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Policy Wordings

a. PREAMBLE:

This Policy is a contract of insurance between ICICI Lombard General Insurance Company Limited and the Proposer/Policyholder named in the Policy Schedule. On receipt of the Proposal form (which, along with any statements, reports, or documents referred to therein, forms part of and is the basis of this Policy), and the premium as specified in the Policy Schedule, We agree to provide insurance benefit(s)/cover(s) stated in the Policy Schedule and provide applicable benefits upon the occurrence of a covered event, subject to proof to Our satisfaction, and the terms, conditions and exclusions of the Policy.

b. DEFINITIONS:

For the purposes of this Policy, the following terms shall have the meaning set forth wherever appearing/specified in this Policy or related Optional Covers:

Unless the context otherwise requires: references to any statute, enactment, or regulation shall include any amendments, re-enactments, or modifications thereto from time to time; words in the singular shall include the plural and vice versa; and references to any gender shall include all genders.

i. Standard Definitions

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

"Associated Medical Expenses" means certain Medical Expenses (including surcharges or taxes) which shall include Room Rent, Qualified Nurse charges, operation theatre charges, fees of Medical

Practitioner within the same Hospital where You have been admitted. These do not include the cost of pharmacy, consumables, implants, medical devices, or diagnostics.

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

"Break in Policy" means the period of gap that occurs at the end of the existing policy term / installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

"Cashless Facility" means a facility of payment provided by us to you, where the cost of treatment covered under the Policy, to the extent approved through pre-authorization, is paid directly by us to the Network Provider.

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

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

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

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

"Co-Payment" means a cost sharing requirement under the Policy where you bear a specified percentage of the admissible claims amount**.** The Co-Payment amount paid by You does not reduce the Sum Insured under the Policy.

Day care Centre" means any institution established for day care treatment of Illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:

i. has qualified nursing staff under its employment
ii. has qualified medical practitioner/s in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out

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

Day Care Centre includes an AYUSH Day Care Centre as defined below

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

"**Day Care Treatment**" means a medical treatment or Surgical Procedure that is undertaken under general or local anesthesia and would require Hospitalisation of more than 24 hours but is completed in less than 24 hours due to technological advancement. Day Care Treatment does not include outpatient treatment or diagnostic procedures.

"Deductible" means a cost-sharing requirement under the Policy where We are not liable to pay a specified rupee amount (in case of indemnity based policies) or for a specified number of days/hours (in case of hospital cash poli cies) before any benefit becomes payable. The Deductible paid does not reduce the Sum Insured under the Policy.

"Domiciliary Hospitalization" means medical treatment for an Illness or Injury that would normally require care and treatment at a Hospital but is taken at home under any of the following circumstances:

i. the condition of the patient is such that he/she cannot be moved to a hospital, or
ii. Unavailability of room in a hospital.

"Emergency Care" means medical treatment of an Illness or Injury which results in sudden and unexpected symptoms and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

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

The grace period for payment of the 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 weshall offer coverage during the grace period, if the premium is paid in instalments during the policy period. =

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"Hospital" - A hospital means any institution established for in-patient care and day care treatment of Illness and/ or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Hospital includes an AYUSH Hospital as defined below:

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

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped
iv. operation theatre where surgical procedures are to be carried out;
v. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

"Hospitalization" means admission in a Hospital for a minimum period of 24 consecutive "in-patient care" hours unless the Optional Cover 32 – 2- Hour Hospitalization is opted and specified in the Policy Schedule.

"Illness" means a sickness, disease, or pathological condition that impairs normal physiological function and requires medical treatment. It can be:

a. Acute Condition – an Illness that responds quickly to medical treatment and results in full recovery.

b. Chronic Condition – an Illness that requires long-term or ongoing medical treatment, including rehabilitation, and continues indefinitely or is likely to recur.

"Injury" means physical bodily harm, excluding Illness, that is solely and directly caused by an Accident and is verified and certified by a Medical Practitioner.

"Inpatient Care" means a medical treatment for which You have to stay in a Hospital for more than 24 hours for a covered event unless the Optional Cover 32 – 2- Hour Hospitalization is opted and specified in the Policy Schedule.

"Intensive Care Unit" means a specialised unit of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), equipped for continuous monitoring and treating patients who are in a critical condition, or require life support facilities and with higher level of care and supervision than in other wards.

"ICU (Intensive Care Unit) Charges" means all Medical Expenses for treatment in an Intensive Care Unit.

"Loyalty Bonus" means any increase or addition in the Sum Insured granted by uswithout an associated increase in the premium**.**

"Maternity Expense" means Medical Expenses incurred during Day Care Treatment or Hospitalisation for childbirth and lawful medical termination of pregnancy during the Policy Period.

"Medical Practitioner" means a person legally registered with the Medical Council of India, any State Medical Council, the relevant authority for Indian Medicine or Homeopathy, or the medical council of any country outside India, and entitled to practice within its jurisdiction, but excludes any member of the Insured Person's family (i.e., Father, Mother, Father-in-law, Mother-in-law, Son, Daughter, Son-in-law, Daughter-in-law, Brother, or Sister).

"Medical Expenses" means expenses necessarily and actually incurred by You for medical treatment of an Illness or Injury on the advice of a Medical Practitioner, provided such expenses do not exceed what would be payable if the Insured Person were uninsured and are reasonable as per charges in the same locality for similar treatment.

"Medically Necessary Treatment" means any treatment, tests, medication, or Hospital stay that:

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

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

iii. must have been prescribed by a Medical Practitioner,

iv. conforms to the accepted professional standards in international medical practice or by the medical community in India.

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

"Migration" means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another within the company.

"Network Provider" means a Hospital or Day Care Centre enlisted by Us or Our TPAs, or jointly by Us and the TPA, to provide medical services to You through a Cashless Facility.

"Newborn Baby" means baby born during the Policy Period and is aged upto 90 days.

"Non- Network Provider" means any Hospital, Day Care Centre or other Service Provider that is not part of the network.

"OPD Treatment" means medical treatment, other than In-patient Care and Day Care Treatment, taken by You at a Hospital, Day Care Centre, or clinic/consultation facility on the advice of a Medical Practitioner.

"Portability" means a facility provided to the You (including all members under family cover), to transfer the credits gained for Pre-existing Diseases and Specific Waiting Periods from Us to another insurer.

"Post-Hospitalization Medical Expenses" means Medical Expenses incurred for the condition requiring Hospitalization but incurred during 180 days after You were discharged from a Hospital.

"Pre-existing Disease" means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by us; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

"Pre-Hospitalization Medical Expenses" means Medical Expenses incurred for the condition requiring Hospitalization but incurred during 90 days before You were admitted to a Hospital.

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

"Reasonable and Customary Charges" the charges for services or supplies that are standard for the provider, consistent with prevailing rates in the geographical area for identical or similar services, and necessarily incurred considering the nature of the Illness or Injury involved.

"Room Rent" means the amount charged by a Hospital towards room and boarding expenses and shall include Associated Medical Expenses.

Specified Disease/Procedure Waiting Period/" means a period up to 24 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

"Surgery" or Surgical Procedure" means any manual and / or operative procedure 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 by a Medical Practitioner at a Hospital or Day Care Centre.

"Unproven/Experimental Treatment" means any treatment, including drug or experimental therapy, that is not based on established medical practice in India, and is considered experimental or unproven.

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

"Accidental Emergency" means a traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a person's health or result in loss of life.

"Admission" means Your admission in a Hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness.

"**Altruistic surrogacy**" means the surrogacy in which no charges, expenses, fees, remuneration or monetary incentive of whatever nature, except the medical expenses and such other prescribed expenses incurred on surrogate mother and the insurance coverage for the surrogate mother, are given to the surrogate mother or her dependents or her representative

"Base Sum Insured" means the sum insured opted by you at the time of policy inception or renewal.

"Commercial surrogacy" means commercialization of surrogacy services or procedures or its component services or component procedures including selling or buying of human embryo or

trading in the sale or purchase of human embryo or gametes or selling or buying or trading the services of surrogate motherhood by way of giving payment, reward, benefit, fees, remuneration or monetary incentive in cash or kind, to the surrogate mother or her dependents or her representative, except the medical expenses and such other prescribed expenses incurred on the surrogate mother and the insurance coverage for the surrogate mother;

"Company" means ICICI Lombard General Insurance Company Limited.

"Commissioning Couple" means an infertile married couple who approach an assisted reproductive technology clinic or assisted reproductive technology bank for obtaining the services authorized of the said clinic or bank;

"Couple" means the legally married Indian man and woman above the age of 21 years and 18 years respectively;

"Contribution" is essentially our right to call upon other insurers, liable to you, to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

"Dependent Child" means a child (natural or legally adopted), who is unmarried, aged between 91 days and 30 years, financially dependent on You and does not have his / her independent sources of income.

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

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

"Elder/Elderly" means any individual aged 55 years and above.

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

"Immediate Family" means spouse, dependent children, brother(s), sister(s) and dependent parent(s) of the Insured.

"**Insured Person**" shall have the same meaning as "You"/"Your"/ "Yours"/ "Yourself".

"Intending Couple" means a couple who have a medical indication necessitating gestational surrogacy and who intend to become parents through Surrogacy;

"Intending Woman" means an Indian woman who is a widow or divorcee between the age of 35 to 45 years and who intends to avail the Surrogacy;

"Oocyte" means a developing egg in the ovary.

"Oocyte Donor" means a person who provides Oocyte with the objective of enabling an infertile intending couple or intending woman to have a child. **"Oocyte retrieval"** means a procedure of removing oocytes from the ovaries of a woman

"Period of Insurance" means the period as specifically appearing in the Policy Schedule and commencing from the Policy Period Start Date of the first Policy taken by You from Us and then, running concurrent to Your current Policy subject to Your continuous renewal of such Policy with Us.

"Policy" means Proposal Form, Policy wordings, the Policy Schedule, the Customer Information Sheet and any applicable endorsements or extensions attaching to or forming part thereof which collectively constitutes as an entire contract of insurance between Us and you .

"Policyholder" means the person referred to as the Proposer/Insured/Insured Person in the proposal form and named as the Policyholder in the Policy Schedule.

"Policy Period" means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy as specified in the Policy Schedule.

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

"Single Private Room" means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital.

"Service Provider" means any person, organization, institution, or company that has been empanelled with Us to provide services specified under the benefits to You. These shall also include all healthcare providers empanelled to form a part of network other than hospitals.

"Sum Insured" means the amount specified in the Policy Schedule, which is Our maximum, total, and cumulative liability for a Policy Year during the Policy Period, in respect of any or all persons named as Insured Persons in the Policy Schedule, for any or all claims arising during that Policy Year.

"Surrogacy" means a practice whereby one woman bears and gives birth to a child for an Intending Couple with the intention of handing over such child to the Intending Couple after the birth;

"Surrogacy clinic" means surrogacy clinic, centre or laboratory, conducting assisted reproductive technology services, invitro fertilisation services, genetic counselling centre, genetic laboratory, Assisted Reproductive Technology Banks conducting surrogacy procedure or any clinical establishment, by whatsoever name called, conducting surrogacy procedures in any form;

"Surrogate Mother" means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the conditions as specified in the Surrogacy (Regulation) Act 2021.**"Surrogacy procedures"** means all gynaecological, obstetrical or medical procedures, techniques, tests, practices or services involving handling of human gametes and human embryo in surrogacy

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

"Twin Sharing Room" means an air conditioned Hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the most economical of all accommodations available as twin sharing rooms in that Hospital

"You/Your/ Yours/ Yourself" means the person(s) that are named as Insured Person(s) in the Policy Schedule. For the purposes of this definition, the term "You" shall collectively refer to all such Insured Persons.

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

c. Benefits

This Policy offers various Basic Covers and Optional Covers as specified below.

The Policy comprises Basic Covers, which are uniformly available across all plan variants, and Optional Covers, which differ between the various plans. The plan-wise Optional Covers are detailed in policy schedule and prospectus. The Insured may also opt for any other Optional Cover offered under the Policy, even if such cover is not part of the selected plan. Only the covers opted by the Insured and reflected in the Policy Schedule shall be applicable and enforceable under this Policy.

We will provide You the benefits / coverage upto sum insured mentioned in policy schedule under the Basic Covers and the Optional Covers depending on the Policy option, as opted by You and as specified to be in force in the Policy Schedule and We agree to pay You the Reasonable and Customary Charges for Medically Necessary Treatment taken for an Illness or Injury covered under this Policy subject to the following:

i. You have contracted or sustained the Illness or Injury during the Policy Period as specified in the Policy Schedule;
ii. Applying any Deductible or Co-payment, and thereafter, the availability of the Sum Insured for the Policy Year, including any additional Sum Insured accrued as Loyalty Bonus (if accrued), Power Booster (Super Loyalty Bonus) (if opted and accrued), Power Booster Plus (if opted and accrued), Reset Benefit (if applicable), and Inflation Protector (if opted and accrued) and any limit/sub-limit specified thereunder on reimbursement and/or cashless basis (as applicable); and
iii. The terms, conditions and exclusion under the Policy.

i. Basic Cover:

We offer the following Basic Covers under the Policy:

1. In-patient Treatment

We will cover the Medical Expenses incurred in respect of Your Hospitalization::

- **i.** Room Rent up to a Single Private AC room;
- **ii.** Intensive Care Unit Charges;
- **iii.** Qualified Nurse charges;
- **iv.** Medical Practitioner's fees;

v. Anesthesia, blood, oxygen, operation theatre charges, medicines, drugs and consumables (other than those specified in the list of excluded expenses (non-medical) in Annexure II).

vi. Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and used intra-operatively during a Surgical Procedure.

vii. Cost of investigative tests or prescribed diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized.

This benefit is subject to the following:

i. If You are admitted to a room with a Room Rent or category higher than that specified in the Policy Schedule, then Associated Medical Expenses shall be payable on a pro-rata basis. However, pro-rate deductions shall not apply to ICU Charges or where the Hospital does not follow differential billing or where expenses are not charged based on the room category.

ii. This benefit does not include expenses associated with the use of automation machines for peritoneal dialysis.

iii. Medical Expenses arising from technological advancements and modern treatments shall be indemnified under this cover only where the relevant treatment or procedure is expressly specified under Cover 3: Technological Advancements and Treatments. Indemnity shall be limited to such treatments as are listed under Cover 3 and shall be subject to all terms, conditions, and sub-limits applicable under the Policy.

2. Day Care Procedures/Treatment

We will cover the Medical Expenses incurred in respect of Your Day Care Treatment at a Day Care Centre, subject to the following:

i. We will not cover any Out Patient Treatment or diagnostic services under this Benefit.

ii. If You are admitted to a room with a Room Rent or category higher than that specified in the Policy Schedule, then Associated Medical Expenses shall be payable on a pro-rata basis. However, pro-rate deductions shall not apply to ICU Charges or where the Hospital does not follow differential billing or where expenses are not charged based on the room category.

iii. This benefit does not include expenses associated with the use of automation machines for peritoneal dialysis.

iv. Medical Expenses arising from technological advancements and modern treatments shall be indemnified under this cover only where the relevant treatment or procedure is expressly specified under Cover 3: Technological Advancements and Treatments. Indemnity shall be limited to such treatments as are listed under Cover 3 and shall be subject to all terms, conditions, and sub-limits applicable under the Policy.

3. Technological Advancements and Treatments

We will cover the Medical Expenses incurred in respect of Your Hospitalization for the following Technological Advancements and Treatments:

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- Hospitalization Medical Expenses

We will cover the Pre-Hospitalization Medical Expenses incurred by You immediately 90 days before Your admission to Hospital provided that We have accepted the claim under Basic Cover - Inpatient Treatment or Basic Cover - Day Care Procedures/Treatment or Basic Cover- In-Patient AYUSH Hospitalization. This benefit does not cover any expenses incurred prior to the Policy Period Start Date with Us or on nursing care at home.

5. Post-Hospitalization Medical Expenses

We will cover the Post-Hospitalization Medical Expenses incurred by You immediately 180 days following Your discharge from Hospital provided that We have accepted the claim under Basic Cover - Inpatient Treatment or Basic Cover - Day Care Procedures/Treatment or Basic Cover- In-Patient AYUSH Hospitalization. We may consider including Post-Hospitalization Medical Expenses incurred.Physiotherapy if it is Medically Necessary Treatment & prescribed by treating medical practitioner.

6. In Patient AYUSH Hospitalization

We will cover the Medical Expenses incurred in respect of Your Hospitalisation for the AYUSH Treatment at a Government Recognized AYUSH Hospital or AYUSH Day Care Centre.

7. Domestic Road Ambulance

We will cover the Medical Expenses incurred on road ambulance services that are offered by a Service Provider, , for transporting the Insured Person in case of an Illness or Injury, subject to the following conditions:

i. We have accepted a claim under "Basic Cover - Inpatient Treatment or Basic Cover - Day Care Procedures/Treatment in respect of the Insured Person for the same Illness or Injury for which road ambulance services were availed.

ii. This benefit only covers the following cost of transportation:
   a. From the location of the Illness/Injury to the nearest Hospital that can provide Medically Necessary Treatment and has emergency facilities for the provision of Emergency Care.
   b. From the current Hospital to the nearest Hospital that can provide Medically Necessary Treatment and has emergency facilities for the provision of Emergency Care, if the same cannot satisfactorily be provided at a Hospital where You are situated, and only if that transportation has been prescribed in writing by a Medical Practitioner and is for Medically Necessary Treatment.
   c. From a Hospital to the nearest diagnostic centre during the course of Hospitalization, for advanced diagnostic treatment not available in the existing Hospital.

iii. The Service Provider shall be a registered provider with the relevant road traffic authority.

