Policy Wordings

A. PREAMBLE:

The insurance cover provided under this Policy to the Insured / Insured Person up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium and (c) Disclosure to Information Norm (including by way of the Proposal or Information Summary Sheet) and (d) Policy Schedule/ Certificate of Insurance.

B. DEFINITIONS:

Any word or expression, to which a specific meaning has been assigned in any part of this Policy Wording or the Policy Schedule/ Certificate of Insurance, shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meaning as set forth herein below:

i. Standard Definitions

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

1.2) **"Any one illness"** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital where treatment was taken.

1.3) **"AYUSH treatments"** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

1.4) **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.

1.5) **"Cashless facility"** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

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

1.7) **"Congenital Anomaly"** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

1.7.1 **Internal Congenital Anomaly -** Congenital anomaly which is not in the visible and accessible parts of the body;

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

1.8) **"Co-payment"** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

1.9) **"Day Care treatment"** means medical treatment, and / or surgical procedure which is:

1.9.1 undertaken under general or local anesthesia in hospital/day care centre in less than 24 hours because of technological advancement, and

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

Treatment normally taken on an out-patient basis is not included in the scope of this definition. The list of Day Care Treatment is available in our website.

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

1.10.1 has qualified nursing staff under its employment ;

1.10.2 has qualified medical practitioner/s in charge;

1.10.3 has a fully equipped operation theatre of its own where surgical procedures are carried out ;

1.10.4 maintains daily records of patients and

will make these accessible to the Insurance Company's authorized personnel.

Day Care Centre includes AYUSH Dare Care Centre

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

1.11) **"Deductible"** means a cost sharing requirement under a health insurance policy that provides that the company will not be liable for a specified rupee amount in case of indemnity sections and for a specified number of days/hours in case of hospital cash section which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

1.12) **"Disclosure to information norm"** means the policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, miss-description or non-disclosure of any material fact.

1.13) **"Domiciliary hospitalization"** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

1.14) **"Emergency care"** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

1.15) **"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.

1.16) **"Hospital/ Nursing Home"** 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:
1.18.1 has qualified nursing staff under its employment round the clock;
1.18.2 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;
1.18.3 has qualified medical practitioner(s) in charge round the clock;
1.18.4 has a fully equipped operation theatre of its own where surgical procedures are carried out;
1.18.5 Maintains daily records of patients and

makes these accessible to the insurance company's authorized personnel.

Hospital includes Ayush Hospital

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

1.17) **"Hospitalisation"** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for Day care treatments, where such admission could be for a period of less than 24 consecutive hours.

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

1.19) **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

I. **Acute condition -** Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

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

1.19.II.1 it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

1.19.II.2 it needs ongoing or long-term control or relief of symptoms

1.19.II.3 it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

1.19.II.4 it continues indefinitely

1.19.II.5 it recurs or is likely to recur

1.20) **"Injury"** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner

1.21) **"Inpatient care"** means treatment for which the insured person has to stay in a hospital for more than 24 consecutive hours for a covered event.

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

1.23) **"Maternity expenses"** means;

A. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

B. expenses towards lawful medical termination of pregnancy during the policy period.

1.24) **"Medical expenses"** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

1.25) **"Medically necessary treatment"** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

I. is required for the medical management of the illness or injury suffered by the insured;
II. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
III. must have been prescribed by a medical practitioner;
IV. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

1.26) **"Medical Practitioner"** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

The registered practitioner should not be the insured or close member of the family.

1.27**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 with the same insurer .

1.28) **"Network Provider"** means hospitals or health care providers enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an insured by a cashless facility.

1.29) **"Newborn baby"** means baby born during the Policy Period and is aged up to 90 days.

1.30) **"Non-Network"** means any hospital, day care centre or other provider that is not part of the network.

1.31) **"Notification of claim"** means the process of intimating a claim to the insurer through any of the recognized modes of communication.

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

1.33) "**Portability**"

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

1.34) **"Post-hospitalization Medical Expenses"** means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

I. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
II. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

1.35) **"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 the insurer; 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.

1.36) **"Pre-hospitalization Medical Expenses"** means medical expenses incurred during predefined number of days preceding the

hospitalization of the Insured Person, provided that:

I. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
II. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

1.37) **"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.

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

1.39) **"Renewal"** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

1.40) **"Room Rent"** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

1.41) **"Specific waiting period/Specified Disease/Procedure waiting period/"** means a period up to 36 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

1.42) **"Subrogation"** means the right of the insurer to assume the rights of the Policyholder/insured person to recover expenses paid out under the policy that may be recovered from any other source.

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

1.44) **"Unproven/Experimental treatment"** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

I. <u>Specific Definitions</u>

1.1) **"Certificate of Insurance"** means the document issued to Individual Insured by the Company detailing the effective date, instalment date, Insured Person(s), Benefits, Sum Insured, Deductible, Franchise, Premium and more generally all special conditions and or endorsements.

1.2) **"Company/We/Our/Ours"** means ICICI Lombard General Insurance Company Limited.

1.3) **"Daily Allowance"** means the benefit amount payable to the Insured/Insured Person for each continuous and completed period of 24 hours as inpatient care in the hospital up to the limits as specified in the Policy Schedule/ Certificate of Insurance .

1.4) **"Dependent Child"** means a natural or legally adopted child, aged between 91 days to 23 years and financially dependent on the Policyholder.

1.5) **"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.

1.6) **"Family Floater"** means the Sum Insured shown in the Policy Schedule/ Certificate of Insurance which represents the Company's maximum liability for any and all claims made by any one Insured and/or all Insured Person(s)

together during the Policy Period.

1.7) **"Franchise"** means the company is not responsible for the loss which does not exceed specified amount or number of days/hours, but is responsible to cover the risk from the first amount or the first day/hour if it exceeds specified amount or specified number of days/hours.

1.8) **"Insured/You/Your"** means the primary Insured who has the highest age amongst other person named in the Policy Schedule/ Certificate of Insurance in case of family floater Policy. In case of an Individual Policy the only member mentioned in the Policy Schedule/ Certificate of Insurance shall be referred as "Insured".

1.9) **"Insured Person(s)"** means the person(s) named in the Policy Schedule/ Certificate of Insurance.

1.10) **"Medical Advice"** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

1.11) **"Period of Insurance"** means the period between the date when the policy had first incepted, its subsequent renewals without any break till policy expiry date under the last renewed policy.

1.12) **"Policy Holder"** means the entity named in the Policy Schedule who is responsible for remitting the premium

1.13) **"Policy period"** means the period between the inception date and the expiry date as specified in the Policy Schedule/ Certificate of Insurance or the cancellation of this insurance, whichever is earlier.

1.14) **"Policy Schedule"** means the document issued to the Policyholder which is attached to and forming part of this Policy mentioning the details of the Insured Person(s), the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

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

1.16) **"Sum Insured"** means the amount specified in the Policy Schedule/ Certificate of Insurance against any one or all the sections, which represents the Company's maximum, total and cumulative liability for any and all claims made in respect of the Insured Person during the Period of Insurance, under that any one or all the sections. Sum Insured, as specified in the Policy/ Certificate of Insurance, can be a lump sum benefit payment upon occurrence of an insured event or indemnity payment basis expenditure of the Insured Person for coverage as specified in the Policy Wording upon occurrence of the insured event

1.17) **"Third Party Administrators or TPA''** means any person who is registered with the and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined by the IRDAI..

C. Benefit Covered under the Policy

As specified in the endorsement wording.

D. EXCLUSIONS:

I. <u>Standard Exclusions</u>

A. Exclusion Name: Pre-Existing Diseases - Code- Excl01

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer as selected by the Insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability / migration norms of the relevant regulatory prescription Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of

36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. Exclusion Name: Specified disease/procedure waiting period/Specific Waiting Period- Code- Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/12 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 stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures

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

C. 30-day waiting period- Code- Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident,

provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

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

D. Investigation & Evaluation- Code- Excl04

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

E. Exclusion Name: Rest Cure, rehabilitation and respite care- Code- Excl05

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

F. 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

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

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

H. Cosmetic or plastic Surgery: Code- Excl08

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

I. Hazardous or Adventure sports: Code- Excl09

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

J. Breach of law: Code- Excl10

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

K. Excluded providers: Code- Excl 11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

domestic reasons. **Code- Excl13**

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

O. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

P. Unproven Treatments: Code- Exel 16

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

Q. Sterility and Infertility: Code- Excl 17

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

R. Maternity: Code Excl18

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

II. Specific Exclusion

S. 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.

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

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

U. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

V. Treatment taken outside the geographical limits of India

W. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

X. List I: Optional Items

E. General Condition

I. Standard General Terms and Clauses (General Terms and clauses whose wordings are specified by IRDAI)

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, misdescription or non-disclosure of any material fact by the policyholder.

2. **Condition Precedent to Admission of Liability:**
   The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. **Basis of Claims settlement:**
   I. The Basis of claims settlement under the policy may either be on indemnity basis or benefit basis. The basis of admissibility shall be specified in the Policy Schedule/Certificate of Insurance specified against the sections. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of claim along with claim form. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
   II. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
   III. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

   (Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) as on the 1st day of the financial year in which claim has fallen due)

4. **Multiple policies:**
In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person 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. **Fraud:**
   If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
   Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s) / policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
   For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
   a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
   b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
   c) any other act fitted to deceive; and
   d) any such act or omission as the law specially declares to be fraudulent

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

6. Cancellation:

• 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.

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

- 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 grounds of misrepresentation, nondisclosure of

7. Migration

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

No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc shall be transferred to the migrated policy

8. Portability

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

For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

9. Renewal of Policy

The 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.

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.

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- Renewal shall not be denied on the ground that the insured person had made a claim or

claims in the preceding policy years.

- Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- 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.
- For individual products, the loadings on renewal premium shall be at portfolio and not based upon any individual policy claim experience.
- No fresh underwriting at renewal stage where there is no change in sum insured offered shall be applicable. Provided that where there is an improvement in the risk profile, the company may endeavour to recognize that for removal of loadings at the point of renewal.

10. Withdrawal of policy

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

11. 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 insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

12. 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)

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 company shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

- 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.
- No interest will be charged If the instalment premium is not paid on due date.
- In case of instalment premium due not received within the grace period, the policy will get cancelled.
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

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

The Company, I, may revise or modify the terms of the policy including the premium rates.

14. 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.

15. GRIEVANCES REDRESSAL PROCEDURE

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

Website: www.icicilombard.com
Toll Free: 1800 2666
E-Mail: customersupport@icicilombard.com
Courier: ICICI Lombard General Insurance Company 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 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 (IRDA) 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 IRDA website: www.irdaindia.org, or on the Company's website at www.icicilombard.com or on https://www.cioins.co.in/Ombudsman"

The Details of Insurance Ombudsman are Available Below:

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD Insurance Ombudsman 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 Insurance Ombudsman 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 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh.

