Prospectus and Sales Literature

Section 1. AGE LIMIT:

1. **Entry age :** This Policy can be offered to an individual with minimum age of 6 years. Maximum entry age is up to 125 years. Children between ages of 91 days to 5 years can be insured only under a floater plan only. Maximum age for dependent children under Floater Policy is 30 years. The age considered is the completed number of years as on last birthday.
2. **Lifetime renewability:** There is no maximum age limit for Renewal.
3. **Floater policy:** You can avail a floater cover and get Your immediate family covered for the same sum insured under a single Policy by paying one premium amount. Any individual above 3 months of age can be covered under the Policy provided 1 Adult is also covered under the Policy
4. **Relationships covered:** You and your immediate family (Immediate family would mean spouse, dependent children, brother(s), sister(s) and dependent parent(s), Grandparents, Grandchildren, Mother-in-law, Father-in-law, Son-in-law and Daughter-in-law. Also individuals/entities with insurable interest can purchase the policy for individuals e.g- employer acting as a proposer for a policy covering employees and their family members.
5. **Premium calculation:** In a family floater policy, the age of eldest member will be considered while computing premium for the members covered under the family floater. Other factors determining premium are addition/deletion of any optional covers, change in policy conditions such as tenure, zone opted, increase or decrease in sum insured opted for and change in any tax laws by the government and health status of the individual being insured.

Section 2. SALIENT FEATURES & BENEFITS:

1. **Policy Tenure :** You can opt for a Policy with Policy period of one year or two years or three years
2. **Tax Benefit :** You can avail of tax benefit on premiums paid under Health sections of this Policy, as per Section 126 of Income Tax Act, 2025 and amendments made thereafter.
3. **Annual Sum Insured :** This denotes the maximum amount of cover available to You for a Policy Period of one year.
   Minimum Sum Insured : ₹10,00,000
   Maximum Sum Insured : Unlimited

4. **Deductible:** This denotes the maximum amount that You will be liable for before any benefits are payable by Us for a Policy Period of one year.

   Minimum: ₹ 3,00,000
   Maximum: ₹ 20,00,000

5. **Cashless hospitalization :** You can avail of cashless Hospitalisation at any of our network providers/ hospitals. A list of these hospitals/ providers will be sent to You along with Your Policy.
6. **Zone based premium :** The premium will be computed basis the zone chosen by You in the proposal form.

Zone	State/District
Zone A	Delhi, Mumbai (including Thane district, Navi Mumbai) , Gurugram district, Karnal district, Sonipat district, Rohtak district, Bhiwani district, Chakri Dadri district, Mahendragarh district, Daman & Diu, Dadra Nagar, Ahmedabad, Surat, Noida City, Ghaziabad district, Hapur district, Meerut district, Muzaffarnagar district, Shamali district
Zone B	Pune, Kolkata, Telangana (incl. Hyderabad), Madhya Pradesh, Goa, Gujarat (excl. Ahmedabad and Surat), Bangalore, Chennai, Andhra Pradesh, Chattisgarh, Pondicherry, Uttarakand
Zone C	Rest of India (Punjab, Rajasthan (excl. NCR region), Chandigarh, Himachal Pradesh, Jammu & Kashmir, Ladakh, Lakshadweep, Kerala, Tamil Nadu (excl. Chennai, Pondicherry), Odisha, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Sikkim, Andaman & Nicobar, Rest of Karnataka, West Bengal (excl. Kolkata), Bihar, Jharkhand, Maharashtra (excl. Mumbai and Pune), UP (excl. NCR Region), Haryana (excl. NCR region)
Zone D	Rest of NCR (Alwar district, Bagpat district, Bharatpur district, Bulandshahr district, Faridabad district, Gautam Buddha Nagar district excl. Noida, Jhajjar district, Jind district, Nuh district, Panipat district, Rewari district, Mewat district, Palwal district)

The premium will depend on Your city of residence and pincode. Please inform us immediately in case of any change in the same. Not doing so, may impact your claim admissibility. There will be no zone based co-payment applicable.

7. **Pre-Policy Medical Check-up:** No medical tests will be required, if You approach us for insurance cover below the age of 45 years up to the Annual Sum Insured of Rs.10 Lakhs. However, if You approach us for insurance when You are 45 years of age* or above, You will have to then

compulsorily undergo medical tests at our designated diagnostic centres. If we accept Your proposal, we will reimburse at least 50% of the costs incurred by You in undertaking such pre-insurance medical tests.
*This age limit may be relaxed for specific channels or plans depending on judgement of medical underwriter.

What is covered?

The Policy provides indemnification of Medical Expenses incurred by You during Your Hospitalisation, for any Illness or Injury suffered during the Policy Year, after the deductible limit is crossed.

A. Basic Cover

If any insured person suffers an illness or Accident during Policy Period, the Policy provides indemnification of the Medical Expenses incurred towards hospitalization which is in excess of the Deductible amount. The below mentioned basic covers are Indemnity based covers and would be payable for actuals (post deductible as applicable) or up to Annual Sum Insured whichever is lower. Notwithstanding anything contained herein below, this Benefit shall not apply to any Medical Charges incurred by the Insured in any place or area outside the geographical boundaries of India.

How Deductible works :

- Deductible will apply on aggregate basis for all hospitalization expenses during the policy year.
- The deductible will apply on individual basis in case of individual policy and on floater basis in case of floater policy.
- Claim amount under optional covers will not be considered for deductible.

1) **In-patient Treatment**: We will pay You for the in-patient Hospitalisation expenses such as room rent charges up to Single Private AC room, intensive care unit charges, qualified nurse charges, medical practitioner's fee, anaesthesia, blood, oxygen, operation theatre charges, charges incurred on medicines drugs, consumables, surgical appliances and prosthetic devices (recommended in writing), costs of investigations or prescribed diagnostic tests etc. incurred by You during Hospitalisation for a minimum period of 24 consecutive hours.

   i. In case You are admitted in a room category that is higher than the one that is specified in the Policy Schedule, then You shall bear a rateable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred

2) **Day Care Procedures/ Treatment**: We will pay You for the Medical Expenses incurred by You while undergoing Day Care Procedures/Treatment, which require less than 24 hours Hospitalisation.

i. In case You are admitted in a room category that is higher than the one that is specified in the Policy Schedule, then You shall bear a rateable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred

3) **Technological Advancements and Treatments** – We will Pay You for the medical expenses incurred on below specified Technological Advancements and Treatments during the policy period up to the Annual Sum Insured.

