SALES LITERATURE AND PROSPECTUS

Eligibility

1. **Entry age:** This Policy can be offered to an individual with minimum age of 56 years without any restriction on maximum entry age
2. **Lifetime renewability:** There is no maximum age limit for Renewal
3. **Number of members:** A maximum of 2 members can be added in a single policy. You can avail a floater cover and get Your spouse covered for the same sum insured under a single Policy by paying one premium amount
4. **Relationships covered:** You and your spouse (Self and spouse)
5. **Premium calculation:** In floater policy, the age of the eldest member will be considered while computing premium for all the members covered under the family floater. Other factors determining premium are addition/deletion of any optional covers, change in policy conditions such as tenure, zone opted, increase or decrease in sum insured opted for and change in any tax laws by the government and health status of the individual being insured.

Salient features

- **Policy tenure:** You can opt for a Policy with Policy period of one year or two years or three years
- **Tax benefit:** You can avail of tax benefit on premiums paid under Health sections of this Policy, as per Section 80D of Income Tax Act, 1961 and amendments made thereafter.
- **Annual sum insured:** This denotes the maximum amount of cover available to You for a Policy Period of one year.
  Minimum Sum Insured: ₹ 3,00,000
  Maximum Sum Insured: ₹ 50,00,000
- **Cashless hospitalization:** You can avail of cashless Hospitalisation at any of our network providers/ hospitals. A list of these hospitals/ providers will be sent to You along with Your Policy.
- **Pre-Policy Medical Check-up:** No medical tests will be required, if You approach us for insurance cover below the age of 70 years. However if You approach us for insurance when You are 70 years of age* or above or for Annual Sum insured greater than or equal to 20 Lakhs, or certain pre-existing conditions, You will have to then compulsorily undergo medical tests at our designated diagnostic centres. If we accept Your proposal, we will reimburse at least up to 50% of the costs incurred by You in undertaking such pre-insurance medical tests.
  *This age limit may be relaxed on a case to case basis evaluation of medical underwriter.
- **Zone Based Pricing:** The premium will be computed basis zone opted by You in the proposal form. Treatment taken in a higher zone (except medically necessary treatment for road traffic accidents) will attract additional co-payment over and above the base co-payment as opted by You. Please refer to the policy wordings for more details
- **Preventive health check-up:** We will also provide You preventive health check-up package that can be utilised at any time during the policy period at our network providers

or empanelled health service providers. The preventive health check-up would be limited to once a year per Insured Person.

Benefits covered under the policy

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

A. Base Cover

1. **In-patient Treatment**:

A. Inpatient Treatment:

We will cover the following Medical Expenses incurred in respect of Hospitalization of the Insured Person during the Policy Period, up to the Annual Sum Insured specified in the Policy Schedule against this Benefit:

i. Room Rent up to Twin sharing room (for Annual Sum Insured below Rs. 10 Lacs and Single private AC room for annual sum insured Rs. 10L and above);
ii. Intensive Care Unit Charges;
iii. Qualified Nurse charges;
iv. Medical Practitioner's Fees ;
v. Anaesthesia, blood, oxygen, operation theatre charges, medicines, drugs and consumables (other than those specified in the list of excluded expenses (non-medical) in Annexure I;
vi. Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and that are 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;

If You are admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this policy, then You shall bear a rateable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred

B. Inpatient Treatment:

We will cover the following Medical Expenses incurred in respect of Hospitalization of the Insured Person during the Policy Period, up to the Annual Sum Insured specified in the Policy Schedule against this Benefit:

i. Room Rent charges as per grid mentioned below

Annual Sum Insured	**Room Rent Limit per day**

Rs. 3L to Rs. 5L	Up to 1% of Sum Insured
Rs. 10L	Up to Rs. 6,000
Rs. 15L	Up to Rs. 7,000
Rs. 20L	Up to Rs. 8,500
Rs. 25L and 50L	Up to Rs. 10,000

ii. Intensive Care Unit Charges;

Annual Sum Insured	ICU Limit per day
Rs. 3L to Rs. 10L	Up to 2% of Sum Insured
Rs. 15L to 50L	At Actuals

iii. Qualified Nurse charges;
iv. Medical Practitioner's Fees ;
v. Anaesthesia, blood, oxygen, operation theatre charges, medicines, drugs and consumables (other than those specified in the list of excluded expenses (non-medical) in Annexure I;
vi. Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and that are 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;

If You are admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this policy, then You shall bear a rateable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred

2. **Day Care Procedures/ Treatment**: We will pay You for the Medical Expenses incurred by You while undergoing Day Care Procedures/Treatment which require less than 24 hours Hospitalisation.
We will cover the Medical Expenses incurred by You in respect of the Day Care Treatment during the Policy Period provided that:

i. The Day Care Treatment is for Medically Necessary Treatment.
ii. The Day Care Treatment follows the written advice of a Medical Practitioner.
iii. The Medical Expenses incurred are Reasonable and Customary Charges.
iv. We will also cover Medical Expenses incurred for procedures including but not limited to intravenous chemotherapy, radiotherapy, hemodialysis or any other therapeutic procedure which requires a period of specialized observation or medical care after completion of the procedure.
v. We will not cover any Out Patient Treatment or diagnostic services under this Benefit.
vi. Expenses associated with automation machine for peritoneal dialysis shall not be payable

vii. Any Medical Expenses payable shall not in aggregate exceed the Sum Insured and Loyalty bonus (if any) specified in the Policy Schedule against this Benefit.

