third Party Administrator and use of Preferred Provider Organization for outpatient surgery, CAT scans, PET scans, MRI procedure, chemotherapy and radiation therapy is necessary prerequisite for admissibility of a Claim under this cover. Failure to pre-certify a Preferred Provider Organization will result in a reimbursement reduction to the extent of 75% of covered charges, approved by the Company, for the entire episode of care.

SECTION 3: *Maternity and New born infant care Benefits*

2.3.1 Scope of Cover: The Company will indemnify the Insured against Medical Charges, as per section 2.3.2 of Part II of the Schedule, incurred by the Insured upon Hospitalisation, during the Policy Period, as a result of pregnancy, including but not limited to childbirth, prenatal, miscarriage and premature birth, subject to the Maximum Limit of Indemnity under this Policy. The coverage under this Benefit is subject to the Wating Period as specified in Part I of the Schedule to this Policy.

2.3.2 Medical Charges reimbursable under Section 3:

Medical Charges incurred for the following services are covered under Section 3: Maternity and New born infant care Benefits. Sub-limits for these charges are provided under clause 2.3.3

a. **Hospital and Obstetrical Services:**
   i. Hospital services rendered in a Hospital or approved birthing centre (including anesthesia, delivery and post-natal care) for any condition related to pregnancy, including but not limited to childbirth and miscarriage.
   ii. Obstetrical services (including prenatal, delivery and post-natal care) and anesthesia services by Medical Practitioners.

   Delivery includes normal delivery, elective caesarean-section and Medically Necessary caesarean-section.

b. **Newborn Infant Care Services:**
   Hospital nursery services and medical care provided by the attending Medical Practitioner for newborn infants in the Hospital shall be covered under this section of

the Policy for a period of 30 days from the date of birth of such new born infant only if the Insured is covered under “Maternity and New born infant care” benefits of the Policy.

However coverage for Insured’s new born infant for a period more than 30 days from the date of birth of such new born infant shall be available only if the Insured’s newborn infant’s proposal form for cover and applicable premium are received by the Company within thirty (30) days of the infant’s date of birth for enrollment under a separate International Health Policy for such new born infant and subject to the following:

Charges for Hospital nursery services and professional services for the newborn infant are covered separately from the Insured’s benefits under Section 3, of the Policy, and are subject to the satisfaction of the Policy Period Deductible and Copayment amounts in accordance with newborn infant’s Policy and the Schedule of Benefits in the newborn infant’s policy.

c. **Congenital Conditions/Premature Birth Services**: This benefit is available only to infants born to the Insured whose pregnancy is covered under Section 3 -Maternity and New born infant care Benefits of the Policy and provided the coverage is continuous and effective from the date of birth of such infant. Where the coverage is available, benefits are provided for Medically Necessary Inpatient and Outpatient services. Such benefits for specific congenital conditions or any sort of defect in the newborn infant due to premature birth will be payable in accordance with the Table of sub-limits 2.3.3 mentioned below.

2.3.3 Sub-limits on Medical Charges reimbursable under Section 3:

Treatment or service	**Age 1-49**	**Age 50+**
Hospital and Obstetrical Services (including Newborn Infant care services) (Policy Period Sum Insured)	Upto a maximum of USD 5,000	Not covered
Congenital Conditions / Premature Birth Services (Lifetime Sum Insured for newborns infants)	Upto a maximum of USD 100,000	Not covered

2.3.4 Special Conditions applicable to Section 3

The Company shall not be liable to make any payment under this Section 3 of the Policy in connection with or in respect of any pregnancy, occurring before the commencement of Period of Insurance or arising within the Waiting Period as mentioned in Part I of the Schedule to this Policy.

2.3.5 Exclusions applicable to Section 3

Charges incurred on account of the following shall not be payable under Section 3: Maternity and New-born infant care Benefit of this Policy:-

1. Any charges not specifically covered under Section 3 – Maternity and New-born infant care Benefit, or which are covered under any other section of this Policy.
2. Any charges incurred in respect of Insured who have attained an age of 50 years or more.
3. Any newborn infant born of a non-covered pregnancy and /or born of Insured who has received fertility or infertility treatments, unless agreed upon by the Company.
4. Any fertility/infertility services, tests, treatments and/or procedures of any kind, including, but not limited to, fertility/infertility drugs, artificial inseminations, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate mother and all other procedures and services related to fertility and infertility. Any pregnancy resulting from such treatments, complications of that pregnancy, delivery and postpartum care are also excluded. Coverage for newborn infants born to mothers who received fertility/infertility treatment is subject to the prevailing underwriting guidelines and eligibility requirements of the Company and will be at the sole discretion of the Company
5. Voluntary medical termination of pregnancy, elective abortions and complications thereof
6. Midwife services
7. Emergency air services, supplies or treatment provided for congenital conditions, hereditary conditions, birth anomalies except to the extent specified in this section
8. Personal care items purchased during a Hospitalization.

Section 4: Human Organ Transplant

2.4.1 Scope Of Cover: The Company will indemnify the Insured against Medical Charges, as per section 2.4.2 of Part II of the Schedule, incurred by the Insured upon his/her Admission, during the Policy Period, on account of a Medically Necessary, non- experimental transplantation as a receptor of a human organ specified in section 2.4.4, based on the advice of a Medical Practitioner, subject to the Maximum Limit of Indemnity under this Policy. The coverage under this Benefit is subject to the Waiting Period as specified in Part I of the Schedule to this Policy.

2.4.2 Medical Charges reimbursable under Section 4:

Necessary charges incurred for the following services are covered under Section 4: Human Organ Transplant. Sub-limits for these charges are provided under clause 2.4.3

1. Medical Charges incurred for availing Hospital, surgical and medical services, during organ transplant, shall be paid on the same basis and at the same level as other similar benefits under this Policy for the Insured
2. Approved storage and transportation costs which are incurred and directly related to the donation of a human organ used in a covered transplant procedure.