Sr. No	Treatment/Procedure
1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
2	Immunotherapy- Monoclonal Antibody to be given as injection
3	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
4	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
5	Balloon Sinuplasty
6	Oral Chemotherapy
7	Robotic surgeries
8	Stereotactic radio Surgeries
9	Deep Brain stimulation
10	Intra vitreal injections
11	Bronchical Thermoplasty
12	IONM - (Intra Operative Neuro Monitoring)

4) **Pre-Hospitalisation Medical expenses**: We will cover You, up to the Annual Sum Insured, for the relevant medical Expenses incurred, immediately upto number of days before hospitalisation as applicable for the plan chosen.

5) **Post Hospitalization Medical expenses**: We will cover You, up to the Annual Sum Insured, for the relevant medical Expenses incurred, immediately upto number of days after Your Hospitalisation as applicable for the plan chosen.

6) **In-Patient AYUSH Hospitalisation:** We will cover expenses for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) treatment only when the treatment has been undergone in a AYUSH hospital or AYUSH day care centre.

7) **Domestic Road Ambulance:** We will cover the expenses incurred on road ambulance services which are offered by a healthcare or ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital from place of Accident/

Illness with adequate emergency facilities for the provision of Emergency Care up to the Annual Sum Insured. Cashless service can be availed via our Mobile application

8) **Donor Expenses:** We will cover You, up to the Annual Sum Insured, for the medical expenses incurred in respect of the organ donor for any of the organ transplant surgery provided the organ donated is for the insured person's use

9) **Domiciliary Hospitalization:** We will cover the medical expenses incurred in respect of Your Domiciliary Hospitalization up to the Annual Sum Insured provided that the Domicilary Hospitalisation continues for at least 3 consecutive days.

We shall not be liable to pay for any claim under this Benefit which arises from or in connection with any of the following :

a) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
b) Arthritis, gout and rheumatism;
c) Ailments of spine/disc
d) Chronic nephritis and nephritic syndrome;
e) Any liver disease;
f) Peptic ulcer
g) Diarrhea and all type of dysenteries, including gastroenteritis;
h) Diabetes mellitus and insipidus;
i) Epilepsy;
j) Hypertension;
k) Pyrexia of any origin

10) **Bariatric Surgery Cover:** We will cover medical expenses incurred in respect of Hospitalisation of the Insured Person for Surgical Procedure/treatment for Obesity up to Annual Sum Insured, subject to the eligibility criteria and conditions specified in the policy wordings. This cover will have a waiting period of 2 years. However, if Optional Cover 1. Jumpstart is opted, the waiting period shall be reduced to 30 days

11) **In patient Hospitalisation for Surrogate Mother:** We will pay for Medical Expenses incurred in respect of In Patient Hospitalization of the Surrogate mother appointed by the "Intending Couple"/"Intending woman" for complications arising out of pregnancy and post-partum delivery complications during the Policy Period, up to a maximum limit of Rs. 5 Lakhs, and subject to the following conditions:

i. Initial waiting period of 30 days will be applicable
ii. This benefit is applicable to all or any female Insured person who has opted for 3 years Policy term

iii. The maximum coverage available for a surrogate mother is a period of thirty-six (36) continuous months after the surrogacy procedure has been successful
iv. Any expenses incurred on delivery of the new born (either via normal delivery or caesarean section) are excluded from the scope of this cover
v. This coverage shall only be available if all the provisions as specified in The Surrogacy Regulation Act (2021), and all the rules and regulations made thereunder are fulfilled
vi. The terms and conditions of In-patient Treatment shall apply

Kindly go through the policy wordings for detailed terms and conditions
Note : This cover is only available in PlanA

12) In patient Hospitalisation for Oocyte Donor: We will pay for medical expenses incurred in respect of Hospitalization of Oocyte donor appointed by the "Intending Couple"/ "Intending woman" for complications arising out of oocyte retrieval during the Policy Period, up to a maximum limit of Rs. 5 Lakhs and subject to the following conditions:

i. This cover shall be available only for a period of twelve months (12 months) after the oocyte retrieval procedure has been successful
ii. This benefit is applicable to all or any female Insured person
iii. Any expenses incurred on delivery of the new born (either via normal delivery or caesarean section) are excluded from the scope of this cover
iv. This coverage shall only be available if all the provisions as specified in The Assisted Reproductive Technology (Regulation) Act, 2021, and all the rules and regulations made thereunder are fulfilled
v. The terms and conditions of In patient Treatment shall apply.

Kindly go through the policy wordings for detailed terms and conditions
Note : This cover is only available in PlanA

13) Home Care Treatment: We will cover medical expenses for home care treatment provided the same is advised by medical practitioner in writing, there is active line of treatment and is not on outpatient basis up to a maximum limit of Rs. 5 Lakhs

Prior approval from us must be taken. The home care treatment must be availed on cashless basis only.
Note: The cover is available only in Plan B

14) Waiver of Deductible : We will offer You an option to waive the Deductible and to opt for any one indemnity health insurance policy (without any Deductible) offered by Us for the same Sum Insured without re-evaluation of health status. Following conditions will apply:

1. Insured Person has been insured with Us for first time under this Policy before the Age of 50 years, and has renewed with Us continuously.
2. This option for waiver of Deductible shall be exercised by the Insured Person during the Age group of the eldest insured member being 55 years to 65 years only, and at the time of Renewal only;; provided that it has been renewed with Us continuously without any break.
3. Insured Person will be offered continuity of coverage in terms of waiver of waiting periods to the extent of Benefits covered under this Policy as a result of waiver of Deductible.
4. Premium for the opted indemnity health insurance policy (without any Deductible) would be charged as per the Age of the Insured Person at Renewal.

In all other cases, no Benefits shall accrue to any Insured Person by virtue of continuity of coverage in the event of discontinuation of this Policy at any point of time or shifting to any other health insurance policy with Us.

15) Wellness Program: The wellness program provides You with the below mentioned benefits-

I. Wellness program

II. Health Assistance [HAT]

III. Ambulance Assistance

IV. Discounts on services and products

I. Wellness program

Wellness program intends to promote, incentivize and reward You for You healthy behavior through various wellness services. The wellness program shall be available to each Adult Insured Person subject to a maximum of 2 Adults in a floater policy. All the wellness activities as mentioned below in Table A enable You to earn wellness points which shall be monitored by the Health Coach.