8. Donor Expenses

We will cover the Medical Expenses incurred in respect of an organ donor's Hospitalization for harvesting of the organ donated to You for the purpose of your own transplantation, subject to the following conditions::

i. The organ donation conforms to the Transplantation of Human Organs Act 1994.
ii. The organ donor is an In-Patient Care in the Hospital.
iii. We have accepted a claim under the Basic Cover - In-Patient Treatment in respect of the Insured Person.
iv. This benefit will not cover the following:
   a. Pre-Hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.
   b. Screening expenses of the organ donor.
   c. Any other Medical Expenses as a result of the harvesting from the organ donor.
   d. Costs directly or indirectly associated with the acquisition of the donor's organ.
   e. Transplant of any organ/tissue where the transplant is experimental or investigational.
   f. Expenses related to organ transportation or preservation.
   g. Expenses incurred by You as a donor.
   h. Medical Treatment / complication of the donor consequent to harvesting.

9. Domiciliary Hospitalization

We will cover the Medical Expenses incurred in respect of Your Domiciliary Hospitalization , subject to the following conditions::

i. The Domiciliary Hospitalization commenced on the written advice of a Medical Practitioner and continues for at least 3 consecutive days.
ii. This benefit will not cover the Medical Expenses incurred in respect of Domiciliary Hospitalization for following:
   a. Asthma, bronchitis, tonsillitis, upper respiratory tract infection, including laryngitis and pharyngitis, cough and cold, and 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; and

k. Pyrexia of any origin.

10. Loyalty Bonus

We will provide a Loyalty Bonus of 20% for each policy year, calculated on the Base sum Insured at inception or in case of renewal on the expiring or renewed Sum Insured (whichever is lower) which is credited to the Sum Insured for the next Policy Year, without any increase in premium and regardless of whether a claim has been made, provided that the Policy is continuously renewed with Us and subject to the following conditions:

i. The Loyalty Bonus cannot exceed 100% of the Sum Insured.

ii. The Loyalty Bonus will accumulate on floater basis for a Family Floater Policy and on individual basis for an individual Policy. In a Family Floater Policy, the accrued Loyalty Bonus will be available to You only if You were covered in the previous Policy Year(s) and continue to be covered in the renewal.

iii. Loyalty Bonus can only be utilized when the Sum Insured is completely exhausted.

iv. If individual Policies with accumulated Loyalty Bonus are renewed as a Family Floater Policy, then the lowest Loyalty Bonus of all individual Policies and not the Loyalty Bonus under each individual policy will not be carried forward to the Family Floater Policy.

v. If a Family Floater Policy is renewed as individual Policies, the Loyalty Bonus shall be apportioned to each renewed Policy in proportion to their respective Sum Insured, as per the table below:

Annual Floater Sum Insured	Accumulated Loyalty Bonus (after 5 years)	Family Floater Policy split to Individual policies with Annual Sum Insured of 10 Lacs each	Revised Annual Sum Insured of each Individual Policy	Revised Accumulated Loyalty Bonus of each Individual Policy
20 Lac	20 Lac		10 Lac	10 Lac

vi. If the Sum Insured is reduced at the time of renewal, the Loyalty Bonus shall also be reduced in the same proportion.

Annual Sum Insured	Accumulated Loyalty Bonus (after 5 years)	Annual Sum Insured reduced to Rs. 10 Lacs	Revised Annual Sum Insured	Revised Accumulated Loyalty Bonus
50 Lac	50 Lacs		10 Lac	10 Lac

vii. If the Sum Insured is increased at the time of renewal, the Loyalty Bonus shall be calculated on the basis of the Sum Insured under the expiring Policy.

Annual Sum Insured	Accumulated Loyalty Bonus (after 5 years)	Annual Sum Insured increased to Rs. 10 Lacs	Revised Annual Sum Insured	Revised Accumulated Loyalty Bonus
5 Lac	5 Lac		10 Lac	5 Lac

viii. In the event of claim, under the Policy during any subsequent Policy Year, the credited Loyalty Bonus will not be reduced.

ix. Loyalty Bonus will not be applicable for a Policy with unlimited Sum Insured.

11. Reset Benefit

We will reset up to 100% of the Sum Insured in a Policy Year for unlimited times for any illness / injury / disease during a Policy Year due to the insufficiency of the Sum Insured (including any accrued Loyalty Bonus, Inflation Protector (if opted), and Power Booster (Super Loyalty Bonus) (if opted), Power Booster Plus (if opted),) cause by the payment of previous claim(s) in that Policy Year, subject to the following conditions:

i. This benefit is not available under a Policy with unlimited Sum Insured.
ii. The Reset Benefit will not be triggered for the first claim made during the Policy Year
iii. The total amount of Reset Benefit will not exceed the Sum Insured for that Policy Year as specified in the Policy Schedule.
iv. The Reset Benefit will be applied only if the claim is made and admissible under “Inpatient Treatment” or “Daycare Treatment” or “In-patient AYUSH Hospitalization” cover.
v. For individual Policies, the amount will be available on individual basis and for Family Floater Policies, the amount will be available on floater basis.
vi. Any unutilized Reset Benefit will not be carried forward to any subsequent Policy Years.

vii. Reset Benefit will not be triggered for claims made outside the geographical limits of India.

12. Bariatric Surgery Cover

, We will cover Medical Expenses incurred in respect of Your Hospitalization for the Surgery for obesity conducted on the advice of a Medical Practitioner, subject to the following conditions:

i. The Surgery shall be supported by clinical protocols.
ii. You are at least 18 years of age and Your Body Mass Index is:
    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
iii. This Benefit has a waiting period of 24 months from date of inception of the first Policy with Us. However, the waiting period will be reduced to 30 days in case You have opted for the Optional Cover 3 - Jumpstart.
iv. Any additional Sum Insured accrued as a part of Loyalty Bonus/Power Booster (Super Loyalty Bonus)/Inflation Protector/Reset Benefit/Power Booster Plus will not be available for this benefit. The Insured Person shall mandatorily obtain cashless approval prior to undergoing the surgery/ treatment

The service will not be provided on reimbursement basis.

13. In-Patient Hospitalization for Surrogate Mother

We will cover the Medical Expenses incurred in respect of the Hospitalization of the Surrogate Mother appointed by You who is the "Intending Couple/ Intending Woman, for complications arising out of pregnancy including post-partum delivery complications subject to the following conditions:

i. An initial waiting period of 30 days is applicable.
ii. This benefit is applicable to all or any female Insured Person(s) who have opted for a Policy Term of 3 years or more.
iii. The maximum coverage available for a Surrogate Mother is for a period of 36 continuous months following the successful completion of the surrogacy procedure, subject to the overall limit of Rs.5 Lakhs.
iv. Any expenses incurred on delivery of the Newborn Baby (either via normal delivery or caesarean section) are excluded from this benefit.

v. The Surrogacy conforms to the Surrogacy Regulation Act 2021, and all the rules and regulations made thereunder.
vi. The terms and conditions of the Basic Cover - In-Patient Treatment shall apply.

14. In-Patient Hospitalization for Oocyte Donor

We will cover Medical Expenses incurred in respect of Hospitalization of the Oocyte Donor, appointed by You who is the "Commissioning Couple"/"Commissioning Woman", for complications arising out of Oocyte retrieval subject to the following conditions:

i. This benefit shall be available only for a period of 12 months after the success of Oocyte retrieval and subject to a limit of Rs. 5 Lakhs.
ii. This benefit is applicable to all or any female Insured Person(s).
iii. Any expenses incurred on delivery of the Newborn Baby (either via normal delivery or caesarean section) are excluded from this benefit.
iv. The Oocyte retrieval conforms to the Assisted Reproductive Technology (Regulation) Act 2021 (and its amendments from time to time), and all the rules and regulations made thereunder.
v. The terms and conditions of Basic Cover - In-Patient Treatment shall apply.

15. Wellness Program

We provide You with the following benefits, each of which is detailed further below:

i. Wellness Activities
ii. Health Assistance
iii. Ambulance Assistance
iv. Discounts on services and products.

I. Wellness Activities

We provide wellness activities under the Basic Cover-Wellness Program, to promote, incentivize, and reward healthy behavior. Under the wellness activities, You can earn wellness points by undertaking the activities (as specified in Table A and Table B) and the total wellness point earned will be redeemed to avail a discount on premium on renewals for the subsequent Policy Year (as specified in Table C and Table D), subject to the following conditions:

i. The wellness activities is available to each adult Insured Person(s) subject to a maximum of 2 adult Insured Persons in case of a Family Floater Policy.

ii. Table A specified the maximum wellness points earned by each of the Insured Person for each completed acitvity and Table B specifies the maximum wellness point earned by each of the Insured Person for completing the targeted number of steps for a minimum of 20 days per month.

iii. These wellness points are monitored by a Health Coach. Health Coach is a personalized digital service available via Our mobile application and is available to a maximum of 2 adult Insured Person(s). You can avail this service by downloading and registering Yourself on Our mobile application within 30 days of Policy Period Start Date.

Table A- Earning wellness points by undertaking the following wellness activities:

Table A.1: For 1 year Policy Period:

Category	Policy Period	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 questionaire	500	250
	Undergoing Health Check-Up & uploading the reports on Our app	1,000	500
	Uploading a face scan on Our app once a quarter	400	200
	First usage of Chat with Health Expert/ Health Coach Service on Our app	100	50
Wellness activities	Participating in one of any ICICI Lombard initiated Contest/ health quiz	200	100
	Completing one of any ICICI Lombard initiated Webinar	200	100
Wellness Tasks	Achieving targeted steps on at least 20 days in a month, tracked via our mobile app, as set out in Table B below	6,000	3,000

	(10/15/25 points/ day depending on steps completed)		
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**

Table A.2: For multi-year Policy Period of 2, 3, 4, and 5 years:

Category	Policy Tenure	Individual				Floater*			
		2 Years	3 Years	4 Years	5 Years	2 Years	3 Years	4 Years	5 Years
	Activity Details	Max Points Earned per Insured	Max Points Earned per Insured	Max Points Earned per Insured	Max Points Earned per Insured	Max Points Earned per Insured	Max Points Earned per Insured	Max Points Earned per Insured	Max Points Earned per Insured
Health Assessment	Health Risk Assessment	1,000	1,500	2,000	2500	500	750	1000	1250
	Undergoing Health Check-Up & uploading the reports	2,000	3,000	4,000	5000	1,000	1,500	2000	2500
	Face scan once a quarter	800	1,200	1,600	2000	400	600	800	1000
	First usage of Chat with Health Expert/ Health Coach Service	200	300	400	500	100	150	200	250
Wellness activities	ICICI Lombard initiated Contest/ health quiz (Any one contest)	400	600	800	1000	200	300	400	500
	ICICI Lombard initiated Webinar (Any one webinar)	400	600	800	1000	200	300	400	500

Wellness Tasks	Achieving targeted steps per month (10/15/25 points/ day depending on steps completed)	12,000	18,000	24,000	30,000	6,000	9,000	12,000	15,000
Fitness challenge	Participation and successful completion of fitness challenge In App	1,000	1,500	2,000	2500	500	750	1000	1250
Health Events	Participation in Professional sporting events like Marathon/Cyclathon/Swimathon etc.	1,000	1,500	2,000	2500	500	750	1000	1250
Grand Total		**18,800**	**28,200**	**37,600**	**47,000**	**9,400**	**14,100**	**18,800**	**23,500**

* In case of a Family Floater Policy, wellness points earned by each Insured Persons for every completed activity shall be accrued to calculate the renewal discount

Table B- 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	4 Years	5 Years
8,000+ steps	500	6000	12000	18000	24000	30000

6,000 to 7,999 steps	300	3600	7200	10800	14400	18000
4,000 to 5,999 steps	200	2400	4800	7200	9600	12000
<4,000 steps	Nil	Nil	Nil	Nil	Nil	Nil

* If the number of active days is less than 20 days, then no wellness points will be awarded for that month. Only the steps achieved up to 90 days prior to the due date of the renewal of the Policy shall be counted towards the computation of wellness for this Policy Year and steps achieved thereafter shall be carried forwarded to the subsequent Policy Year.

iv. Table C specifies the discount on renewal premium that can be availed against the accumulated wellness points where the maximum discount available is as follows:
   a. For individual Policies: Up to 30% discount.
   b. For Family Floater Policies: Up to 15% per Insured Person subject to the respective wellness points and a maximum of 30% at Policy level.

Table C- Renewal Discount against Accumulated Wellness Points

						Renewal discount	
Regular fitness related activities	**Wellness points accumulated per Insured Person***					**Individual**	**Floater (Per Insured Person)**
	1 Year	**2 Year**	**3 Year**	**4 year**	**5 Year**		
Points	2500-3999	5000-7999	7500-11999	10000-15999	12500-19999	2.50%	1.25%

	4000-4999	8000-9999	12000-14999	16000-19999	20000-24999	5%	2.50%
	5000-6999	10000-13999	15000-20999	20000-27999	25000-34999	10%	5%
	7000-8999	14000-17999	21000-26999	28000-35999	35000-44999	20%	10%
	>9000	**>18000**	**>27000**	**>36000**	**>45000**	**30%**	**15%**

*For each consecutive year, You have to accumulate a minimum of 9,000 wellness points in the first year, 18,000 in the second year, and 27,000 in the third year to avail the maximum discount on the renewal premium.

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

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	10%		
	Total Discount-25%	Rs. 25,000	Rs. 25,000- (Rs. 25,000x25%)=Rs. 18,750

v. Renewal discount will apply only to the next Policy Year. All wellness points accumulated up to the renewal will be mandatorily redeemed towards renewal discount of that Policy Year and cannot be carried forward to the next Policy Year.

vi. Renewal discount is computed based on the wellness points earned 90 days before the due date of renewal. Any unused points that remain after calculating the discount (residual points) will be carried forward and be added to the next Policy Year's earnings.

vii. In an individual Policy, the discount applies to the individual's premium whereas in a Family Floater Policy, the discount applies to the total premium.

viii. If You have opted for a higher Policy Period at renewal:

a. From a 1-year policy: discount applies in Policy Year 1 only
b. From a 2-year policy: discount applies in Policy Years 1 and 2
c. From a 3-year policy: discount applies in Policy Years 1, 2, and 3
d. And so on for higher tenures

ix. If You have opted for a lower Policy Period at renewal, a flat discount applies to all Policy Years before tenure discount.

x. For Health Risk Assessment services availed through Our mobile application/online/digital mode through IL platform, the Insured Person must provide required details to establish authenticity and validity before availing of any services. Any information provided will be used solely for delivering wellness services and kept confidential with Us, Our Network Providers, and Service Providers. The Insured Person must notify Us and submit relevant documents, reports, or receipts within 60 days of undertaking any wellness activity.

xi. The wellness points cannot be carried forward after the expiry of the Policy, and no cash reimbursement or redemption is available.

xii. We may remove or reduce the wellness points if obtained unfairly or through manipulation.

xiii. The wellness program offered is subject to change as per the insurance statutory and regulatory framework.

xiv. It is agreed and understood that (1) You have obtained the services under this wellness program on Your own discretion, and risk; (2) the services under the wellness program shall not be construed as medical advice nor a substitute for physical consultation with an independent Medical Practitioner or healthcare professional; (3) You must seek assistance from a qualified Medical

Practitioner/healthcare professional when interpretating and applying any recommendations under this wellness program; and (4) We shall not be held responsible for any loss, damage, or adverse outcome arising out of or in connection with any opinion, advice, prescription, or any actual or alleged errors, omissions, or representations made by the Medical Practitioner or healthcare professional delivering the services under the wellness program.

II. **Health Assistance Team:**

We provide the services of the Health Assistance Team who helps You to understand Your health condition and access care by providing various services, including but not limited to:

i. Identifying the Medical Practitioners and Hospitals (including bed availability).
ii. Arranging Qualified Nurses, attendants, mobility/daily living aids, and medical equipment.
iii. Scheduling appointments (consultations, second opinions, diagnostics) with our empanelled Service Providers.
iv. Assisting with Cashless Facilities.
v. Providing medicine delivery options and preventive health information.
vi. Guiding post Hospitalization care such as physiotherapy or nursing at home.

This is subject to the following conditions:

i. This service is available via our mobile app or by calling 040-66274205 (subject to change) between 8:00 am–8:00 pm, Monday to Saturday (excluding public holidays).
ii. Our role is limited to that of facilitator and any charges incurred in obtaining consultations, diagnostics, or treatments with the assistance of the Health Assistance Team shall be borne by You. We are not liable for the quality, defects, or deficiencies of services provided by the Network Providers or Service Providers.
iii. By using this service, You consent agree and consent to health records being maintained by Us for internal use only.
iv. It is agreed that You have voluntarily obtained and decided to whether and how to use the services of the Health Assistance Team.