2.4.3 Sub-limits on Medical Charges reimbursable under Section 4:

Treatment or service	Age 1-49	Age 50+
Single organ transplant	Upto a Maximum of USD 125,000	Upto a Maximum of USD 125,000
Organ Transplant (Life Time Sum Insured)	Upto a Maximum of USD 250,000	Upto a Maximum of USD 250,000

2.4.4 Special Conditions applicable to Section 4

1. The following organs are covered for transplant under the Policy:
   i. Heart
   ii. Lungs
   iii. Kidney
   iv. Liver
   v. Pancreas
   vi. Cornea
   vii. Bone marrow transplants (covered only for approved diagnosis, including but not limited to aplastic anemia and severe immune deficiency; Hodgkin's disease; acute and chronic myelogeneous and granulocytic leukemia; multiple myeloma)
2. The Company shall not be liable to make any payment under this Section 4 in connection with or in respect of any organ transplant, occurring before the commencement of Period of Insurance or arising within the Waiting Period as mentioned In Part I of the Schedule to this Policy.
3. Benefits are limited to a Single transplant Sum Insured and Transplant Life Time Sum Insured per Insured as specified in Section 2.4.3 of Part II of the Schedule to this Policy, for all human organ transplants and related services, supplies, drugs and treatments. This limit would apply to all expenses related to an organ transplant procedure and follow-up care received while covered under this Policy. In respect of such a procedure, no benefit will be payable under any other section of this Policy
4. Transplant must be deemed necessary by two (2) independent medical or surgical consultants in the relevant medical specialty most closely related to the transplant.
5. Pre-certification and using Preferred Provider Organization for a human organ transplant is mandatory. The Insured or Insured's Medical Practitioner must give prior notice in writing to

the Company before a covered transplant procedure. Failure to pre-certify or failure to have the procedure performed in a Preferred Provider Organization will result in a reimbursement reduction to the extent of 50% of covered charges, approved by the Company, for the entire episode of care

2.4.5 Exclusions applicable to Section 4

Charges incurred on account of the following shall not be payable under Section 4: Human Organ Transplant

1. Any charges not specifically covered under Section 4 – Human Organ Transplant, or which are covered under any other section of this Policy.
2. Charges related to donors or donor organss
3. Subsequent transplants if the initial transplant was not covered under the Policy for any reason.
4. Transplant procedures and related services which are deemed experimental
5. Transplants resulting from or made necessary by congenital conditions are not covered under this Organ Transplant benefit. They are subject to the limitation and benefits applicable to the Congenital Conditions benefit specified in Part ll of the Schedule, Section 3- Maternity and New born infant care Benefits, and all terms and conditions mentioned thereof

Section 5: Mental Health Benefits

2.5.1 Scope of Cover: The Company will indemnify the Insured against Medical Charges, as per section 2.5.2 of Part II of the Schedule, incurred by the Insured, during the Policy Period, on account of a Medically Necessary mental health service in respect of a psychiatric treatment, if such treatment has been prescribed and rendered to the Insured as an Outpatient or Inpatient of a Hospital or other approved health care facility or an approved independent facility, and must be based on the advice of and carried out by a registered qualified psychiatrist for such facility and professional services, subject to the Maximum Limit of Indemnity under the Policy.

2.5.2 Medical Charges reimbursable under Section 5:

Medical Charges incurred for the following services are covered under Section 5: Mental Health Benefits. Sub-limits for these charges are provided under clause 2.5.3

1. 50% of Medical Charges upto the maximum amount as specified in the clause 2.5.3, for psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric diagnosis
2. Amounts that are paid on any balance remaining after the Company has reimbursed 50% of the Medical Charges for covered mental health care services will not be applied toward the Insured's Copayment.
3. All mental health care services must be provided by a Medical Practitioner or a licensed clinical psychologist. Services of a clinical psychologist must be rendered to the Insured as an Outpatient in the Provider's office

2.5.3 Sub-limits on Medical Charges reimbursable under Section 5:

Treatment or service	**Age 1-49**	**Age 50+**
Mental Health (includes psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric diagnosis) (Policy Period Sum Insured)	50% of Medical Charges upto a maximum of USD 1,000	50% of Medical Charges upto a maximum of USD 1,000
Mental Health (includes psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric diagnosis) (Lifetime Sum Insured)	Upto a maximum of USD 10,000	Upto a maximum of USD 10,000

2.5.4 Exclusions applicable to Section 5

Charges incurred on account of the following shall not be payable under Section 5: Mental Health Benefit

1. Any charges not specifically covered under Section 5 – Mental Health Benefits, or which are covered under any other section of this Policy.
2. Aptitude testing, educational testing and services
3. Services for conditions not classified by the TPA/ Company as emotional or personality Illnesses
4. Psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation
5. Services for mental disorders or Illness which are not amenable to favorable modification

Section 6: Durable Medical Equipment

2.6.1 Scope of Cover: The Company will indemnify the Insured against Allowable/Medical Charges, as per section 2.6.2 of Part II of the Schedule, incurred by the Insured, during the Policy Period, on account of a Medically Necessary prosthetic or artificial devices or any Durable medical equipment as specifically mentioned below and prescribed by a registered Medical Practitioner, subject to the Maximum Limit of Indemnity under the Policy.

2.6.2 Allowable/Medical Charges reimbursable under Section 6:

Necessary charges incurred for the following services are covered under Section 6: Durable Medical Equipment. Sub-limits for these charges are provided under clause 2.6.3

1. Allowable / Medical Charges incurred by the Insured for obtaining prosthetic devices (artificial devices replacing body parts), orthopedic braces and Durable medical equipment (including but not limited to wheelchairs and Hospital beds)
2. Prosthetics may include, but are not limited to leg, arm, back, and neck braces, artificial legs, arms and eyes. The amount payable is based on the reasonable charge for the equipment, which meets the Insured's basic medical needs.
3. Medical Charges in respect of one breast prosthesis for cancer patients who have a mastectomy shall be covered under this Policy.
4. Allowable charges for repairs or replacement of artificial devices, prosthetics or other Durable medical equipment originally obtained under this Policy will be paid at 50% of the Reasonable and Customary Charges incurred.

2.6.3 Sub-limits on Allowable/ Medical Charges reimbursable under Section6

Treatment or service	Age 1-49	Age 50+
Durable medical equipment: Rental amount up to purchase price / repairs or replacement charges (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Prosthetics/ artificial devices: Purchase Price / repairs or replacement charges (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity

2.6.4 Special Conditions applicable to Section 6

Such Durable medical equipment should satisfy the following conditions:

1. Prescribed by a Medical Practitioner
2. Customarily and generally useful to a person only during an Illness or an Injury
3. Determined by the TPA to be Medically Necessary and appropriate
4. Rent amount must not exceed the allowable purchase price of the durable medical equipment.