BHUBANESHWAR **Insurance Ombudsman** Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
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. Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI **Insurance Ombudsman** 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 **Insurance Ombudsman** 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 **Insurance Ombudsman** 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 **Insurance Ombudsman** 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 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR **Insurance Ombudsman** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363/ 2740798 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 **Insurance Ombudsman** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW **Insurance Ombudsman** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 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 **Insurance Ombudsman** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. el.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA **Insurance Ombudsman** 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, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE **Insurance Ombudsman** 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.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

"For updated list of ombudsman details kindly visit https://www.cioins.co.in/Ombudsman"

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

16. Consideration:

The Frequency of Premium payable under the policy and or each Certificate of the Insurance issued under this Policy shall be single payment premium or instalment basis.

- In the case of single payment – full premium is payable before the beginning of risk.

17. Condition Precedent to Admission of Liability:

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

18. Material Change:

The Policyholder/ Insured / Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business, partial disclosure of the medical history at Insured / Insured person's own expense. The Company may, adjust the scope of cover and / or the premium, if necessary, accordingly.

19. No Constructive Notice:

The Company shall not take notice of any information relating to the Insured person unless the Policyholder / Insured submit such information in writing, even if such information was available with the Company.

20. Notice of Charge:

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to the Policy. However, any payment by the Company to Policyholder/ Insured or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

21. Special Provisions:

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

22. Electronic Transaction:

The Policyholder/ Insured / Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDAI regulations for protection of Policy holder's interests.

23. Duty of the Insured on occurrence of loss/event leading to claim

On the occurrence of loss/event/claim within the scope of cover under the Policy resulting in a claim, the Policyholder/ Insured / Insured Person shall:

- Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.
- Allow the Medical Practitioner or any representative of the Company to inspect the medical and hospitalization records and to examine the Insured / Insured Person
- Assist and not hinder or prevent the Company or any of its representatives in pursuance of their duties

In case the Policyholder/ Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Policyholder/ Insured / Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

24. Right to Investigate:

If required by the Company, a representative of the Company including a physician appointed in that behalf in case of any loss/event/claim or any circumstances that have given rise to a claim to the Insured / Insured Person, be permitted at all reasonable times to investigate into the circumstances of such loss/event leading to claim. The Insured / Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss/event or such circumstance in his/her possession including presenting himself/herself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or shall assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

The Company shall bear all cost of investigation required under this section.

25. Position after a claim:

As from the day of receipt of the claim amount by the Policyholder/ Insured / Insured Person, the days Insured for the remainder of the Policy year of insurance shall stand reduced by a corresponding amount.

26. Grace Period:

All applications for renewal of the Policy must be received by us before the end of the Policy. A Grace Period of 30 days for renewing the Policy is provided under this Policy.

However, there is no coverage provided during the break period for which premium is not received.

27. Termination:

The Policy will terminate at the expiration of the period for which premium has been paid or on Expiration Date shown in the Policy Schedule, whichever is earlier.

Termination of Individual Certificates of Insurance: Each Certificate of Insurance will terminate on the earliest of the following dates

- The date the expiry of the certificate of Insurance.
- The date the Insured person is no more eligible to get covered under the group.
- The instalment premium is not paid.
- The date We or You cancel the Certificate of Insurance.

28. Cause of action/Currency of payment:

Coverage under the policy shall be primarily restricted to territorial limits of India except when worldwide cover is opted by the Policyholder/Insured Person and specified under the Schedule/Certificate of Insurance for Medical Evacuation and International treatment for 25 critical illness (indemnity basis). All claims shall be payable in India in Indian Rupees only.

29. Policy Disputes:

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is

understood and agreed to by both the Policyholder/ Insured and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

30. Arbitration:

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 arbitrators, comprising of 2 arbitrators - 1 to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such 2 arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.

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

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

31. Inclusion of members under the Policy:

New Person can be added to this Policy, either by way of endorsement in case of mid-term inclusion or at the time of renewal subject to acceptance by underwriters.

- **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, change in zone opted, any co-payment opted, policy tenure, etc, Increase/ decrease in the Sum insured opted for, Change in any tax laws by the Government. Risk based loading (if any) on premium will be applicable from Policy Period Start Date including subsequent Renewal(s) with Us.

- In the likelihood that this policy is withdrawn in future, we will intimate the insured person regarding the same at least 3 months prior to expiry of the policy.

In case of withdrawal, the insured person have the option to migrate to the nearest substitute policy as available with Us at the time of renewal with all the continuity benefits, provided the policy has been maintained without a break as per relevant regulatory prescriptions

32. Notices:

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

- In case of the Policyholder/ Insured, at the address given in the Policy Schedule/ Certificate of Insurance.
- In case of the Company, to the Policy issuing office/nearest office of the Company.

33. 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.

F. Other Terms and Conditions

CLAIM SERVICING:

I. **Claim Notification - Multi Model Intimation:**

It is the endeavor of Company to give multiple options to the Insured Person/Insured Person's representative to intimate the claim to the Company. The intimation can be given in following ways:

- Toll Free call Centre of the TPA (24x7) - 1800-2666
- Toll Free call Centre of the Insurance Company (24x7) - 1800-2666
- Login to the website of the Insurance Company and intimate the claim – http://www.icicilombard.com/contact-us
- Send an email to the TPA/Company- customerservice@icicilombard.com
- Post/courier to TPA/Company - Consumer Affairs Department- Grievance Redressal Cell, Insurance Regulatory and Development Authority of India (IRDAI), Sy.No.115/1,Financial District, Nanakramguda, Gachibowli, Hyderabad-500032
- Directly Contacting our Company office but in writing. ICICI Lombard House, 414, P Balu Marg, Veer Savarkar Road, Prabhadevi, Mumbai – 400025, Telephone: 18001032292

In all the above, the intimations are directed to a central team for prompt and immediate action.

I.Information Details

When the Insured Person/Insured Person's representative intimate the claim as mentioned above the following information should be given for prompt services.

- Policy number
- Name of the Policyholder/ Insured
- Name of Covered person/Insured member making the claim
- Contact details
- Nature of the Disease, Illness or Injury
- Name and address, phone number of the attending medical practitioner/hospital.
- Date of hospitalization
- The Insured / Insured Person must provide notification of claim within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier. The Notification of Claim should be ideally provided by the Insured/Insured Person. In the event Insured / Insured Person is unwell, then the Notification of Claim should be provided by Insured Person's representative.

II. Claim Form

On occurrence of any claim under this policy, you are requested to submit completed and duly filled claim form along with other requisite documents. Claim forms will be available with the network hospitals, TPA and Company offices and on its website.

III. Claim Procedure

- The Company shall be under no obligation to make any payment under this Policy unless all the premium payments are received in full and all payments have been realized.
- The Company will only make payment as per the Policyholder/ Insured's direction. In case of Insured's unfortunate demise, the Company will only make payment to the Nominee (as named in the Policy Schedule/ Certificate of Insurance).
- Unless otherwise specified, This Policy only covers medical treatment taken in India, and payments under this Policy shall only be made in Indian Rupees within India.
- The Company is not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured/ Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Insured/ Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
- The Company will process the claims and make claim payments.
- If there is any deficiency in the documents/ information submitted by Insured person,

the Company will send the deficiency letter within 7 days of receipt of the claim documents.

- On receipt of the complete set of claim documents to the Company's satisfaction, the Company will send offer of settlement, along with a settlement statement within 30 days to the insured. Payment will be made within 7 days of receipt of acceptance of such settlement offer.

CLAIMS PROCEDURE

(A) For Cashless Settlement

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

Pre-authorization

i. Prior to taking treatment and/or incurring Medical Expenses at a Network Provider, You must contact the Company or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Proposer, nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request pre-authorisation at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation. To avail of Cashless Hospitalisation facility, you are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card Or You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. We will consider Your request after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalisation facility is sought by You and We will decide on request within 1 hours of the actual receipt of such pre authorization request.

(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 Proposer;
- Nature of Illness or Injury;
- Name and address of the attending Medical Practitioner and the Hospital;

- Any other information that may be relevant to the Illness/ Injury/ Hospitalisation

The above information needs to be provided to Us or Our In house claim processing team immediately and in any event within 10 days of Hospitalisation, failing which We will have the right to treat the Claim as inadmissible, as We may deem fit at Our sole discretion.

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 within 30 days of Your discharge from a Hospital (for post-hospitalisation expenses, within 30 days from the completion of post-hospitalisation 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. In case there is a delay beyond 30 days in submission of claim documents, we may condone the delay provided the insured person submits a valid reason justifying the delay to us in writing. The claim will be processed within 15 days of receipt of claim along with claim form and documents.

However, in both the above cases i.e. g. Claim Administration I.1(A) & (B)You must take reasonable steps or measures to minimise 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.

IV. Documents

It is the Policy of the Company to seek documents in a single request. Based on documents submitted, if any further documentation is required then it will be sought promptly, at the earliest.

In cases where investigation is deemed necessary, the same will be conducted in all promptitude. Every attempt will be made to keep the process transparent.

V. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

VI. Claim settlement

- The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

List of documents required for Claims processing:

- You shall be required to furnish the following documents for or in support of a reimbursement Claim:
  1. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from our website www.icicilombard.com

2. Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner
3. Original bills from chemists supported by proper prescription.
4. Original investigation test reports and payment receipts.
5. Indoor case papers
6. Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.
7. Any other document as required by Us or to investigate the Claim or Our obligation to make payment for it

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

For 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 must promptly and in any event within 30 days of Your discharge from a Hospital (for post-hospitalisation expenses, within 30 days from the completion of post-hospitalisation 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. In case there is a delay beyond 30 days in submission of claim documents, we may condone the delay provided the insured person submits a valid reason justifying the delay to us in writing. The claim will be processed within 15 days of receipt of claim along with claim form.

- In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, The Company shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider along with settlement letter.

List I: Optional Items

Sl 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

Sl 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

Sl 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

Sl 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

ENDORSEMENT WORDINGS – Group Health Assure

SECTION I- CURE

Subject to Sum Insured, co-payment, sublimit, deductible/franchise, annual policy limits specified under the policy schedule/certificate of Insurance, the policy intends to extend /restrict coverage towards:-

Modern Treatment Methods and Advancement in Technologies:

Subject to policy coverages opted for by the Insured, claims pertaining to the following treatment methods, will be admissible under this policy and claims, if payable, would be paid in accordance with the Endorsement Wordings:

A. Uterine Artery Embolization and HIFU
B. Balloon Sinuplasty
C. Deep Brain Stimulation
D. Oral Chemotherapy
E. Immunotherapy- Monoclonal antibody to be given as injection
F. Intra Vitreal Injections
G. Robotic Surgeries
H. Stereotactic Radio Surgeries
I. Bronchical Thermoplasty
J, Vaporisation of the Prostrate (Green Laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditons to be covered.

Sub-limits if applicable for any of the above treatments shall be specified in the Policy schedule/Certificate of Insurance.