3. **Technological advancements and Treatments**

A. Coverage for Technological advancements and Treatments

We will pay You for medical expenses incurred by You for the below mentioned Technological advancements and Treatments during the policy period up to the annual sum insured

Sr. No	Treatment/Procedure
1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
2	Immunotherapy- Monoclonal Antibody to be given as injection
3	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
4	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological 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)

*Robotic surgeries shall be subject to sub-limits as mentioned in “15. A. Sub-limits applicable”

B. Coverage for Technological advancements and Treatments

We will pay You for medical expenses incurred by You for the below mentioned Technological advancements and Treatments during the policy period maximum up to the limits as mentioned in the table below

Technological advancements and Treatments								
Limit per person per policy period (In Rs)								
Sum Insured (In Rs)	**3,00,000**	**4,00,000**	**5,00,000**	**10,00,000**	**15,00,000**	**20,00,000**	**25,00,000**	**5000000**
Uterine artery Embolization and HIFU	1,50,000	2,00,000	2,25,000	2,75,000	3,00,000	3,25,000	3,50,000	3,50,000
Balloon Sinuplasty	1,50,000	2,00,000	2,25,000	2,75,000	3,00,000	3,25,000	3,50,000	3,50,000
Deep Brain Stimulation	1,50,000	2,00,000	2,25,000	2,75,000	3,00,000	3,25,000	3,50,000	3,50,000

Oral Chemotherapy* (Sublimits including Pre and Post Hospitalisation)	2,00,000	2,25,000	2,75,000	3,50,000	4,00,000	4,50,000	5,00,000	5,00,000
Immunotherapy- Monoclonal Antibody to be given as injection	2,00,000	2,25,000	2,75,000	3,50,000	4,00,000	4,50,000	5,00,000	5,00,000
Intra Vitreal injections	20,000	25,000	30,000	50,000	60,000	75,000	1,00,000	1,00,000
Robotic surgeries	1,50,000	2,00,000	2,25,000	2,75,000	3,00,000	3,25,000	3,50,000	3,50,000
Stereotactic radio surgeries	1,50,000	2,00,000	2,25,000	2,75,000	3,00,000	3,25,000	3,50,000	3,50,000
Bronchical Thermoplasty	1,50,000	2,00,000	2,25,000	2,75,000	3,00,000	3,25,000	3,50,000	3,50,000
Vaporisation of the prostate (Green laser treatment or holmium laser treatment)	1,50,000	2,00,000	2,25,000	2,75,000	3,00,000	3,25,000	3,50,000	3,50,000
IONM-(Intra Operative Neuro Monitoring)	1,50,000	2,00,000	2,25,000	2,75,000	3,00,000	3,25,000	3,50,000	3,50,000
Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions	2,00,000	2,25,000	2,75,000	3,50,000	4,00,000	4,50,000	5,00,000	5,00,000

4. **Pre Hospitalisation expenses**:

   A. Pre-hospitalisation expenses:
   We will compensate You for the relevant medical Expenses incurred, immediately 60 days before Your Hospitalisation.

B. Pre-hospitalisation expenses
We will compensate You for the relevant medical Expenses incurred, immediately 30 days before Your Hospitalisation.

5. **Post Hospitalisation expenses :**

A. Post-hospitalisation expenses
We will compensate You for the relevant medical Expenses incurred, immediately 180days after Your Hospitalisation.

B. Post-hospitalisation expenses
We will compensate You for the relevant medical Expenses incurred, immediately after Your Hospitalisation up to 7% of hospitalisation expenses incurred subject to limits as mentioned below

Annual Sum Insured	Limits
Rs. 3L to Rs. 5L	Rs. 5,000
Rs. 10L and 15L	Rs. 7,000
Rs. 20L, 25L and 50L	Rs. 10,000

6. **Donor Expenses:** We will cover the Medical Expenses incurred in respect of an organ donor's Hospitalization during the Policy Period for the harvesting of the organ donated provided the organ donated is for Your use as per the terms and conditions mentioned in the policy wordings**.** Any Medical Expenses payable during the Policy period shall not in aggregate exceed the Annual Sum Insured and Loyalty bonus (if any) as specified in the Policy Schedule against this Benefit subject to an overall limit of Rs. 10,00,000 only

7. **Domiciliary Hospitalization** We will cover the expenses incurred on Your medically necessary treatment up to annual sum insured as specified in the policy schedule during the Policy Period provided that the Domiciliary Hospitalization continues for at least 3 consecutive days

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

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

8. **Home Care Treatment**: We will cover the medical expenses incurred by You on home care treatment up to 5% of Annual Sum Insured provided the medical practitioner has

advised You to undergo treatment at home Treatments that can be availed on outpatient basis are outside the scope of this cover.