III. Ambulance Assistance

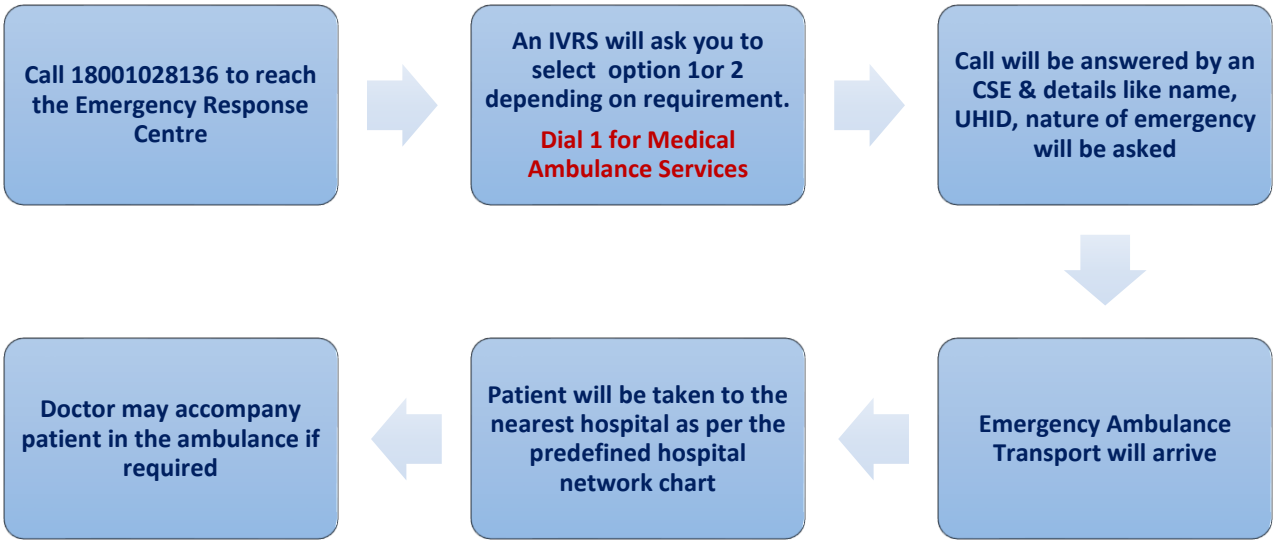
We will assist in arranging ground medical transportation by a Service Provider to transfer You from the location of the Illness/Injury to the nearest Hospital, clinic, or nursing home within the same city for Medically Necessary Treatment subject to the following conditions:

-
- The ground medical transportation is available at the location of Illness or Injury. Please visit Our website to see the list of cities where such services are available.
- The Illness/Injury must be life-threatening and requires urgent transfer, certified in writing by a Medical Practitioner.
- You must be in India and treatment must take place in India.
- This is an assistance service only and You must bear charges for the transportation, unless You are eligible for reimbursement under the Basic Cover- Domestic Road Ambulance.

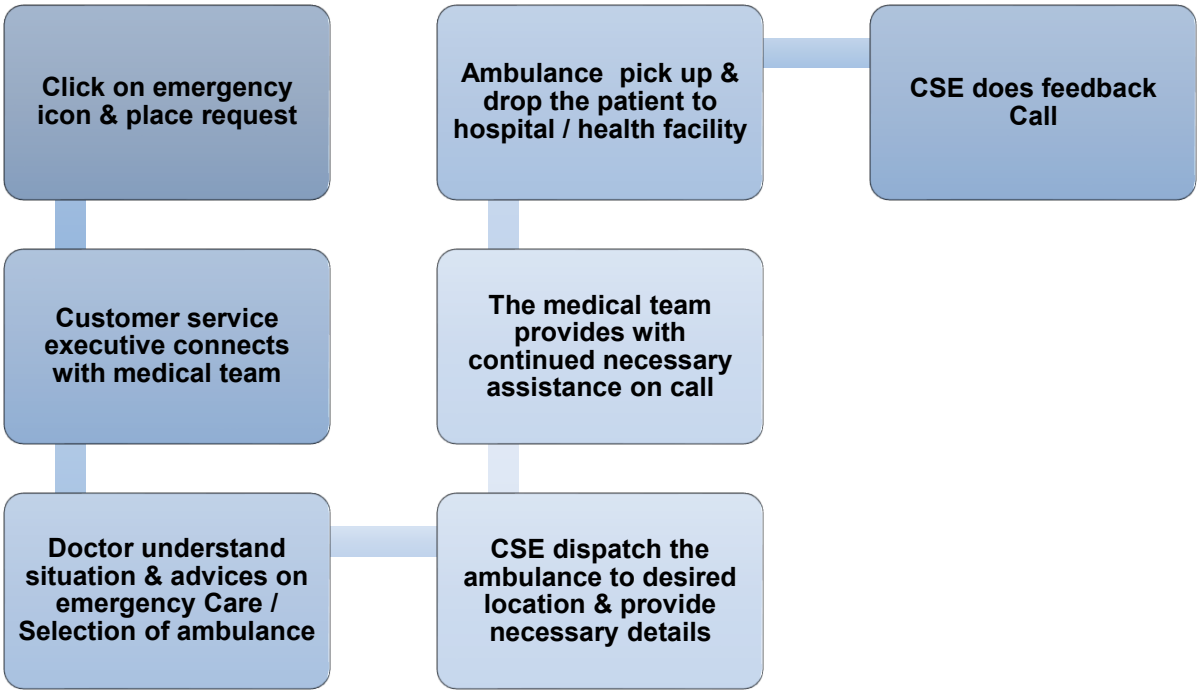
Process to avail Ambulance Assistance:

a. On calling Our helpline number provided below, Our trained customer service executive (CSE) will ask the Insured Person relevant questions to assess the situation.
b. The call may be redirected to a Medical Practitioner to evaluate the requirement for an ambulance with advanced life support based on the Insured Person's condition.
c. The below details are to be made available for availing the services:
    1. UHID of Insured Person, as provided on the Health Card.
    2. Contact number of the Insured Person.
    3. Location of Insured Person.

How to Call an Ambulance? (Via Call)



How to Call an Ambulance? (Via Mobile Application)



IV. Discounts/Vouchers on services/products

We will facilitate discounts for You on various services and products, including but not limited to investigations, diagnostic tests, laboratory tests, health supplements, medical equipment, homecare services, virtual health and wellness sessions, AYUSH products, fitness/gymnasium membership and wellness related activities and products from Our empanelled diagnostic centres, drugs and medicines ordered from pharmacies or offered by our Network Providers/Service Providers. These discounts can be viewed and availed on our mobile app, subject to availability and applicable terms and conditions.

For avoidance of doubt we will facilitate gymnasium memberships through digital vouchers and they are subject to availability and applicable terms and conditions as governed by our empanelled service providers.

ii. **Optional Covers:**

We offer the following Optional Covers under the Policy and in this regard, please note that:

a. No additional premium is required to be paid under the Optional Cover 19 - Voluntary Co-Payment, Optional Cover 20 -Voluntary Deductible, Optional Cover 29 - Network Advantage, Optional Cover 30 - NRI Advantage- Cover for NRI and Optional Cover 33 – Vital Essence.
b. The Sum Insured for each of the Optional Covers (except Optional Cover 10 - Claim Protector and Optional Cover 22 - Durable Medical Equipment Cover) shall be over and above the Sum Insured of the Policy.
c. Claims under this Optional Covers will not impact the Sum Insured (except Optional Cover 10 - Claim Protector, Optional Cover 1 - Infinite Care, and Optional Cover 22 - Durable Medical Equipment Cover) or Loyalty Bonus (except Optional Cover 1 - Infinite Care) Optional Cover 32. 2 – Hour Hospitalization and Optional Cover 33 – Vital Essence.
d. Based on the plan you have opted for, certain optional add-ons will be provided as built-in covers.

1. Infinite Care

We will cover Medical Expenses incurred in respect of any one claim under the Basic Cover - Inpatient Treatment or Basic Cover - Day Care Procedures/Treatment or Basic Cove r- In-Patient AYUSH Hospitalization without any limits on the Sum Insured, subject to the following conditions:

i. The time period to opt for this Optional Cover shall be limited to the first 2 Policy Years (irrespective of the Policy Period) such that:
   a. If the Policy Period is of 1 year and is renewed annually as a 1 year Policy, then this Optional Cover must be opted either at the inception of the Policy or the first renewal.
   b. If the Policy Period is of 2, 3, 4 & 5 years, the cover must be opted at the inception of the Policy.

ii. The claim must be admissible under the Basic Cover - Inpatient Treatment or Basic Cover - Day Care Procedures/Treatment or Basic Cover- In-Patient AYUSH Hospitalization and comply with the conditions therein.

iii. Once opted, this Optional Cover must be opted continuously until any one claim is made under this cover. Once a claim is made or if the Insured Person opts out of this Optional Cover, the same cannot be opted again.

iv. Where applicable, the total Sum Insured shall be utilized per following sequence in the event of a claim under this cover:
   1. Sum Insured
   2. Loyalty Bonus
   3. Power Booster (Super Loyalty Bonus) or Power Booster Plus
   4. Inflation Protector

v. After utilization of all the above, the total Sum Insured shall be zero for that Policy Year following the payment of claim under this Optional Cover.

vi. Optional Cover - Voluntary Co-payment or Optional Cover - Voluntary Deductible, if opted by the You, shall be applicable under this cover.

vii. This cover will not be applicable in case of claims lodged under Optional Cover - Worldwide Cover, Basic Cover - In-Patient Hospitalization for Surrogate Mothers, Basic Cover - In-Patient Hospitalization for Oocyte Donors, and for Policies with unlimited Sum Insured option.

viii. Room category applicable under this Optional Cover shall be capped at Single Private Room unless You have opted for Optional Cover - Room Modifier.

2. Power Booster (Super Loyalty Bonus)

We will provide a Loyalty Bonus of 100% of the expiring or renewed Sum Insured (whichever is lower) at the end of each Policy Year which is credited to the Sum Insured for the next Policy Year without any increase in premium and regardless of whether a claim has been made, provided that the Policy is continuously renewed with Us and subject to the following conditions:

i. The Power Booster can be accumulated up to an unlimited Sum Insured.
ii. This Optional Cover shall not be available to Policies with unlimited Sum insured, although it can accumulate up to an unlimited Sum Insured.
iii. If You opt out of this Optional Cover at the time of renewal, all the bonus accumulated under this Optional Cover will reduce to zero
iv. Power Booster (Super Loyalty Bonus) and Power Booster Plus cannot be opted together
v. All the conditions under the Basic Cover - Loyalty Bonus shall be applicable to this Optional Cover.

3. Jumpstart

We will cover the Medical Expenses incurred which are admissible under the Basic Covers for the below listed Illnesses from Day 31 of the first Policy Period Start Date, provided that:

i. The Illnesses have been disclosed by You or detected during pre-policy medical examination, and accepted by Us at the inception of the Policy and mentioned in the Policy Schedule.
ii. The Optional Cover shall be applicable on an individual basis for an individual Policy, and on a floater basis for a Family Floater Policy.
iii. This Optional Cover will be available only during inception of the Policy or upon addition of a new member in the Policy during renewal.
iv. A waiting period of 30 days shall apply on the increased Sum Insured at the time of renewal, as illustrated below:

Sum Insured	**Jumpstart Applicable on Sum Insured**	**Sum Insured increased to Rs. 20 Lacs upon renewal**	**Revised Sum Insured**	**Jumpstart Applicable on Sum Insured**	**Waiting Period Applicable on the incremented Sum Insured**
Rs. 15 Lac	Rs. 15 Lac		Rs. 20Lac	Rs. 20Lac	Rs. 5 Lac

v. Once chosen, this Optional Cover will need to be opted for a period of 3 continuous Policy Years.
vi. Exclusion Pre-Existing Diseases (Code- Excl01) shall not apply to this Optional Cover .
vii. This Optional Cover shall not apply for claims made under Optional Cover - Worldwide Cover.

List of Illnesses covered:

1. Asthma
2. Diabetes
3. Hypertension
4. Hyperlipidemia
5. Obesity
6. Coronary Artery Disease (PTCA done prior to 1 year)

Specific Definitions of these Illnesses are mentioned below for your ease of understanding and the same will be covered, provided the Insured Person's condition meets the criteria defined.

1. **Asthma** is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath.
2. **Hypertension** is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.
3. **Hyperlipidemia** is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease.
4. **Diabetes mellitus** is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages every organ in the body, which causes serious health consequences.
5. **Obesity** where Obesity means abnormal or excessive fat accumulation that presents risk to the health (Body Mass Index i.e. BMI is less than or equal to 39.99. This BMI limit will be modified in case of co-morbidities.)
6. **Coronary Artery Disease with PTCA done prior to 1 year:**

i. Coronary artery disease is the buildup of lipid-rich plaque in the arteries that supply oxygen-rich blood to the heart. Plaque causes a narrowing or blockage that could result in a heart attack.

ii. PTCA (Coronary Angioplasty) is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

iii. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

iv. Diagnostic angiography or investigation procedures without angioplasty / stent insertion are excluded from the scope of this definition.

4. Chronic Disease Management Program (Only Cashless Basis)

, If You have disclosed any of the following Illnesses and the same have been accepted by Us, then You shall be enrolled under Our Chronic Disease Management Program, which can be availed from our Service Provider on cashless basis:

1. Asthma
2. Diabetes
3. Hypertension
4. Hyperlipidemia
5. Obesity
6. Coronary Artery Disease (PTCA done prior to 1 year)

Under this Chronic Disease Management Program, We shall provide You the following services:

i. Assistance in tracking health through Our Service Providers.

ii. Assistance in availing a dietician and nutritional counseling.

iii. 2 pre-defined diagnostic health check-ups for the Illness specified above, with a gap of 6 months between each. The health check-ups are in addition to cover under the Optional Cover - Health Check-up, if opted and specified in the Policy Schedule.

iv. Assistance in availing counselling for lifestyle modifications, such as quitting tobacco/alcohol etc.

v. The service will not be provided on reimbursement basis.

This benefit is subject to the following condition:

1. This Optional Cover is available only to Insured Persons of age 18 years and above.
2. You can opt for this Optional Cover at renewals subject to the Your declaration and Our acceptance of any of Illness specified above.
3. The health check-ups under this Optional Cover can be availed only through Our mobile app or by calling at our toll free number: 1800 2666.
4. The Service Provider shall be assigned by Us once We receive Your request to avail a health check-up under this Optional Cover.
5. Utilization of this health check-up will not impact the Sum Insured.
6. We reserve the right to modify, add, or restrict any Network Providers/Service Providers at our sole discretion. You are advised to check the updated list of Network Providers and Service Providers on Our website.
7. We may introduce other Illnesses under this Optional Cover.
8. It is agreed and understood that (1) You have obtained the services under this Optional Cover on Your own discretion, and risk; (2) the services under this Optional Cover shall not be construed as medical advice nor a substitute for physical consultation with an independent Medical Practitioner or healthcare professional; (3) You must seek assistance from a qualified Medical Practitioner/healthcare professional when interpretating and applying any recommendations under this Optional Cover; and (4) We shall not be held responsible for any loss, damage, or adverse outcome arising out of or in connection with any opinion, advice, prescription, or any actual or alleged errors, omissions, or representations made by the Medical Practitioner or healthcare professional delivering the services under this Optional Cover.

5. Maternity Benefit

We will cover the Maternity Expenses incurred, up to 10% of the Sum Insured. Expenses related to medically recommended lawful termination of pregnancy but only ina life-threatening situation/condition and on the advice of a Medical Practitioner, subject to the following conditions:

i. This Optional Cover can be opted at renewal of the Policy.
ii. This Optional Cover is available only under a Family Floater Policy and subject to a maximum limit of Rs. 1 Lakh.
iii. The Optional Cover is limited to a maximum of 3 deliveries or terminations during the lifetime of a female Insured Person between the ages of 18 to 50 years.
iv. Pre-natal expenses (from conception until delivery) and post-natal expenses (up to 30 days from delivery) are covered within the above limit, provided they are incurred on an in-patient basis.

v. This Optional Cover will have a waiting period of 24 months from the date it is opted and specified in the Policy Schedule.

vi. Any expenses incurred for management of ectopic pregnancy are excluded under this Optional Cover. claim for these can be made under Basic Cover - In-Patient Treatment. This Optional Cover shall not be available outside the geographical boundaries of India.
You cannot opt for optional cover Elevate HER Women care if you have opted for Maternity benefit add on.

6. New Born Baby Cover

We will cover Medical Expenses incurred in respect of Hospitalization of the Your Newborn Baby for a minimum period of 24 consecutive hours and a maximum period of 90 days, subject to the following:

i. This Optional Cover is available only if You have opted for the Optional Cover- Maternity Benefit or Elevate HER Nurture plan/Elevate HER Nurture Plus Plan under the Elevate HER – Women Care Add-on and We have accepted a claim under the above mentioned Optional Cover.

The Sum Insured under this Optional Cover shall be twice the Sum Insured applicable or Rs 200,000, whichever is lower under the Optional Cover – Maternity Benefit or the Elevate HER Nurture/Elevate HER Nurture Plus Plan under Elevate HER Women care Add on. This amount shall be available in addition to the Sum Insured under the respective Maternity Benefit or Elevate HER Nurture/Elevate HER Nurture Plus Plan.

7. Vaccinations for Newborn Baby in the first year

We will cover expenses incurred in respect of vaccinations of the Newborn Baby till he/she reaches 1 year of age, subject to the following:

i. This Optional Cover is available only if You have opted for the Optional Cover - Maternity Benefit or Elevate HER Nurture/ Elevate HER Nurture Plus and Optional Cover - New Born Baby Cover and We have accepted a claim under the Optional Cover - Maternity Benefit or Maternity claim under Elevate HER Nurture plan/ Elevate HER Nurture Plus plan.

ii. This Optional Cover is limited to 1% of the Sum Insured or Rs. 10,000, whichever is lower and applies over and above the Sum Insured under the Optional Cover – Maternity Benefit or Elevate HER Nurture Plan/ Elevate HER Nurture Plus Plan.