2.2.4 Exclusions applicable to Section 6

Charges incurred on account of the following shall not be payable under Section 6: Durable Medical Equipment

1. Any charges not specifically covered under Section 6 – Durable Medical Equipment, or which are covered under any other section of this Policy.
2. Bras will not be a covered expense.
3. Charges for repairs or replacement of artificial devices, prosthetics or other durable medical equipment not originally obtained under this Policy.

Section 7: Extended Care/ Inpatient Rehabilitation

2.7.1 Scope of Cover: The Company shall indemnify the Insured, against Medical Charges incurred, as per section 2.7.2 of Part II of the Schedule, during the Policy Period, for Medically Necessary rehabilitation or Confinement and related services as deemed necessary by a registered Medical Practitioner, as a result of a covered Illness, or Injury, provided in an approved Extended Care Facility following, or in lieu of, an admission to a Hospital, subject to the Maximum Limit of Indemnity under this Policy.

2.7.2 Medically Necessary services covered under Section 7:

Necessary Medical Charges incurred for the following services are covered under Section 7: Extended care/ Inpatient rehabilitation. Sub-limits for these charges are provided under clause 2.7.3

1. Skilled nursing and related services to an Inpatient who requires medical or nursing care for a covered Illness/ Injury.
2. Rehabilitation for the Inpatient who requires such care because of a covered Illness, or Injury

N 2.7.3 Sub-limits on Medical Charges reimbursable under Section 7:

Treatment or service	Age 1-49	Age 50+
Extended Care Daily benefit	Upto a maximum of USD 500 per day	Upto a maximum of USD 500 per day
Extended Care (Policy Period Sum Insured)	Upto a maximum of USD 15,000 over a Policy Period	Upto a maximum of USD 15,000

2.7.4 Special Conditions applicable to Section 7

1. The Company reserves the right to review a Confinement, as it deems necessary, to determine if the stay is medically appropriate

2.7.5 Exclusions applicable to Section 7

Charges incurred on account of the following shall not be payable under Section 7: Extended Care/ Inpatient Rehabilitation

1. Any charges not specifically covered under Section 7 – Extended care/ Inpatient rehabilitation, or which are covered under any other section of this Policy.
2. Intermediate, custodial, rest and homelike care services
3. Services which are not skilled and not approved by a registered Medical Practitioner.

Section 8: Emergency Ambulance

2.8.1 Scope of Cover: The Company will indemnify the Insured against Allowable Charges, as per section 2.8.2 of Part II of the Schedule, incurred by the Insured, during the Policy Period, on account of a Medically Necessary Emergency ambulance service, for transportation of the Insured, by air or ground, to the nearest Hospital, as a result of an Illness or Injury, subject to the Maximum Limit of Indemnity under the Policy.

2.8.2 Allowable Charges reimbursable under Section 8:

Necessary charges incurred for the following services are covered under Section 8: Emergency ambulance. Sub-limits for these charges are provided under clause 2.8.3

1. *Emergency Ground Ambulance Services:* Medically Necessary Emergency ground ambulance transportation to the nearest Hospital which is able to provide the required level of care.

2. *Emergency Air Ambulance Services:* Medically Necessary Emergency air ambulance transportation to the nearest Hospital which is able to provide the required level of care. This benefit is subject to a per occurrence maximum limit of indemnity as per table 2.8.3 below

   Charges pertaining to the following services rendered will be covered under Emergency Air Ambulance services:

   (a) **Medical Evacuation:** The Company will reimburse the necessary and reasonable travel expenses incurred as a result of evacuation of the Insured under a Medical Emergency to the nearest Hospital or any other approved facility. For the purposes of this section 'Medical Emergency' shall cover only myocardial infarction, cerebro vascular accident and multiple injuries caused due to an Accident which may result in a life threatening and unforeseen emergency situation requiring immediate medical intervention not available within the specified limits.

   (b) **Repatriation of Mortal Remains:** The Company will reimburse the necessary transport expenses for the return of an Insured's mortal remains through the Company's nominated air transport agency (wherever applicable) to the normal place of residence, as specified in Part I of the Schedule to this Policy, by the shortest route.

2.8.3 Sub-limits on Allowable Charges reimbursable under Section 8:

Treatment or service	Age 1-49	Age 50+
Emergency Ground Ambulance (Policy Period Sum Insured)	Upto Maximum Limit of Indemnity	Upto Maximum Limit of Indemnity
Emergency Air Ambulance per occurrence (Policy Period Sum Insured)	Upto a maximum of USD 25,000	Upto a maximum of USD 25,000
Emergency Air Ambulance	Upto a maximum of	Upto a maximum of

(Lifetime Sum Insured)	USD 100,000	USD 100,000

2.8.4 Special Conditions applicable to Section 8

Pre-authorization is mandatory before the Insured incurs any evacuation and assistance costs for any transportation. If the Insured does not obtain pre-authorization in case of Emergency Air Ambulance, then the Insured will have to bear the full costs. However in case of Emergency Ground Ambulance, the Insured needs to obtain pre-authorization within 48 hours of availing of this service, failing which he will have to bear the full cost.

2.8.5 Exclusions applicable to Section 8

Charges incurred on account of the following shall not be payable under Section 8: Emergency Ambulance

1. Any charges/ services not specifically covered under Section 8 – Emergency Ambulance, or which are covered under any other section of this Policy.
2. If the Insured could have been transported in a private car if one was available, the ambulance is not covered.

Section 9: Wellness and Preventative Benefits

2.9.1 Scope of Cover: The Company will indemnify the Insured against Allowable Charges, as per section 2.9.2 of Part II of the Schedule, incurred by the Insured, during the Policy Period, for routine physical examinations and related diagnostic testing, subject to the Maximum Limit of Indemnity under the Policy.

2.9.1.1 Routine physical examinations and related diagnostic testing: Benefits are provided for the Medical Practitioner office visits and diagnostic testing charges for routine preventative examinations provided there were no symptoms, conditions or diagnosis. Only those visits, diagnostic tests and other procedures related to routine physical examinations are covered.