1. **In-Patient Care Expenses** - Necessary & Reasonable expenses incurred during in-patient care for a Medical/Surgical treatment of a Disease/Illness/Injury at any hospital in India on advice of a qualified Medical Practitioner. In-patient Care Expenses include
   - I. Room Rent/Boarding Expenses (as per eligibility)
   - II. Nursing Expenses
   - III. ICU Charges
   - IV. Medical Practitioner's and Surgeon fees
   - V. Anaesthetist, Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Fees
   - VI. Drugs, Medicines, X-ray & Diagnostic tests.
   - VII. Radiotherapy, Chemotherapy & Physiotherapy
   - VIII. Cost of Prosthetic devices used intra operatively during the Surgical Procedure.
   - IX. Kidney Dialysis
   - X. Computerized tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques

   Any expenses related to 24 hours hospitalization for the purpose of evaluation/investigation or items listed as excluded shall not be payable.

2. **Day Care Treatment Expenses** - This Section covers hospitalization expenses towards **specified** medical treatments, and/or procedures incurred by the Insured / Insured Person which is undertaken under General or Local Anesthesia in a Hospital/day care centre (where 24 hours of hospitalization is not required due to technologically advanced treatment) which shall be payable. The coverage under this Section is limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance. Kindly refer annexure for the list of specified Day Care Treatments covered under the policy.

3. **Domiciliary Hospitalization Expenses** - Medical treatment for an Illness/Disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:
   1. The condition of the Patient is such that he/she

is not in a condition to be removed to a Hospital or,

2. The Patient takes treatment at home on account of non-availability of room in a Hospital.

However, this does not cover

I. Treatment of less than 3 days. (Coverage will be provided for expenses incurred in first three days also if treatment period is greater than 3 days);

II. Post-Hospitalization expenses;

III. The following medical conditions:

a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,
b. Arthritis, Gout and Rheumatism,
c. Chronic Nephritis and Nephritic Syndrome,
d. Diarrhoea and all type of Dysenteries including Gastroenteritis,
e. Diabetes Mellitus and Insipidus,
f. Epilepsy,
g. Hypertension,
h. Psychiatric or Psychosomatic Disorders of all kinds,
i. Pyrexia of unknown origin.

Domiciliary hospitalization also covers expenses on qualified nurse(s) engaged on the recommendation of the attending Medical Practitioner.

This Section is limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

4. **Organ Donor Expenses** - The expenses incurred in organ donor's treatment for the harvesting of the organ donated, provided that:

I. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs and tissues rules 2014 (amendment) and the organ donated is for the use of the Insured Person, and

II. There shall be an admissible claim under In-patient Care or Day Care Treatment. In case this Section has been opted as standalone basis, the admissibility of the claims for this cover shall be determined based on the admissibility of claim under In-patient Care/Day Care Treatment had the same been covered under the policy

III. If agreed by us and specifically mentioned in the Policy Schedule/Certificate of Insurance, the policy shall be extended to cover cost of successful screening and testing of the Donor followed by transplantation of the Organ & Donor's Post Hospitalisation Expenses incurred within 60 days from the date of transplantation of the organ. The Donor's Post Hospitalization Expenses do not relate to any complication(s) arising due to the harvesting of the organ donated.

This section does not cover costs directly or indirectly associated with the acquisition of the donor's organ. The coverage under this Section is limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

5. **AYUSH** - This section provides reimbursement to the Insured/ Insured Person of Medical Expenses incurred for In-patient treatment taken under Ayurveda, Yoga, Unani, Siddha and Homeopathy systems provided that the treatment has been undertaken in

a) Central and State Government Hospitals

If agreed by us and specifically mentioned in the Policy Schedule/Certificate of Insurance, the policy shall be extended to cover treatment undertaken in:-

b) NABH accredited Ayurvedic hospitals

c) Teaching hospitals attached to Ayurvedic colleges recognized by Central Government/Central Council of Indian Medicine
d) Ayurvedic hospitals having registration with a Government Authority under appropriate Act in a State/UT, minimum fifteen beds, minimum five qualified and registered Ayurvedic doctors, adequate number of qualified paramedical staff, dedicated Ayurveda therapy sections and daily maintenance of medical records.

Note:
a) The reimbursement under Ayush will be applicable for inpatient hospitalization claims only;
b) The Insured/ Insured person will not be entitled for Domiciliary Hospitalization;

This Section is limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** Sum Insured as mentioned in the Policy Schedule/Certificate of Insurance.

6. Pre- Post Hospitalization Expenses - Necessary & Reasonable expenses incurred prior to or following an In-patient Care/ Day Care Treatment/ Domiciliary Hospitalization (as applicable) shall be covered subject to Pre & Post Hospitalization period specified in the Policy Schedule/Certificate of Insurance and Exclusions/Conditions under the policy. Such costs should be incurred in respect of the same condition for which the Insured Person's subsequent Hospitalisation/earlier Hospitalisation was required as Pre-Post Hospitalisation respectively.

re Hospitalization	**Post Hospitalization**
Doctor's Consultation Charge	Doctor's Consultation for Follow-up
Cost of Medicine & Drugs	Cost of Medicine & Drugs
Diagnostic Tests	Diagnostic Tests
	Physiotherapy treatment in Hospital Premises

The coverage under this section is limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

7. Surface Ambulance Cost:

The Company shall reimburse the expenses incurred on an ambulance offered by a registered healthcare or ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention), provided that:

The maximum liability of the Company shall be restricted as per policy schedule/Certificate of Insurance per hospitalisation and subject to the condition that

- We have accepted an inpatient Hospitalisation or Day Care Treatment claim under the policy
- Ambulance should be from a registered healthcare or ambulance service provider.
- It is for emergency cases or where it has been medically advised by the treating practitioner.

There shall be an admissible claim under In-patient Care or Day Care Treatment (as applicable). The coverage under this Section shall be limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

8. Non Payable Items (Extension)

On payment of additional premium, the company agrees to pay to the Insured person(s) for all the reasonable expenses incurred by the Insured towards the cost of Non Payable items including Hospital Registration Fees, Surcharges & Other Misc. hospital charges.

as mentioned in the Appendix for Non Payable Items.

The below exclusion stands modified to the extent covered under this policy "Non payable items as per appendix for Non Payable items"

There shall be an admissible claim under In-patient Care or Day Care Treatment. The section under this Section shall be limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

9. Newborn cover from Day 1

The Company agrees to cover the new born babies of any Insured Person listed in the Policy Schedule, from the date of birth of the baby until discharge from the hospital immediately following the delivery, provided that:
The Company's maximum liability under this Section shall be limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses or available Sum Insured under Maternity Section** per new born baby.

Newborn cover from Day 1 does not imply that the baby shall be covered thereafter post-delivery. The coverage of the baby shall be subject to minimum entry age specified in the policy schedule/Certificate of Insurance and if advance deposit premium has been maintained in adequate and appropriate for inclusion of the baby in the policy and intimated to us on time.

The definition of Dependent in **Section: Inclusion of Primary Insured's Dependent** will stand modified to this extent.

10. INTERNATIONAL TREATMENT EXTENSION

The Company shall indemnify the Insured Person, through Cashless or Reimbursement Facility, for Hospitalisation expenses incurred outside India for 25 named critical illness, upto the amount specified against the section in the Policy Schedule/Certificate of Insurance, subject to the conditions specified below:

- The Cover under this section is available for 45 continuous days from the date of travel in a single trip and 90 days on a cumulative basis as a whole in a policy year.
- Unless agreed by us and specified in the Policy Schedule/Certificate of Insurance, the Company's liability under this Section shall be restricted to worldwide treatment excluding United States of America.
- The medical expenses payable shall be limited to Inpatient Care & Day care Treatment. Pre-Post hospitalisations are not covered under the purview of this cover.
- The payment of any claim under this Section shall be payable in Indian currency.
- An Initial waiting period of 90 Days shall be applicable from first inception date. No waiting period shall apply on continuous renewals with Us.
- The coverage is applicable only for the first diagnosis of the Critical Illness during the lifetime of the insured having occurred within the policy period.
- Critical illness means one of the following only:
    1. CANCER OF SPECIFIED SEVERITY

2. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS
3. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS
4. MAJOR ORGAN / BONE MARROW TRANSPLANT
5. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES
6. OPEN CHEST CABG
7. STROKE RESULTING IN PERMANENT SYMPTOMS
8. PERMANENT PARALYSIS OF LIMBS
9. FIRST HEART ATTACK - OF SPECIFIED SEVERITY
10. COMA OF SPECIFIED SEVERITY
11. PARKINSON'S DISEASE
12. BENIGN BRAIN TUMOUR
13. ALZHEIMER'S DISEASE
14. END STAGE LIVER FAILURE
15. SURGERY TO AORTA
16. DEAFNESS
17. LOSS OF SPEECH
18. MAJOR BURNS
19. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS
20. PRIMARY PULMONARY HYPERTENSION:
21. PULMONARY ARTERY GRAFT SURGERY;
22. MUSCULAR DYSTROPHY
23. SYSTEMIC LUPUS ERYTHEMATOSUS (SLE):
24. PNEUMONECTOMY
25. MEDULLARY CYSTIC DISEASE

- The coverage under this Section shall be limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

11. OUTSIDE AREA COVERAGE EXTENSION –

The Company shall pay or reimburse to the Insured/ Insured Person expenses incurred for availing emergency medical assistance required on account of any disease/ illness/ injury sustained or contracted whilst on a Trip upto the limit of Sum Insured as specified in the Policy Schedule/Certificate of Insurance.

This is an annual multi trip cover and the insured shall have the option to opt for this cover only at the time of policy inception.

The Sum Insured offered under this section shall be equal to and over and above the In-Patient Care Expenses Sum Insured.

- This section intends to cover - Out-patient treatment, provided, the same is critical and cannot be deferred till the insured/ insured person's return to the Republic of India.
- The proposer covered under the policy shall be employed or having business in India.
- The coverage under this section is applicable for business &/or leisure trips where the duration of trip should not exceed 5 days.
- Unless otherwise agreed by Us and mentioned in the Policy Schedule/Certificate of Insurance to

cover dependent family members and Including Trips availed for Leisure purposes, the coverage shall be restricted to the Primary Insured for trips availed on business purposes only.

- "Multi Trip Cover" means a cover under which the Insured Person can undertake one or more Trips during the Period of Insurance but not exceeding the maximum number of travel days specified in the Policy Schedule/Certificate of Insurance
- In-patient treatment in a local hospital at the place the Insured Person is staying at the time of occurrence of an insurable event.
- Medical aid prescribed by a Medical Practitioner as Medically Necessary part of a treatment for broken limbs or injuries (e.g. plaster casts, bandages and walking aids).
- Radiotherapy, heat therapy or photo therapy and other such treatment prescribed by a Medical Practitioner.
- X-ray, diagnostic tests and all reasonable costs towards diagnostic methods and treatment of all disease/illness/injury provided these pertain to the disease/illness/injury due to which hospitalization was deemed Medically Necessary.
- Cost of transportation, including necessary medical care, by recognized medical service providers for medical attention to the nearest hospital or to the nearest Medical Practitioner or to a special clinic if prescribed by a Medical Practitioner.
- Lifesaving unforeseen emergency measures provided to the Insured Person by the Medical Practitioner for the disease/illness/injury arising out of a Pre-existing condition. The treatment for these emergency measures would be paid till the Insured Person becomes medically stable, as ascertained by the Panel Doctor of the Emergency Assistance Service Provider. All further medical costs to maintain medically stable state would have to be borne by the Insured/Insured Person.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule/Certificate of Insurance shall apply.