Home care treatment can only be availed on a cashless basis through our empanelled service providers.

9. **In Patient AYUSH Hospitalisation:** We will cover the Medical Expenses incurred in respect of Inpatient AYUSH Treatment taken by You during the Policy Period up to the Annual Sum Insured specified in the Policy Schedule provided that medical expenses incurred are Reasonable and Customary Charges.

10.Domestic road Ambulance cover:

A. Domestic road ambulance cover
We will cover the expenses up to 1% of Annual Sum Insured subject to a maximum of Rs. 10,000, incurred on road ambulance services which are offered by a healthcare or ambulance service provider and which have been used during the Policy Period to transfer You to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care.

B. Domestic road ambulance cover
We will cover the expenses incurred on road ambulance services which are offered by a healthcare or ambulance service provider and which have been used during the Policy Period to transfer You to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care subject to the limits as mentioned below

Annual Sum Insured	**Limit per hospitalisation**	**Limit per policy period**
Rs. 3L and 4L	Rs. 600	Rs. 1,200
Rs.5L and 10L	Rs. 1,000	Rs. 2,000
Rs. 15L, Rs. 25L and Rs. 50L	Rs. 1,500	Rs. 3,000

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

11. **Base Co-Payment:** This policy will be subject to 50% base co-payment and You shall be liable to pay 50% of admissible claim amount of each and every claim. Base Co-payment once chosen cannot be changed mid-term. Modification of base co-payment may happen only during renewal. Fresh waiting periods shall be applicable on the modified portion of base co-payment.

    i. Base Co-payment shall be applicable to all benefits under the policy except any benefits availed under care management program, care management plus program, preventive health check-up,. .
    ii. Base Co-payment shall not be applicable in case voluntary deductible has been opted for.

12. **Loyalty Bonus:** We will provide a Loyalty Bonus of 10% of the Annual Sum insured at the end of each Policy Year if continuously renewed with Us. The Loyalty Bonus will not be accumulated for more than 100% of the Annual Sum insured under any circumstances.

13. **Reset Benefit:** We will reset the Annual Sum insured up to 100% of the Annual Sum insured unlimited times, for all future Claims within the same Policy year not related to the illness/disease/injury for which a claim has been paid for the same insured person, subject to the terms and conditions mentioned in the Policy Wordings. The Reset Benefit will not be triggered for the first claim made during the Policy Year. The Reset benefit will be triggered only once for all future claims within the same policy which are related to the illness/disease/injury for which a claim has already been paid/registered for the same insured person

14. **Sub- limits applicable:**

A. Sub-limits applicable:

The expenses payable during the entire policy period for treatment of the following diseases/ conditions (either as a day care or as an in-patient exceeding 24hrs of admission in the hospital) shall be maximum up to the amount mentioned in the table below;

Procedures/Medical Conditions/Ailments/Diseases	Annual Sum Insured		
	3L/4L/5L	10L/15L/20L	>20L
Treatment of cataract	Up to Rs. 25,000/ eye	Up to Rs. 50,000/ eye	Up to Rs. 75,000/ eye
Treatment of each and every ailment/procedure mentioned below			
Treatment of cerebrovascular and cardiovascular disorders	Rs. 2,00,000	Rs. 3,50,000	Rs. 5,00,000
Treatment/surgeries for cancer(including chemo/radio/oral)			
Treatment of other renal complications and disorders			
Treatment for breakage of long bones/Joint replacements			
Robotic surgeries for any ailment/condition/disease	Rs. 1,00,000	Rs. 1,75,000	Rs. 2,50,000

Sub-limits will include the expenses incurred on pre hospitalisation and post hospitalisation expenses

B. Sub-limits applicable:

Sub-limit (In Rs)			
Sum Insured (In Rs)	**Cataract**	**Cerebro vascular Accident, Cardio vascular Diseases, Cancer (Including Chemotherapy / Radiotherapy), Medical Renal Diseases (Including Dialysis), Treatment of Breakage of Long Bones**	**All other major surgeries**
	Limit per person, per period for each diseases/condition Rs		
3L	18,000	2,00,000	1,50,000
4L	20,000	2,25,000	2,00,000
5L	21,500	2,75,000	2,25,000
10L	25,000	3,50,000	2,75,000
15L	30,000	4,00,000	3,00,000
20L	35,000	4,50,000	3,25,000
25L	40,000	5,00,000	3,50,000
50L	40,000	5,00,000	3,50,000

The expenses payable during the entire policy period for treatment of the following diseases/ conditions (either as a day care or as an in-patient exceeding 24hrs of admission in the hospital) shall be maximum up to the amount mentioned in the table below

Sub-limits will include the expenses incurred on pre hospitalisation and post hospitalisation expenses

15. **Enhanced Annual Sum insured for Road Traffic Accidents:** If You meet with a Road Traffic Accident whilst travelling as a pillion rider in a two wheeler/ four wheeler, resulting in in-patient hospitalization, then the Annual Sum Insured shall be doubled, if it is declared and proven that You were taking due safety precautions such as use of seat-belt/ helmet/ following road traffic signals. This benefit is available only once during the policy period and shall be available only after exhaustion of the annual sum insured in the Policy.