2.9.2 Allowable Charges reimbursable under Section 9:

Necessary charges incurred for the following services are covered under Section 9: Wellness and preventative benefits. Sub-limits for these charges are provided under clause 2.9.3

1. **Child Wellness:** Benefits for the wellness visits and medical exams as specified below, are payable in accordance with the Table of sub-limits 2.9.3, subject to the Maximum Limit of Indemnity under the Policy.

   i. **Well Child Routine Medical Exams**: upto the age of 19

      Services include:

      - Health History
      - Physical Examinations
      - Development Assessments
      - Anticipatory Guidance
      - Appropriate Immunizations and
      - Age Related Diagnostic Tests

2. **Adult Female Wellness:** Benefits are provided based on age, which include Medical Practitioner office visit, routine blood and urinalysis, routine gynecological examinations, including PAP tests and routine mammogram, as mentioned below:
   i. **Routine Physical Examinations**
      - Ages 19 and beyond - One exam annually

   ii. **Routine Mammogram**
      - Ages 35-39: One baseline exam
      - Ages 40-49: One exam every year
      - Age 50 and beyond: One exam every year
      - (Required every twenty-four (24) months for Insured aged 50 or more)Age less than 35: Whenever necessary

   iii. **Papanicolaou (PAP) Screening**
      - Any Age: One test per Policy Period for all females.
      - Age 50 plus: One test per Policy Period for all females

      (Required every twenty-four (24) months for Insured aged 50 or more)

3. **Adult Male Wellness:** Benefits are provided, based on age for routine physical examinations to include Medical Practitioner office visit, routine blood urinalysis and Prostate-Screening Antigen (PSA) screening as mentioned below:
   i. Routine Physical Examinations
      - Ages 19 and beyond - One exam annually

   ii. Prostate-Specific Antigen (PSA) Screening Test
      - Up to Age 49: No benefit for routine PSA test
      - Age 50 and more: One test every Policy Period

      (Required every twenty-four (24) months for Insured aged 50 or more)

4. **Wellness Diabetic Education:** Educational services provided to a diabetic patient that provides information relating to diabetes, the medical necessary care that is required for self analysis and/or directives on dietary analysis and restrictions as directly related to being a diabetic.

2.9.3 Sub-limits on Allowable Charges reimbursable under Section 9:

Treatment or service	Age 1-49	Age 50+
Child Wellness : upto age 19 (Policy Period Sum Insured)	Upto USD 50 per visit and upto maximum USD 100	Benefit not available
Adult Female : Age 19 and beyond Routine Physical Exam, PAP & Mammogram	Upto maximum USD 100	Upto maximum USD 250
Adult Male : Age 19 and beyond Routine Physical Exam, PSA exam (Policy Period Sum Insured)	Upto maximum USD 100	Upto maximum USD 250
Wellness Diabetic Education (Policy Period Sum Insured)	Upto maximum USD 100	Upto maximum USD 250

2.9.4 Special Conditions applicable to Section 9

1. Policy Period Deductible and Copayment, as specified in Part I of the Schedule to this Policy do not apply for this particular benefit.
2. Failure to have the required exam results every twenty-four (24) months at renewal will result in a 50% reduction for any treatments, services and supplies covered under this Policy, for the Policy Period.

Surgical and Medical benefits as applicable for Sections 1 – 4.

1. **Surgical Services**: Benefits will be provided for covered surgical services received in a Hospital or a Medical Practitioner's office or an approved surgical facility for the following:
   (a) Operative and cutting procedures
   (b) Treatment of fractures and dislocations
   (c) When Medically Necessary, assistant surgical fees will be paid up to 20% of the Medical Charge of the primary surgeon
2. **Surgical/ Multiple Surgical Procedures:** Benefits will be provided for covered surgical procedures received in a Hospital or a Medical Practitioner's office or an approved surgical facility only.
   (a) When multiple or bilateral surgical procedures are performed by the same physician through separate incisions during the same operation, the Company will pay the applicable percentage of the total Medical Charge for the procedure which has the highest charge plus half of the Medical Charges for the remaining procedure(s).
   (b) When multiple surgical procedures are performed by the same physician through the same operative incision, the Company will pay the applicable percentage of the Medical Charges only for the one procedure which has the highest cost.
   (c) When a surgical procedure normally performed in one stage is performed in two or more stages, the surgical payment for the entire procedure is the same as it would be were the procedure performed in one stage.
3. **Anesthesia Services:** Benefits are provided for the service of an anesthesiologist, other than the operating surgeon or his/her assistant, who administers anesthesia for a covered surgical or obstetrical procedure and are payable up to 30% of the Medical Charges of the primary surgeon in accordance to the current Schedule of Benefits.

3. POLICY EXCLUSIONS AND LIMITATIONS

The following services, conditions and other items are excluded from coverage under the Policy:

1) In case of Pre-Existing Conditions, benefits will not be available until 48 months of continuous coverage have elapsed, since inception of the first International Health Policy with us.

2) Any Claim arising within first 120 days from the commencement of Period of Insurance which is in excess of 2500 USD, post satisfaction of Policy Period Deductible and Co-pay Limits, as explained under clause number 6.4 i.e. "Assessment of Claims" of the Policy. However, this exclusion shall not apply for any Medical Emergency

related services, as covered under the Policy.

3) Expenses incurred on treatment of following diseases within the first 12 months from the commencement of the Period of Insurance, will not be payable:
   - Cataract
   - Benign prostatic hypertrophy
   - Myomectomy, endometriosis, hysterectomy unless because of malignancy (Proven on biopsy)
   - All types of hernia, hydrocele, varicocele
   - Fissures &/or fistula in anus, haemorrhoids/piles, pilonidal sinus
   - Arthritis, gout, rheumatism and spinal disorders including Prolapse Intervertebral Disc (PIVD)
   - Sinusitis and related disorders
   - Stones in the urinary and biliary systems
   - Therapeutic dilatation and curettage
   - All types of skin and internal tumours/ cysts/nodules/ polyps/ulcers of any kind including breast lumps unless malignant(proven on biopsy)
   - Haemodialysis required for chronic renal failure
   - Surgery on tonsils, adenoids and sinuses, chronic suppurative otitis media
   - Gastric and duodenal ulcers
   - Deviated Nasal Septum(DNS)
   - Surgery for varicose veins
   - Coronary Artery Bypass Graft (CABG)
   - Percutaneous Transluminal Coronary Angioplasty (PTCA)
   - Heart valve replacement
   - Heart Surgery

4) Expenses incurred on treatment of following diseases within the first twenty four (24) months from the commencement of the Period of Insurance, will not be payable:
   - Joint replacements unless due to Accident

5) Any fertility/infertility services, tests, treatments and/or procedures of any kind, including, but not limited to, fertility/infertility drugs (including contraceptives, even if used for other than contraceptive purposes), artificial inseminations, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate mother and all other procedures and services related to fertility and infertility
6) Dental services
7) Services and supplies related to visual therapy or orthoptics, routine vision exams, eyeglasses, contact lenses or hearing aids and/or examination for the prescription or fitting of same, except to the extent as specified in this Policy and the Schedule of Benefits.
8) Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and corrective shoes.
9) Rest cures, custodial care or homelike care, whether or not they are prescribed by the Medical Practitioner.
10) Treatment, services, benefits, supplies, drugs and/or emergency air services payable by another insurance company or government or treatment rendered without cost by any institution that is owned or operated by the government of any country
11) Services, supplies or treatment provided by the Insured, a family member or any enterprise owned partially or completely by the aforementioned persons.