8. BeFit

We provide You with the following, each of which is detailed further below:

I. Physical Consultations

II. Routine Diagnostics and Minor Procedure Cover

III. Pharmacy
IV. Physiotherapy Session
V. E-Counseling
VI. Diet and Nutrition e-Consultation

This benefit is subject to the following conditions:

i. This Optional Cover can only be opted by the Insured Persons up to the age of 65 years during first time issuance.
ii. There will be a waiting period of 30 days for this cover.
iii. All benefits under the Optional Cover - BeFit can be availed only through a Cashless Facility via registration on our mobile app and are subject to any limits specified in the Policy Schedule.
iv. All services shall be provided through Our Service Providers / Network Providers, subject to availability at the time of appointment.
v. Any unutilized Consultations / E- consultations / Sum Insured / Sessions cannot be carried forward to the next Policy Year.
vi. The service will not be provided on reimbursement basis.

It is agreed and understood that (1) You have obtained the services under this Optional Cover on Your own discretion, and risk; (2) the services under this Optional Cover shall not be construed as medical advice nor a substitute for physical consultation with an independent Medical Practitioner or healthcare professional; (3) You must seek assistance from a qualified Medical Practitioner/healthcare professional when interpretating and applying any recommendations under this Optional Cover; and (4) We shall not be held responsible for any loss, damage, or adverse outcome arising out of or in connection with any opinion, advice, prescription, or any actual or alleged errors, omissions, or representations made by the Medical Practitioner or healthcare professional delivering the services under this Optional Cover.

i. Physical Consultations

We will cover the Medical Expenses incurred for out-patient consultations with a Medical Practitioner, whether in person or through virtual modes such as chat, email, video call, online portal, or mobile application, in connection with any Illness or Injury contracted or suffered by

You, subject to the overall maximum number of consultations specified in the Policy Schedule. This Optional Cover does not include Medical Expenses incurred towards dental treatment.

The Optional Cover-BeFit (I. Physical Consultation) does not cover the Medical Expenses incurred in physiotherapy sessions or for counselling availed for psychiatric ailments or mental health issues as the same are covered under Optional Cover-BeFit (IV. Physiotherapy Sessions) and Optional Cover-BeFit (V. e-counselling) respectively.

ii. Routine Diagnostic and Minor Procedure Cover

We will cover the Medical Expenses incurred for out-patient diagnostic tests (such as histopathology, biochemistry, hematology, immunology, microbiology, serology, pathology, radiology, ultrasound, and TMT) and minor procedures (specified below), when recommended or performed by a Medical Practitioner, in connection with any Illness or Injury contracted or suffered by You. We may also arrange for such diagnostic tests to be conducted at Your location, provided it falls within the geographical reach of the Service Provider on the date of the request.

This Optional Cover does not include genetic studies.

The Optional Cover-BeFit (II. Routine Diagnostic and Minor Procedure Cover) includes only the cost of administration. The actual cost of consumables will be covered under the Optional Cover - BeFit (III. Pharmacy). However, You will bear the cost of consumables in case the Sum Insured under the Optional Cover - BeFit (III. Pharmacy) is exhausted, or the consumables are outside of its scope of cover, or if the consumable is a non-payable item as listed under **List I- Items for which coverage is not available in the Policy of Annexure II** of this Policy.

List of Minor Procedures covered under this Optional Cover*

Drainage of abscess
Injection including Intramuscular (Per Injection cost)

Intravenous injection (IV)
Sprain Management (Joint movement/exercise)
Otoscopic examination (Magnifying otoscopy)
Nasal packing for control of haemorrhage
Nebulizer therapy
Removal of foreign body
Suturing (Staple under LA)
Removal of suture
Stabilization of joint
Syringing ear to remove wax
Application or removal of plaster cast
Laryngoscopy
Minor wound management

*

iii. Pharmacy

We will cover Medical Expenses incurred on the purchase of medicines, drugs, and medical consumables, as prescribed by a Medical Practitioner for any Illness/Injury contracted or suffered by the You.

The Optional Cover-BeFit (III. Pharmacy) does not cover health supplements, nutraceuticals, foods for special dietary use, foods for special medical purpose, foods with added probiotics and/or foods with added prebiotics, vaccinations, vitamins, tonics, and other related products .

iv. Physiotherapy Session

We will cover the Medical Expenses incurred for physiotherapy sessions with a qualified physiotherapist, as advised by a Medical Practitioner, in connection with any Illness or Injury contracted or suffered by You. This includes physical methods of treatment such as, but not limited to, massage, heat therapy, ultrasound, laser, and therapeutic exercises.
The time duration of each physiotherapy session shall be restricted to 30 minutes only.

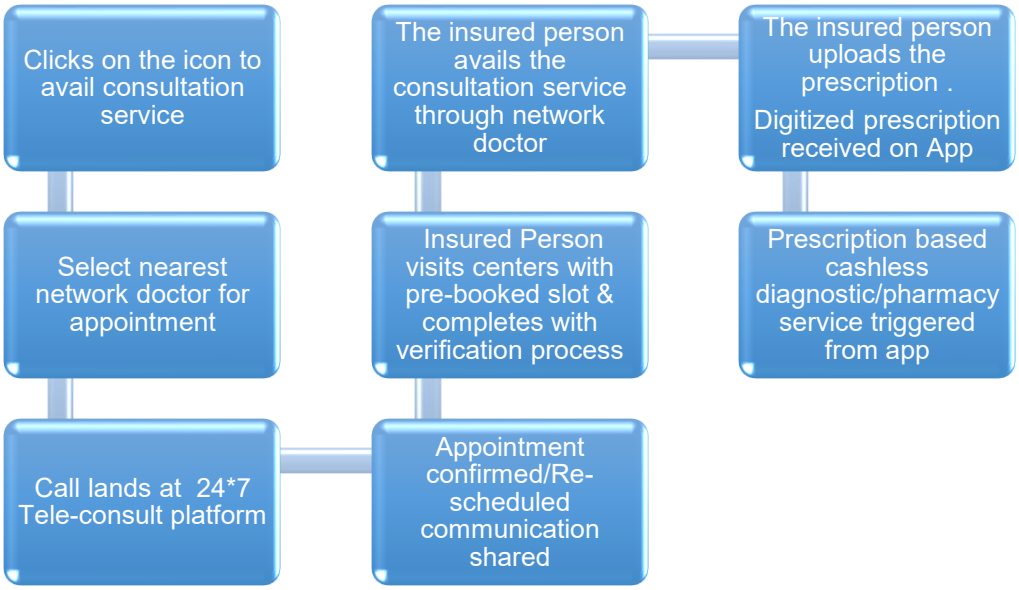
v. e-Counseling

We will cover expenses incurred on e-counseling sessions with a psychologist for providing assistance in dealing with issues, including but not limited to personal and lifestyle imbalance, pre-marital counselling, parenting and child care, speech impairment, and problems related to psychological/mental illness/ psychiatric and psychosomatic disorders, stress, and anxiety.

vi. Diet and Nutrition e-Consultation

We will cover expenses incurred on diet and nutrition e-consultation.

How to avail cover under BeFit on the mobile app: Post download mobile application from App store/Play store etc. the Insured Person will have to complete the registration process and login to the home page.



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

- To avail the Cashless Facility from the Service Provider / Network Provider for benefits under this cover, You are required to make a request on Our mobile application and produce information on the health card available on the app, for verification and validation.
- The request shall be considered after having obtained accurate and complete information for the Illness/Injury and We shall confirm the request digitally.
- If the services availed exceed the eligibility/limits of the Policy, the difference shall be paid by the Insured Person directly to the Hospital / Network Provider / Service Provider.
- The Optional Cover - BeFit (II. Routine Diagnostics and Minor Procedure Cover) and (III. Pharmacy) shall only be covered for prescriptions from a Medical Practitioner through our mobile application.
- We reserve the right to modify, add, or restrict any Network Provider / Service Provider for Cashless Facility at Our sole discretion.
- The Optional Covers "BeFit" and "Elevate HER – Women Care Plan" may be opted together under the Policy, subject to eligibility. Where an Insured Person is eligible for and opts for both Optional Covers during the same Policy Year, the benefits for Outpatient Consultation and Diagnostic Tests available under the Optional Cover "Elevate HER – Women Care Plan" shall be over and above the corresponding benefits, if any, available under the Optional Cover "BeFit". All other benefits under each Optional Cover shall be governed by their respective terms, conditions, sub-limits and utilization criteria, as specified in the Policy.

9. Worldwide Cover

We will cover Medical Expenses incurred in respect of Hospitalization of the Insured Person outside of India, subject to the following:

i. This Optional Cover is subject to a maximum of Rs. 3 crores.

ii. This Optional Cover can only be availed by You up to the age of 65 years and who are resident of India and are within the geographical boundaries of India during Policy issuance.

iii. The expenses covered under this benefit will be limited only to the Basic Cover - In-Patient Treatment, Basic Cover-In-Patient AYUSH Hospitalization, and Basic Cover - Day Care Treatment.

iv. The Sum Insured for this Optional Cover shall be in addition to the total Sum Insured under the Basic Covers. Any additional Sum Insured as available under Loyalty Bonus or Power Booster (Super Loyalty Bonus) or Inflation Protector or Power Booster Plus will not be available for this cover.

v. Treatment under this cover should be taken at a Hospital or clinic duly recognized and registered under the applicable law of the country where the treatment is taken.

vi. The coverage shall only be available on cashless basis through Our Network Providers / Service Providers (Kindly visit our website www.icicilombard.com for the complete list of Service Providers / Network Providers or contact Us on Our toll free 1800 2666 number for the details.). We reserve the right to modify, add, or restrict any Network Provider / Service Provider for Cashless Facilities at Our sole discretion.

vii. There will be a waiting period of 2 years for any claim under this cover. There will be no waiting period for Emergency Care. In case of addition of any new members to the Policy, they will have to serve the waiting period of 2 years before availing cover. In case of an increase in the Sum Insured at renewal, a fresh waiting period shall be applicable for the incremental Sum Insured.

viii. In case of planned Hospitalization, prior intimation of at least 7 days of the travel shall be provided to Us / Service Provider / Network Provider and due approval from Us will be necessary.

ix. The coverage is available for 45 consecutive days from the date of travel in a single trip, and 90 days on a cumulative basis as a whole in a Policy Year. Any expenses incurred beyond 45 days from date of travel shall not be covered in any case.

x. The payment of any claim will be based on the rate of exchange on the date of loss, published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees. If RBI rates are not published on that date, the next available rate will be used.

xi. Maternity Benefit, Jumpstart, Power Booster (Super Loyalty Bonus), Infinite Care, Reset benefit, Power Booster Plus and Claim Protector will not be available for worldwide cover.

xii. Countries / Territories / Geographies placed in the Grey and Black List by the Financial Action Task Force shall be excluded from this cover. For updated list please visit: https://www.fatf-gafi.org/en/countries/black-and-grey-lists.html.

Any expenses incurred on the following additional exclusions shall not be applicable specifically to this cover:

i. Convalescence, cure, sanatorium treatment, private duty nursing, treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification centre, home for the

aged, mentally disturbed remodeling clinic, or any treatment taken in an establishment which is not a recognized Hospital.

ii. Any physical, psychiatric, or psychological examinations or testing.

iii. Admission for nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner, is medically required, and administered as part of in-patient Hospitalization treatment.

iv. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, muscle stimulation by any means except treatment of fractures (excluding hairline fractures), and dislocations of the mandible and extremities.

v. Cost of issuance of medical certificates and examinations required for employment or travel or any other such purpose.

vi. Treatment for Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, KTP Laser Surgeries, cyber knife treatment, femto laser surgeries, bioabsorbable stents, bioabsorbable valves, and bioabsorbable implants.

vii. Use of Radio Frequency (RF) probe for ablation or other procedures unless specifically approved by Us in writing in advance.

viii. General debility or exhaustion.

10. Claim Protector

If a claim is accepted under the Basic Cover- In-Patient Treatment or Basic Cover - Daycare Treatment, the non-payable items included under **List I- Items for which coverage is not available in the Policy** of Annexure II will become payable under this cover, subject to the following:

i. This cover shall not be available outside the geographical boundaries of India, even where Optional Cover – Worldwide Cover has been opted.

ii. Any Sum Insured accrued under Loyalty Bonus/Inflation Protector/Reset Benefit will not be available for this cover.

11. Inflation Protector

The Inflation Protector Cover is designed to protect the Sum Insured against rising inflation by linking the Sum Insured under the Basic Cover to the Consumer Price index (CPI). The Sum Insured will increase on a

cumulative basis at each renewal on the basis of the inflation rate for previous year. The inflation rate will be computed as the average CPI for the entire calendar year, as published by the Central Statistical Organization (CSO).

The percentage increase applies only on the Sum Insured and not on Loyalty Bonus or any other covers which increase the Sum Insured.

If, at the time of renewal, the Insured Person opts out of this cover, any increase in the Sum Insured accrued under this cover up to the expiring Policy Year will be forfeited.

Illustration-

Year	Sum Insured	Opted for Inflation Protector	Inflation Protector at renewal computation*	Overall Inflation Protecto
0	Rs. 10,00,000	Yes	Not applicable	Not applicable
1	Rs. 10,00,000	Yes	10,00,000x6% = 60,000	Rs. 60,000
2**	Rs. 15,00,000	Yes	10,00,000x6% = 60,000	Rs. 60,000 + Rs. 60,000 = Rs. 1,20,000
3	Rs 15,00,000	Yes	15,00,000x6%=90,000	Rs. 1,20,000 + Rs. 90,000 = Rs. 2,10,000
4	Rs. 15,00,000	No	Nil as customer opted out of the Optional Cover	Nil

* Considering Consumer Price Index to be 6%
** Insured Person has enhanced Sum Insured from Rs. 10 Lakhs to Rs. 15 Lakhs

12. Domestic Air Ambulance Cover

We will cover the Medical Expenses incurred on air ambulance offered by a Service Provider for transporting You to the nearest Hospital with adequate facilities for the provision of Emergency Care, subject to the following conditions:

i. This Optional Cover applies only in the event of a life-threatening emergency health condition that requires immediate and rapid ambulance transportation from the place of Illness or

Injury to a Hospital, for Medically Necessary Treatment certified in writing by a Medical Practitioner.

ii. The Optional Cover does not include any transportation/air ambulance expenses incurred outside the geographical scope of India.

iii. We have accepted a claim under the Basic Cover – In-patient Treatment in respect of the Insured Person for the same Illness or Injury for which air ambulance services were availed.

iv. The Service Provider shall be duly licensed to operate as such by a competent government Authority.

13. Convalescence Benefit

We will pay a fixed allowance of Rs.20,000 once in a Policy Year if You are Hospitalized for a continuous period of 10 days or more for the treatment of any Illness or Injury for which a valid claim is admissible under the Policy.

For a Policy Period of 1 year, You are eligible for this benefit once during that Policy Year. For a Policy tenure of 5 years, You are eligible to receive this benefit once in each Policy Year.

14. Nursing at Home

We will cover the expense incurred in availing the medical services of a Qualified Nurse at Your residence after Your Hospitalization up to a maximum of 10 days, subject to the following conditions:

i. The Qualified Nurse is employed in a Hospital.

ii. This Optional Cover is subject to a limit of Rs.2,000 per day.

iii. The engagement of such Qualified Nurse is advised by a Medical Practitioner in writing and relates directly to the Illness/Injury covered under the Policy.

iv. This cover is payable only if We have accepted a claim under the Basic Cover - In-Patient Treatment.

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15. Compassionate Visit

We will indemnify the cost of an economy class air/railway ticket for one of Your Immediate Family Member to travel to and from the Hospital from their place of origin or residence in case Your Hospitalization extends beyond 5 consecutive days and in the opinion of the attending Medical Practitioner, provided that the aggregate does not exceed Rs. 20,000 for any one or all Hospitalizations during a Policy Year.

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16. Health Check-Up

We will provide a Health Check-Up to any Insured Person aged 18 years and above, anytime during the Policy Period, through pre-designed health packages (specified below) offered by Our Network Providers/Service Provider, subject to the following:

i. This Optional Cover is available only once per Policy Year per Insured Person covered as an Adult during first time issuance as mentioned in the policy schedule .. Any unutilized Health Check-up benefits will not be carried forward to the next Policy Year. It is Your responsibility to utilize the benefit within the Policy Period, and We will not issue any reminders or notifications.

ii. This Optional Cover is up to 0.5% of Sum Insured or Rs. 5,000, whichever is lower.

iii. These pre-designed health packages are based on eligibility as per the Sum Insured. We may modify these packages from time to time without prior notice; however, You will not be permitted to modify them.

iv. This Optional Cover can be obtained only on cashless basis and can be availed through our mobile app or by calling Our Toll-free number: 1800 2666.

v. We will assign the Network Provider/Service Provider once We receive Your request.

vi. It is agreed and understood that (1) You have obtained the services under this Optional Cover on Your own discretion, and risk; (2) the services under this Optional Cover shall not be construed as medical advice nor a substitute for physical consultation with an independent Medical Practitioner or healthcare professional; (3) You must seek assistance from a qualified Medical Practitioner/healthcare professional when interpretating and applying any recommendations under this Optional Cover; and (4) We shall not be held responsible for any loss, damage, or adverse outcome arising out of or in connection with any opinion, advice, prescription, or any actual or alleged errors, omissions, or representations made by the Medical Practitioner or healthcare professional delivering the services under this Optional Cover.

vii. The service will not be provided on reimbursement basis.