16. **Preventive Health Check Up:** You can avail a preventive health check-up as per our pre-defined package only at our network providers or empanelled health service providers anytime during the Policy period subject to policy terms and conditions.

    Please Note:

    a. We shall not hold any responsibility towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner/ Healthcare professional

b. Choosing the services under this Benefit is purely upon the customer's own discretion and at own risk.

c. You should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If You have any concerns about Your health, You may consult Your general practitioner.

17. **Incentives associated with Vaccination against pneumococcal disease**

We will provide an additional 2.5% discount on premium (fresh or renewal) for Insured Person(s) who have taken the Pneumococcal vaccine or its equivalent vaccine which helps prevent pneumococcal disease. All the members covered under the policy should have been vaccinated in the past one year (1 year) from policy start date to avail this discount. . i.e. if policy start date is 1st January 2022, all insured persons under the policy should have been vaccinated against Pneumococcal disease in the period from 1st January 2021 to 31st December 2021. This discount shall be provided lifetime as long as the insured person continues to renew this policy

Further, the following optional covers/extensions can be provided under the Policy on payment of additional premium.

C. Optional Cover

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1. **Claim Protector**: In consideration of payment of additional premium to Us, the insured person can avail the benefit as mentioned under claim protector. If a claim has been accepted under the inpatient hospitalization cover, then the items which are not payable under the claim as per the List of Excluded items that is related to the particular claim will become payable. The maximum claim pay-out under this benefit shall be limited to Annual Sum Insured under your policy.

    - Base Co-payment as opted by You shall be applicable for this cover

2. Modification of Base Co-payment: In consideration of payment of additional premium to Us, The insured person will have the option to reduce his base co-payment from 50% to 40% or 30% or 20% and He/She shall be liable to pay the percentage (%) of admissible claim amount of each and every claim.

    Base Co-payment once chosen cannot be changed mid-term. Modification of co-payment may happen only during renewal subject to underwriting. In case, base co-payment is reduced during renewal, fresh waiting periods shall be applicable on the modified portion of base co-payment.

3. **Voluntary Deductible:** In case You have opted for a voluntary deductible, the deductible will be applicable on aggregate basis for all Hospitalization expenses during the Policy Year before it becomes payable by Us, subject to terms, conditions and exclusions of the Policy. The voluntary deductible option available will be 20% of Annual Sum Insured opted by You.

    i. In case voluntary deductible has been opted for, base co-payment shall not be. chosen. Zone based co-payment shall be applicable in case medically necessary treatment (except medically necessary treatment for road traffic accidents) has been taken in a zone higher (Zone A being the highest followed by Zone B and then Zone C) than the zone for which premium has been paid on issuance of the policy.
    ii. The deductible will apply on individual basis in case of individual policy and on floater basis in case of floater policy.
    iii. Deductible once chosen cannot be changed mid-term. Modification of deductible may happen only during renewal subject to underwriting approval.

4. **Care Management Program:**

In consideration of payment of additional premium, Insured Person can avail benefits under the Care Management Program. The Care Management Program aims to provide solutions which will solve everyday challenges/issues faced by You, promote holistic wellbeing and empower You to lead independent and enriching lives.

Our care management program focusses on providing You with assistance and support in case of any challenge but at the same time equipping you for the future. Our endeavour is to promote longevity, productivity and incentivise You for your healthy behaviour which will enable dignified living.

You shall have access to a host of benefits under the care management program (which are listed below) on downloading and registering on our mobile application. This activity is to ensure adequate utilization of services offered and to redeem the wellbeing points awarded.

1. Tele Consultation(s)

2. Second E-opinion for Critical Illness
3. Diet and Nutrition e-consultation
4. E-Counselling
5. Health Management Program

a. Care Calls

b. Goal based incentives on outcome of Preventive health check-up

6. Participation in Yoga/Meditation Sessions/ Completion of Targeted Steps
7. Medical Vault
8. Health Assistance (HAT)
9. Ambulance Assistance
10. Discounts on services/products

Please go through the Policy Wordings for details on each of the above listed benefits