12) Diagnostic examinations or laboratory test performed as a Hospital Inpatient for the convenience or observation when these services can be safely performed as an Outpatient.
13) Services by a medical department of Insured's employer, school, infirmary or student health staff.
14) Services or supplies for cosmetic purposes, including but not limited to , aesthetic treatment, treatment of acne, breast augmentation and/or reduction, cosmetic and plastic surgery including any complications arising out of or attributable to these, unless necessitated due to Accident or as a part of any Illness.
15) Treatment, emergency air services, supplies or services provided for congenital conditions/ premature birth except as specified in the relevant section in Part II of the Schedule to this Policy.
16) Treatment, emergency air services for drug and alcohol use/abuse and/or any related condition.
17) All services, including emergency air services not directly related to or Medically Necessary for the diagnosis or treatment of an Illness or Injury
18) Routine services including but not limited to diagnostic tests, x-rays immunizations, vaccinations (unless post animal bite), or physical examinations except as specified in the Wellness and Preventive Benefits section of this Policy.
19) Services and/or drugs in any way related to the treatment of alopecia (unless for an approved medical diagnosis), weight reduction and smoking cessation whether or not recommended by a Medical Practitioner.
20) Services and supplies which are deemed to be experimental or investigational.
21) Human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), aids related complex (ARC), sexually transmitted diseases and all related conditions.
22) Any Injury/Illness sustained or contracted due to war invasion, act of foreign enemies, hostilities (whether declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, riot, strike, lockout, military or popular uprising, civil commotion martial law, loot, sack or pillage.
23) Any losses directly or indirectly due to contamination caused by any act of terrorism, regardless of any contributory causes (if the Company alleges that by reason of these exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured.)
24) Any Injury/Illness sustained or contracted due to nuclear weapons, materials ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
25) Emergency ambulance for Illness or Injury directly or indirectly related to war, invasion, act of a foreign enemy, civil war, , rebellion, revolution, insurrection, civil commotion, military or usurped power, martial law, riots or act of any lawfully constituted authority, army, naval operation, nuclear accident or emergency air services whether war has been declared or not.
26) Pregnancy and or any related condition, except ectopic pregnancy, which arises during the Waiting Period as specified against the relevant section in Part I of the Schedule to this Policy.
27) Voluntary sterilization and complication thereof, including reversal of voluntary sterilization.
28) Services and treatment , supplies, laboratory tests or imaging services prescribed or rendered by a chiropractor, naturopaths, homeopaths, naturopathic or homeopathic medications or supplements and any other alternative methods of treatment
29) All self-inflicted Injuries including suicide or attempted suicide and emergency

ambulance for the same

30) Treatment or emergency services required as a consequence or complication of services not covered under this Policy including, but not limited to, treatment rendered as follow up to non-covered services or recommended by non-covered Providers.
31) Services related to the following therapies: speech, cardiac rehabilitation, physical and occupational, except as specified in this Policy
32) Tempormandibular joint disorder (TMJ) and all related services and conditions.
33) Services rendered by a licensed clinical social worker or licensed psychiatric social worker.
34) Sexual dysfunction and all related services, supplies, drugs and treatment.
35) Allergy testing and treatment, routine foot care including corns and calluses.
36) All services, supplies, emergency air services and/or treatments, under the direction of public authorities, related to epidemics.
37) Physical, psychological, educational and emotional developmental disorders including but not limited to attention deficit/hyperactivity disorder (ADD/ADHD).
38) All services, supplies and treatment related to acupuncture, acupressure, hypnotherapy, cognitive therapy, primal therapy, rolfing, psychodrama, megavitamin therapy, carbon dioxide therapy and bio-energetic therapy, both Inpatient and Outpatient.
39) Emergency air services for cases which has not been pre-authorized and approved and for Illnesses/ Injuries, mental diseases which can adequately be treated locally.
40) Any case directly or indirectly related to criminal acts.
41) Growth hormones.
42) Reimbursement for photo copies, taxes and any other not covered expense.
43) Charges not incurred during the Policy Period
44) Any charges resulting from participation in professional sporting events and dangerous sporting activities as determined by the Company and more specifically including, motor-racing, aerial sports, circus, skiing, mountaineering, big game hunting, ballooning, hang gliding, bungee-jumping, river rafting, winter sports, ice hockey ,polo & such other activities
45) Treatment, services, benefits, supplies, drugs and/or emergency air services that are provided free of charge or would not have been charged in the absence of insurance
46) Telephonic consultations
47) Emergency room treatment if no Emergency exists
48) Injuries and/or Illnesses resulting or arising from or occurring during the commission of continuing perpetration of a violation of law by an Insured with any criminal intent
49) Health care services and associated expenses related to or associated with treatment of morbid or non-morbid obesity, including, but not limited to, gastric bypass, gastric balloons, gastric stapling, jejunal, ileal bypass, and any other procedures or complications arising there from. Medical fast diets, weight loss programs and educational dietary counseling related to weight loss efforts
50) Health care services associated with conditions as a result of travel undertaken despite health care Provider's advice against travel because of health reasons, including, but not limited to, necessary surgery, pending delivery or treatment in progress.
51) Health care services and associated expenses for conditions for which the Insured refuses to follow a recommended treatment plan when a health care Provider, based on acceptable standards of care, believes that no professionally acceptable alternative exists and the Insured has been so advised and upon being advised, refuses to follow the recommended treatment plan or terminates the scheduled services or treatment against the advise of the health care Provider

52) Personal comfort and convenience items including but not limited to, television, private rooms, house keeping services, guest meals and accommodations, special diets, telephone charges, take home supplies, travel expenses, ambulance services (other than those provided by this Policy), and all other services, including private duty nursing and supplies that are not Medically Necessary and do not form a part of Accommodation charges as covered under the Policy
53) Items that can be obtained over the counter without a prescription are not covered except for diabetic test strips and lancets
54) Genetic counseling, screening, testing or treatment
55) Any stay in the Hospital for any domestic reason or where no active regular treatment is given by the specialist or treatment taken for general debility, convalescence (convalescent home, convalescent Hospital).
56) Any treatment related to sleep disorder or sleep apnoea syndrome.
57) Any treatment undertaken after the point at which it is certified by a Medical Practitioner that the condition is of such a nature that further medical treatment may serve to stabilize or maintain it but is unlikely to result in a material improvement within a reasonable time frame
58) List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy as per the Standardisation Guidelines given by IRDA.