The Health Coach shall only be available to a maximum of 2 Adult Insured Persons. The Health Coach is a personalized service that shall encourage and promote optimal health and physical and mental wellness through a digital platform. You shall have access to the health coach on downloading and registering on our mobile application. This activity needs to be done within 30 days of policy start date to ensure adequate utilization of services offered and to redeem the wellness points awarded.

Post Registration and successful completion of Health Risk Assessment [HRA], You shall be evaluated by the Health Coach to assess and educate You on adapting a healthy lifestyle.

Table A- Journey of earning Wellness points

Category	Policy Tenure	Individual Policy 1 Year	Floater Policy* 1 Year
	Activity Details	Max Points Earned per Insured Person	Max Points Earned per Insured Person
Health Assessment	Health Risk Assessment	500	250
	Undergoing Health check-up & uploading the reports	1,000	500
	Face scan once a quarter	400	200
	First usage of Chat with Health Expert/ Health Coach Service	100	50

Wellness activities	ICICI Lombard initiated Contest/ health quiz (Any one contest)	200	100
	ICICI Lombard initiated Webinar (Any one webinar)	500	250
Wellness Tasks	Achieving targeted steps per month (10/15/25 points/ day depending on steps completed)	6,000	3,000
Fitness challenge	Participation and successful completion of fitness challenge In App	500 (250 per challenge)	250 per challenge
Health Events	Participation in Professional sporting events like Marathon/Cyclathon/Swimathon etc.	500	250
Grand Total		**9,400**	**4,700**

For multi-year policies, with policy tenure of 2 years and 3 years, the maximum wellness points that can be accumulated shall be as per table mentioned below

Category	Policy Tenure	Individual		Floater*	

		2 Years	3 Years	2 Years	3 Years
	Activity Details	Max Points Earned per Insured	Max Points Earned per Insured	Max Points Earned per Insured	Max Points Earned per Insured
	Health Risk Assessment	1,000	1500	500	750
Health Assessment	Undergoing Health check-up & uploading the reports	2,000	3,000	1,000	1,500
	Face scan once a quarter	800	1,200	400	600
	First usage of Chat with Health Expert/ Health Coach Service	200	300	100	150
Wellness activities	ICICI Lombard initiated Contest/ health quiz (Any one contest)	400	600	200	300
	ICICI Lombard initiated Webinar (Any one webinar)	400	600	200	300
Wellness Tasks	Achieving targeted steps per month (10/15/25 points/ day depending on steps completed)	12,000	18,000	6,000	9,000

Fitness challenge	Participation and successful completion of fitness challenge In App	1,000	1,500	500	750
Health Events	Participation in Professional sporting events like Marathon/Cyclathon/Swimathon etc.	1,000	1,500	500	750
Grand Total		**18,800**	**28,200**	**9,400**	**14,100**

* In case of a floater policy, the wellness points earned by each of the Insured Persons for every completed wellness activities shall be accrued to calculate the renewal discount.

As a part of wellness tasks, You shall be awarded wellness points for achieving the daily targeted steps for atleast 20 days in a month

Table B- A Journey of earning Wellness Points by achieving targeted steps

Average Steps achieved per day for 20 days in a month	Maximum Wellness Points per month	Maximum Wellness Points accumulated in a year		
		1 Year	2 Year	3 Year
8,000+ steps	500	6000	12000	18000
6,000 to 7,999 steps	300	3600	7200	10800

4,000 to 5,999 steps	200	2400	4800	7200
<4,000 steps	Nil	Nil	Nil	Nil

Redemption of wellness points

The total wellness points earned by You (as detailed in Table A and Table B) will be redeemed towards availing discount on renewal premium in the subsequent year. Table C shows the renewal discount that can be availed against the accumulated wellness points. Maximum discount that can be availed is 30% on the renewal premium for the subsequent year

Table C- Renewal Discount against Accumulated Wellness Points

Regular fitness related activities	Wellness points accumulated per Insured Person*			Renewal discount	
				Individual	Floater (Per Insured Person)
	1 Year	2 Year	3 Year		
Points	2500-3999	5000-7999	7500-11999	2.5%	1.25%
	4000-4999	8000-9999	12000-14999	5%	2.5%
	5000-6999	10000-13999	15000-20999	10%	5%
	7000-8999	14000-17999	21000-26999	20%	10%
	>9000	**>18000**	**>27000**	**30%**	**15%**

*For each consecutive year, an Insured Person has to accumulate a minimum of 9,000 Wellness Points in the first year, 18,000 Wellness Points in the second year, and 27,000 Wellness Points in the third year to avail the discount.

Table D- Illustration showing Redemption Mechanism through the Wellness Discount for Floater Policies

Redemption mechanism	Wellness discount	Fresh Premium	Renewal premium payable
Discount accrued on renewal premium by Insured 1	15%		
Discount accrued on renewal premium by Insured 2	15%		
	Total Discount- 30%	Rs. 25,000	Rs. 25000- (Rs. 25000x30%)=Rs.17,500

Terms and Conditions for Redemption of Wellness Points

i. Renewal discount will only be applicable on a per year basis upon the subsequent year of the Policy. Points accumulated will be mandatorily redeemed towards renewal discount of the subsequent year and cannot be carried forward to the next Policy Year.

ii. Renewal discount is computed based on the Wellness Points earned on 90 days before the due date of renewal. The residual points will be carried forward to next Policy Year and accrued with that Policy Year's Wellness Points. Hence, these points are not lost.

iii. Discount is on the individual's premium in Individual plan and on Floater Policy Premium in Floater plans. Discount will be considered only for Insured Persons aged 18 years and above In case the insured has opted for a higher or a lower Policy Tenure during renewal, the discount will be given basis the expiring premium of the previous Policy Year of the Policy Period

iv. In case the insured has opted for a higher Policy Tenure during renewal, the discount will be given : -
   a. On the first Policy Year of a 2/3 year Policy Tenure (in case of an existing 1 year Policy Tenure), and
   b. On the first and second Policy Year of a 3 year Policy Tenure (in case of an existing 2 year Policy Tenure)

v. In case the insured has opted for a lower Policy Tenure during renewal, flat discount will be applied on all year premium before tenure discount.