Terms and Conditions for Care Management Program

- There shall be no minimum wellness points limit for redemption against health related deals and discounts offered on our mobile application.
- The Insured Person(s) can choose to carry forward the wellness points for 3 years, in case they do not wish to redeem the same provided the policy is continuously renewed without any break. The wellness points so accrued shall have to be redeemed at the end of the 3rd Policy year.
- The Insured Person shall notify Us and submit the relevant documents, reports, receipts as and when required by us within 60 days of undertaking any activity for us to reward appropriate wellness points
- In case of expiry of policy and the policy not being renewed, the accrued wellness points may be carried forward for a period not exceeding three months
- There shall not be any cash reimbursement or redemption available against the wellness points accumulated by an Insured Person.
- We or Our Health Service Providers or Our Network Providers do not warrant the validity, accuracy, completeness, safety, quality, or applicability of the content or anything said or written or any suggestions provided in the course of providing the wellbeing services.
- We do not accept any liability towards quality of the services made available by our network providers/ health service providers and are not liable for any defects or deficiencies on their part
- Availability of all Services under the Care Management Program is subject to availability of Health Service provider at the requested location
- We, Our group entities, or affiliates, their respective directors, officers, employees, agents, vendors, shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person may claim to have suffered, sustained or incurred, as a result of any advice or information obtained by way of the wellness program or any actions chosen by the Insured Person on the basis of such advice or information.
- The Care Management Program offered is subject to revisions based on the insurance regulatory framework from time to time.

5. **Care Management Plus Program:**

In consideration of payment of additional premium, You can avail the benefits associated with Care Management Plus Program as detailed below

i. Health Care Professional
ii. Update to family members
iii. Out-patient consultations
iv. Routine Diagnostics and Minor Procedure cover
v. Pharmacy cover
vi. Nursing at Home

Please go through the Policy Wordings for details on each of the above listed benefits

EXCLUSIONS UNDER THE POLICY

We will not be liable for any Voluntary Deductible amount, if applicable and as specifically defined in the Policy Schedule under the Policy.

We will not be liable to make any payment under this Policy in connection with or in respect of any expenses whatsoever incurred in connection with or in respect of:

1. ***Standard exclusions Code- Excl01: Pre-Existing Diseases***
   a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If the Insured Person is continuously covered without any break as defined under the portability norms of the relevant Regulations / circulars / guidelines, then waiting period for the same would be reduced to the extent of prior coverage
   d. Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. **Code- Excl02:** Specified disease/procedure waiting period
   a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific Illness and Surgical Procedures as mention below:

Sr. no	Organ /Organ System	Illness/ diagnosis (irrespective of treatments medical or surgical)	Surgeries/ Procedures (irrespective of any illness or diagnosis other than cancers)
1	ENT	Deviated Nasal Septum	Septoplasty
		CSOM-Chronic Suppurative Otitis Media	Mastoidectomy
			Tympanoplasty, Myringotomy & Myringoplasty
			Any treatment for conditions related to tonsils, adenoids, sinuses, Turbinates/ concha
2	Gynaecological	Fibroids (fibromyoma)	Dilatation and curettage (D&C)
		Endometriosis, Cervicitis	Myomectomy
		Uterine Prolapse	Hysterectomy (unless due to malignancy
		Dysfunctional uterine bleeding	
		Polycystic Ovarian Syndrome(PCOS)	
3	Orthopaedic	Arthritis	Surgeries for joint replacements
		Gout and Rheumatism	Repairs/ reconstruction of ligaments/ meniscus/ tendons
		Spinal and Vertebral Disorders including diagnosis as low back ache	Spinal & Vertebral Surgeries
		Arthroscopy	

4	Gastrointestinal	Stones in gall bladder & Biliary System, cholecystitis, acalculous cholecystitis	Cholecystectomy, Procedures for biliary stones
		Fissure/fistula in anus, hemorrhoids, pilonidal sinus	Endoscopy
		Esophageal Varices & Gastric Varices	Procedures for Esophageal Varices & Gastric Varices
		All types Hernia	
		Gastrointestinal ulcers including Gastritis & Duodenitis/ Erosions of gastrointestinal tract	Endoscopy
		All forms of Liver cirrhosis	
5	Uro-genital	Stones in Urinary system	Surgeries and procedures related to Stones in Urinary system
		Benign Hyperplasia of prostate	Prostatic Surgeries
		Chronic Renal Failure or end stage Renal Failure or chronic kidney disease including dialysis	Dialysis but not limited to haemodialysis & peritoneal dialysis
		Hydrocele, varicocele/ rectocele/ Spermatocele	
6	Eye	Cataract	
		Retinal detachment	
		Glaucoma	
		Usage of intra vitreal injections including but not limited to avastin & lucentis	
7	Other General conditions (Applicable to all organ systems/ organs/ disciplines whether or not described above)	All internal/ external tumors, cysts, nodules, polyps, sinus, fistula	Any transplant and related Surgery
		Varicose veins & Varicose ulcers	
		Parkinson's disease/Alzheimer's disease	

3.

a. Expenses related to the treatment of the below mentioned illness within 90 days from the first policy commencement date shall be excluded unless they are pre-existing and disclosed at the time of underwriting
   i. Hypertension
   ii. Diabetes
   iii. Cardiac Conditions

b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4. Code- Excl03: 30-day waiting period
   a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
   c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