4. GENERAL TERMS AND CONDITIONS APPLICABLE TO THE POLICY

It is hereby declared and agreed that:

1. Any notice or declaration for the attention of Insured shall be deemed served if sent by the Company to the Policyholder at his/her address given in the Schedule.

2. Any payment, due to the Insured under this Policy shall be paid by the Company to the Policyholder and the receipt by the Policyholder shall be complete discharge of the Company’s liability against the claim. The Company shall not be responsible for any liability arising out of the Policyholder’s delay or default in making payment to any Insured. However, the Company reserves its right to pay the Claim directly to the Insured in whose respect the Claim has been lodged.

3. The Company shall have full discretion to decide under which Section, a particular claim should be payable.

4. All Claims admitted by the Company as a liability, having denomination other than USD, shall be paid in the respective currency of invoice, but shall be converted into equivalent USD based on the exchange rate applicable as on the date of settlement of claim for purposes of calculating the balance Sum Insured. All Claims worldwide shall be subject to Reasonable and Customary Charges as determined by the Company.

5. It is the Insured's responsibility to keep records of amounts paid as Claim under each Section. Neither the Company nor the TPA undertakes to give notification regarding the utilization of Policy limits. Claims submitted after the Maximum Limit of Indemnity has been reached, will be rejected.

6. Denial of Liability: The Company is not responsible for the quality of care received from any institution or individual. This Policy does not give the Insured any claim,

right or cause of action against the Company, based on an act of omission or commission of a Hospital, Medical Practitioner or other Provider of care or service

7. The Company has full and exclusive discretion in determining whether to make payment to the Insured or to the Provider. Benefit payments under this Policy are not assignable.

5. SPECIAL TERMS AND CONDITIONS APPLICABLE TO THE POLICY

1. Any Extension under this Policy shall be opted only at the inception of this Policy.

6. CLAIMS ADMINISTRATION

It is a condition precedent to the Company's liability that upon the discovery or happening of any Illness or Injury that may give rise to a claim under this Policy, the Insured or (if the Insured is incapacitated or a minor, then his representative) shall undertake the following:

6.1 CLAIM NOTIFICATION

The Insured or his representative, as the case may be, shall give immediate notice to the appointed Third Party Administrator or the Company by calling the toll free number as specified in the health card/ Policy provided to the Insured and also in writing at the address of the Company with particulars as below:

- Policy number;
- Name of the Insured availing treatment;
- Policyholder's relation to the Insured;
- Nature of Illness or Injury;
- Name and address of the attending Medical Practitioner and Hospital/ Provider/ Extended Care Facility / approved facility; and
- Any other information that may be relevant to the Illness/ Injury/ Hospitalisation/ Confinement.

The above information needs to be provided to the TPA/Company immediately and prior to availing treatment. If the information is not received within 30 days of admission, by the TPA / Company, then the TPA/Company has the right to treat the claim as inadmissible, as they may deem fit at their sole discretion.

6.2 PRE – CERTIFICATION REQUIREMENTS

For certain designated services, treatments, as mentioned below, Pre certification for using Preferred Provider Network or other approved facility is mandatory:

1. Hospitalisation
2. Outpatient Surgery
3. CAT Scans, PET Scans, MRI Procedures
4. Chemo and Radiation Therapy
5. Human Organ Transplant

Non-emergency Pre-certifications must be received 72 hours in advance of the Admission or procedure.

Medical Emergency Pre-Certifications must be received within 48 hours of the Admission or procedure.

The fact that certain medical services have been Pre-Certified as Medically Necessary does not mean that they will be covered by this Policy.

Failure to pre-certify and to utilize the appropriate network when required shall result in a reimbursement reduction to the extent of 75% of covered charges (for point 1-4, as mentioned above) and reimbursement reduction to the extent of 50% of covered charges (for point 5, as mentioned above). However, this condition shall cease to apply in case the Insured fails to pre-certify due to justified unavoidable circumstances.

6.3 CLAIM PROCESSING

The TPA appointed by the Company will process the claim on behalf of the Company and make all payments in the currency of the country in which treatment has been taken. However all claims denominated in currency other than the USD shall be converted into equivalent USD, based on the exchange rate applicable as on the date of settlement of Claim, and the maximum limit of indemnity shall be revised accordingly.

The Proposer or the Insured is required to deliver at their own costs, to the TPA/Company, within 30 days of the Insured's discharge from Hospital, any and all information and documentation in original concerning the Claim or the Company's liability for it, including but not limited to:

- Duly completed claim form(s).
- Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner/Provider or other approved facility where the treatment was taken.
- Original bills from chemists supported by proper prescription.
- Original investigation test reports and payment receipts.
- Indoor case papers
- Medical Practitioner's referral letter advising Hospitalisation in non- Accident cases.
- Any other document as required by the Company/ TPA to investigate the Claim or Our obligation to make payment for it.

If so requested by the TPA/Company, the Insured will have to submit to a medical examination by the Company's or TPA's nominated Medical Practitioner as and when the TPA/Company considers necessary for the existing covers, the cost of the same would be borne by the Company
In the event of Insured's death, written notice accompanied by a copy of the post mortem report (if any) should be given by nominee/legal heir, as applicable to the Company within 14 days regardless of whether any prior notice has been given to the Company. In addition, the Company shall have the right to require an autopsy in case of the death.

CASHLESS HOSPITALISATION FACILITY

The Company shall also provide a Health card to the Insured under this Policy to avail of Cashless Hospitalisation facility. The Insured can avail this facility under the Policy at the time of admission into any Hospital, Provider or any approved facility which has a tie-up with the TPA/Company by production of this card subject to the terms and conditions for the usage of the card as communicated by the TPA/Company.

Cashless facility will not be available if treatment is taken in a Hospital or provider where the TPA/Company does not have any tie-up to provide such facility.