List of health check-up packages shall be as under:

No. of Members	Sum Insured	Health Check - up Packages
1	5 Lakhs	CBC, ESR, HbA1c, BSF, Lipid Profile, Liver Function Test, Kidney Function Test, Iron Studies, Thyroid Profile Total, Vitamin B12, Vitamin D 25 Hydroxy
	7.5 Lakhs	CBC, ESR, BSF, HbA1c, Lipid Profile, Liver Function Test, Kidney Function Test, , Iron Studies, Thyroid Profile Total, Vitamin B12, Vitamin D 25 Hydroxy, Electrolytes, Hscrp.
	>=10 Lakhs	CBC, ESR, BSF, HbA1c, Lipid Profile, Liver Function Test, Kidney Function Test, , Iron Studies, Thyroid Profile Total, Vitamin B12, Vitamin D 25 Hydroxy, Electrolytes, Hscrp, C Reactive Protein, PSA (males), Ca125(females).
2	5 Lakhs	CBC, ESR, BSF, Lipid Profile, Liver Function Test, Kidney Function Test, Thyroid Profile Total, Vitamin D 25 Hydroxy, Urine Routine
	7.5 Lakhs	CBC, ESR, HbA1c, BSF, Lipid Profile, Liver Function Test, Kidney Function Test, Iron Studies, Thyroid Profile Total, Vitamin B12, Vitamin D 25 Hydroxy
	>=10 Lakhs	CBC, ESR, BSF, HbA1c, Lipid Profile, Liver Function Test, Kidney Function Test, , Iron Studies, Thyroid Profile Total, Vitamin B12, Vitamin D 25 Hydroxy, Electrolytes, Hscrp

Viii) Benefit under this cover can be obtained over and above the Optional Add-On No. 4 - Chronic Disease Management Program and the Optional Add on No 34-Elevate HER Women care (Elevate HER Bloom, Elevate HER Thrive, Elevate HER Nurture and Elevate HER Harmony and Elevate HER Plus plans) if opted by You.

17. Critical Illness (For persons aged between 18 to 50 years)

For persons aged between 18 to 50 years we will pay the Sum Insured for this benefit as stated in the Policy Schedule on Your first diagnosis with one or more of the Critical Illnesses specified below during Your lifetime:

i. Cancer of Specified Severity
ii. Myocardial Infarction (First Heart Attack of Specified Severity)
iii. Coronary Artery Disease
iv. Open Chest CABG
v. Open Heart Replacement or Repair of Heart Valves
vi. Surgery to Aorta
vii. Stroke resulting in Permanent Symptoms
viii. Kidney Failure requiring Regular Dialysis
ix. Aplastic Anaemia
x. End Stage Lung Disease
xi. End Stage Liver Failure
xii. Coma of Specified Severity
xiii. Third Degree Burns
xiv. Major organ /bone marrow transplant
xv. Multiple Sclerosis with Persisting Symptoms
xvi. Fulminant Hepatitis
xvii. Motor Neuron Disease with Permanent Symptoms
xviii. Primary Pulmonary Hypertension
xix. Terminal Illness
xx. Bacterial Meningitis

This benefit is subject to the following conditions:

i. The Sum Insured under this benefit shall be subject to a maximum limit of Rs.50 Lakhs as specified in the Policy Schedule.
ii. This Optional Cover is payable only once during Your lifetime.
iii. This Optional Cover is available for Insured Person aged between 18 to 50 years at the time of first issuance of this Policy.
iv. This Optional Cover has a Specified Waiting Period of 90 days.

v. No claim shall be admissible in case any of the Critical Illnesses is a consequence of or arises out of any Pre-existing Disease.

vi. In the event of diagnosis of multiple Critical Illnesses, the benefit payable shall be limited to the Sum Insured specified for this Optional Cover in the Policy Schedule.

1. Cancer of Specified Severity

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

The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

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

I.The first occurrence of heart attack or myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial Infarction (for e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris
   iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Coronary Artery Disease

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

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

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

II. The following are excluded:
   i. Angioplasty and/ or any other intra-arterial procedures

5. Open heart replacement or repair of heart valve

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

6. Surgery to Aorta

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

Surgery performed using only minimally invasive or intra-arterial techniques are excluded. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures are excluded.

7. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic Injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions

8. Kidney failure requiring regular dialysis

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

9. Aplastic Anaemia

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

I. Blood product transfusion;
II. Marrow stimulating agents;
III. Immunosuppressive agents; or
IV. Bone marrow transplantation

The diagnosis must be confirmed by a haematologist.

10. **End Stage Lung Failure**

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

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

11. End Stage Liver Failure

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

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.

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

12. Coma of specified severity

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

i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

13. Third Degree Burns

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

14. Major organ /bone marrow transplant

I.The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II.The following are excluded:

i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

15. Multiple Sclerosis with persistent symptoms

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

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

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

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

16. Fulminant Hepatitis

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

I. Rapid decreasing of liver size;
II. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
III. Rapid deterioration of liver function tests;
IV. Deepening jaundice; and
V. Hepatic encephalopathy.

17. Motor Neuron Disease with permanent symptoms

I.Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months

18. Primary Pulmonary Hypertension

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

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

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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

19. Terminal Illness

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

20. Bacterial Meningitis

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

I. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
II. A consultant neurologist.

18. Personal Accident

This cover is available only for adult members aged maximum up to 65 years during first time issuance. We will pay you or your nominee / legal heir a specified percentage of the Sum Insured, as stated in the Policy Schedule and subject to a maximum limit of Rs. 50 Lakhs, upon the occurrence of any of the following events:

a. Accidental Death

On occurrence of Your death due to an Injury sustained during the Policy Period or within 12 calendar months from the date of occurrence of such Injury, We shall pay 100% of the Sum Insured under this benefit..

b. Permanent Total Disablement

On the occurrence of any of the Permanent Total Disability specified below, arising from an Injury sustained during the Policy Period or within 12 calendar months from the date of such Injury, We shall pay the corresponding percentage of the Sum Insured as specified against each type of disablement:

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

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

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

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

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

c. Permanent Partial Disablement

On the occurrence of any of the Permanent Partial Disability specified below, arising from an Injury sustained during the Policy Period or within 12 calendar months from the date of such Injury, We shall pay the corresponding percentage of the Sum Insured as specified against each type of disablement:

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

	c) One phalanx	2%
IX	Loss of little finger	
	a) Three phalanges	4%
	b) Two phalanges	3%
	c) One phalanx	2%
X	Loss of metacarpus	
	a) First or second	3%
	b) Third, fourth or fifth	2%
XI	Permanent partial disablement not otherwise provided for under serial no. I to X	Such % of the Sum Insured as determined in accordance with the medical assessment carried out by the Company's Network Hospital that the %age under Insured event Sr. No. XI shall not exceed 50% of the Sum Insured

19. Voluntary Co-Payment

We will provide a corresponding discount on the premium payable under the Policy and You shall bear the Co-payment percentage of the admissible claim amount, as stated in the Policy Schedule, for each and every claim approved by Us, subject to the following conditions:

i. This Optional Cover cannot be opted with Optional Cover 20 – Voluntary Deductible.
ii. This Optional Cover, if opted, shall apply to all Basic Covers (excluding Wellness Program) and shall not apply to Add-ons/Optional Covers, except for Optional Cover – Infinite Care and Optional Cover – Worldwide Cover.
iii. Once this Optional Cover is chosen and specified in the Policy Schedule, it cannot be modified during the Policy Term. Any change to the Co-Payment can be made only at the time of Renewal and will be subject to the Our underwriting approval.

20. Voluntary Deductible

We will provide a subsequent discount on the premium payable under the Policy and, You will be liable to bear the Deductible as stated in the Policy Schedule, subject to the following conditions:

i. This Optional Cover cannot be opted with Optional Cover – Voluntary Co-Payment.
ii. This Optional Cover, if opted, shall apply to all Basic Covers (excluding Wellness Program).

iii. This Optional Cover will apply on an aggregate basis, meaning that You shall be liable to bear all Hospitalization expenses covered under the Basic Covers of the Policy, up to the Deductible amount specified in the Policy Schedule, before We make any payment towards an admissible claim under this Policy.

iv. The Deductible will apply on individual basis in case of an individual Policy and on floater basis in case of a Family Floater Policy.

v. Once this Optional Cover is chosen and specified in the Policy Schedule, it cannot be modified during the Policy Term. Any change to the Deductible can be made only at the time of Renewal and will be subject to the Our underwriting approval.

21. Dependent Accommodation Benefit

If You are Hospitalized for a Medically Necessary Treatment of an Illness or Injury sustained during the Policy Period, then We will pay a fixed daily amount, up to a maximum of Rs. 1,000 per day, towards the accommodation expenses of one Immediate Family Member, for each continuous and completed day of Your Hospitalization, subject to a maximum of 10 consecutive days and the following conditions:

a) We have accepted the claim under hospitalization expenses in respect of Insured Person for the same Illness or Injury.

b) The Medical Practitioner has certified that You are required Hospitalization of minimum 3 consecutive days, maximum up to 10 days.

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22. Durable Medical Equipment Cover

If You are Hospitalized for a Medically Necessary Treatment or undergoes Day Care Treatment for an Illness or Injury sustained during the Policy Period and the treating Medical Practitioners prescribes the use of any of the specified Durable Medical Equipment during Hospitalization/Day Care Treatment/ In-Patient AYUSH Hospitalization or within 30 days after Your discharge from Hospital/Day Care Centre, We will cover the expenses incurred towards rental or purchase of any of the specified Durable Medical Equipment during the Policy Year, subject to the following conditions:

i. The claim payable under this Optional Cover shall be limited to the Sum Insured, subject to a maximum of Rs. 5 Lakhs, and shall be within the overall Sum Insured under the Basic Covers.

ii. We have accepted the claim under "Inpatient Treatment" or "Day Care Procedures/Treatment" or "In-Patient AYUSH Hospitalization" Cover in respect of Insured Person for the same Illness/Injury.

iii. The need for a Durable Medical Equipment has been prescribed by an authorized Medical Practitioner during Hospitalization or within 30 days post discharge of the Insured Person from the Hospital.

List of Durable Medical Equipment Covered under this Optional Cover:

i. CPAP Machine
ii. Ventilator
iii. Wheelchair
iv. Prosthetic device
v. Suction Machine
vi. Commode Chairs
vii. Infusion Pump
viii. Continuous Passive motion devices in case of Knee Replacement
ix. Oxygen Concentrator

23. Tele Consultation(s)

We will arrange Tele Consultations for Insured Persons which involve consultation with a qualified Medical Practitioner or health care professional for routine health issues provided through audio, video, online portal, chat or mobile application, subject to the following conditions:

i. The Tele Consultation(s) can be availed only through Our mobile application only.
ii. The Tele Consultation will be available 24 hours a day and 365 days a year.
iii. There shall be no limit on the count of Tele-Consultations that can be availed in a Policy Year.
iv. The Medical Practitioner may, on a case-to-case basis, suggest, recommend, or prescribe over-the-counter medication based on the information provided. We, or the Medical Practitioner/healthcare professional, may refer You to another specialist or general physician outside Our empanelled network, if required and You shall bear cost of such consultation.
v. It is agreed and understood that (1) You have obtained the services under this Optional Cover on Your own discretion, and risk; (2) the services under this Optional Cover shall not be construed as

medical advice nor a substitute for physical consultation with an independent Medical Practitioner or healthcare professional; (3) You must seek assistance from a qualified Medical Practitioner/healthcare professional when interpretating and applying any recommendations under this Optional Cover; and (4) We shall not be held responsible for any loss, damage, or adverse outcome arising out of or in connection with any opinion, advice, prescription, or any actual or alleged errors, omissions, or representations made by the Medical Practitioner or healthcare professional delivering the services under this Optional Cover.

vi. The service will not be provided on reimbursement basis.

24. Waiting Period Reduction Option (Other than those listed under JumpStart)

We will reduce the waiting period for any Pre-existing Diseases declared by You and accepted by Us applicable under the **Exclusion - Pre-Existing Diseases (Code- Excl01)** from 36 months to 24 months or 12 months as opted by You and specified in the Policy Schedule, subject to the following conditions:

i. This Optional Cover is available only the inception of the Policy and only for the Sum Insured chosen at the the inception of the Policy and as stated in the Policy Schedule.

ii. This Optional Cover must be continued for a minimum of 3 consecutive Policy Years.

iii. The reduced waiting period shall not be applicable for claims made under Optional Cover 9 - Worldwide Cover.

25. Maternity Waiting Period Reduction Option

We will reduce the waiting period applicable under the Optional Cover 5 - Maternity Benefit from 24 months to 12 months, subject to the following conditions:

i. This Optional Cover is available only at the time of opting for the Optional Cover 5 - Maternity Benefit and only for the Sum Insured chosen at that time and as stated in the Policy Schedule.

ii. This Optional Cover must be continued for a minimum of 2 consecutive Policy Years.

iii. All the terms and conditions mentioned under the Optional Cover 5 - Maternity Benefit shall be applicable to this Optional Cover.

26. Specific Illness Waiting Period Reduction Option

We will reduce the waiting period applicable under **Exclusion- Specified disease/procedure waiting period (Code- Excl02)** from 24 months to 12 months, subject to the following conditions:

i. This Optional Cover is available only at the inception of the Policy, and only for the Annual Sum Insured chosen at that time and as stated in the Policy Schedule.
ii. This Optional Cover must be continued for a minimum of 2 consecutive Policy Years.
iii. The reduced waiting period shall not be applicable for claims made under Optional Cover 9 - Worldwide Cover.

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27. Worldwide Cover Waiting Period Reduction Option

We will reduce the waiting period applicable under the Optional Cover 9 - Worldwide from 24 months to 12 months, subject to the following conditions:

i. This Optional Cover is available only at the time of opting for the Optional Cover 9 – Worldwide Cover and only for the Sum Insured chosen at that time and as stated in the Policy Schedule.
ii. This Optional Cover must be continued for a minimum of 2 consecutive Policy Years.
iii. All the terms and conditions mentioned under the Optional Cover 9 - Worldwide Cover shall be applicable to this Optional Cover.

28. Room Modifier

We will provide You the option to modify the Room Rent eligibility as opted and specified in the Policy Schedule from the following:

i. To modify the Room Rent eligibility to any room category without any restriction; or
ii. To modify the Room Rent eligibility to Twin Sharing Room or
iii. To modify the Room Rent eligibility to a Room Rent capping of 1% of the Sum Insured for Single Private Room and 2% of the Sum Insured for ICU per day.

This benefit is subject to the following:

i. This Optional Cover is available across all Sum Insured options under the Policy.

ii. If You are admitted to a room with a Room Rent or category higher than that specified in the Policy Schedule, then Associated Medical Expenses shall be payable on a pro-rata basis. However, pro-rate deductions shall not apply to ICU Charges or where the Hospital does not follow differential billing or where expenses are not charged based on the room category.

29. Network Advantage

We will provide You a discount of 10% on every renewal premium (including the premium payable in the first Policy Year), subject to the following conditions:

i. You must avail treatment under "In-patient Treatment" or "Day Care Procedures/Treatment" or "In-patient AYUSH Hospitalization" cover from Our Network Provider listed on Our website/Mobile Application.

ii. 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.

30. NRI Advantage - Cover for NRI

We will provide a discount of 25% on the premium payable under the Basic Covers to the Insured Person(s) who are Non Resident Indians/Overseas Citizens of India, subject to the following conditions:

i. You must provide (1) a declaration confirming that You are a Non-Resident Indian or Overseas Citizens of India residing outside India for the entire Policy Year and at each subsequent renewals; (2) valid proof of residence outside India for the upcoming Policy Year at subsequent renewals; and (3) other relevant proof of identity required for Indian citizenship.

ii. You must have an Indian bank account for the purpose of premium/claims payment.

iii. If You cease to be a Non Resident Indian/ Overseas Citizens of India, then no further discount shall be applicable upon renewal.

iv. The Optional Cover - Worldwide Cover is not available for Non Resident Indians.

v. All waiting periods under terms and conditions of the Policy will be applicable for the Insured Persons.

31. Senior Care Value Added Services (Only Cashless Basis)

We will provide the services listed under the table below to the Insured Person aged 55 years and above only through the Network providers/Service Provider empaneled by Us on cashless basis, subject to the following conditions:

i. The services under this Optional Cover will be provided as per the plan opted and as specified in the Policy Schedule.

ii. The service will not be provided on reimbursement basis.

iii. It is agreed and understood that (1) You have obtained the services under this Optional Cover Your own discretion, and risk; (2) the services under this Optional Cover shall not be construed as medical advice nor a substitute for physical consultation with an independent Medical Practitioner or healthcare professional; (3) You must seek assistance from a qualified Medical Practitioner/healthcare professional when interpretating and applying any recommendations under this Optional Cover; and (4) We shall not be held responsible for any loss, damage, or adverse outcome arising out of or in connection with any opinion, advice, prescription, or any actual or alleged errors, omissions, or representations made by the Medical Practitioner or healthcare professional delivering this Optional Cover.