Specific Definition:

"Emergency Assistance Service Provider" means any organization or institution appointed by the Company for providing services to the Insured/Insured Person for an insurable event.

Specific Exclusions:

1. Any pre-existing condition, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured/Insured person's life.

2. Where the insured person is travelling against the advise of a physician or receiving or on a waiting list for specified medical treatment; or is travelling for the purpose of obtaining treatment or has received a terminal prognosis for a medical condition; or

3. Treatment of orthopedic, degenerative, oncological diseases, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured Person's life.

4. Treatment which could be reasonably delayed until the Insured Person's return to the

Republic of India. The question of what can or what cannot be reasonably delayed will be decided jointly by the treating Medical Practitioner, Emergency Assistance Service Provider and the Company and shall be in accordance with accepted standards of medical care.

5. Charges in excess of reasonable and customary charges incurred for emergency treatment on account of an insured event.

6. Treatment relating to the removal of physical flaws or anomalies (cosmetic treatment or plastic surgery in any form or manner unless medically required as part of treatment for cancer, accidents and burns).

7. Expenses incurred in connection with rest or recuperation at a spa, health resort, Sanatorium, convalescence home, rehabilitation measures, private duty nursing, respite care, domiciliary care, long-term nursing care, custodial care and treatment related alcoholism and drug dependency.

8. Maternity, child birth and any consequences, including changes in other chronic conditions as a result of pregnancy. However, this exclusion will not apply in following cases:

a) Ectopic Pregnancy proved by diagnostic means and certified to be life threatening condition / situation by the attending Medical Practitioner

b) If the medical assistance provided abroad involves unforeseen emergency measures to save the Insured Person's or the child's life in the event of acute complications, provided that the Insured Person has not completed the age of 38 years and the 30th week of the pregnancy is not yet completed.

9. Rehabilitation and/or physiotherapy or the costs of prostheses/ prosthetics (artificial limbs) etc.

12. Enhanced Sum Insured

If an Insured Person suffers Accidental bodily Injury that requires treatment as Inpatient care, the Company agrees to enhance the **In-Patient Care Expenses** Sum Insured as stated in the Policy Schedule/Certificate of Insurance provided that the event of accident and treatment falls within the Period of Insurance.

OR

If an Insured Person is diagnosed with any named Critical Illnesses that requires treatment as Inpatient care, the Company agrees to enhance the **In-Patient Care Expenses** Sum Insured as stated in the Policy Schedule/Certificate of Insurance provided that the Hospitalisation as In-patient is within the Period of Insurance.

The Enhanced Sum Insured can be utilized for Accident &/Or Critical Illness in the event of Base Sum Insured being exhausted as a result of related/unrelated treatment for the Insured/Insured Members of the family.

13. Corporate Floater

- The Company agrees to provide a Corporate Floater of Rs. [XXX] during the Policy Period
  a) This sum insured will be available for those insured person &/or family members, who have already exhausted their Individual/ Family Sum Insured
  b) However, the amount is restricted to cover **25 named Critical Illness upto Rs [XXX]** in respect of each and every Primary Insured or His family (if applicable).
  c) The Corporate Floater will not be available to **Dependent Parents & Parent in laws.**
  d) The Corporate Floater will not be available if any sublimit is applicable.

- The Company agrees to provide a Corporate Floater of Rs. [XXX] during the Policy Period

a) This sum insured will be available for those insured person &/or family members, who have already exhausted their Individual/ Family Sum Insured
b) However, the amount is restricted to cover **25 named Critical Illness upto Rs [XXX]** in respect

of each and every Primary Insured or His family (if applicable).
c) The Corporate Floater will not be available if any sublimit is applicable.

- The Company agrees to provide a Corporate Floater of Rs. [XXX] during the Policy Period

a) This sum insured will be available for those insured person &/or family members, who have already exhausted their Individual/ Family Sum Insured
b) However, the amount is restricted to cover **disease/illness/injury upto Rs [XXX]** in respect of each and every Primary Insured or His family (if applicable).
c) The Corporate Floater will not be available to **Dependent Parents & Parent in laws.**
d) The Corporate Floater will not be available if any sublimit is applicable.

- The Company agrees to provide a Corporate Floater of Rs. [XXX] during the Policy Period

a) This sum insured will be available for those insured person &/or family members, who have already exhausted their Individual/ Family Sum Insured
b) However, the amount is restricted to cover **disease/illness/injury upto Rs [XXX]** in respect of each and every Primary Insured or His family (if applicable).
c) The Corporate Floater will not be available if any sublimit is applicable.

- The Company agrees to provide a Corporate Floater of Rs. [XXX] during the Policy Period

a) This sum insured will be available for those insured person &/or family members, who have already exhausted their Individual/ Family Sum Insured
b) However, the amount is restricted to cover **disease/illness/injury without any restriction on per person/per family Sum Insured** in respect of each and every Primary Insured or His family (if applicable).
c) The Corporate Floater will not be available if any sublimit is applicable.

- The Company agrees to provide a Reinstatement Corporate Floater during the Policy Period

a) This sum insured will be available for those insured person &/or family members, who have already exhausted their Individual/ Family Sum Insured
b) However, the amount is restricted to cover **unrelated disease/illness/injury that has resulted in the exhaustion of the Individual/Family Sum Insured or family member who has not claimed during the policy period upto Rs [XXX]** in respect of each and every Primary Insured or His family (if applicable).
c) The Corporate Floater will not be available if any sublimit is applicable..

- The Company agrees to provide a Corporate Floater of Rs. [XXX} during the Policy Period

a) This sum insured will be available for all insured person &/or eligible family members, floating across any or all insured person covered under the policy and opted to by the policyholder.
b) However, the amount is restricted to cover disease/illness/injury upto Rs [XXX] in respect of each and every Primary Insured &/or eligible family member.

14. Restricted Ailments coverage

Upon request from the proposer and specifically agreed by the Company, the scope of coverages, Sum Insured under **In-Patient Care Expenses** of the policy shall become restricted to the named ailments as specified in the Policy Schedule/Certificate of Insurance.
Restricted Ailments means any of the below listed illnesses and in any combination:

1. CANCER OF SPECIFIED SEVERITY
2. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS
3. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS
4. MAJOR ORGAN / BONE MARROW TRANSPLANT
5. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES
6. OPEN CHEST CABG
7. STROKE RESULTING IN PERMANENT SYMPTOMS
8. PERMANENT PARALYSIS OF LIMBS
9. FIRST HEART ATTACK - OF SPECIFIED SEVERITY
10. COMA OF SPECIFIED SEVERITY
11. PARKINSON'S DISEASE
12. BENIGN BRAIN TUMOUR
13. ALZHEIMER'S DISEASE
14. END STAGE LIVER FAILURE
15. SURGERY TO AORTA

16. DEAFNESS
17. LOSS OF SPEECH
18. MAJOR BURNS
19. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS
20. PRIMARY PULMONARY HYPERTENSION:
21. PULMONARY ARTERY GRAFT SURGERY;
22. MUSCULAR DYSTROPHY
23. SYSTEMIC LUPUS ERYTHEMATOSUS (SLE):
24. PNEUMONECTOMY
25. MEDULLARY CYSTIC DISEASE
26. TUBERCULOSIS
27. KIDNEY STONES
28. TETANUS
29. MENINGITIS
30. TYPHOID
31. IMPACTED WISDOM TEETH
32. MATERNITY
33. ICD 10 CATEGORY SPECIFIC

15. Maternity Expenses

This Section covers treatment taken in Hospital/ Nursing Home arising from or traceable to pregnancy, child birth including Normal &/or Caesarean section.

- Claim under this section is admissible only if the expenses are incurred in Hospital/ Nursing Home as in-patient in India.
- Unless otherwise specified under the Policy Schedule/Certificate of Insurance, a waiting period of 9 months is applicable for payment of any claim related to normal delivery, caesarean section and complications of maternity (including and not limited to medical complications). The waiting period stands waived if additional premium is paid for the same.
- Claim in respect of delivery for only first two biological children and/ or operations associated therewith during the lifetime will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who are already having two or more living biological children will not be eligible for claim under this section. In case the first delivery is a twin (more than 1 child) delivery, then the second delivery will not be covered.
- Pre-natal and Postnatal treatment is covered within the maternity limits as inpatient only. Here Prenatal would mean complete antenatal period, and Post natal would mean up to six weeks after date of delivery.
- If Self and Spouse are both covered under the policy, maternity sectionwill be available only once.
- The cover is available to female Insured members of age 18 years or above.
- The Company shall be liable to make payment in respect of any hospitalization arising due to involuntary medical termination of pregnancy, as per MTP Act, 1971 (amended) and other applicable laws and rules.

The coverage under this Section shall be limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

16. Pre-Post Natal Expenses

This Section covers routine pre-natal care, post-natal care up to 6 weeks following delivery, post-natal complications received within 90 days following the delivery

- The cover is available to female Insured members of age 18 years or above.
- Claim under this section is admissible only if the expenses are incurred in

Hospital/ Nursing Home as in-patient in India.

- Claim in respect of delivery for only first two biological children and/ or operations associated therewith during the lifetime will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who are already having two or more living biological children will not be eligible for claim under this section. In case the first delivery is a twin (more than 1 child) delivery, then the second delivery will not be covered.
- The Company has accepted a claim under Maternity Expenses in respect of the Insured Person for the same period of Hospitalization.
- In case this section has been opted as standalone basis, the admissibility of the claims for Pre-Post Natal Expense shall be determined based on the admissibility of claim under Maternity Expenses had the same been covered under the policy
- Expenses related to treatment availed in Out-patient department of a Hospital/Nursing Home shall also be covered under this section.
- All the exclusions and conditions applicable to Maternity expenses shall also be applicable to this Section also.

The coverage under this Section shall be limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

SECTION II: AMBULATORY CARE

The Company shall pay the necessary Out Patient treatment cost during the Policy Period taken for any or all Insured Persons, provided that:

- The condition of minimum Hospitalisation of 24 hours as an in-patient stands deleted.

Subject to the Sum Insured, The Company's maximum liability under this section shall be limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** Sum Insured specified in the policy schedule/Certificate of Insurance.