6.4 ASSESSMENT OF CLAIMS

When the Company shall admit liability for a Claim, the assessment of Claims will be done on the following basis:

6.4.1 Policy Period Deductible: The Company shall be liable to pay for the Allowable/ Medical Charges, only once the Allowable/ Medical Charges exceed the chosen Policy Period Deductible amount as mentioned in Part I of the Schedule to this Policy, in aggregate during the Policy Period.

6.4.2 Policy Period Co-payment: The Claim amount admissible under the Policy post satisfaction of the Policy Period Deductible (as mentioned in Part I of the Schedule to this Policy) shall be shared by the Insured upto the percentage as mentioned against Co-payment in point No. 10 in part I of the Schedule to this Policy, until the Aggregate Maximum Copayment Limit is reached.

6.4.3 Post satisfaction of Clause 6.4.1 and 6.4.2, the remaining admissible claim amount shall be fully borne by the Company, subject to the Maximum Limit of Indemnity under the Policy and as per the respective table of sub-limits as applicable under Sections 1-9 in Part ll of the Schedule

Settlement/Rejection of Claim –The settlement of claims would be done by Us within 30 days, any rejections if done, would be provided with proper reasons by Us. The role of the TPA (if any) would be limited to facilitate the flow of information between You and Us.

Penal interest provision shall be as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2002.

6.5 LIMITATION PERIOD

Notwithstanding anything to the contrary stated herein, the Company shall not be liable to admit any claims under the Policy if the same is not intimated within 30 days of the date of Admission/availing treatment in writing to the Company or TPA (as applicable).;

It being expressly agreed and declared that if the Company shall disclaim liability for any Claim hereunder and such Claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the Claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

7 ADDITIONAL INFORMATION

Payment of renewal premium in case the Insured opts for Annual premium payments:

If the Policy is renewed, and the renewal premium is received within 30 days (Grace Period) from the Policy Period End date, the Company shall offer renewal policy with continued coverage. However the Company shall not be liable for any Claim during the Period for which the premium is not received.

If the renewal premium is received after 31 days and within 45 days following the Policy Period End date, then a completed good health declaration will be required in order to process the renewal. Upon the satisfaction of the Company that there has been no materially adverse change in circumstances mentioned in the proposal or declaration herein before mentioned and that nothing is known to the Insured that may result in enhancement of risk under the Policy hereby given, the Company shall offer renewal policy with continued coverage. Nothing herein or otherwise shall affect the Company's 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 the Company and signed by an authorised official of the Company.

However, if the renewal premium is received after 46 days following the Policy Period End date, then the existing coverage shall cease to continue and the Company shall not renew the existing Policy in any case. If the person wishes to have insurance coverage thereafter, then he/ she has to reapply for the coverage under a new policy altogether subject to full underwriting, and if accepted, a new policy will be issued by the Company, subject to the Waiting Periods, as applicable.

TERMS OF RENEWABILITY

a. *Guaranteed Renewals* – We will provide you guaranteed renewal coverage, subject to your timely payments of premium and provided you have not exhausted your **Life time Sum Insured** of USD 1 million.

b. *Renewal Premium* – Premium payable on renewals and on subsequent continuation of cover are not guaranteed and subject to change with prior approval from IRDA

- The Policy can be renewed under the then prevailing International Health Policy product or its nearest substitute (in case the product International Health Policy is withdrawn by the Company) approved by IRDA.
- A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured

The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the Policy and in no case later than 30 days (Grace Period) from the expiry of the Policy. The Insured will be treated as continuously covered in terms of continuity of benefit during such Grace Period. However, the Company shall not be liable for any claim for the period for which the premium is not received by the Company.

If the renewal premium is received after 31 days and within 45 days following the Policy Period End date, then a completed good health declaration will be required in

order to process the renewal. Upon the satisfaction of the Company that there has been no materially adverse change in circumstances mentioned in the proposal or declaration herein before mentioned and that nothing is known to the Insured that may result in enhancement of risk under the Policy hereby given, the Company shall offer renewal policy with continued coverage. Nothing herein or otherwise shall affect the Company's 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 the Company and signed by an authorised official of the Company.

However, if the renewal premium is received after 46 days following the Policy Period End date, then the existing coverage shall cease to continue and the Company shall not renew the existing Policy in any case. If the person wishes to have insurance coverage thereafter, then he/ she has to reapply for the coverage under a new policy altogether subject to full underwriting, and if accepted, a new policy will be issued by the Company, subject to the Waiting Periods, as applicable.

PART III OF THE SCHEDULE

Standard Terms and Conditions

1. *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 or any one acting on his behalf to obtain any benefit under this Policy.

2. *Reasonable Care*

The Insured shall take all reasonable steps to safeguard the interests of the Insured against any circumstances that may give rise to the Claim.

3. *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, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

4. *Material change*

The Insured shall immediately notify the Company in writing of any material change in the risk in relation to the queries made in the proposal form and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

5. *Records to be maintained*

The Insured shall keep an accurate record containing all relevant medical records and shall allow the Company to inspect such record. The Insured shall also exercise necessary co-operation in obtaining the medical records from the hospital, as may require in relation to the Claim within such reasonable time limit as specified in the Policy.

6. *No constructive Notice*

Any knowledge or information of any circumstances or condition in connection with the Insured in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

7. *Notice of charge etc.*

The Company 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 the Company to the Insured or his legal representative of any compensation or benefit under the Policy shall in all cases be an effectual discharge by the Company.

8. *Overriding effect of Part II of the Schedule*

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

9. *Duties of the Insured on occurrence of loss*

On the occurrence of any loss, within the scope of cover under the Policy the Insured shall:
(i) Forthwith file/submit a Claim Form in accordance with ‘Claim Procedure’ Clause as provided in Part II of the Schedule.
(ii) Assist and not hinder or prevent the Company or any of its representatives from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.
If the Insured does not comply with the provisions of this Clause or other obligations cast upon the Insured under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at the option of the Company.

10. *Subrogation*

In the event of payment under this Policy, the Company shall be subrogated to all the Insured’s rights or recovery thereof against any person or organisation, and the Insured shall execute and deliver instruments and papers necessary to secure such rights.

The Insured and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured’s indemnification, in enforcing or

endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated.

11. *Contribution*

If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would but for the existence of this Policy) and the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, in the same Claim (in whole or in part), then We shall not be liable to pay or contribute more than Our rateable proportion of any Claim.