S. No	Service/ Benefit	Plan A	Plan B	Plan C	Plan D
1	Access to Mobile application: Access to specially designed mobile application for managing clinical and non-clinical medical needs of members. This app is managed by our empaneled Service Provider.	Available	Available	Available	Available
2	Access to Elderly health camps: organized by our empaneled Service Provider for mental and psychological wellbeing of members. (Participation cost to be borne by You)	Available	Available	Available	Available
3	Personal specialized geriatric telephonic assistance for clinical and non clinical medical needs	Once/ 2 month	Once/2 month	Once/ month	Twice/ month

4	Concierge Service: Access to our empaneled Service Provider(s)'online helpdesk for support with everyday chores including but not limited to medicine delivery, lab tests, hospital visits, booking travel and tech assistance	Available	Available	Available	Available
5	Discount on specialized geriatric health services: Following services when availed through our empaneled Service Providers' platform: 1. upto 10% off on first 30 days of Home Healthcare services (Qualified Nurses & Attendants) 2. upto 20% off on medicine orders (20% on price of medicines) 3. upto 10% off on physiotherapy sessions 4. upto 35% off on diagnostic services 5. upto 20% off on medical equipments (Walking stick, wheelchair, BP machine, Sugar testing,)	Available	Available	Available	Available

6	Electronic Health Records: Our empaneled Service Provider (specialized for geriatric care) will assist in creating health profile (details about personal doctors, hospital registrations and health insurance) and Digital health records (Store all diagnostics, lab reports & vitals online at one place) on their digital platform	Available	Available	Available	Available
7	Other services: Following services can be availed through our empanelled Service Provider (specialized for geriatric care). Cost of the services to be borne by Insured. 1. Doctor visit at home 2. Psychological counselling 3. Facilitation of lifestyle management program via diet, exercise and reading material, for medical conditions like Diabetes, Hypertension, Obesity, Arthritis, Hyperlipidemia.	Access Only	Access Only	Access Only (Upto 5% Discount) For Lifestyle management program under this section : Access Only	Access Only (Upto 10% Discount) For Lifestyle management program under this section : Access Only (Upto 5% Discount)

8	Access to offline events: Access to participation in offline health engagement events organized or facilitated by our empaneled service provider for mental and psychological wellbeing of members. (Participation cost to be borne by Insured)	Not Applicable	Not Applicable	Available	Available
9	Safety Guidance: Tailored guidance by expert specializing in geriatric care, through online mode, on safety aspects like making home safer, reducing risk of falls etc.	Access Only	Access Only	Available	Available
10	Access to Customized event for mental and physical well-being - curated for elderly by our empaneled service provider. (Event planning cost to be borne by Insured)	Not Applicable	Not Applicable	Available	Available
11	Specialized Geriatric Virtual preventive health risk profiling: Customized for Elderly, to prepare preventive health risk profiling to provide personalized Recommendations.	Access Only	Access Only	Access Only	Available

12	Virtual medical second e-opinion : Specialized Geriatric Expert medical advice provided through virtual platforms to review diagnosis or treatment plans	Access Only	Access Only	Access Only (Upto 5% Discount)	Access Only (Upto 10% Discount)
13	Specialized Geriatric Attendant Care:Attendant care at home in case of doctor recommended post hospitalization home care only	Access Only	Access Only	Access Only	4 Sessions per annum
14	Specialized Geriatric Ergonomic assessment & recovery program through movement therapy specialist.	Access Only	Access Only	Access Only (Upto 5% Discount)	Access Only (Upto 10% Discount)
15	Home Fumigation	Access Only	Access Only	Access Only (Upto 5% Discount)	Available

Please Note: - "Not Applicable" in above table stands for respective assistance service not covered under given plan.
- "Access Only" in above table stands for customer can avail services under respective plan on pay per use basis.

32. 2 - Hour Hospitalization:

We will cover the Medical Expenses incurred in respect of Your Hospitalization for 2 hours or more (minimum 24 hours for AYUSH Treatment in a AYUSH Hospital) for the following:

i. Room Rent up to Single Private AC room;
ii. Intensive Care Unit Charges;
iii. Qualified Nurse charges;

iv. Medical Practitioner's fees;

v. Anesthesia, blood, oxygen, operation theatre charges, medicines, drugs and consumables (other than those specified in the list of excluded expenses (non-medical) in Annexure II).

vi. Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and used intra operatively during a Surgical Procedure.

vii. Cost of investigative tests or prescribed diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized.

This benefit is subject to the following:

i. If You are admitted to a room with a Room Rent or category higher than that specified in the Policy Schedule, then Associated Medical Expenses shall be payable on a pro-rata basis. However, pro-rate deductions shall not apply to ICU Charges or where the Hospital does not follow differential billing or where expenses are not charged based on the room category.

ii. This benefit does not include expenses associated with (1) the use of automation machines for peritoneal dialysis and (2) the Hospitalization of the Insured Person in case there was no active line of treatment and only diagnostic or investigative procedures were performed (e.g., MRI, CT Scan, Endoscopy, Colonoscopy, etc).

iii. Treatments or procedures covered under this add on and "Day care procedures/ Treatment" are separate.

iv. If this add on is opted by you, treatments like IV Fluid Therapy for Severe Dehydration, Platelet Transfusions, Iron Infusions, Ligament Sprain & Immobilization etc. will be covered in addition to the treatments covered under In-patient Hospitalization. Please note the above mentioned treatments are indicative only.

33. Vital Essence:

If you are hospitalized during the Policy Period for any of the listed Illnesses or Conditions mentioned in the sub-limits table below and this optional cover has been opted, then our total liability for all treatments related to those illnesses or procedures during the Policy Year shall be capped at the amount corresponding to the respective category.

The sub-limits defined under this section shall be applicable for the Policy Lifetime starting from Policy Inception.

A co-payment of a pre-defined percentage shall be applicable on each and every claim made by you under this policy during the policy year, irrespective of whether the claim pertains to the listed Illnesses or Conditions mentioned in the sub-limits table forming part of this optional add-on. This co-payment shall apply uniformly across all claims, beyond the scope of the sub-limits table in this policy.

The pre-defined co-payment shall be applied first on the admissible claim amount, and subsequently, the applicable sub-limit (if any) shall be applied to arrive at the final payable amount.

If you opt for this optional add-on, you shall not be eligible to opt for the Voluntary Co-payment optional add-on & Voluntary Deductible optional add-on under the same policy. Additionally, if this optional add-on is opted, the Reset Benefit shall be triggered only once instead of unlimited times for any illness / injury / disease during a Policy Year up to the Sum Insured as specified in the Policy Schedule.

The premium applicable will reflect the inclusion of the Vital Essence add-on, along with adjustments made based on your health profile at the time of policy issuance.
In case, if the Vital Essence add-on is not continued at the time of renewal, the associated discount shall be withdrawn and the renewal premium shall be recalculated, basis the risk assessment.
This clause applies only if the Vital Essence add-on was selected during the initial policy term and is discontinued at renewal.

Sub-limit Table:

Category	Sub-limit Amount

Cataract (Per Eye)	**Up to INR 30,000 per eye**
Treatment of Total Knee Replacement and Treatment of Total Hip Replacement	**Up to INR 1,00,000 per knee/per hip**
i.Cerebrovascular Accident and Cardiovascular Diseases ii.Cancer (Including Chemotherapy / Radiotherapy) iii.Medical Renal Diseases (Including Dialysis) iv. Treatment of Breakage of Long Bones	**Up to INR 2,00,000/Policy year**
i. Surgery for treatment of all types of Hernia ii.Hysterectomy iii. Surgeries for Benign Prostate Hypertrophy (BPH) iv. Surgical treatment of stones of Renal systems	**Upto INR 80000/Policy year**

Surgeries related to Diabetic complications **i. Amputations due to gangrene, foot ulcers, wound debridement etc.** **Ii. laser photocoagulation or vitrectomy for retinopathy** **iii. Renal complications due to Nephropathy** **iv. Diabetic Ketoacidosis or Hyperosmolor hyperglycemic state**	**Upto INR 80000/Policy year**

Illustrations for claim settlement

Heading	Particulars	Scenario 1	Scenario 2	Scenario 3
A	Annual Sum Insured	Rs. 10,00,000	Rs. 10,00,000	Rs. 10,00,000
B	Predefined Co-payment opted at time of policy issuance	20%	20%	20%
C	Treatment taken for / Diagnosis	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease	Dengue Fever with Severe thrombocytopenia (low platelet count)
D	Hospitalisation expenses Amount	Rs. 2,40,000	Rs. 1,70,000	Rs. 1,10,000
E	Pre and Post hospitalization Expenses	Rs. 10,000	Rs. 10,000	Rs. 10,000
F	Total claimed Expenses*[D+E]	Rs. 2,50,000	Rs. 1,80,000	Rs. 1,20,000
G	Sub-limit for Diagnosis / Treatment mentioned in [C]	Rs. 2,00,000	Rs. 2,00,000	NA**

H	Insured Person liability after application of co-payment [F*B]	Rs. 50,000	Rs. 36,000	Rs. 24,000
I	ICICI Lombard Liability after deduction of co-payment [F- H]	Rs. 2,00,000	Rs. 1,44,000	Rs. 96,000
J	Final payable amount to Insured Person [lesser amount out of F,G,I]	Rs. 2,00,000	Rs. 1,44,000	Rs. 96,000
K	Balance Annual Sum Insured [A-J]	Rs. 8,00,000	Rs. 8,56,000	Rs. 9,04,000

* It has been assumed that total claimed expenses are same as total payable expenses. i.e. there are no deductions in the claimed amount
** As Diagnosis / Treatment mentioned in [C] does not fall under Sub limit section

34. Elevate HER – WOMEN CARE ADD-ON

The Elevate HER – Women Care Add-on has been designed exclusively for women covered under the Elevate base health insurance policy.
You can select one eligible Elevate HER Plan for each covered female member. The selected Plan will always run along with the base Policy Period and can be renewed only together with the base Policy. Elevate HER Plans are valid PAN India and must be renewed annually for single-year policies and at the time of renewal for multi-year base policies.
For the purpose of this Add-on, the age of the Insured Person shall be determined based on the completed age as on the date of inception of this Add-on or at renewal, as applicable. Where an Insured Person attains an age beyond the eligibility criteria of the selected Elevate HER Plan during the Policy Period, all benefits and coverage under such Elevate HER Plan shall continue to be available until the expiry of the Policy Period. The Elevate HER Add-on shall be co-terminus with the Base Policy and shall be eligible for renewal subject to the applicable age and plan eligibility criteria

at the time of renewal. The premium for the Elevate HER Add-on shall not be refunded or prorated solely on account of any change in age eligibility during the Policy Period.
If you have Elevate HER plan along with any other add-on or optional cover that offers outpatient consultations, diagnostic tests, Health checkup, diet, teleconsultation and nutrition counselling, or mental wellness counselling, the benefits under Elevate HER- Women care add on will be available to you in addition to the benefits provided under such other add-on , subject to the terms and limits applicable to each. Any unutilized Consultations / E- consultations / Sum Insured / Sessions cannot be carried forward to the next Policy Year.

The following Plans are available under the **Elevate HER – Women Care Add-on:**
Elevate HER Bloom, Elevate HER Nurture, Elevate HER Thrive and Elevate HER Harmony **(Standard Variant)** and *Elevate HER Bloom Plus, Elevate HER Nurture Plus, Elevate HER Thrive Plus and Elevate HER Harmony Plus* **(Plus Variant).**

Each Plan may be opted in either:

a. **Standard Variant**; or
b. **Plus Variant**, which provides additional benefits as specified under Clause 34.1.

The applicable variant shall be specified in the Policy Schedule.

ELEVATE HER BLOOM – ADOLESCENT & EARLY REPRODUCTIVE HEALTH ADD-ON

This Plan is available if you are between **14 to 22 years of age**. You may renew this Plan only until you reach 22 years. After that, you must move to the next eligible Elevate HER Plan at renewal. If you have a multi-year base Policy, the transition to the next Plan will take place only at the time of renewal, even if you cross the eligible age mid-term.

Digital & Wellness Services
We will provide unlimited teleconsultations with gynaecologists (Elevate HER Gynae care plus), nutritionists (Elevate HER Nutri care Plus) and mental health (Elevate HER Mind Care Plus) professionals through our designated digital platform. You will also have access to app-based services (Elevate HER Wellness Hub) for menstrual health tracking, reproductive health and contraception education, Polycystic Ovary Syndrome/ Polycystic Ovarian Disease (PCOS/PCOD) support, irregular period support, mental wellbeing, bullying and peer pressure counselling and peer group support.

Diagnostic credits

We will provide a Diagnostic credit points for each Policy Year, representing the maximum payable limit for all diagnostic tests covered under this Plan.

Under Elevate HER Bloom, the eligible diagnostic tests shall include CBC, FBS, TSH, Vitamin D, Serum Ferritin, Urine Routine & Microscopy and HbA1c. These tests shall be availed only as a bundled health check-up, without the requirement of a consultation prescription, on a cashless basis through our partner network.

USG is included under this Plan and shall be covered only if advised by a gynaecologist. The test may be availed at any diagnostic centre on cashless (within network) or reimbursement mode. Reimbursement shall be subject to submission of the USG report, payment receipt and consultation note from Gynaecologist, limited to the available Diagnostic credit balance.

The aggregate amount payable for all diagnostics, including the bundled health check-up tests and USG Pelvis, shall be limited to 2,000 credit points per Policy Year. Diagnostics availed beyond the available Diagnostic credit balance or outside the scope of this Plan shall not be payable.

This benefit is in addition to any Optional Cover for Health Check-up, diagnostic test for Be-fit if opted and specified in the Policy Schedule.

Elevate HER GynaeCare Visit -OPD Consultations

We will cover up to two (2) physical outpatient gynecology consultations per Policy Year on a cashless basis through our network, subject to an aggregate sub-limit of ₹1,500 per Policy Year, whichever is lower.
This benefit shall be available over and above the outpatient consultation limits, if any, provided under the BeFit Optional Cover, where opted for and specified in the Policy Schedule.
Consultations in excess of the above limits or availed outside our network shall not be payable.
A 30-day initial Waiting Period applies on Diagnostic credits and Elevate HER GynaeCare Visit- OPD Consultations unless renewed continuously.

ELEVATE HER THRIVE – WOMEN'S PREVENTIVE & HORMONAL WELLNESS ADD-ON

This Plan is available if you are **23 to 45 years**.
If you were earlier covered under Elevate HER Bloom and have completed 22 years, you must move to this Plan or to Elevate HER Nurture at renewal.

Digital & Wellness Services

We will provide unlimited teleconsultations with gynaecologists(Elevate HER Gynae care plus) , mental health professionals (Elevate HER Mind Care Plus) and nutritionists(Elevate HER Nutri care Plus) , along with app-based (Elevate HER Wellness Hub) hormonal, metabolic, thyroid and menstrual wellness programs.

Diagnostic credits

We will provide a Diagnostic credits for each Policy Year, representing the maximum payable limit for all diagnostic tests covered under this Plan.

Under Elevate HER Thrive , the eligible diagnostic tests shall include CBC, FBS, HbA1c, TSH, LFT, Lipid Profile, Vitamin D, Serum Ferritin and Urine Routine & Microscopy. These tests shall be availed only as a bundled health check-up, without the requirement of a consultation prescription, on a cashless basis through our partner network.

USG is included under this Plan and shall be covered only if advised by a gynaecologist. The test may be availed at any diagnostic centre on cashless (within network) or reimbursement mode. Reimbursement shall be subject to submission of the USG report, payment receipt and consultation note from Gynaecologist, limited to the available Diagnostic credit balance.

Pap smear is included under this Plan after a waiting period of one (1) Policy Year, i.e., from the second Policy Year onwards. After the first use, it can be availed once every two (2) Policy Years. The test may be availed at any diagnostic centre on cashless (within network) or reimbursement mode. Reimbursement shall be subjected to submission of the test report and payment receipt, limited to the available Diagnostic credit balance.

The aggregate amount payable for all diagnostics, including the bundled health check-up tests, USG and Pap smear, shall be limited to 2,500 credit points per Policy Year. Diagnostics availed beyond the available Diagnostic credit balance or outside the scope of this Plan shall not be payable.

This benefit is in addition to any Optional Cover for Health Check-up, diagnostic test for Be-fit, if opted and specified in the Policy Schedule.

Elevate HER GynaeCare Visit -OPD Consultations

We will cover up to two (2) physical outpatient gynaecology consultations per Policy Year on a cashless basis through our network, subject to an aggregate sub-limit of ₹1,500 per Policy Year,

whichever is lower.
This benefit shall be available over and above the outpatient consultation limits, if any, provided under the BeFit Optional Cover, where opted for and specified in the Policy Schedule.
Consultations in excess of the above limits or availed outside our network shall not be payable.

A 30-day initial Waiting Period applies on Diagnostic credit and Elevate HER GynaeCare Visit- OPD Consultations unless renewed continuously.

ELEVATE HER NURTURE – MATERNITY, WELLNESS & ART ADD-ON

This Plan is available if you are **23 to 45 years** and are covered as an **adult** under an individual or floater base Policy with a **base Sum Insured of ₹7.5 lakh or above**We will also cover:

- Pre-natal expenses (from conception until delivery), and
- Post-natal expenses up to 30 days after delivery

—but only when these form part of an admissible inpatient maternity claim.

This optional cover will have a waiting period of 24 months for maternity cover from the date it is opted and specified in the Policy Schedule.

Artificial Reproductive technology (ART) Cover

We will cover medically necessary ART procedures including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and IUI, performed at **Government registered centres as per** The Assisted Reproductive Technology (Regulation) Act, 2021 and associated rules for insured female only.

All ART services under this Add-on will be governed by, and must comply with, the eligibility criteria and regulatory requirements prescribed under The Assisted Reproductive Technology (Regulation) Act, 2021 and associated rules.

One ART procedure is admissible per Policy Year after completing a **3-year Waiting Period (**from the date it is opted and specified in the Policy Schedule),with a lifetime maximum of three procedures.

Pre-procedure tests, drug therapy, oocyte retrieval, embryo transfer and daycare treatment for Artificial Reproductive technology (ART) will be covered for insured female only. ART for elective or non-medical reasons will not be covered.

Expenses incurred for male diagnostic tests, male drug therapy, surgical sperm retrieval procedures performed exclusively for the male partner, and any procedure or treatment undertaken for male partner shall not be covered under this Add-on.

Maternity Event and ART Coverage Limit under Elevate HER Nurture

This Optional Cover provides a separate Sum Insured for Maternity event and ART benefits over and above the Base Policy Sum Insured, subject to the terms and limits of this Optional Cover. The applicable Sum Insured depends on the Base Policy Sum Insured, as shown in the table below.