For detailed Terms and conditions, disclaimers for availing the Wellness Program kindly refer to the policy wordings

II. Health Assistance:

Our Health Assistance Team (HAT) will assist You in understanding Your health condition better by providing responses to any queries related to health and health care providers

The services provided under this shall include:

- Identifying a Physician/ Specialist
- Availability of hospital beds

- Providing guidance on engaging attendants/ nurses
- Facilitation with respect to arrangement of mobility aids, daily living aids, medical equipment etc.
- Scheduling an appointment with any Medical Practitioner empanelled with Us
- Scheduling appointments for a second opinion
- Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
- Scheduling appointments from diagnostic labs empanelled with us
- Providing information, assistance and facilitation on door step delivery of medicines
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.

Please note that services provided under this Cover are solely for assistance, and should not be construed to be a substitute for a visit/ consultation to an independent Medical Practitioner. This service is available on our mobile application or by calling on 040-66274205 (please note that this number is subject to change) from 8am to 8pm from Monday to Saturday except public holidays.

For detailed Terms and conditions, disclaimers for availing Health Assistance kindly refer to the policy wordings

III. Ambulance Assistance :

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

Process to avail Ambulance Assistance:

i. On calling Our helpline number provided below, Our trained customer service executive (CSE) will ask You relevant questions to assess the situation.

ii. The call may be redirected to a qualified Medical Practitioner in order to evaluate the requirement for an ambulance with Advanced Life Support based on Your condition.

iii. The below mentioned details are to be made available for availing the services:

a) Your UHID as provided on the Health Card.
b) Your Contact number
c) Your Location

IV. Discounts on services/products:

We shall only facilitate You in availing discounts on services/products including but not limited to investigations/diagnostic tests/ laboratory tests /health supplements/ /medical equipment/homecare services/virtual health & wellness sessions/AYUSH products/Fitness & wellness related activities & products etc. at our empanelled diagnostic centres, drugs/medicines ordered from pharmacies etc. offered by our network providers/ health service providers. These discounts can be viewed on our mobile application and one can avail these discounts depending on terms and conditions and subject to availability.

B. Add-Ons/Optional Cover

The following optional covers can be provided under the Policy on payment of additional premium except Optional Cover 16. Network Advantage, and Optional Cover 17. NRI Advantage- Accidental Emergencies Cover for NRI.

Pre-hospitalisation Medical expenses/Post-hospitalisation medical expenses will not be applicable for this Section. Claims under this Section will not impact the Annual Sum Insured (except Optional cover 4. Claim Protector and Optional cover 11. Durable Medical Equipment Cover)

The Sum Insured for each of the Optional Covers (except Optional cover 4. Claim Protector and Optional cover 11. Durable Medical Equipment Cover, Optional cover **18. Guaranteed Deductible Reduction**) shall be over and above the Annual Sum Insured of the Policy.

1. **JumpStart :** In case you have opted for this optional cover, the following Pre-existing diseases declared by You and accepted by Us **or** have been detected duing pre-policy medical check-up and accepted by Us shall be covered after a reduced waiting period of 30 days
    1. Asthma
    2. Diabetes
    3. Hypertension
    4. Hyperlipidemia

5. Obesity
6. Coronary Artery Disease (PTCA done prior to 1 year)

i. The above reduced waiting period of 30 days shall be applicable only for specified insured persons who have opted and paid additional premium as specified in the policy schedule.
ii. This cover will be available only during inception of the policy and only for the Annual Sum Insured chosen at the time of Policy Inception
iii. Once chosen, this optional cover will have to be opted for a period of 3 continuous policy years.
iv. Exclusions e.i.1 Pre-Existing Diseases (Code- Excl01) shall not apply if this Optional Cover has been opted by the Insured Person(s).

2. **Chronic Disease Management Program :** In case You have declared any of the listed diseases /illnesses /conditions – Asthma, Diabetes, Hypertension, Hyperlipidemia, Obesity, and/or Coronary Artery Disease (PTCA done prior to 1 year) - and the same have been accepted by Us, You shall be enrolled under Our Chronic Disease Management Program.

As a part of this program, we shall provide the below mentioned services to You

I. Assistance to the Insured Person(s) to track their health through Our empaneled medical experts who will guide them in maintaining/ improving their health condition(s).
II. Dietician and nutritional counseling as per their health condition(s).
III. 2 Pre-defined diagnostic Health check-ups for the listed conditions with a gap of six months between the 2 tests. The health checkups are over and above to the Optional Cover 9. Health Check-up if opted.
IV. Assistance to avail Counselling for lifestyle modifications such as quitting tobacco/alcohol etc.

This program shall be subject to the following conditions-

1. The insured person(s) shall be enrolled to this program only if Optional cover 1. Jumpstart has been opted.
2. The health check-up can be availed only on a cashless basis through our mobile application or by calling at our Toll free number: 1800 2666.
3. The Network Provider/Health Service Provider shall be assigned by Us post receiving Insured Person's request to avail a Health Check-up under this cover.
4.

3. **BeFit :** All benefits under BeFit cover will be provided on cashless basis via our mobile application. All services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment. BeFit cover can only be opted by Insured

Person(s) up to the age of 65 years. A waiting period of 30 days will be applicable for this cover. Any unutilized consultations/e-consultations/ sessions cannot be carried forward to the next policy year.