17. Dental Treatment (Accident)

The Section covers reimbursement of medical expenses incurred towards dental treatment following an accident where the Insured Person(s) suffers injuries or damage to his/her natural teeth and/or gums. This section further provides cover for medical expenses incurred for follow up treatment for the same accidental dental injury up to a maximum of 15 days by the same Dentist. The coverage under this section is limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** Sum Insured as specified in the Policy Schedule /Certificate of Insurance.

Dental Treatment can be availed as Out-patient or In-Patient Care/ Day care Treatment Basis.

18. Dental OPD

The Company shall pay the reasonable costs of any necessary dental treatment as Out-patient during the Policy Period taken from a Network dentist by an Insured Person and Exclusion stands deleted for all Insured Persons to this extent, provided that:

- The Company only pays for extractions, amalgam or composite fillings, root canal treatments, prescribed drugs General Diagnostic, Preventive Check-

ups, Scaling, Cleaning, Polishing, Braces, Teeth alignment, Crowning, Capping, Fillings, Bridges, Investigative & Preventive Care, Basic Restorative, Periodontal Treatment, Major Restorative & Orthodontic Treatment for the same, and

- Unless otherwise specifically mentioned in the Policy Schedule/Certificate of Insurance, the Company shall not pay for any dental treatment that comprises cosmetic surgery, use of precious metals, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer, and

The coverage under this Section shall be limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

Investigative & Preventative Treatment

Under thisSection, We will pay Reasonable and Customary Charges to cover the fees of a dental practitioner and associated costs for carrying out the following routine Dental Treatment procedures in respect of an Insured

person:

• Clinical Oral examinations;

• Palliative treatment for dental pain

• Minor Procedures

• Tooth cleaning;

• Normal compound fillings; or

• Simple non-surgical extractions.

This Sectionexcludes orthodontic treatment, restorative treatment and dental implants.

Basic Restorative, Periodontal Treatment)

Under this Section We will pay the Reasonable and Customary Charges to cover the fees of a dental practitioner and associated costs for the Treatment of the following specified procedures in respect of an Insured person:

• Amalgam Filling

• Composite/Resin Filling

• Root Canal Treatment

• Osseous Surgery

• Periodontal Scaling & Root Planning

• Adjustments

• Recement Bridge

• Routine Extractions

• Surgical removal of impacted tooth

• Local or general Anaesthesia including Sedation

This Section excludes orthodontic treatment, routine treatment and dental implants.

Major Restorative & Orthodontic Treatment

Under this Section We will pay the Reasonable and Customary Charges to cover fees of a dental practitioner carrying out restorative Dental

Treatment and associated costs for the following specified procedures in respect of an Insured person:

• removal of impacted or buried teeth;

• removal of roots;

• removal of solid odontomes;

• apicectomy;

• new or repair of bridge work;

• new or repair of crowns;

• root canal treatment;

• new or repair of upper or lower dentures;

• removal of wisdom teeth.

Orthodontic Treatment includes Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

This Sectionexcludes dental implants.

Exclusions Applicable to Dental Section

We will not pay claim for the following treatment

i. replacing any dental appliance which is lost or stolen;

ii. replacing a bridge, crown or denture which is or can be made useable according to a standard acceptable to a dentist of ordinary competence and skill;

iii. replacing a bridge, crown or denture within five years of original fitting unless:

iv. the replacement is needed because of the placement of an original opposing full denture or extraction of natural teeth is needed; or

v. the bridge, crown or denture, while in the mouth, has been damaged beyond repair because of an injury the employee or their dependant receives while covered under the Policy.

vi. porcelain or acrylic veneers on the upper and lower first, second and third molars and premolars;

vii. crowns or pontics on or replacing the upper and lower first, second and third molars unless- they are constructed of either porcelain bonded-to metal or metal alone, e.g. gold alloy crown; or a temporary crown or pontic is required as part of routine or emergency dental treatment.

viii. surgical implants of any type including any attaching prosthetic device;

ix. procedures and materials which are experimental or which do not meet accepted dental standards;

x. instruction for plaque control, oral hygiene and diet;

xi. procedures, services and supplies which are deemed by us to be medical procedures, services and supplies including mouthwashes and also including services and supplies provided in a hospital (except where dental treatment is neither wholly nor partly the reason for the stay in hospital);

xii. bite registration, precision or semi-precision attachments;

xiii. procedures, appliances or restorations (except full dentures) whose main

purpose is to:

• change vertical dimensions; or

• diagnose or treat conditions or dysfunction of the temporo-mandibular joint or

• stabilise periodontally involved teeth; or

• restore occlusion.

• major treatment on deciduous or baby teeth for dependent children;

19. Consultation Cover

- The Company shall pay for the Medical Expenses incurred during the Policy Period for any of the following consultations with or second opinions from a Medical Practitioner in relation to any Illness contracted or Injury suffered by the Insured Person during the Period of Cover.
- Based on the information provided by the Insured Person while availing any of the features under this Coverage, medicines including over the counter medicines or other suggestions may be prescribed or suggested. The Company shall not be liable or responsible or deemed to be liable or responsible for any discrepancy in the information provided, or Medical Advice provided by such Medical Practitioners.
- Choosing to avail the features under this Coverage is purely on Insured Person's discretion and at his/her own risk. The Insured Person is free to choose whether or not to obtain services under this Coverage, and, if obtained, then whether or not to act on the advice/suggestions received in whole or in part.
- By seeking and availing services under this Coverage, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
- The Policy Schedule/Certificate of Insurance shall specify the number of consultations which may be availed under this coverage and whether any specific specialty consultations are covered/excluded.

1. GP Consultation

Consultation with a general Medical Practitioner, who for the purpose of this Section, is a Medical Practitioner who typically manages the types of Illnesses that manifest in an undifferentiated way at an early stage of development but may require a Medical Practitioner's intervention.

2. **Specialist Consultation**

Consultation with a specialist/super specialist Medical Practitioner, i.e. a Medical Practitioner having additional expertise in any one or more types of medicine, including but not limited to, cardiology, diabetology, endocrinology, ENT, gastroenterology, general surgery, gynecology /obstetrics, internal medicine, nephrology, neurology, ophthalmology, orthopedics, pediatrics, psychiatry, urology, dietitian, nutritionist, dermatology and pulmonology.

3. Physiotherapy Consultation

Consultation with a Medical Practitioner/healthcare professional qualified to treat any Illness, Injury, or deformity

by physical methods such as but not limited massage, heat treatment, and exercise.

4. AYUSH Consultation

Consultation with a Medical Practitioner/Healthcare Professional specializing in providing AYUSH treatment in any particular mode.

5. Dental Consultation

Consultation with a Medical Practitioner who is qualified to treat Illnesses and other conditions that affect the teeth and gums, particularly the repair and extraction of teeth and the insertion of artificial teeth.

6. Counselling

Session with a Medical Practitioner/Healthcare Professional for providing assistance with dealing with issues such as but not included to personal and lifestyle imbalance, speech impairment, and problems related to psychological/mental illness.

7. Tele Consultation

Consultation with a Medical Practitioner through Network Service Providers' helpline for assessing the medical records or routine health issues of the Insured Person over the phone.

8. Home Consultation

Consultation given by a Medical Practitioner/ Healthcare Professional at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request for availing this Section.

9. Online / Digital Consultation

Consultation given by a Medical Practitioner/Healthcare Professional or a panel of such Medical Practitioners/Healthcare Professionals through a virtual mode of communication such as via chat, email, video, online portal, or mobile application.

20. Pharmacy Cover & Diagnostic Cover

We will pay the Medical Expenses incurred on purchase during the Period of Cover of medicines (including over the counter medicines), drugs, medical consumables, prosthetics, medically necessary spectacles or cochlear implants, external medical aids, vaccinations, vitamins, tonics or other related products as specified in the Policy Schedule/Certificate of Insurance from a Network Provider/Health Service Provider that are prescribed by a Medical Practitioner for any Illness contracted or Injury suffered by the Insured Person during the Period of Cover.

We may arrange for delivery of the products purchased under this Coverage at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request for availing this Coverage and only if the Policy

Schedule/Certificate of Insurance specifies that this option is in force for the Insured Person.

We will pay the Medical Expenses incurred on Outpatient diagnostics tests including but not limited to, biochemistry, haematology, immunology, microbiology, serology, pathology, x-ray, ultrasound and TMT for the Insured Person from a Network Provider/Health Service Provider the Period of Cover.

The Policy Schedule/Certificate of Insurance will specify whether there is any limit on the nature and type of diagnostic tests which may be availed under this Coverage and whether the Insured Person is required to have a written prescription from a Medical Practitioner in advance of carrying out the diagnostic tests.

We will arrange for diagnostic tests available under this Coverage to be carried out at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request for availing this Section and only if the Policy Schedule/Certificate of Insurance specifies that this option is in force for the Insured Person.

21. Routine Physical & Preventive Health Check-up:

If the Insured Person undertakes any of the Routine Physical and Preventive Examinations specified in the Policy Schedule/Certificate of Insurance during the Period of Cover, then We shall pay the costs incurred.

For the purpose of this Section, 'Routine Physical and Preventive Examinations' shall mean on-site or off-site health check-ups of all health parameters, including any consultations from relevant Medical Practitioners/Healthcare Professionals.

22. Baby Care Expenses

This Section covers well baby care expenses including routine paediatrician visit, Screenings for congenital conditions including infectious, endocrine, nutritional, or metabolic diseases

We will also pay the Reasonable and Customary Charges for tests towards an Insured dependent child who is Aged 5 or less for charges made for the purpose of preventive care, consisting of the following services delivered or supervised by a Medical Practitioner, which services amount to orthodox treatment:

• Medical history of the Insured dependent child;

• Physical examination;

• Development assessment;

• Anticipatory guidance; and

• Immunizations (as listed below) and laboratory tests.

- DPT (Diphtheria, Pertussis and Tetanus)

- MMR (Measles, Mumps and Rubella)

- HiB (Haemophilus influenza Type b)

- Polio

- Influenza

- Hepatitis B

- Meningitis

- Human Papilloma Virus (HPV)

- Tetanus - every 10 years

- Hepatitis A

- Hepatitis B

- Meningitis

- Rabies

- Cholera

- Yellow fever

- Japanese encephalitis

- Polio booster

- Typhoid

- Malaria - tablet form, daily or weekly

The following charges are excluded under this Section:

• More than one visit to a Medical Practitioner for child preventive care services at each of the appropriate Age intervals up to a total of upto 13 visits for each Insured dependent child;

• Services for which Benefits are otherwise provided under this Plan.