Unless covered by way of an appropriate extensions/optional covers, We shall not be liable to make any payment under this Policy in connection with or in respect of

5. Permanent Exclusions

   i. Code- Excl04: Investigation & Evaluation
      a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
      b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

   ii. Code- Excl05: Exclusion Name: Rest Cure, rehabilitation and respite care- Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
      a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
      b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

   iii. Code- Excl06: Obesity/ Weight Control
   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

iv. Code- Excl07: Change of Gender treatments
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

v. Code- Excl08: Cosmetic or plastic Surgery
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

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

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

viii. Code- Excl11: Excluded Providers
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim. The list of excluded providers/delisted hospitals is available on our website www.icicilombard.com

ix. Code- Excl12: Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

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

xi. 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 claim or day care procedure.

xii. Code- Excl15: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

xiii. Code- Excl16: Unproven Treatments: Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

xiv. Code- Excl17: Sterility and Infertility: Expenses related to sterility and infertility. This includes:
   i. Any type of contraception, sterilization
   ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   iii. Gestational Surrogacy
   iv. Reversal of sterilization

xv. Code- Excl18: Maternity: Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

i. Specific exclusions (Exclusions other than those mentioned under e.i. above)

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

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

8. Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home

9. Expenses incurred on dental treatment unless necessitated due to an Accident

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

11. Acupressure, acupuncture, magnetic and other therapies

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

13. Expenses for venereal disease or any sexually transmitted disease (except HIV/AIDS)

14. Any Treatment or medical service taken outside the geographical boundaries of India

15. Any expense incurred on out-patient(OPD) treatment (This exclusion shall not be applicable in case care management plus program has been opted for by payment of additional premium)

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

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

18. Any Illness or Injury caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel

19. Treatment for any condition / illness which requires hormone replacement therapy

20. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:
    a. Deep coma and unresponsiveness to all forms of stimulation; or
    b. Absent pupillary light reaction; or
    c. Absent oculo-vestibular and corneal reflexes; or
    d. Complete apnea.

Discounts/Loading Factors:

1. **Tenure discount**

Tenure of policy	Discount percentage
2 years	10%
3 years	15%

2. **Discount for online renewal:** A discount of 5% will be offered for renewing the Policy online.
3. **Voluntary Deductible Discount:** Discount as per following grid will be applicable on opting voluntary deductible.

Sum Insured	Voluntary Deductible	Discount
₹ 5,00,000	₹ 1,00,000	5%
₹ 10,00,000	₹ 2,00,000	30%
₹ 15,00,000	₹ 3,00,000	50%
₹ 20,00,000	₹ 4,00,000	70%
₹ 25,00,000	₹ 5,00,000	70%
₹ 50,00,000	₹ 10,00,000	70%

4. **Risk Based Loading:** We may apply a risk based loading on premium payable (based upon the declarations made and the health status of the person proposed for insurance). The maximum risk loading applicable shall not exceed 200% per individual.

   This risk based loading will be applicable, to the extent as applied at the time of first policy, at renewals as well.

   We will not apply any additional loading at renewal based on claim experience.

   We will inform you about the applicable risk loading through a counter offer letter at the time of Your risk assessment before first policy. You need to revert to us with consent and additional premium, if any within 15 days of issuance of such counter offer letter. If You neither accept Our letter nor revert to Us within 15 days, We will cancel Your application and refund the premium paid within the next 7 days.

How do I claim my insurance?

Cashless Basis

In case of emergency or planned Hospitalisation, use Your health ID card at our Network Provider and avail of cashless service OR You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. Cashless approval is subject to Pre-authorisation by Us. If You notify pre authorization request for cashless facility through any of our empanelled network hospitals along with complete set of documents & information, We will decide on request within 1 hours of the actual receipt of such pre authorization request. Further, we shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital.

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

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

Reimbursement Basis

In case of reimbursement settlement, you should immediately notify Us about the claim by calling at the toll free number as specified in the Policy. You or someone claiming on Your behalf, should then send us the following documents in original within 30 days after Your discharge from the Hospital:

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 Hospitalisation in non-Accident cases.
g. Any other document as required by Us or Our In house claim processing team to investigate the Claim or Our obligation to make payment for it

The claim will be processed within 15 days of receipt of claim along with claim form.