However, this condition shall not be applicable for all the benefit based covers under the Policy, as applicable

12. *Fraudulent claims*

If any claim 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 or anyone acting on his behalf to obtain any benefit under this Policy, or if a claim is made and rejected and no court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

13. *Cancellation/ termination*

(a) **Disclosure to information norm**
The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
(b)The Policyholder/ Insured may also give 15 days notice in writing to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales as mentioned herein 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.

PERIOD ON RISK	RATE OF PREMIUM RETAINED
Up to 1 month	25% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	75% of annual rate
Exceeding six months	100% of annual rate

14. *Policy Disputes*

It has been agreed between the parties that any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to be adjudicated or interpreted in accordance with the Laws of India and the competent courts in India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

15. *Arbitration clause*

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

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

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

16. *Renewal notice*

a) We shall ordinarily renew the policy except on grounds of moral hazard, misrepresentation or fraud or non cooperation by the Insured. We shall not be bound to give notice that the renewal premium is due. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to You that may result to enhance Our risk under the guarantee hereby given. Any change in the risk will be intimated by You to Us. 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.
b) The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to Us on or before the date of expiry of the Policy and in no case later than Grace Period of 30 days from the expiry of the Policy

17. *Notices*

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

In case of the Insured, at the last known address of the Insured.

In case of the Company:

ICICI Lombard General Insurance Company Limited
ICICI Bank Towers
Bandra Kurla Complex
Mumbai 400 051

AND

ICICI Lombard General Insurance Company Limited
Zenith House
Keshav Rao Khadye Marg
Mahalaxmi
Mumbai 400 034.

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.

18. *Customer Service*

If at any time the Insured requires any clarification or assistance, the Insured may contact the offices of the Company at the address specified, during normal business hours.

19. *Free Look Up period*

You would be given a period of 15 days (Free Look Period) from the date of receipt of the Policy to review its terms and conditions. Where the Policy Holder disagrees to any of the terms or conditions of the Policy, he has the option to return the Policy stating the reasons for his objection, when he shall be entitled to a refund of the premium paid, subject only to a deduction of the expenses incurred by Us on medical examination of the Insured Person(s) and the stamp duty charges. In case the request for cancellation comes 30 days after the Policy Period start date, pro-rata refund of premium would be paid to You

20. *Grievances*

In case the Insured is aggrieved in any way, the Insured should do the following:

1. Call the Company at toll free number: 1800 209 8888 or email us at insuranceonline@icicilombard.com

2. If he/she is not satisfied with the resolution then he/she may successively write to the 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
   Zenith House, Keshavrao Khadye Marg,
   Mahalaxmi, Mumbai-400 034

If the issue still remains unresolved, he/she may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of his grievance.

The details of Insurance Ombudsman are available below:

Ombudsman Offices	
Delhi, Rajasthan	2/2 A, 1st Floor, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI – 110 002
West Bengal, Bihar	29, N. S. Road, 3rd Fl., North British Bldg. KOLKATA -700 001
Maharashtra	3rd Flr., Jeevan Seva Annexe, S.V. Road, Santa Cruz (W), MUMBAI - 400 054

Tamil Nadu, Pondicherry	Fatima Akhtar Court, 4th Flr., 453(old 312), Anna Salai, Teynampet, CHENNAI -600 018
Andhra Pradesh	6-2-46, 1st Floor, Moin Court, LaneOpp.SaleemFunctionPalace A.C. Guards, Lakdi-Ka-pool, HYDERABAD - 500 004.
Gujarat	2nd Flr., Ambica House, Nr.C.U. Shah College, 5, Navyug Colony, Ashram Road, AHMEDABAD - 380 014
Kerla, Karnataka	2nd Flr., CC 27/ 2603, PulinatBuilding, Opp. Cochin Shipyard, M.G. Road, ERNAKULAM - 682 015
North Eastern States	Aquarius, Bhaskar Nagar, R.G. Baruah Rd. GUWAHATI
Uttar Pradesh	Jeevan Bhawan, Phase 2, 6th Floor, Nawal Kishore Rd., Hazartganj,LUCKNOW - 226 001
Madhya Pradesh	1st Floor, 117, Zone II, (Above D.M. Motors Pvt. Ltd.) Maharana Pratap Nagar, BHOPAL - 462 011
Punjab, Haryana, Himachal Pradesh, J & K, Chandigarh	S.C.O. No. 101,102 & 103, 2nd Floor, BatraBuilding, Sector 17-D, CHANDIGARH - 160 017
Orissa	62, Forest Park, BHUBANESWAR - 751 009

The updated details are also available on IRDA website: www.irdaindia.org, on the website of General Insurance Council: www.generalinsurancecouncil.org.in, website of the company www.icicilombard.com or from any of the offices of the Company

ENDORSEMENT– PREMIUM INSTALLMENT CLAUSE

1. All premiums including applicable taxes and cess are payable by the Insured as per the Schedule of Policy Premiums Installment as mentioned in Part I of the Schedule to this Policy. No part payment of any premium installment or applicable taxes shall be accepted.

2. After the payment of First Premium, as mentioned in Part I of the Schedule to the Policy, a Grace Period of _15_days from the respective due date(s) of the subsequent premium Installment(s) (“Grace Period”) will be allowed for payment of each such subsequent Installment(s). The Policy will remain in force during the Grace Period.

3. After payment of the First Premium, failure to pay subsequent premium installment(s), including applicable taxes & cess, in full, after its due date will constitute a default in premium payment.

4. If a default in premium payment occurs and the premium remains unpaid beyond the Grace Period, then the Policy will terminate with effect from 00 hours of the due date of premium payment, for which there is default in payment and consequently the Company shall not be liable for any claim that may arise under the Policy thereafter.

   However the Company may at its sole option re-instate the Policy, subject to the maximum limit of indemnity existing on the due date of premium payment for which there was a default in payment, from the date and time of receipt of such premium installment till the Policy Period end date, provided the Policyholder makes full payment, of the due installment Premium for which there is a default in payment, before the due date of the immediately following installment, as per the Schedule of Policy Premium Installment as mentioned in Part I of the Schedule, or the Policy end date whichever is earlier. The company shall not be liable for any claims which may arise post the default in premium payment and until the date of reinstatement of the policy

5. If the Company were to become liable to pay a Claim, under any section of the Policy, any due premium installments may be deducted from the proceeds payable to the Insured, under the Policy

6. Additionally in the event of the Maximum Limit of Indemnity getting exhausted before the Policy Period End Date, for any cause whatsoever, all the subsequent premium installments shall immediately become due and payable notwithstanding anything to the contrary herein above contained.