- Unless specifically agreed by us and specified in the Policy Schedule/Certificate of Insurance, the cover is only available to children born during the policy period.
- Claim under this section is admissible only if the expenses are incurred in Hospital/ Nursing Home as in-patient in India.
- Claim in respect of first two biological children during the lifetime will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who are already having two or more living biological children will not be eligible for this Section. In case the first delivery is a twin (more than 1 child) delivery, then the second delivery will not be covered.
- Unless specifically agreed by us and specified in the Policy Schedule/Certificate of Insurance, the liability of the Company is restricted to the child born during the policy period and where Maternity expenses claim with respect to the delivery of the child for the same period of Hospitalization.
- In case this section has been opted as standalone basis, the admissibility of the claims for Baby Care Expenses shall be determined based on the admissibility of claim under Maternity Expenses had the same been covered under the policy
- Expenses related to treatment availed in Out-patient department of a Hospital/Nursing Home shall also be covered under this section.
- All the exclusions and conditions applicable to Maternity expenses shall also be applicable to this Section also.
- Company's liability does not exceed the Sum Insured or limit specified in the Policy Schedule/Certificate of Insurance.

23. Eye Related –

The Policy provides an option for coverage of Vision Tests. The Policy Schedule will specify if the Vision Test cover is in force for the Insured person including the available Sum Insured under each section.

If the Vision Test cover is in force in respect of an Insured person, we will pay the Reasonable and Customary Charges for the following

Medical

Expenses incurred in respect of that Insured person:

- one eye examination by an optometrist or ophthalmologist per Policy Year;
- the provision of lenses to correct vision;
- the provision of eyeglass frames.

This Section will exclude:

- sunglasses, unless medically prescribed by a optometrist;
- medical or surgical treatment of the eye;
- lenses which are not a medical necessity and are not prescribed by an optometrist or ophthalmologist or frames for such lenses.

24. Animal Bite (Incl. vaccinations)

The Company will cover Medical Expenses of OPD Treatment for vaccinations or immunizations for treatment post an animal bite, up to the limit provided in the Policy Schedule/Certificate of Insurance.

25. Preventive vaccination & Immunization (with/ wo Travel)

The Company will cover Medical Expenses of OPD Treatment for routine vaccinations or immunizations for treatment post an animal bite, travel vaccinations such as below up to the limit provided in the Policy Schedule/Certificate of Insurance.

- Tetanus - every 10 years;
- Hepatitis A;
- Hepatitis B;
- Meningitis;
- Rabies;
- Cholera;
- Yellow fever;
- Japanese encephalitis;
- Polio booster;
- Typhoid; and
- Malaria - tablet form, daily or weekly.

The above list is indicative. We may cover additional vaccination costs in respect of medically necessary vaccinations toward the Insured person as mandated before undertaking any travel.

SECTION III.ENHANCE

26. Air Ambulance

The Company shall pay for transportation in an airplane or helicopter, which is certified to use as an ambulance for Emergency Care which require immediate and rapid transportation from the site of first occurrence of the Illness / Accident to the nearest Hospital within a reasonable timeframe. This cover is available only where the medical treatment required and as advised by medical practitioner is not available in any Hospital of the city of first occurrence. The claim would be reimbursed up to the actual expenses subject to the maximum limit as specified in the Policy Schedule/Certificate of Insurance.

The Company shall not pay for air ambulance for the transfer of Insured / Insured Person within the same city of first occurrence. Return transportation is excluded.

The liability under this Section shall be limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance.

Scope of Cover for Air Ambulance shall be restricted to Domestic Transfer Unless

otherwise specified under the policy schedule/Certificate of Insurance to include Air Ambulance for International/Worldwide Transfer.

27. Home Nursing Coverage

The Company shall pay the Reasonable and Customary Charges incurred during the Policy Year towards a Qualified Nurse arranged by the Hospital or by the Company's network of service providers to visit the Insured Person's home to give expert nursing services limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance., provided that:

1. The Insured Person must have significant difficulty coping with the required activities of daily living and specialist Medical Practitioner who treated the Insured Person must have recommended these services in writing.
2. The claim becomes payable provided that a claim has been admitted under this policy under the In-Patient Care Expenses and is related to the same condition.
3. The Company shall cover visits by a Qualified Nurse for the period as specified in the Policy Schedule/Certificate of Insurance as it is required for a medically necessary treatment which would normally have been provided in a Hospital subject to the limits as specified in the Policy Schedule/Certificate of Insurance.
4. The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons).
    a. Eating (being able to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available).
    b. Bathing (being able to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene).
    c. Dressing (being able to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other Surgical Appliances).
    d. Toileting (being able to get on and off the toilet and manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene).
    e. Transferring (being able to get in and out of bed or a chair without assistance).
    f. Mobility (being able to move indoors from room to room on level surfaces at the normal place of residence).
5. Home nursing coverage is not related to any Domiciliary Hospitalisation.
6. The company is liable to expert nursing services limited for the period for which services have been availed not exceeding 6 weeks during the policy year.
7. All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the Policy Schedule/Certificate of Insurance shall apply.

28. Compassionate Visit

If the Insured Person is Hospitalized for more than three (3) consecutive days, and no adult Immediate Family Member is present, the Company shall pay or reimburse the amounts incurred by any one Immediate Family Member for obtaining return tickets in economy class on a Public Transport in Air/Rail/Road modes to visit the Insured Person, and expenses for the duration of the stay in the Hospital

up to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** of this Policy as mentioned in the Policy Schedule/Certificate of Insurance., provided that the attending Medical Practitioner certifies in writing that it is advisable that he/she would benefit from the visit of an Immediate Family Member.

Claim under this section is payable subject to the following:

1. The treatment is availed within the territorial limits of India.
2. The Company has accepted a claim as In-patient/Domiciliary Treatment in respect of the Insured Person for the same period of Hospitalization.
3. In case this section has been opted as standalone basis, the admissibility of the claims for compassionate visit shall be determined based on the admissibility of claim under In-patient/Domiciliary Treatment had the same been covered under the policy
4. All the exclusions and conditions applicable to In-patient/Domiciliary Treatment shall also be applicable to this Section also

29. External Aids, Durable Medical Equipment & Appliances

The Company shall pay the Reasonable and Customary Charges incurred for instruments or devices or durable medical equipment which are prescribed by the medical practitioner as a medically necessary aid to the function or capacity such as and limited to compression stockings, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint, orthopedic supports, spectacles, contact lenses, abdominal belts (used post-hernia and related surgeries), belts for prolapsed inter-vertebral disc (PIVD), and trusses (used post-hernia and related surgeries)

The Company shall also pay for all the costs associated with fitting artificial limbs, including the artificial limbs, its maintenance, consultations and necessary medical or surgical procedures.

30. Rehabilitation, Weight management & Disease management program

Reimbursement of medically necessary reasonable & customary expenses incurred in programs such as but not limited to Rehabilitation, Dietitian, Nutrition, Weight management, Disease management programs from respective centers.

a. The Company is not liable to pay if the service has been availed for recreational purpose.
b. The Company may define eligibility criteria with respect to minimum Body Mass Index level under the Policy Schedule/Certificate of Insurance.
c. It is for acute or chronic medical conditions where it has been medically advised by the treating practitioner.

31. Alternative & Well-being Medicine - This section provides reimbursement to the Insured/ Insured Person of Medical Expenses incurred for In-patient treatment taken under Naturopathy, Acupuncture, Chiropody, Osteopathy, Traditional Chinese Medicine, Traditional Tibetan Medicine provided that the treatment has been undertaken in recognised centres

Note:
a) Unless otherwise specified under the Policy Schedule/Certificate of Insurance, the reimbursement under Alternative Treatments will be applicable for inpatient hospitalization claims only;

b) The Insured/ Insured person will not be entitled for Domiciliary Hospitalization;

This Section is limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** Sum Insured as mentioned in the Policy Schedule/Certificate of Insurance.

32. Magnet Therapy –

This section provides reimbursement to the Insured/ Insured Person of Medical Expenses incurred in regards to magnet therapy for therapeutic treatment of diseases & conditions and treating pain, such as foot, back, or joint pain, reduce inflammation & speed recovery from injuries provided that the treatment has been undertaken in recognised centres under medical advice from the medical practitioner

Specific Exclusions:-

a. Children below 18 years, pregnant women and if the Insured person has a medical device or implant such as a Pacemaker fitted.
b. Any use of magnetic therapy that is not medically necessary and related to recreational value such as personal comfort, increase in circulation, weight management

This Section is limited to the **Sum Insured specified or available Sum Insured under In-Patient Care Expenses** Sum Insured as mentioned in the Policy Schedule/Certificate of Insurance.

33. In/sub/artificial fertility & Sterility –

We shall cover the Medical Expenses incurred by the Insured Person during the Policy Period for Sterility, In-fertility, Sub-fertility, Artificial Fertility such as IVF (in-vitro fertilization) treatment undertaken at a clinic duly registered in accordance with applicable law and on advise of a specialist Medical Practitioner, maximum up to the Sum Insured, limit as mentioned in the Policy Schedule/Certificate of Insurance, provided that the Insured Person undergoes the treatment before 40 years of Age.

Following shall be excluded under this Section:

a) Any expenses with respect to the Insured Person's use of third party surrogate or gestational carrier in pregnancy
b) Unless otherwise specified in the Policy Schedule/Certificate of Insurance, any expenses for consultation, diagnostic tests or procedure or any such other expenses for diagnosis of infertility
c) Any specific waiting period from the date of Policy Inception as specified under the policy.

34. Travel Expenses for Medical Treatment:

We will pay the travel costs incurred by an Insured Person during the Period of Cover to purchase medicines prescribed by a Medical Practitioner from a pharmacy or to undergo diagnostic tests provided that We will pay for the costs incurred in such travel up to a maximum of one time for each prescription from a Medical Practitioner and one visit to Diagnostic center and/or pharmacy for each prescription even if the prescription/diagnostic tests are executed in parts, unless specified otherwise.

35. External Congenital Ailments

The policy is extended to cover expenses related to External congenital ailments at par with internal congenital ailments. The policy

exclusion related to external congenital ailments stand modified to the extent stated under the policy schedule/certificate of Insurance.

36. Lasik Surgery

We shall cover the Medical Expenses incurred by the Insured Person during the Policy Period for undergoing LASIK Surgery for correction of refractive error, maximum up to the limit

as mentioned in the Policy Schedule/Certificate of Insurance, provided that:

a) the Insured Person is Aged 40 years or below;

b) the Insured Person has a refractive index of plus/minus 8 or more; and

c) the procedure is prescribed as medically necessary by a Medical Practitioner who is an ophthalmologist.

A waiting period of 3 years from the Policy Inception Date shall be applicable for this Section.

Lasik surgery undergone for cosmetic purposes shall be specifically excluded under the policy.

37. Age Related Macular Degeneration

The policy is extended to cover medically necessary expenses related to Age Related Macular Degeneration shall stand covered under the policy.

38. Bariatric Surgery

We shall cover the Medical Expenses incurred by the Insured Person during the Policy Period for undergoing medically necessary Bariatric Surgery prescribed by a specialist Medical

Practitioner, maximum up to the limit as mentioned in the Policy Schedule/Certificate of Insurance, provided that

a) the Insured Person's BMI is above 35; and

b) the Bariatric Surgery is non- cosmetic in nature.