The following benefits will be available subject to the limits as specified in the Policy Schedule

i. Physical consultations

ii. Routine diagnostic and minor procedure cover

iii. Pharmacy cover

iv. Physiotherapy sessions

v. e-counselling

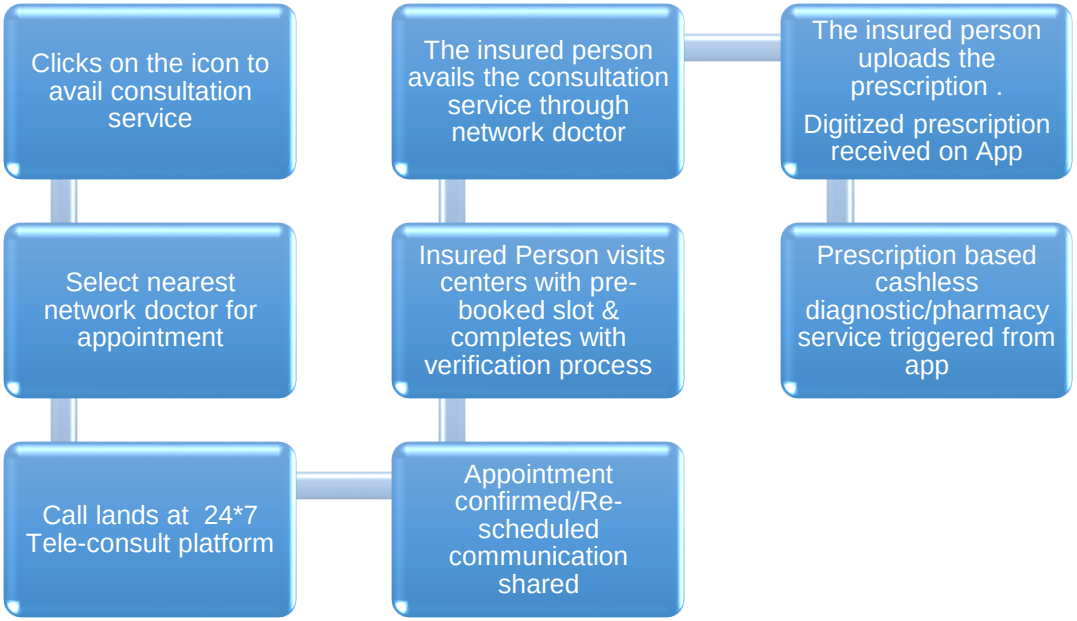
vi. Diet and nutrition e-consultation

Available plans under BeFit

Coverage	Details	Plans

		A	B	C	D	E	F	G
Outpatient Consultation	Count of consultations	1	2	4	6	8	10	12
Routine Diagnostics Cover and Minor Procedures Cover	Sum Insured (INR)	500	1000	1000	2000	3000	5000	7500
Pharmacy Cover	Sum Insured (INR)	500	1000	1000	2000	3000	5000	7500
Physiotherapy Session	Count of sessions	0	0	6	8	10	12	12
e-Counselling	Count of sessions	6	6	6	8	12	Unlimited	Unlimited
Diet and Nutrition e-Consultation	Count of sessions	6	6	6	8	12	Unlimited	Unlimited

Claim procedure for BeFit



4. **Claim Protector:** If a claim has been accepted under the inpatient hospitalization cover or "Day-care procedures/treatment', then the items which are not payable under the claim as per the List of Excluded items released by IRDAI that is related to the particular claim will become payable. The maximum claim payout under this benefit shall be limited to Annual Sum Insured under your policy. Any sum insured as available under /Inflation Protector/ will not be available for claim protector cover.

5. **Inflation Protector:** The Inflation protector is designed to protect the Sum Insured against rising inflation by linking the Annual Sum Insured under the base plan to the Consumer Price index (CPI).

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

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

At the time of renewal if You opt out of this optional cover, then the sum insured under the Inflation Protector cover accrued up until the expiring policy year will be forfeited.

Sample Illustration

Year	Annual Sum Insured	Opted for Inflation Protector	Inflation Protector at Renewal computation#	Overall Inflation Protector
0	Rs. 10,00,000	Yes	Not applicable	Not applicable
1	Rs. 10,00,000	Yes	Rs. 10,00,000 * 6%=60,000	Rs. 60,000
2##	Rs. 15,00,000	Yes	Rs. 10,00,000 * 6%= 60,000	Rs. 60,000 + Rs. 60,000 = Rs. 1,20,000
3	Rs 15,00,000	Yes	Rs. 15,00,000 * 6%= 90,000	Rs. 1,20,000 + Rs. 90,000 = Rs. 2,10,000
4	Rs. 15,00,000	No	Nil as Insured has opted out	Nil

Considering Consumer Price index (CPI) of previous year to be 6%
Insured Person has enhanced his/her annual sum insured from Rs. 10 Lakhs to Rs. 15 Lakhs

6. **Domestic Air Ambulance Cover:** We will cover the expenses incurred by You on Air Ambulance services which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer You to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, up to the Annual sum insured.

7. **Nursing at home:** We will pay You up to Rs. 2,000 per day, for a maximum of up to 10 days post hospitalisation for the medical services of a Qualified nurse at Your residence. The Claim under this Optional Cover will be payable only if We have admitted Our liability under "In-patient Treatment" section of the Policy.

Note : This cover is only available in Plan B

8. **Compassionate Visit:** We will reimburse You the cost of economy class air ticket/railway ticket incurred by Your *"immediate family member"* while travelling to Your place of hospitalisation from the place of origin/ residence and back in the event of Your Hospitalisation exceeding 5 days. This cover is subject to a maximum limit of Rs 20,000 per policy year.
   Note : This cover is only available in Plan B

   Health Check-up: We will provide You pre-designed health check-up packages that can be utilised only on cashless basis with our network providers or empanelled health service providers. The health packages can be utilised only by Adult Insured Persons aged 18 years and above up to 0.5% of annual sum insured, subject to a maximum of Rs. 5,000 on cashless basis. This Cover can be availed through our mobile application or by calling at our Toll free number 1800 2666.
   Note : This cover is only available in Plan B

9. **Dependent Accomodation Benefit:** If You contract an Illness or suffer an Injury due to Accident during the Policy Period and are Hospitalized, We will pay the daily amount for the accommodation of the dependent in the hospital only up to Rs. 1,000 per day in respect of each continuous and completed day of your Hospitalizatio provided the medical practitioner certifies that hospitalization is required for a minimum of 3 consecutive days, maximum up to 10 days.
   Note : This cover is only available in Plan B

10. **Durable Medical Equipment Cover :** We will cover the expenses incurred by You towards renting or purchase of any of the listed durable medical equipment up to Annual Sum Insured subject to a limit of Rs. 5 Lakhs (within overall basic sum insured) only if the same has been prescribed by the treating Medical Practitioner post Hospitalisation for the same condition for which the Hospitalisation claim was admissible

List of Durable Medical Equipment Covered under this Optional Cover-

1. CPAP Machine
2. Ventilator
3. Wheelchair
4. Prosthetic device
5. Suction Machine
6. Commode Chairs
7. Infusion pump
8. Continuous Passive motion devices in case of Knee Replacement
9. Oxygen concentrator

11. **Tele Consultation(s) :** We will arrange consultations and recommendations for routine health issues by a qualified Medical Practitioner or health care professional. For the purpose of this Optional Cover, Tele Consultation shall mean consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile application. Kindly go through our mobile application for more details on the same. There shall be no maximum limit on the count of tele-consultations that can be availed by You in a policy year.