Illustrations for claim settlement

Illustration 1 – Insured Person opted for base co-payment

Heading	Particulars	Scenario 1	Scenario 2	Scenario 3
A	Annual Sum Insured	₹ 10,00,000	₹ 10,00,000	₹ 10,00,000
B	Base Co-payment opted at time of policy issuance	20%	20%	20%
	Zone opted	B (Goa)	B (Goa)	B (Goa)
	Hospitalization Diagnosis	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease
	Treatment taken in	Goa (Zone B)	Mumbai (Zone A)	Guwahati (Zone C)
C	Hospitalisation expenses Amount	₹ 4,00,000	₹ 5,00,000	₹ 3,00,000

D	Pre and Post hospitalisation expenses	₹ 35,000	₹ 50,000	₹ 20,000
E	Total claimed Expenses*[C+D]	₹ 4,35,000	₹ 5,50,000	₹ 3,20,000
F	Zone based co-payment	0%	15%	0%
G	Claimed amount after application of zone based co-payment [E*F]	₹ 4,35,000	₹ 4,67,500	₹ 3,20,000
H	Sub-limit for cardiovascular diseases	₹ 3,50,000	₹ 3,50,000	₹ 3,50,000
I	Insured Person liability after application of base co-payment [G*B]	₹ 87,000	₹ 93,500	₹ 64,000
J	ICICI Lombard Liability after deduction of co-payment [G-I]	₹ 3,48,000	₹ 3,74,000	₹ 2,56,000
K	Final payable amount to Insured Person [lesser amount out of G, H, J]	₹ 3,48,000	₹ 3,50,000	₹ 2,56,000
L	Balance Annual Sum Insured [A-K]	₹ 6,52,000	₹ 6,50,000	₹ 7,44,000

*It has been assumed that total claimed expenses are same as total payable expenses. i.e. there are no deductions in the claimed amount

Illustration 2 – Insured person opted for voluntary deductible

Heading	Particulars	Scenario 1	Scenario 2	Scenario 3
A	Annual Sum Insured	₹ 20,00,000	₹ 20,00,000	₹ 20,00,000
B	Voluntary deductible opted at time of policy issuance	₹ 4,00,000	₹ 4,00,000	₹ 4,00,000
C	Base Co-payment applicable	NA	NA	NA
	Zone opted	B (Goa)	B (Goa)	B (Goa)
	Hospitalization Diagnosis	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease
	Treatment taken in	Goa (Zone B)	Mumbai (Zone A)	Guwahati (Zone C)
D	Hospitalisation expenses Amount	₹ 4,00,000	₹ 5,00,000	₹ 3,00,000
E	Pre and Post hospitalisation expenses	₹ 35,000	₹ 50,000	₹ 20,000
F	Total claimed Expenses*[D+E]	₹ 4,35,000	₹ 5,50,000	₹ 3,20,000
G	Zone based co-payment	0%	15%	0%
H	Claimed amount after application of zone based co-payment [F*G]	₹ 4,35,000	₹ 4,67,500	₹ 3,20,000
I	IL Liability after application of voluntary deductible[H-B]	₹ 35,000	₹ 67,500	NA as expenses have not crossed voluntary deductible amount

J	Sub-limit for cardiovascular diseases	₹ 3,50,000	₹ 3,50,000	₹ 3,50,000
K	Final payable amount to Insured Person [lesser amount out of I,J]	₹ 35,000	₹ 67,500	₹ -
L	Balance Annual Sum Insured [A-K]	₹ 19,65,000	₹ 19,32,500	₹ 20,00,000

*It has been assumed that total claimed expenses are same as total payable expenses. i.e. there are no deductions in the claimed amount

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. Reset Sum Insured (If applicable)

CLAIM DOCUMENTS

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

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

Terms of Renewal

- The Policy can be renewed under the then prevailing Golden Shield product or its nearest substitute (in case the Golden Shield product is withdrawn by the Company).

- A health insurance policy shall ordinarily be renewable except on grounds of established fraud, or misrepresentation or non-disclosure by the insured provided the policy is not withdrawn and also subject to Moratorium conditions.

- Auto Renewal option is available. You can opt for ECS payment for Policy renewal at the time of buying this Policy.

- We shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at renewal stage where there is no change in sum insured offered. Provided that where there is an improvement in the risk profile, the insurer may endeavour to recognize that for removal of loadings at the point of renewal.**Renewal Premium** - Premium payable on renewal and on subsequent continuation of cover are subject to change . Renewal premium may change basis the age of the Insured Person, Addition or deletion of any extensions/optional covers, Change in any policy conditions such as – floater/ individual, any deductible opted, zone opted, policy tenure, etc. Increase/ decrease in the Sum insured opted for, Change in any tax laws by the Government. Risk based loading (if any) on premium will be applicable from Policy Period Start Date including subsequent Renewal(s) with Us.

- Lifetime renewability

- In the likelihood that this policy is /withdrawn in future, we will intimate the You regarding the same at least 3 months prior to expiry of the policy. In case of withdrawal, You have the option to migrate to the nearest substitute policy as available with Us at the time of renewal with all the continuity benefits, provided the policy has been maintained without a break.