A waiting period of 3 years from the Policy Inception Date shall be applicable to this section.

39. Hormone Replacement Therapy

We will pay Reasonable and Customary Charges for costs of Medically Necessary treatment prescribed by a medical practitioner in respect of an Insured person for Hormone Replacement Treatment. However, this section will not cover unproven or experimental methods or procedures.

SECTION IV: SLICE

40. DAILY HOSPITAL CASH

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay upto the daily amount specified in the Policy Schedule/ Certificate of Insurance against this section for each continuous and completed day of Hospitalization of the Insured Person.

Claim shall be payable subject to the following:

- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the

written advice of the treating Medical Practitioner.

- We shall not be liable to pay the daily amount for more than the maximum number of days as specified in the Policy Schedule/ Certificate of Insurance for each Insured Person, during the Policy Year.
- Our liability to make any payment under this section shall be in excess of the per event Deductible or per event Franchise stated in the Policy Schedule/ Certificate of Insurance, if applicable.
- We shall not be liable to make any payment under this section, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance (unless due to an Accident).
- If We have admitted a Claim under this section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this section directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

41. ACCIDENT DAILY HOSPITAL CASH

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be hospitalized, then We will pay upto the daily amount specified in the Policy Schedule/ Certificate of Insurance against this section for each continuous and completed day of Hospitalization of the Insured Person.

Claim under this section shall be payable subject to the following:

- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- We shall not be liable to pay the daily amount for more than the maximum number of days as specified in the Policy Schedule/ Certificate of Insurance for each Insured Person, during the Policy Year.
- Our liability to make any payment under this Section shall be in excess of the per event Deductible or per event Franchise stated in the Policy Schedule/ Certificate of Insurance, if applicable.
- We shall not be liable to make any payment under this Section, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance (unless due to an Accident).
- If We have admitted a Claim under this Section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Section directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

42. Intensive Care Cash Section**:**

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized in an Intensive Care Unit, then We

will pay upto the daily amount specified in the Policy Schedule/ Certificate of Insurance against this Section for each continuous and completed day of confinement of the Insured Person in the Intensive Care Unit.

Claim shall be payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured Person for the same Illness/Injury in respect of which the Insured Person was Hospitalized in the Intensive Care Unit.
- The Hospitalization in the Intensive Care Unit is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule/ Certificate of Insurance for each Insured Person, during the Policy Year.
- Our liability to make any payment under this Section shall be in excess of the per event Deductible or per event Franchise stated in the Policy Schedule/ Certificate of Insurance, if applicable. However, the Deductible/Franchise will not apply to the extent of days in respect of which the Insured Person has already been admitted in the Hospital in a non- ICU room.
- We shall not be liable to make any payment under this Section, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance (unless due to an Accident).
- If We have admitted a Claim under this Section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Section directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

43. Cancer Hospitalization Cash Section**:**

If an Insured Person contracts 'Cancer of Specified Severity' during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay upto the daily amount specified in the Policy Schedule/ Certificate of Insurance against this Section for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Cancer of Specified Severity.

Claim shall be payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- Our liability to make any payment under this Extension shall be in excess of the per event Deductible / per event Franchise stated in the Policy Schedule/ Certificate of Insurance, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule/ Certificate of Insurance for each Insured Person during the Policy Year.

- We shall not be liable to make any payment under this Section, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance.
- If We have admitted a Claim under this Section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Section directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

44. Brain & Stroke Hospitalization Cash Section**:**

If an Insured Person contracts any of the Brain Ailment or Stroke listed below during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay upto the daily amount, specified in the Policy Schedule/ Certificate of Insurance against this Section for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Brain Ailment or Stroke.

Claim under this section shall be payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for a Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- Our liability to make any payment under this Section shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule/ Certificate of Insurance, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule/ Certificate of Insurance for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Section, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance. If We have admitted a Claim under this Section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

45. Organ Transplant Hospitalization Cash Section**:**

If an Insured Person undergoes Organ Transplant during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized for the procedure for transplantation, then We will pay upto the daily amount specified in the Policy Schedule/ Certificate of Insurance against this Section for each continuous and completed day of Hospitalization of the Insured Person for

transplantation of the organ.

For the purpose of this Section, Organ Transplant shall mean the following:

The actual undergoing of transplant of:

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

The following are excluded:

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

Claim under this section shall be payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- We shall not be liable to make any payment under this Section in respect of any organ transplantation that is not carried out in accordance with the Transplantation of Human Organs Act 1994, as amended.
- Our liability to make any payment under this Section shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule/ Certificate of Insurance, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule/ Certificate of Insurance for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Section, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance, unless due to an Accident.
- If We have admitted a Claim under this Section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Section directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

46. Heart Ailment Hospitalization Cash Section**:**

If an Insured Person contracts any of the Heart Ailments listed below during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay upto the daily amount specified in the Policy Schedule/ Certificate of Insurance against this Section for each continuous and completed day of Hospitalization of the Insured Person for treatment of that Heart Ailment.

Claim under this section shall be payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured

Person for the same period of Hospitalization.

- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- Our liability to make any payment under this Section shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule/ Certificate of Insurance, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule/ Certificate of Insurance for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Section, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance.
- If We have admitted a Claim under this Section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Section directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

47. Fracture & Burns Cash Section**:**

If an Insured Person suffers a Fracture and/or Second Degree Burns and/or Third Degree Burns during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay upto the daily amount specified in the Policy Schedule/ Certificate of Insurance against this Section for each continuous and completed day of Hospitalization of the Insured Person for treatment of that Fracture, Second Degree Burns or Third Degree Burns.

For the purpose of this Section the following definitions will apply:

Fracture means a medical condition in which there is damage in the continuity of the bone. A bone fracture may be the result of high force impact or stress, or a minimal trauma Injury as a result of certain medical conditions that weaken the bone, such as Osteoporosis, bone cancer, or osteogenesis imperfect, where the fracture is then properly termed a pathologic fracture.

Second Degree (partial thickness) Burns means burns which involves the epidermis and part of the dermis layer of skin.

Third Degree (full thickness) Burns means burns which affects and destroys the epidermis and the dermis.

Claim under this section shall be payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- Our liability to make any payment under this Section shall be in excess of the per event Deductible/per event Franchise as stated in the Policy

Schedule/ Certificate of Insurance, if applicable.

- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule/ Certificate of Insurance for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Section, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance (unless such Fracture is due to an Accident).

If We have admitted a Claim under this Section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Section directly to the Hospital where the Insured Person was treated, provided that

We are able to offer Cashless Facility at that Hospital. If the payment due under this Section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

48. Day Care Treatment Cash Section**:**

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to undergo a Day Care Treatment during the Period of Cover We will upto pay the per event amount specified in the Policy Schedule/ Certificate of Insurance against this Section.

For the purpose of this Section, Day Care Treatment and Day Care Centre may be defined as under:

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

- undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
- which would have otherwise required a hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

- has qualified nursing staff under its employment;
- has qualified medical practitioner/s in charge;
- has fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Claim under this Section shall be payable subject to the following:

- The Day Care Treatment is for Medically Necessary Treatment and is commenced and continued on the

written advice of the treating Medical Practitioner.

- We shall not be liable to pay the event amount for more than 5 times for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Section, if the Day Care Treatment was taken prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance (unless due to an Accident).

49. Convalescence Cover**:**

If an Insured Person contracts an Illness or suffers an Injury due to Accident during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized for a continuous period of at least 10 consecutive days, then We will pay upto the event amount specified in the Policy Schedule/ Certificate of Insurance against this Section towards convalescence of the Insured Person.

Claim under this section is payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured Person for the same period of Hospitalization. If a Claim is not admitted under the Section in respect of the Insured Person for the same period of Hospitalization, then no Claim will be admitted under this Section even if the period of Hospitalization of the Insured Person exceeds 10 days.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- We shall not be liable to pay the event amount for more than 5 times specified in the Policy Schedule/ Certificate of Insurance for each Insured Person during the Policy Year.
- We shall be liable to pay the claim amount under this Section, only once per hospitalization event.
- We shall not be liable to make any payment under this Section, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance (unless due to an Accident).
- If We have admitted a Claim under this Section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Section directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

50. Child Care Cash Section**:**

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay upto the daily amount specified against this Section for the purpose of providing care to the Insured Person's Dependent Child/Children.

For the purpose of this Section, Dependent Child/Children means:

Child/Children (including step child/children) of the Insured Person up to the age of 18 years who are dependent on the Insured Person for maintenance and financial support.

Claim under this section shall be payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- Our liability under this Section shall not increase if the Insured Person has more than one Dependent Child.
- We shall not be liable to make any payment under this Section if the Insured Person has no Dependent Children on the date of the Insured Event giving rise to the Claim under this Section.
- Our liability to make any payment under this Section shall be in excess of the per event Deductible/Franchise as stated in the Policy Schedule/ Certificate of Insurance, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule/ Certificate of Insurance for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Section, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance (unless due to an Accident).

51. Hospital Attendant Cash Section**:**

If an Insured Person contracts an Illness or suffers an Injury due to Accident during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay upto the daily amount specified in the Policy Schedule/ Certificate of Insurance against this Section in respect of each continuous and completed day of Hospitalization of the Insured Person which requires a Hospital Attendant to be present.

For the purpose of this Section, Hospital Attendant means the Insured Person's family member / relative / acquaintance / any other registered third party service provider who would be available to take care of the Insured Person during his/ her Hospitalization.

Claim under this section shall be payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- Our liability to make any payment under this Section shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule/ Certificate of Insurance, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule/ Certificate of Insurance for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Section, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance (unless due to an Accident).
- If We have admitted a Claim under this Section, then on the Insured Person/Nominee's advance written

request, We may pay the amount due under this Section directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Section is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

52. Compassionate Cash Section**:**

If an Insured Person contracts an Illness or suffers an Injury that occurs during the Period of Cover that Illness or Injury solely and directly requires the Insured Person to be Hospitalized for at least 3 continuous days at a location outside the Insured Person's city of residence, We will pay upto the event amount specified against this Section in the Policy Schedule/ Certificate of Insurance towards the expenses incurred on the travel of the Insured Person's Immediate Family Member(s) to the place of Hospitalization.

For the purpose of this Section, Immediate Family Member means:

The Insured Person's lawful spouse; children including stepchildren and children legally adopted by the Insured Person; siblings; parents; sister(s) in law, brother(s) in law; parents-in-law; legal guardian; ward; step-parents.