12. **Waiting Period Reduction Option (Other than those listed under JumpStart) :** If You have opted for this Optional Cover, the waiting period applicable under Exclusion- **Pre-Existing Diseases (Code- Excl01)** for any declared and accepted pre-existing diseases shall be reduced from 36 months to 24 months or 12 months as opted. This cover will be available only during inception of the policy and only for the Annual Sum Insured chosen at the time of Policy Inception. Once chosen, this optional cover will have to be opted for a period of 3 continuous policy years

13. **Specific Illness Waiting Period Reduction Option :** If You have opted for this Optional Cover, the waiting period applicable under Exclusion- **Specified disease/procedure waiting period (Code- Excl02)** shall be reduced from 24 months to 12 months. This cover will be available only during inception of the policy and only for the Annual Sum Insured chosen at the time of Policy Inception. Once chosen, this optional cover will have to be opted for a period of 2 continuous policy years

14. **Room Modifier :** If You have opted for this Optional Cover, You shall have an option :

A. To Modify the room rent eligibility to any room category without any restriction or
B. To modify the room rent eligibility to twin sharing room or
C. To Modify the room rent eligibility to a room rent capping of 1% of Annual Sum Insured for normal room and 2% of Annual Sum Insured for ICU per day.

This cover shall be available across all Annual Sum Insured options, subject to the following :

i. If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this policy, then the Insured Person shall bear a rateable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred
    a. For the purpose of this cover, “Associated medical expenses” shall include room rent, nursing charges, operation theatre charges, fees of medical practitioner including surgeon/anesthetist/ specialist within the same hospital where the insured person has been admitted and will not include the cost of pharmacy and consumables, cost of implants, medical devices and cost of diagnostics.
    b. Proportionate deductions are not applicable for ICU charges

c. Proportionate deductions shall not be applicable for hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

15. Network Advantage :

i. If You have opted for this Optional Cover, You shall be entitled for a discount of 10% on every renewal premium (including the first year premium), subject to the following conditions

ii. The treatment as applicable under In-patient Treatment, Daycare Procedures/Treatment and In-Patient AYUSH Hospitalisation is taken in a hospital listed under the "Preferred Provider Network" List available on Our website www.icicilombard.com and on Our Mobile Application.

iii. A co-payment of 20% will be applicable on each and every claim in case the treatment is taken in a hospital which is not included in the "Preferred Provider Network" List.

16. NRI Advantage- Accidental Emergencies Cover for NRI : We will provide cover to Non-Resident Indians/Overseas Citizens of India (NRI/OCI) under this policy only for Accidental Emergencies and no claim will be admissible under any other cover of this policy. Further, we will provide an additional 25% discount on premium if this cover has been opted, provided that the Insured Person(s)-

i. Provides declaration upon Policy Issuance and subsequent renewals that they are based abroad in entirety for the Policy Year

ii. Provides proof of overseas residence for the upcoming year upon each renewal to continue availing the discount

iii. Possesses and provides other relevant identity proof documents as mandated for Citizenship of India

iv. Has an Indian bank account for premium/claims payment.

If the Insured person ceases to reside outside India, then no further discount shall be applicable upon renewal. This discount can be availed only for a maximum period of five continuous Policy Years and the same will be applicable on a Policy level. All waiting periods as per the policy terms and conditions will be applicable for the Insured Persons.

17. **Guaranteed Deductible Reduction** :

We will reduce the deductible applicable by 10% of the deductible as applicable to the expiring or renewed Policy as specified in the Policy Schedule at the end of each Policy Year if the expiring Policy has been continuously renewed with Us. The reduction in deductible shall be continued until the deductible is reduced to 50% of the deductible opted during first policy issuance subject to the policy terms and conditions. This optional cover is available only for policies with minimum deductible of 5 lakhs.

WHAT WE WILL NOT PAY (EXCLUSIONS UNDER THE POLICY)

We will not be liable for any Deductible amount or Co-payment amount, if applicable and as specifically defined in the Policy Schedule under the Policy. We shall not be liable to make any payment under this Policy in connection with or in respect of any expenses whatsoever incurred by You in connection with or in respect of:

i. Standard Exclusion

1. Pre-Existing Diseases - Code- Excl01

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

2. Specified disease/procedure waiting period/ Specific waiting period - Code- Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures-
    1. Any types of gastric or duodenal ulcers
    2. Benign prostatic hypertrophy
    3. All types of sinuses
    4. Hemorrhoids
    5. Dysfunctional uterine bleeding

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

3.

a. Expenses related to the treatment of the below mentioned illness within 90 days from the first policy commencement date shall be excluded unless they are pre-existing and disclosed at the time of underwriting
   i. Hypertension
   ii. Diabetes
   iii. Cardiac Conditions
b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher sum insured subsequently.

4. 30-day waiting period- Code- Excl03

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

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

5. Investigation & Evaluation- Code- Excl04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes :
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

7. Obesity/ Weight Control: Code- Excl06

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

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a. greater than or equal to 40 or
   b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

8. Change-of-Gender treatments: Code- Excl07

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

9. Cosmetic or plastic Surgery : Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

10. **Hazardous or Adventure sports : Code- Excl09**
    Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

11. **Breach of law : Code- Excl10**
    Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

12. **Excluded providers : Code- Excl 11**
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
    (The list of excluded providers/delisted hospitals is available on our website www.icicilombard.com and is timely updated.)