Any treatment related to the complication of pregnancy or termination will be treated within the maternity event sub limits. On Renewal, if an enhanced sub-limit is applicable under this Add on, waiting period as mentioned above for Maternity and ART would apply afresh to the extent of the increased coverage limit.

Base SI	Coverage limit for Maternity+ART
₹7.5 lakh	₹75,000
₹10 lakh	₹1,00,000
₹15 lakh	₹1,00,000
₹20 lakh	₹1,00 ,000
₹25 lakh	₹1,50,000
₹50 lakh	₹1,50,000
₹1 crore	₹2,00,000
₹3 crore	₹2,00,000
Unlimited	₹2,00,000

Digital & Wellness Services

We will provide unlimited teleconsultations with gynaecologists (Elevate HER Gynae care plus),

nutritionists (Elevate HER Nutri care Plus) and mental health (Elevate HER Mind Care Plus)professionals through our designated digital platform. You will also have access to app-based services (Elevate HER Wellness Hub) such as lactation support, postpartum fitness, childbirth and parenting workshops, fertility preservation counselling, cord blood banking awareness, menstrual tracking tools and mental health programs through our designated digital partner (ILTC app).

Elevate HER GynaeCare Visit -OPD Consultations

We will cover up to two (2) physical outpatient gynaecology (includes Obstetrician consultation)consultations per Policy Year on a cashless basis through our network, subject to an aggregate sub-limit of ₹1,500 per Policy Year, whichever is lower.
This benefit shall be available over and above the outpatient consultation limits, if any, provided under the BeFit Optional Cover, where opted for and specified in the Policy Schedule.
Consultations in excess of the above limits or availed outside our network shall not be payable.

Diagnostic credit points

We will provide a Diagnostic credits for each Policy Year, representing the maximum payable limit for all diagnostic tests covered under this Plan.

Under Elevate HER Nurture, the eligible diagnostic tests shall include CBC, FBS, TSH, Urine Routine & Microscopy, HbA1c, LFT, Lipid Profile, Vitamin D, FSH, LH and Prolactin. These tests shall be availed only as a bundled health check-up, without the requirement of a consultation prescription, on a cashless basis through our partner network.

USG is included under this Plan and shall be covered only if advised by a gynaecologist. The test may be availed at any diagnostic centre on cashless (within network) or reimbursement mode. Reimbursement shall be subject to submission of the USG report, payment receipt and consultation note from Gynaecologist, limited to the available Diagnostic credit balance.

Pap smear is included under this Plan after a waiting period of one (1) Policy Year, i.e., from the second Policy Year onwards. After the first use, it can be availed once every two (2) Policy Years. The test may be availed at any diagnostic centre on cashless (within network) or reimbursement mode. Reimbursement shall be subjected to submission of the test report and payment receipt, limited to the available Diagnostic credit balance.

The aggregate amount payable for all diagnostics, including the bundled health check-up tests, USG and Pap smear, shall be limited to 3,000 credits points per Policy Year. Diagnostics availed beyond the available Diagnostic credit balance or outside the scope of this Plan shall not be payable.

This benefit is in addition to any Optional Cover for Health Check-up, diagnostic test for Be-fit if opted and specified in the Policy Schedule.

Waiting Periods: 24 months for maternity, 36 months for ART, and 30 days for Diagnostic credits and Elevate HER GynaeCare-OPD ConsultationVisit unless renewed continuously.

ART conducted at non-ICMR centres, elective abortions, expenses beyond financial limits, cosmetic care and claims arising within applicable Waiting Periods will not be covered.

ELEVATE HER HARMONY – MENOPAUSE & HORMONAL HEALTH ADD-ON

This Plan is available if you are **46 to 60 years** and may be renewed lifelong as long as the base Policy is renewed.

Digital & Wellness Services

We will provide unlimited teleconsultations with gynaecologists (Elevate HER Gynae care plus), nutritionists (Elevate HER Nutri care Plus) and mental health (Elevate HER Mind Care Plus) professionals through our designated digital platform. You will also have access to app-based services (Elevate HER Wellness Hub) related to menopause and hormonal health programs.

Elevate HER GynaeCare Visit -OPD Cover

We will cover up to two (2) physical outpatient gynaecology consultations per Policy Year on a cashless basis through our network, subject to an aggregate sub-limit of INR1,500 per Policy Year, whichever is lower.

This benefit shall be available over and above the outpatient consultation limits, if any, provided under the BeFit Optional Cover, where opted for and specified in the Policy Schedule.

Consultations in excess of the above limits or availed outside our network shall not be payable.

Diagnostic credits

We will provide a Diagnostic credit points for each Policy Year, representing the maximum payable limit for all diagnostic tests covered under this Plan.
Under Elevate HER Harmony, the eligible health check-up tests shall include CBC, FBS, HbA1c, TSH, LFT, Lipid Profile, Vitamin D and Vitamin B12, Urine routine and microscopy. These tests shall be availed only as a bundled annual health check-up, without the requirement of a consultation prescription, on a cashless basis through our partner network.
DEXA scan, Mammography, Pap smear and TMT/ECG are included under this Plan after a waiting period of one (1) Policy Year, i.e., from the second Policy Year onwards. After the first use, it can be availed once every two (2) Policy Years. These tests may be availed at any diagnostic centre, on cashless (within network) or reimbursement mode without the requirement of a doctor's advice. Reimbursement shall be subject to submission of the test reports and payment receipts, limited to the available Diagnostic credits balance.

USG is included under this Plan and shall be covered only if advised by a gynaecologist. The test may be availed at any diagnostic centre on cashless (within network) or reimbursement mode. Reimbursement shall be subject to submission of the USG report, payment receipt and consultation note from Gynaecologist, limited to the available Diagnostic credits balance.

The aggregate amount payable for all diagnostics, including the bundled health check-up tests, USG, DEXA scan, Mamogram, Pap smear and TMT/ECG shall be limited to 4,500 credit points per Policy Year.
Diagnostics availed beyond the available Diagnostic credit balance or outside the scope of this Plan shall not be payable.

This benefit is in addition to any Optional Cover for Health Check-up, diagnostic test for Be-fit if opted and specified in the Policy Schedule.

A 30-day initial Waiting Period applies on Diagnostic credits and Elevate HER GynaeCare Visit- OPD Consultations unless renewed continuously.

34.1 Women Cancer Benefit (Applicable only under Plus Variant)

Under the Elevate HER – Women Care Add-on, each Plan, namely Elevate HER Bloom, Elevate HER Thrive, Elevate HER Nurture and Elevate HER Harmony, may also be offered in a Plus

Variant, referred to as Elevate HER Bloom Plus, Elevate HER Thrive Plus, Elevate HER Nurture Plus and Elevate HER Harmony Plus.

The Plus Variant shall provide all benefits, features, terms and conditions applicable to the corresponding base Plan, and shall additionally include the Women Cancer Benefit as specified under this section.

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Further, where a claim has been admitted and paid under the Women Cancer Benefit provided under the Plus Variant, the Insured Person shall not be eligible to opt for Optional Cover 17 – Critical Illness at any future renewals under this Policy.

34.1.1. Scope of Benefit

The benefit payable under this Add-on shall be an amount equal to the Sum Insured of the Base Policy as specified in the Policy Schedule, subject to a maximum cap of INR 50,00,000, upon First Diagnosis of any of the specified Women-specific Cancers during the Policy Period and subject to the terms, conditions, exclusions, and definitions herein.

34.1.2. Covered Conditions

This Benefit shall cover the following:

a. Breast Cancer
b. Cervical Cancer
c. Ovarian Cancer
d. Fallopian Tube Cancer
e. Vaginal Cancer
f. Cancer of Vulva
g. Uterine / Endometrial Cancer
h. Thyroid Cancer

34.1.3. Benefit Trigger

The Benefit shall be payable upon satisfaction of all the following:

i. First Diagnosis of a covered cancer during the Policy Period;
ii. Diagnosis confirmed by histopathological evidence and certified by a Pathologist;
iii. Signs or symptoms first occurring after completion of the applicable Waiting Period.

34.1.4. Sum Insured

The Sum Insured under this Benefit shall:

i. Be equal to the Base Policy Sum Insured;
ii. Be subject to a maximum cap of ₹50,00,000 per Insured Person;
iii. Be payable independent of and without reducing the Base Policy Sum Insured.

34.1.5. Nature of Benefit and Termination

i. This is a fixed benefit payout, irrespective of actual expenses incurred.
ii. The Benefit shall be payable once during the lifetime of the Insured Person.
iii. Upon payment of a claim: Coverage under this Benefit shall terminate for that Insured Person; and The Insured Person shall not be eligible for subsequent renewal of the Plus Variant.

34.1.6. Waiting Period

A Specified Waiting Period of 90 days shall apply from the date of inception of the Plus Variant for the women cancer benefit. Waiting period for other services (Wellness, Maternity, ART etc) will be same as mentioned for the standard plan for corresponding plus plans.

No Benefit shall be payable for:

i. Any condition where signs or symptoms first occur within the Waiting Period;
ii. Any condition arising out of a Pre-existing Disease.

34.1.7. Specific Definitions

a. Breast Cancer
Includes:

- Carcinoma in situ (localized pre-invasive lesion confirmed histologically);
- Invasive malignancy with tissue invasion and destruction confirmed by histopathology.

Pre-malignant lesions (other than carcinoma in situ) are excluded.

b. Cervical Cancer
Includes:

- Cervical intraepithelial neoplasia (CIN) and squamous intraepithelial lesions;
- Invasive malignancy confirmed by histopathology.

c. Other Covered Cancers
Shall mean histologically confirmed malignant tumors characterized by uncontrolled growth and invasion of normal tissues.

34.1.8. Claim Conditions

i. In case of diagnosis of more than one listed cancer, the maximum liability shall be limited to the Sum Insured under this Benefit.

ii. The date of diagnosis shall be the date of first histopathological confirmation.

34.1.9. Claim Documentation

a. Claim form duly filled and signed
b. Certificate by treating medical practitioner duly attested
c. Current and past consultation papers
d. All histology/cytology/FNAC/Biopsy/Immuno-chemistry reports, X-ray, CT Scan, MRI, PET Scan, Bone Marrow Test, Cancer Markers, all other pathological tests
e. Discharge summary where applicable (in case of hospitalisation)
f. Indoor case papers where available (in case of hospitalisation)

g. Bills and receipts from hospitals, doctor consultations and diagnostic procedures, where applicable

34.1.10. Exclusions (Specific to Women cancer Benefit)

The following are specifically excluded:

a. Where the symptoms indicative of such cancer have first manifested or first occurred prior to the Risk Inception Date
b. Where the symptoms indicative of such cancer have first manifested or first occurred within the mandatory waiting period as specified in the policy schedule
c. Arising on account of or in connection with any Pre-Existing Disease(s).
d. Arising out of any external congenital anomaly of the Insured Person.
e. Where any claim made without a medical certificate or records from the treating Medical Practitioner evidencing the diagnosis of such Cancer

34.2. Applicability of Base Plan Wordings

All benefits, terms, conditions and exclusions applicable to the respective Elevate HER Plans shall continue to apply to both Standard and Plus Variants unless expressly modified under Clause 34.1.

34.3. Benefit Matrix Interpretation

The Benefit Matrix shall specify Plan-wise benefits.

For policies where the **Plus Variant** is opted, the Women Cancer Benefit shall be deemed to be included **in addition to** the benefits specified for the respective Plan.

Benefit Matrix –Elevate HER- Women care Add on

Benefit Parameter	Elevate HER Bloom	Elevate HER Thrive	Elevate HER Nurture	Elevate HER Harmony
Eligible Age (Completed Age)	14 – 22 years	23 – 45 years	23 – 45 years	46 – 60 years

Base Policy Eligibility	Any Elevate Base Policy	Any Elevate Base Policy	Base SI ≥ ₹7.5 lakh (Individual/Floater)	Any Elevate Base Policy
Renewal Eligibility	Up to 22 years only	Up to 45 years only	Up to 45 years only	Lifelong renewal if enrolled ≤ 60
Gynaecologist teleconsultation (Elevate HER Gynae care plus)	Unlimited	Unlimited	Unlimited	Unlimited
Nutritionist teleconsultation (Elevate HER Nutri care Plus)	Unlimited	Unlimited	Unlimited	Unlimited
Mental health teleconsultation (Elevate HER Mind Care Plus)	Unlimited	Unlimited	Unlimited	Unlimited
Elevate HER GynaeCare Visit - OPD Cover	Up to 2 per Policy Year, ₹1,500 aggregate	Up to 2 per Policy Year, ₹1,500 aggregate	Up to 2 per Policy Year, ₹1,500 aggregate	Up to 2 per Policy Year, ₹1,500 aggregate
Diagnostic credits (Annual)	2,000 points	2,500 points	3,000 points	4,500 points
Bundled Health Check-up	Yes (Defined tests)	Yes (Defined tests)	Yes (Defined tests)	Yes (Defined tests)
USG Pelvis	Covered if advised	Covered if advised	Covered if advised	Covered if advised
Pap Smear	Not Covered	Once every alternate year	Once every alternate year	Once every alternate year
DEXA / Mammography / TMT / ECG	Not Covered	Not Covered	Not Covered	Once every alternate year
Wellness & Digital Programs	Menstrual tracking, PCOS/PCOD, mental wellness, peer support	Hormonal, metabolic & thyroid wellness	Lactation, postpartum fitness, fertility counselling, mental wellness	Menopause & hormonal wellness

Maternity Hospitalisation	Not Covered	Not Covered	Covered (Normal/C-section/LTP)	Not Covered
Maternity Sum Insured	NA	NA	Separate SI linked to Base SI	NA
Pre & Post-Natal Expenses	NA	NA	Covered when part of admissible inpatient claim within maternity limit	NA
Lifetime Maternity Limit	NA	NA	Maximum 3 events	NA
Maternity waiting period	NA	NA	24 months	NA
ART / IVF Coverage	Not Covered	Not Covered	Covered (IVF, ICSI, IUI)	Not Covered
ART Waiting Period	NA	NA	36 months	NA
Initial Waiting Period (For Diagnostic credits and Elevate HER Gynae care Visit)	30 days	30 days	30 days	30 days
Women cancer benefit waiting period (*applicable only for* ***Plus Plans***)	90 days	90 days	90 days	90 days

35. Power Booster Plus:

If the Insured Person opts for this optional cover at renewal, We will provide an additional Bonus SI of 100% of Sum Insured, irrespective of a claim being initiated in the Policy period. Following conditions shall apply:

i. This optional cover shall be available only at renewal of policy

ii. This optional cover shall not be available for opting if Power Booster is applicable in expiring Policy. On subsequent renewals as well, only one of the two optional covers- Power Booster and Power Booster Plus can be opted/renewed.

iii. Power Booster Plus bonus Sum insured shall be available from the policy start date of such renewed policy

iv. The Power Booster Plus can be accumulated up to an Unlimited Sum Insured.

v. This cover shall not be available to policies with Unlimited Annual sum insured

vi. In case, the Insured Person opts out of this cover at the time of any subsequent renewal, all the bonus accumulated under Power Booster Plus will be reduced to zero

vii. While opting this optional cover for first time, Power Booster Plus amount shall be same as renewal policy Annual base SI.

viii. In subsequent renewals if base SI is reduced, already accumulated power booster plus amount shall be reduced by same proportion, Power booster Plus earned for that year shall be same as renewal base Annual SI.

ix. In subsequent renewals if base SI is increased, already accumulated power booster plus amount shall be not be changed, Power booster Plus earned for that year shall be same as renewal base Annual SI.

x. All the conditions mentioned under the Basic Cover Loyalty Bonus shall be applicable to this optional cover.

This optional cover shall be available at the time of renewal only and shall be subject to underwriting discretion.

Illustration:

Policy Tenure		Base SI	Opted	Power Booster Plus		
				Accumulated from previous years (this will get carry forwarded)	Earned on renewal	Total as on start date

1	Fresh	10L	Not Applicable	0	0	0
1	1st Renewal	10L	Yes	0	10L	10L
1	2nd Renewal	15 L	Yes	10L	15L	25L
1	3rd Renewal	15L	Yes	25L	15L	40L
2	Fresh	10lacs	Not Applicable	0	0	0
2	1st Renewal	10lacs	Yes	0	10L	10L
2	2nd Renewal	15 lacs	Yes	20L	15L	35L

d. EXCLUSIONS:

Any expenses incurred by You in relation to the following are excluded from the scope of cover and therefore not payable by Us:

i. Standard Exclusions

1. Pre-Existing Diseases - Code- Excl01

Treatment of a Pre-existing Disease and its direct complications, until the expiry of 36 months of continuous coverage after the date of inception of the first Policy with Us.

a. In case of enhancement of the Sum Insured, this exclusion shall apply afresh to the extent of Sum Insured increased.
b. If You are continuously covered without any Break in Policy, then the waiting period for the same would be reduced to the extent of prior coverage, subject to the IRDAI norms on portability and migration.
c. 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 Us.