- **Zone based premium-** This Policy only covers medical treatment taken within India arising during the Policy Period. All payments under this Policy will only be made in Indian Rupees within India. For the purpose of Policy issuance, the premium will be computed basis the zone chosen by the Insured Person in the proposal form. The premium that would be applicable zone wise and the cities defined in each zone are as under:

    - Zone A- NCR*, Mumbai, Thane District,, Navi Mumbai, Gujarat, Kolkata

    - Zone B- Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Navi Mumbai)

    - Zone C- Rest of India

NCR* includes Includes Delhi and the following districts: Faridabad, Gurgaon/Gurugram, Mewat, Rohtak, Sonipat, Panipat, Jhajjhar, Palwal, Karnal, Ghaziabad, Noida/Gautam Budh Nagar, Bulandshahr, Baghpat, Hapur, Shamli, Muzaffarnagar

Additional zone based Co-Payment would be levied on each and every claim (over and above the base co-payment opted by the Insured person) in case medically necessary treatment has been taken in a zone higher (Zone A being the highest followed by Zone B and then Zone C) than the zone for which premium has been paid on issuance of the policy. Zone based co-payment shall not be applicable in case of medically necessary treatment taken for road traffic accidents.

The additional zone based co-payment that will be levied will be as per tables mentioned below

Additional zone based Co-Payment Grid			
Treatment taken in Zone	Zone opted at policy issuance		
	A	B	C
A	0%	15.0%	25.0%
B	Nil additional co-payment	0%	12.0%
C	Nil additional co-payment	Nil additional co-payment	0%

- **Grace Period -**
  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 need 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 the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period."

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Cancellation: The insured may cancel the policy at any time during the term, by giving 7 days notice in writing. The Company shall

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

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

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

The Company may cancel the Policy at any time on grounds of established fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on the grounds of established fraud.

- **Withdrawal of Policy:** In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
  Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as loyalty bonus, waiver of waiting period as per the regulatory prescriptions, provided the policy has been maintained without a break.

- **Moratorium period:** After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the Company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.
  The coverage for the insured person shall automatically terminate in case of His/Her demise and upon exhaustion sum insured and additional sum insured (if any), for the policy year

- **Migration**: In case of migration of this policy with the Company, the insured can transfer the credits gained to the extent of the Sum Insured and benefits available in the previous policy to the migrated policy. The Company may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

- **Portability**
  a. The insured has the choice to port his / her policies from one Insurer to another.
  b. The insured is entitled to transfer the credits gained to the extent of the sum insured and the benefits available in the previous policy, subject to the underwriting policy of the Company
  c. The company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines .
  d. This benefit is not applicable for enhanced sum insured.

- **Premium Payment in instalments**

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

i. 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 the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
ii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iii. No interest will be charged If the instalment premium is not paid on due date.
iv. In case of instalment premium due not received 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. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

Renewal of policy:

I. 1. A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to Moratorium conditions as provided in the policy.
II.
III. 2. The Company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.
IV. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
V. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
VI. 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.
VII. No loading shall apply on renewals based on individual claims experience.

- **Policy Alignment Option:** Policy alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy. Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.
- **Free look period:** Every insured of new health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium

paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the insured and stamp duty charges.

- **Redressal of Grievances**

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

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

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

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

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

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

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

- **Endorsements:** The proposer may be changed only at the time of renewal. The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India. Mid- term endorsement of addition of member in the policy shall not be permitted

- **Possibility of Revision of Terms of the Policy Including the Premium Rates**
  The Company, may revise or modify the terms of the policy including the premium rates.

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

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

Enclosed: Rate chart

Benefit Illustration (Golden Shield Essentia Plan)

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount	Premium after discount (Rs.)	Sum insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)
61	18,233	5,00,000	18,233	0.00%	18,233	5,00,000	40,923	5,947	34,976	5,00,000
66	22,690	5,00,000	22,690		22,690	5,00,000				
Total Premium for all members of the family is Rs. 40,923 (excluding GST), when each member is covered separately.			Total Premium for all members of the family is Rs. 40,923 (excluding GST), when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 34,976 (excluding GST).			
Sum insured available for each individual is Rs 5,00,000 for 1 yr			Sum insured available for each family member is Rs 5,00,000 for 1 yr				Sum insured of Rs 5,00,000 for 1 yr is available for the entire family.			

Note: The Premium mentioned above are for Zone A and 50% co-pay. It is subject to change if the selected Zone and co-pay is different at the time of issuance.

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount	Premium after discount (Rs.)	Sum insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)
56	14,584	10,00,000	14,584	0.00%	14,584	10,00,000	34,870	4,961	29,909	10,00,000
61	20,286	10,00,000	20,286		20,286	10,00,000				
Total Premium for all members of the family is Rs. 34,870 (excluding GST), when each member is covered separately.			Total Premium for all members of the family is Rs. 34,870 (excluding GST), when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 29,909 (excluding GST).			
Sum insured available for each individual is Rs 10,00,000 for 1 yr			Sum insured available for each family member is Rs 10,00,000 for 1 yr				Sum insured of Rs 10,00,000 for 1 yr is available for the entire family.			

Note: The Premium mentioned above are for Zone A and 50% co-pay. It is subject to change if the selected Zone and co-pay is different at the time of issuance.