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

14. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code- Excl13**

15. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code- Excl14**

16. **Refractive Error : Code- Excl15**
    Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

17. **Unproven Treatments : Code- Exel 16**
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

18. **Sterility and Infertility : Code- Excl 17**
    Expenses related to sterility and infertility. This includes :
    a. Any type of contraception, sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy
d. Reversal of sterilization

The above exclusion part b. Assisted Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI shall not apply to claims which are otherwise admissible under Basic cover 14 “In patient Hospitalisation for Oocyte Donor” which pertains to Medical Expenses incurred in respect of Hospitalization of the Oocyte donor for complications arising due to oocyte retrieval process"

The above exclusion part c. Gestational surrogacy shall not apply to claims which are otherwise admissible under Basic cover 13. “In patient Hospitalisation for Surrogate Mother” which pertains to Medical Expenses incurred in respect of Hospitalization of the Surrogate mother for complications arising out of pregnancy and post-partum delivery complications"

19. Maternity : Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

ii. <u>Specific Exclusions (Exclusions other than those specified under i. Standard exclusions above)</u>

20. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

21. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion :

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

22. Any expenses incurred on Out Patient treatment. This exclusion will not be applicable in case optional cover 3. BeFit has been opted

23. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively.

24. Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

25. Treatment taken outside the geographical limits of India.

26. Personal comfort, cosmetics, convenience and hygiene related items and services

27. Acupressure, acupuncture, magnetic and other therapies

28. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident.

29. Expenses for venereal disease or any sexually transmitted disease except HIV.

30. Screening, counselling or Treatment relating to external birth defects and external congenital Illnesses or defects or anomalies

31. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)

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

Discounts/Loading Factors :

1. Tenure discount

Tenure of policy	Discount percentage
2 years	10% discount on 2nd year premium
3 years	15% discount on 3rd year premium

2. Zone based discount

Zone	State/District	Discount/Loading on Premium
Zone A	Delhi, Mumbai (including Thane district, Navi Mumbai) , Haryana (excl. Faridabad, Jhajjar, Jind, Nuh, Panipat, Rewari, Mewat, Palwal), Daman & Diu, Dadra Nagar, Ahmedabad, Surat, Noida City, Ghaziabad district, Hapur district, Meerut district, Muzaffarnagar district, Shamali district	No discount on premium
Zone B	Pune, Kolkata, Telangana (Incl. Hyderabad), Madhya Pradesh, Goa, Gujarat (excl. Ahmedabad and Surat), Bangalore, Chennai, Andhra Pradesh, Chattisgarh, Pondicherry, Uttarakand	10% discount on Zone A premium
Zone C	Rest of India (Punjab, Rajasthan (excl. NCR region), Chandigarh, Himachal Pradesh, Jammu & Kashmir, Ladakh, Lakshadweep, Kerala, Tamil Nadu (excl. Chennai, Pondicherry), Odisha, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Sikkim, Andaman & Nicobar, Rest of Karnataka, West Bengal (excl. Kolkata), Bihar, Jharkhand, Maharashtra (excl. Mumbai and Pune), UP (excl. NCR Region))	15% discount on Zone A premium
Zone D	Rest of NCR[Alwar, Bagpat, Bharatpur, Bulandshahr, Faridabad, Gautam Buddha Nagar excluding Noida, Jhajjar, Jind, Nuh, Panipat, Rewari, Mewat, Palwal]	12.5% loading on Zone A Premium

The premium will depend on Your city of residence and pincode. Please inform us immediately in case of any change in the same. Not doing so, may impact your claim admissibility. There shall be no zone-based co-payment applicable.

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3. **Loading:** We may apply a risk based loading on premium payable (based upon the declarations made and the health status of the person proposed for insurance). The maximum risk loading applicable shall not exceed 200% of base premium. This risk based loading will be applicable, to the extent as applied at the time of first policy, at renewals as well. We will not apply any additional loading at renewal based on claim experience. We will inform you about the applicable risk loading through a counter offer letter at the time of Your risk assessment before first policy. You need to revert to us with consent and additional premium, if any within 15 days of issuance of such counter offer letter. If You neither accept the counter offer letter nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid. Please note that We will issue policy only after getting Your consent.

How do I claim my insurance ?

Cashless Basis

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

Pre-authorization

Prior to taking treatment and/ or incurring Medical Expenses at a Network Provider, You must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request preauthorization at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization.

To avail of Cashless Hospitalization facility, you are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card Or You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. We will consider Your request after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalization facility is sought by You and We will confirm Your request in writing.

If You notify pre-authorization request for cashless facility through any of Our Service Providers / Network Providers along with complete set of documents and information, We will respond within 1 hour of the actual receipt of such pre-authorization request. Further, we shall grant final authorization within 3 hours of the receipt of discharge authorization request from the hospital.

Pre-authorization means prior to taking any treatment or incurring Medical Expenses at a Network provider, You must contact Us accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, nature of Illness or Injury, name and address of the doctor/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request pre-authorisation at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation. If You notify pre-authorization request for

cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will respond within 1 hour of the actual receipt of such pre-authorization request.

Reimbursement Basis

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

- Policy number;
- Your Name;
- Your relationship with the Policyholder;
- Nature of Illness or Injury;
- Name and address of the attending Medical Practitioner and the Hospital;
- Any other information that may be relevant to the Illness/ Injury/ Hospitalisation

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

iii. You or someone claiming on Your behalf must promptly and in any event as soon as possible of Your discharge from a Hospital (for Post-Hospitalization Medical Expenses, as soon as possible from the completion of post-Hospitalization period) deliver to Us the documentation (written details of the quantum of any claim along with all original supporting documentation) as more particularly listed in claim documents section collected from the Hospital at the time of discharge along with the claim form. The claim will be processed within 15 days of receipt of claim along with claim form and documents.

However, whether through Cashless Facility or reimbursement, You must take reasonable steps or measure to minimize the quantum of any claim that may be covered under the Policy.

If so requested by Us, You will have to undergo a medical examination from Our nominated Medical Practitioner, as and when We or Our in house claim processing team considers reasonable and necessary. The cost of such examination will be borne by Us.

Claim falling in two Policy periods

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

1. Claim Documents

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

1. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from our website www.icicilombard.com
2. Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner
3. Original bills from chemists supported by proper prescription.
4. Original investigation test reports and payment receipts.
5. Indoor case papers
6. Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.
7. Any other document as required by Us or to investigate the Claim or Our obligation to make payment for it

The relevant documents to be sent to -

ICICI Lombard Health Care,
1st, 4th (Half) , 5th and 6th floors,
Varun Towers- II , Opp. Hyderabad Public school,
Begumpet, Hyderabad, District Hyderabad, Telangana Pin code -500016

Terms of Renewal

- The Policy can be renewed under the then prevailing Activate Booster product or its nearest substitute (in case the product Activate Booster is withdrawn by the Company) approved by IRDAI.
- A health insurance policy shall ordinarily be renewable except on grounds of established fraud, or misrepresentation or non-cooperation by the insured
- Auto Renewal option is available. You can opt for ECS payment for Policy renewal at the time of buying this Policy.