2. Specified Disease / Procedure Waiting Period / Specific Waiting Period - Code- Excl02

Treatment of the below-listed conditions and surgeries/treatments, until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.

a. In case of enhancement of Sum Insured, this exclusion shall apply afresh to the extent of Sum Insured increased.
b. If any of the below-listed conditions and surgeries/treatments fall under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.
c. The waiting period for the below-listed conditions and surgeries/treatments shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
d. If You are continuously covered without any Break in Policy, then waiting period for the same would be reduced to the extent of prior coverage, subject to the IRDAI norms on portability and migration.
e. List of conditions and surgeries/treatments:
    i. Any types of gastric or duodenal ulcers.
    ii. Benign prostatic hypertrophy.
    iii. All types of sinuses.
    iv. Hemorrhoids.
    v. Dysfunctional uterine bleeding.
    vi. Endometriosis.
    vii. Stones in the urinary and biliary systems.
    viii. Surgery on ears / tonsils / adenoids / paranasal sinuses.
    ix. Cataracts.
    x. Hernia of all types and hydrocele.
    xi. Fistulae in anus.
    xii. Fissure in anus.
    xiii. Fibromyoma.
    xiv. Hysterectomy.
    xv. Surgery for any skin ailment.
    xvi. Surgery on all internal or external tumours / cysts / nodules / polyps of any kind including breast lumps with exception of malignancy.
    xvii. Dialysis required for chronic renal failure.
    xviii. Joint replacement surgeries unless necessitated by Accident happening after the Policy risk inception date.
    xix. Dilatation and curettage.
    xx. Varicose veins and varicose ulcers.
    xxi. Non-infective arthritis and other form arthritis.
    xxii. Gout and rheumatism.
    xxiii. Prolapse inter vertebral disc and spinal diseases, including spondylitis/spondylosis, unless arising from Accident.

3. 90-day Waiting Period

Treatment of the below mentioned Illnesses within 90 days from the first Policy start date, unless they are Pre-existing Diseases and disclosed at the time of Policy issuance:

i. Hypertension
ii. Diabetes
iii. Cardiac Conditions

a. This exclusion shall not apply if You have continuous coverage for more than 12 months.
b. The 90 day waiting period applies to the enhanced Sum Insured in the event of subsequent enhancements to the Sum Insured.

4. 30-day Waiting Period- Code- Excl03

Treatment of any Illness within 30 days from the first Policy start date, except covered claims arising due to an Accident.

a. This exclusion shall not apply if You have continuous coverage for more than 12 months.
b. The 30 day waiting period applies the enhanced Sum Insured in the event of subsequent enhancements to the Sum Insured.

5. Investigation & Evaluation- Code- Excl04

Any admission for diagnostics and evaluation purposes only, and any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

6. Rest Cure, Rehabilitation and Respite care- Code- Excl05

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

Custodial care, either at home or in a nursing facility, for personal care such to help with activities of daily living, such as bathing, dressing, and moving around, either by Qualified Nurses or assistants or non-skilled persons.b. 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
Treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

9. Cosmetic or Plastic Surgery: Code- Excl08
Cosmetic or plastic surgery or any treatment to change appearance, unless for reconstruction following an Accident, Burn, or Cancer, or as part of Medically Necessary Treatment to remove a direct and immediate health risk to You. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

10. Hazardous or Adventure Sports: Code- Excl09
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, and deep-sea diving.

11. Breach of Law: Code- Excl10
Treatment directly arising from or consequent to Your commission or attempt to commit a breach of law with criminal intent.

12. Excluded Providers: Code- Excl11
Treatment in any Hospital or by any Medical Practitioner or any other Service Provider / Network Provider specifically excluded by Us and disclosed on Our website / notified to You.
a. However, where Emergency Care is required following an Illness or Injury, expenses up to the stage of stabilization are payable but not the complete claim.
b. (The list of excluded Service Providers / Network Provider / delisted Hospitals is available on our website www.icicilombard.com).

13. Alcohol, Drugs, or Substance Abuse: Code- Excl12
Treatment for alcoholism, drug or substance abuse, or any addictive condition and consequences thereof.

14. Hydrotherapy: Code- Excl13

Treatment received in health hydros, nature cure clinics, spas or similar establishments, in private beds registered as a nursing home attached to such establishments, or where admission is arranged wholly or partly for domestic reasons.

15. Dietary Supplements: Code- Excl14

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 or Day Care Treatment.

16. Refractive Error: Code- Excl15

Treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

17. Unproven Treatments: Code- Excl 16

Unproven/Experimental Treatment and any services or supplies in connection with the same.

18. Sterility and Infertility: Code- Excl 17

Expenses related to sterility and infertility. This includes:

a. Any type of contraception or sterilization.
b. Assisted reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI (except where admissible under Basic Cover – In-Patient Hospitalization for Oocyte Donor).
c. Gestational Surrogacy (except where admissible under Basic Cover – In-Patient Hospitalization of the Surrogate Mother).
d. Reversal of sterilization.

The above exclusion part b. 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 exclusion under Clause (b) above shall not apply to Medical Expenses towards Assisted Reproductive Technology (ART) procedures, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI, where the Insured Person has opted for the Optional Cover "**Elevate HER Nurture-Maternity, Wellness & ART add-on**", and such expenses are admissible

strictly in accordance with the terms, conditions, waiting periods, sub-limits and other provisions specified under the said Optional Cover.

19. Maternity: Code Excl18

a. Treatment traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy.
b. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the policy period.
c. This exclusion will not be applicable in case Optional Cover- Maternity Benefit or Elevate HER Nurture plan has been opted.

ii. Specific Exclusions (Exclusions other than those specified under (d)(i) above)

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 or Injury.
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 or Injury.
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 or Injury.

22. Out-Patient treatment, unless Optional Cover - 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 apnea syndrome or cost of cochlear implant(s), unless necessitated by an Illness or Injury 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. This exclusion shall not be applicable in case Optional Cover - Worldwide Cover has been opted.

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

27. Acupressure, acupuncture, magnetic, and other therapies.

28. Circumcision, unless it is Medically Necessary Treatment of an Illness or Injury.

29. 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 Illness or Injury or treatment or service that is specifically excluded in the Policy Schedule under "Special Conditions".

e. GENERAL Terms and CONDITIONS:

i. Standard General Terms and clauses

1. Disclosure of Information:

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

"Material facts" for the purpose of this Policy shall mean all relevant information sought by Us in the proposal form and other connected documents to enable Us to take informed decision on underwriting the risk.

2. Condition Precedent to Admission of Liability:

The terms and conditions of the Policy must be fulfilled by You for Us to make any payment for claim(s) arising under the Policy.

3. Fraud:

If You make any fraudulent claim, or give any false statement or declaration, or use fraudulent means (directly or through anyone acting for them), all benefits under this Policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy, but which are found fraudulent later, shall be repaid by all person(s) who made that particular claim, who shall be jointly and severally liable for such repayment to Us.

For the purpose of this clause, "fraud" means any of the following acts committed by You or by Your agent or the Hospital / Medical Practitioner / any other party acting on Your behalf, with intent to deceive Us or to induce Us into issuing an insurance policy:

a) stating as fact something known to be untrue, or believed to be untrue;
b) the active concealment of a fact known or believed to be true;
c) any other act fitted to deceive; and
d) any act or omission declared fraudulent by law.

We shall not repudiate the claim and / or forfeit the Policy benefits on the ground of fraud, if You can prove that either (i) the misstatement was true to the best of Your knowledge, (ii) there was no deliberate intention to suppress the fact, or (iii) that the We already knew of such misstatement or suppression of material fact.

4. Multiple Policies

In case of multiple policies taken by You during a period from one or more insurers to indemnify treatment costs, You shall have the right to require a settlement of Your claim in terms of any of Your policies. In all

such cases, the insurer chosen by You shall be treated as the primary insurer and shall be obliged to settle the claim, as long as the claim is within the limits of and according to the terms of the chosen policy.

5. Free Look Period:

Under a new individual health Policy, , You shall be provided a free look period of 30 days beginning from the date of receipt of the Policy, whether received electronically or otherwise, to review the terms and conditions of such Policy. If You cancel the Policy within the free look period, then You 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 Us on Your medical examination and stamp duty charges.

6. Cancellation:

You may cancel this policy by giving 7 days' written notice and in such an event, We shall:

i. Refund proportionate premium for unexpired Policy Period, if the term of the Policy is up to 1 year and claim was made during the Policy Period.

ii. 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: The abovementioned refund clause shall not be applicable for Policies with a free look period; Premium refund for cancellations during the free look period will be provided as per Clause 5 - Free Look Period.

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 You under the Policy.

We may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, and established fraud by You, by giving 7 days' written notice. There would be no refund of premium on cancellation on these grounds.

7. Renewal of Policy:

The Policy shall ordinarily be renewable, except on grounds of established fraud, non-disclosure of material facts, or misrepresentation by You, provided the Policy is not withdrawn and also subject to moratorium conditions:

i. Renewal shall not be denied on the ground that You had made a claim(s) in the preceding Policy Years.
ii. Requisite premium shall be received by Us before the end of the Policy Period / grace 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.
iv. For individual products, the loadings on renewal premium shall be at portfolio and not based upon any individual Policy claim experience. However, discount in premium may be provided by us to You for good claims experience.
v. You shall notify Us in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each renewal and We may adjust the scope of cover and/or premium, if necessary, accordingly
vi. We will not carry out any fresh underwriting at renewal stage where there is no increase in the Sum Insured. Provided that where there is an improvement in the risk profile, the company may endeavor to recognize that for removal of loadings at the point of renewal.

8. Premium Payment in Instalments:

If You have opted for payment of premium on an installment basis ie Annually, quarterly, half-yearly, or monthly, as mentioned in the Policy Schedule, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. The grace period is 15 days where premium payment mode is on an installment basis, and 30 days in all other cases. We will offer coverage during the grace period, if the premium is paid in installments during the Policy Period.
ii. You will get the accrued continuity benefit in respect of the waiting periods, Specified Disease/ Procedure Waiting Period/ Specific Waiting Periods in the event of payment of premium within the stipulated grace period.
iii. No interest will be charged if the installment premium is not paid on the due date.
iv. If the installment premium due is not received by Us within the grace period, the Policy will get cancelled.
v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vi. We have the right to recover and deduct all the pending installments from the claim amount due under the Policy.

9. Portability

a) You have the choice to port your Policies from one Insurer to another. You shall apply to such insurer to port the entire policy along with all the members of Your family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal.
b) You are entitled to transfer the credits gained to the extent of the Sum Insured and the benefits available in the previous Policy, subject to Our underwriting policy.
c) We will provide Your information to the new insurerin not more than 72 hours from receiving your request through the Insurance Information Bureau of India.

10. Migration

In case of migration of this Policy with Us, You can transfer the credits gained to the extent of the Sum Insured and benefits available in the previous Policy to the migrated Policy. We may underwrite the proposal in case of migration, if You have not been continuously covered for 36 months.

11. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, We will intimate You about the same 90 days prior to expiry of the Policy.
ii. You will have the option to migrate to a similar health Policy available with Us at the time of renewal with all the accrued continuity benefits, such as Loyalty Bonus and waiver of waiting period as per regulatory prescriptions, provided the Policy has been maintained without a Break in Policy.

12. Moratorium Period

After completion of 60 continuous months of coverage (including portability and migration) under the Policy, no Policy and claim shall be contestable by Us except on grounds of established fraud. The moratorium would be applicable for the Sums Insured of the first Policy. Wherever the Sum Insured is enhanced, completion of 60 continuous months would be applicable from the date of enhancement of Sums Insured only on the enhanced limits.

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

We reserve the right to revise or modify the terms of the Policy, including the premium rates.

14. Nomination

You are 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 Your death. Any change of nomination shall be communicated to Us in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of Your death, We will pay the nominee (as named in the Policy Schedule / Endorsement (if any)) and in case there is no subsisting nominee, to Your legal heirs or legal representatives whose discharge shall be treated as full and final discharge of its liability under the Policy.

15. Grievance Redressal Procedure:

In case of any grievance, You may contact us through:
Website: www.icicilombard.com
Toll free number: 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.

You may also approach the grievance cell at any of Our 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 You not satisfied with the redressal of grievance, You may contact the grievance officer at the details provided in the below link: https://www.icicilombard.com/grievanceredressal.com

If You are not satisfied with the redressal of grievance, You may also approach Insurance Regulatory and Development Authority of India (IRDAI) through the Bima Bharosa Portal -

https://bimabharosa.irdai.gov.in/ or IRDAI Grievance Call Centre (IGCC) at their toll free no. 1800 4254 732 / 155255.

You 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 Our website at www.icicilombard.com or on https://www.cioins.co.in/Ombudsman.

LIST OF INSURANCE OMBUDSMEN

The contact details of the **Insurance Ombudsman** offices are mentioned as an **Annexure I** to this policy. These details can also be found at https://www.cioins.co.in/ombudsman .

16. Complete Discharge

Any payment that We make to You or Your nominees or legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by Us to the extent of that amount for the particular claim.

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

17. Zone based premium

For the purpose of premium computation, the country has been divided into 4 zones.

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 pin code. 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.

18. Records to be Maintained

You shall keep an accurate record containing all relevant medical records and shall allow Us or Our representatives to inspect such records. You shall furnish such information as We may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

19. Notice & Communication

Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
Such communication shall be sent to Our address or through any other electronic modes specified in the Policy Schedule.
We shall communicate with You at the address or through any other electronic mode mentioned in the Policy Schedule.

20. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only, unless Optional Cover - Worldwide Cover has been opted for.

21. Automatic change in Coverage under the policy

Your coverage shall automatically terminate:

a. In the case of Your demise.
   i. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case the other Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with You) must be submitted to Us along with the application. Provided no claim has bee made, and termination takes place on account of Your death, pro-rata refund of Your premium for the balance period of the Policy will be effective.
b. Upon exhaustion of Sum Insured and any other additional Sum Insured (if any), for the Policy Year. However, the Policy is subject to renewal on the due date as per the applicable terms and conditions.

22. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

23. Arbitration

If any dispute or difference shall arise as to the quantum to be paid by the 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 here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising 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 and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy, iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

24. Policy Alignment

a. Policy alignment option will be available where You have two separate health 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.
b. Such policies will be charged with premium on a pro-rata basis though the Sum Insured under the Policy shall remain constant.

25. Endorsements (Changes in Policy)

a. This Policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except Us. Any change made by Us shall be evidenced by a written endorsement signed and stamped.
b. Any change in coverages i.e Optional Covers opted may happen only during renewal, subject to underwriting.
c. The proposer may be changed only at the time of renewal. The new proposer must be the legal heir/immediate family member. Such change would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without Break in Policy.
d. The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.
e. Mid- term endorsement of addition of member in the Policy shall only be allowed for newly wedded spouse by marriage and Newborn Baby with relevant documentation.

26. Change of Sum Insured

The Sum Insured can be increased or decreased only at the time of renewal or at any time, subject to Our underwriting. For any increase in Sum Insured, the waiting period shall start afresh only for the enhanced portion of the Sum Insured post fresh underwriting

27. Non Payables

The non-payable items applicable in the Policy are mentioned as **Annexure II**. The list may be updated from time to time, as per the direction of the IRDAI. For an updated list please visit Our website: www.icicilombard.com

f. Other Terms and Conditions

I. Claim Administration

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

The claim pay-out would be adjudicated in following sequence:

i. If a room accommodation has been opted for where the Room Rent or category is higher than that specified in the Policy Schedule, then the Associated Medical Expenses shall be payable on a pro-rated basis.

ii. The Optional Cover - Voluntary Deductible (if opted) shall be applied to the aggregate of all claims that are either paid or payable (not excluded) under this Policy. Our liability to make payment shall commence only once the aggregate amount of all claims payable or paid exceed the Deductible. Optional Cover - Voluntary Co-Payment shall not be applied incase Optional Cover - Voluntary Deductible has been opted for.

iii. Optional Cover - Voluntary Co-Payment shall be applicable on the amount payable by Us and Our liability to make payment shall then be arrived at.

The claim amount assessed above would be deducted from the following amounts in the following progressive order:

1. Annual Sum Insured
2. Loyalty Bonus (if accrued and available)

3. Power Booster (if accrued and available) or Power Booster Plus (if accrued and available),

4. Inflation Protector (if accrued and available)
5. Reset Sum Insured (if applicable)

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

1. Claims Procedure

A. For Cashless Settlement

Cashless Facility is only available at a Service Provider / Network Provider. In order to avail of Cashless Facility, the following procedure must be followed by You:

Pre-authorization

Prior to taking treatment and/ or incurring Medical Expenses at a Service Provider / 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 the Insured Person (if You are an Insured Person under a Family Floater Policy), nature of Illness or Injury, name and address of the Medical Practitioner / Hospital and any other information that may be relevant to the Illness / Injury / Hospitalization. You must request pre-authorization at least 48 hours before a planned Hospitalization and in case of an Emergency Care, within 24 hours of Hospitalization.

To avail of Cashless 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 a Cashless Facility. We will consider Your request after having obtained accurate and complete information for the Illness or Injury for which Cashless 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.

B. For Reimbursement Settlement

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 Insured Person (if You are an Insured Person under a Family Floater Policy);
   - 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 / Hospitalization.

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 You shall be reduced by any outstanding premium due for the renewal or next due date of the Policy, if such premium has not already been received.

2. Claim Documents

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

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

The relevant documents can 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

Annexure I

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429	Orissa.

Email: bimalokpal.bhubaneswar@cioins.co.in	
CHANDIGARH Mr. Atul Jerath Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram,

	Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe- a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340	West Bengal, Sikkim, Andaman & Nicobar Islands.

Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Insurance Ombudsman Office of the Insurance Ombudsman,	Bihar, Jharkhand.

2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.
THANE Shri Umesh Sinha Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane - 400604 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T

For updated list of Insurance Ombudsman details, kindly visit- https://www.coins.co.in/Ombudsman.

Annexure II

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

S.No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES

4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE

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

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

S.No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX I MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/VARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES

35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

S.No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV — Items that are to be subsumed into costs of treatment

S.No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER

4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

~~SS~~

- ~~Base covers are common to all plan variants.~~
- ~~In addition to the optional covers inbuilt in the selected plan, customers may opt for any remaining optional add-ons.~~