- In case of any change in risk material to the queries raised in proposal form, medical examination report to be provided on renewal.

- **Renewal Premium** - Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDAI. Renewal premium may change basis the age of the Insured Person, Addition or deletion of any add-ons/optional covers, Change in any policy conditions such as – floater/ individual, change in zone opted, any co-payment opted, policy tenure, etc, Increase/ decrease in the Sum insured opted for, Change in any tax laws by the Government. Risk based loading (if any) on premium will be applicable from Policy Period Start Date including subsequent Renewal(s) with Us

- Lifetime renewability

- **Withdrawal of Policy:** In the likelihood that this policy is revised/modified/withdrawn in future,. In case of withdrawal, the insured person have the option to migrate to the nearest substitute policy as available with Us at the time of renewal with all the continuity benefits, provided the policy has been maintained without a break.

- **Grace Period -** The Policy may be renewed by mutual consent and in such event the renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 15 days in case premium is paid in monthly instalments and 30 days in all other cases from the expiry of the Policy. We will not be liable for any Claim which occurs during the Grace Period. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period

- **Cancellation -** The Policyholder may cancel this Policy by giving 7 days' written notice, and in such an event, the Company shall refund premium for the unexpired Policy Period detailed below:-

    a) Refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.

    b) Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

  Note : Above mentioned refund clause shall not be applicable for policies with free look period; Premium refund for cancellations during the free look period will be provided as per the Free look clause.

i. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

ii. The Company may cancel the Policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

iii. After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

iv. The coverage for the insured person shall automatically terminate in case of His/Her demise and upon exhaustion sum insured and any other additional sum insured (if any), for the policy year

- **Migration:**

- In case of migration of indemnity based health insurance policy (except Personal Accident and Travel Policies) with the same Insurer, the insured can transfer the credits gained to the extent of the Sum Insured and benefits available in the previous policy to the migrated policy. The Company may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

- **Portability:**

a. The insured has the choice to port his / her policies from one Insurer to another. An Insured desirous of porting his/her policy to another insurer shall apply to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal.
b. The insured is entitled to transfer the credits gained to the extent of the sum insured and the benefits available in the previous policy, subject to the underwriting policy of the Company
c. The Company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines .
d. This benefit is not applicable for enhanced sum insured

- **Premium Payment in instalments**

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

i. Grace Period for payment of premiums shall be fifteen days where premium payment mode is monthly and thirty days in all other cases.
ii. The grace period for payment of premium for all types of insurance policies shall be fifteen days where premium payment mode is monthly and thirty days in all other cases Provided the insurers shall offer coverage during grace period, if the premium is paid in installments during the policy period.
iii. The insured person will get the accrued continuity benefit in respect of the 'Waiting Periods', 'Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period
iv. No interest will be charged If the installment premium is not paid on due date.
v. In case of installment premium due not received within the grace Period, the Policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

- **Renewal of policy:**

The policy shall ordinarily be renewable except on grounds of established fraud, misrepresentation by the insured person provided the policy is not withdrawn and also subject to moratorium conditions.

i. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period
iii. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

- **Policy Alignment Option:**

Policy alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy. Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.

- **Free Look Period:**

Every insured of new individual health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

- **Endorsements:**

Any change in plan, add ons / optional covers opted may happen only during renewal subject to underwriting. The proposer may be changed only at the time of renewal. The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India. Mid-term endorsement of addition of member in the policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation

- **Change of Sum insured:**

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time for the same deductible, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhanced portion of the sum insured.

- **Nomination:**

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

- **Grievance Redressal Procedure:**

In case of any grievance the insured person may contact the Company through
Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com
ICICI Lombard General Insurance Co. Ltd. Ground floor- Interface 11, Sixth floor- Interface 16 ,
Office no 601 & 602, New linking Road, Malad (West), Mumbai – 400064

There is an interactive voice response (IVR) facility for senior citizens' grievance redressal for easy and faster resolution

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. For branch details, please visit https://www.icicilombard.com/docs/default-source/policy-wordings-product-brochure/final-gro-mapping.pdf.

If Insured person is not satisfied with the redressal of grievance ,insured person may contact the grievance redressal officer at the details provided in the below link:

https://www.icicilombard.com/grievanceredressal.com

If Insured person is not satisfied with the redressal of grievance, the insured person may also approach Insurance Regulatory and Development Authority of India (IRDAI) through the Bima Bharosa Portal - https://bimabharosa.irdai.gov.in/ or IRDA Grievance Call Centre(IGCC) at their toll free no. 1800 4254 732 / 155255

Insured may also approach Insurance Ombudsman, subject to vested jurisdiction, for the redressal of grievance. Details of Insurance Ombudsman offices are available at IRDAI website: www.irdai.gov.in, or on the Company's website at www.icicilombard.com or on https://www.cioins.co.in/Ombudsman

Benefit Illustration

Annexure – A

Benefit Illustration in respect of policies offered on individual and family floater basis (Activate Booster)

Age of the members insured	**Coverage opted on individual basis covering each member of the family separately (at a single point in time)**		**Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)**			**Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)**			
	Premium (₹)	Sum insured (₹)	Discount	Premium after discount (₹)	Sum insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount, if any	Premium after discount (₹)	Sum insured (₹)
44	5,113	10,00,000	0.00%	5,113	10,00,000	8,469	-	8,469	10,00,000
48	6,515	10,00,000		6,515	10,00,000				
Total Premium for all members of the family is ₹ 27,002 when each member is covered separately.			Total Premium for all members of the family is ₹ 27,002 when they are covered under a single policy.			Total Premium when policy is opted on floater basis is ₹ 19,667			
Sum insured available for each individual is ₹ 10,00,000 with deductible of ₹ 3,00,000 under super top up policy.			Sum insured available for each family member is ₹ 10,00,000 with deductible of ₹ 3,00,000 under super top up policy.			Sum insured of ₹ 10,00,000 is available for the entire family with deductible of ₹ 3,00,000 under super top up policy.			

Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also the premium rates shall be exclusive of taxes applicable.