Claim under this section shall be payable subject to the following:

- We have accepted a Claim under the Section in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- The Insured Person is hospitalized at a distance of at least 100 kilometres from his place of residence.
- The Medical Practitioner treating the Insured Person recommends in writing the personal attendance of an Immediate Family Member.
- The Insured Person has not be Hospitalized for any planned treatment or Surgery.
- Our liability to make any payment under this Section shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule/ Certificate of Insurance, if applicable.
- We shall not be liable to pay the event amount for more than 2 times for each Insured Person within the Policy Year.
- We shall be liable to pay the claim amount under this Section, only once per Hospitalization event.
- Our liability under this Section shall not increase if more than one Immediate Family Member of the Insured Person travels to the Insured Person's place of Hospitalization.
- We shall not be liable to make payment of the event amount under this Section more than once for any period of Hospitalization of the Insured Person.
- We shall not be liable to make any payment under this Section, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Schedule/ Certificate of Insurance (unless due to an Accident).

53. Critical Illness

If the Insured Person is at any time during the Policy period (after the initial waiting period as specified in the Policy Schedule/Certificate of Insurance for Critical Illness), being diagnosed as contracting any Critical Illness as specified below, the limit as mentioned in Policy Schedule/Certificate of Insurance for this Section shall be payable to the Insured Person

In case of diagnosis of multiple illnesses qualified as Critical Illness under the Policy, the payment of compensation shall be limited to the limit specified in the schedule and shall be payable only once in the lifetime of Insured Person.

"Critical Illness" shall mean any one or all the following critical illnesses and is subject to fulfillment of all conditions as applicable particularly to each Critical Illness as defined in this section.

Specific Exclusions applicable to this Section

1. Coverage will not be available for any Pre-Existing Critical Illnesses including signs or symptoms that existed prior to Policy Period Start Date as specified in the Policy Schedule/Certificate of Insurance
2. No claim shall be payable, if the diagnosis of the Critical Illness is during the Initial waiting Period applicable to Critical Illness. Furthermore, on such diagnosis, the coverage for all named Critical Illness shall stand extinguished.
3. In case of demise of the Insured person after being diagnosed with any Critical Illness within a "Survival Period" specified in the policy.

54. Suicide Benefit

If an Insured Member commits suicide during the policy period, then the Company will pay the Sum Insured specified against this Benefit as specified in the Policy Schedule/Certificate of Insurance, to the Nominee or legal heir of the Insured Member subject to waiting period for Suicide as specified in the Policy Schedule/Certificate of Insurance.

The Permanent Exclusions is super ceded to the extent covered under the policy.

55. Minor Procedures:

We will pay the Medical Expenses incurred on a Medical Procedure related to any specialties, including dental procedures, undergone at a Network Provider/Health Service Provider or at the location of the Insured Person for any Illness contracted or Injury suffered by the Insured Person during the Period of Cover.

For the purpose of this Coverage, Medical Procedure shall mean as following:

Medical Procedure means Surgical Procedure and/or non-Surgical Procedure(s) required for treatment of an Illness or Injury, including but not limited to, audiometry, application of cast, cast removal, injection administration, wound switching, retinoscopy, biopsy, drainage of abscess, and any other procedures which can be done on outpatient basis excluding the Day Care Treatment and not requiring any Hospitalization, performed in Health Service Provider or Insured Person's premises by a Medical Practitioner.

The Policy Schedule/Certificate of Insurance will specify whether there is any limit on the nature and type of Medical Procedures which may be availed under this Coverage.

We will arrange for the Medical Procedures available under this Coverage to be carried out at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request for availing this Coverage and only if the Policy Schedule/Certificate of Insurance specifies that this option is in force for the Insured Person.

56. SPECIFIC VECTOR BORNE DISEASE RELATED HOSPITALIZATION COVER

We will reimburse upto the Sum Insured specified against this section as specified in the Policy Schedule/Certificate of Insurance if an Insured Person is diagnosed with a Specific Vector Borne Disease that solely and directly requires the Insured Person to be hospitalized during the Period of Cover.

Specific Vector Borne Disease shall mean the following:-

1. Dengue
2. Chikungunya
3. Kala-Azar
4. Japanese encephalitis
5. Filariasis
6. Malaria

This valid claim shall be payable subject to the following:

- The Hospitalization is for Medically Necessary Treatment of the Specific Vector Borne Disease and is commenced and continued on the written advice of the treating Medical Practitioner.
- The Insured Person's stay in the Hospital should continue for a minimum period of 48 successive hours.
- We shall not be liable to make any payment under this Section, if the Specific Vector Borne Disease is first Hospitalized prior to the commencement of the Period of Cover.
- We shall not be liable to make any payment under this Section, if the Insured Person is hospitalized due to Specific Vector Borne Disease within a period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.
- We shall not be liable to make any payment under this Section in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.
- If We have admitted a claim under this Section, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Section t directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.
- We will only accept one claim under this Section during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Section, all cover under this Section in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Section under this Policy during the Period of Cover shall continue subject to the availability of the

Sum Insured and the terms, conditions and exclusions of the Policy.

57. Specific Vector Borne Disease related Death Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Schedule/Certificate of Insurance in the manner specified in the Policy Schedule/Certificate of Insurance if an Insured Person is diagnosed with a Specific Vector Borne Disease during the Period of Cover that solely and directly results in the Insured Person's death within 15 days from the first laboratory diagnosis of the Insured Person contracting the Specific Vector Borne Disease.

Specific Vector Borne Disease shall mean the following:-

1. Dengue
2. Chikungunya
3. Kala-Azar
4. Japanese encephalitis
5. Filariasis
6. Malaria

This Benefit shall be payable subject to the following:

- We shall not be liable to make any payment under this Benefit, if the Specific Vector Borne Disease is first diagnosed prior to the commencement of the Period of Cover
- We shall not be liable to make any payment under this Benefit, if the Specific Vector Borne Disease is first diagnosed within a period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.
- The first laboratory diagnosis of the Specific Vector Borne Disease is certified and attested by a registered pathologist, unless the death has occurred post admission in a Hospital and cause of death is certified by the Hospital as death due to the Specific Vector Borne Disease.
- On the acceptance of a claim under this Benefit and any other applicable Benefit pertaining to the same event, all cover under this Policy in respect of the Insured Person shall immediately and automatically cease.

58. Maternal Complication Benefit:-

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Schedule/Certificate of Insurance) which is specified in the table below if an Insured Person suffers one or more of the medical complications (of the nature listed below) during maternity during the Period of Cover:

For the purpose of this Policy the maternal complications listed above shall have the following meanings:

- Eclampsia means a life threatening pregnancy complication that causes a pregnant woman, usually previously diagnosed with preeclampsia (high blood pressure and protein in the urine), to develop seizures or coma.
- Abruptio Placenta means premature separation of the placenta from the wall of the uterus
- Placenta Increta means a condition in which part or all of the placenta remains firmly attached and invades the muscles of the uterus

- Placenta Percreta means a condition in which part or all of the placenta remains firmly attached and grow through the uterine wall
- Amniotic Fluid Embolism means an obstetric complication in which amniotic fluid, enters the blood stream of the mother to trigger a cardio respiratory arrest and/or massive bleeding
- Acute Fatty Liver of Pregnancy means potentially fatal complication of the liver that occurs in the third trimester or early postpartum period caused by a disordered metabolism of fatty acids by mitochondria in the mother
- Disseminated Intravascular Coagulation means the pathological process characterized by the widespread activation of the clotting cascade that results in the formation of blood clots in the small blood vessels throughout the body. 8. Still Birth means baby born with no signs of life at or after 28 weeks' gestation
- Pre Eclampsia means a pregnancy complication characterized by high blood pressure and signs of damage to another organ system, most often the liver and kidneys associated with proteinuria and which usually begins after 20 weeks of pregnancy in women whose blood pressure had been normal prior to the initiation of the pregnancy
- Hyperemesis gravidarum is a pregnancy complication that is characterized by severe nausea, vomiting, weight loss, and possibly dehydration.
- Ectopic Pregnancy means a condition where a fertilized egg implants itself outside of the uterus

This Benefit shall be payable subject to the following:

a) If the Insured Person dies undiagnosed before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but We may consider a claim under any other applicable Benefits under the Policy.

b) We shall not be liable to make any payment under this Benefit, if the maternal complication occurs or is first diagnosed prior to the commencement of the Period of Cover or within a period of 30 days from the commencement of the Period of Cover or after the completion of 30 days following the delivery. This exclusion of first 30 days from the period of commencement of cover shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.

c) If the Insured Person suffers more than one of the maternal complications specified in above, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.

d) If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

Specific Exclusions:-

- Any pregnancy arising out of In Vitro Fertilization, surrogacy or any other type of assisted reproduction.
- Medical Termination of Pregnancy

- Whilst engaging in Adventure Sports.
- Self-medication or any treatment that is not scientifically recognized or which is taken not in accordance with or against the advice of a Medical Practitioner.
- Any claim arising on account of or in connection with any Neonatal Illness/condition

Major Surgical Procedures If the Insured Person is Hospitalized on the written advice of the treating Medical Practitioner due to an Illness contracted or any Injury sustained during the Period of Cover, and is advised by a Medical Practitioner qualified as a Surgeon to undergo a Surgical Procedure specified in Annexure to this Policy, then We will pay the amount specified against such Surgical Procedure in Annexure A as a lumpsum amount.

This Benefit shall be payable subject to the following:

- We will consider more than one claim in respect of the Insured Person under the Policy, subject to the availability of the overall Sum Insured as specified in the Policy Schedule/Certificate of Insurance under the Section and provided that the Illness/Accident causing the Injury is distinct and unrelated for each such claim. On exhaustion of the Sum Insured, the cover under this Benefit will terminate in relation to the Insured Person.
- Once a claim has been considered admissible and payable by Us under this Section, no subsequent Renewal of the Policy will be allowed.
- In case of multiple Surgeries/Surgical Procedures performed in a single Admission to a Hospital, or arising out of the same Illness/Injury, We will pay the amount specified against only one such Surgical Procedure, whichever is specified as having the higher amount payable under the table.
- 24 hours of continuous and completed Hospitalization is mandatory for any claim to be admissible.

SECTION VI: EXTEND

59. Terrorism

The policy is extended to cover medically necessary expenses incurred as a result of an act of Terrorism shall stand covered under the policy.

60. Epidemic

The policy is extended to cover medical expenses incurred for the treatment of a widespread occurrence of an infectious disease in a community at a particular time shall stand covered under the policy.

61. AIDS/ HIV Cover

We will pay the Reasonable and Customary Charges for the Medical Expenses that arise from, or are in any way related to, Human

Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof in respect of an Insured person.

Medical Necessary Expenses prescribed by a Medical Practitioner shall be covered under the Policy and shall be limited to pre and post diagnosis consultations, routine check-ups for this condition, drugs and dressings (except experimental or those unproven), Hospital accommodation and nursing fees. Testing for AIDS/HIV will only be paid if medically requested i.e. if the patient is showing symptoms.

SECTION VII: VALUE ADD

62. Onsite Health Services:

If the Insured Person undertakes any Onsite Health Services, during the Period of Cover, then We shall arrange.

For the purpose of this Section, "Onsite Health Consultation' shall mean any consultation, health audit, provided by a Medical Practitioner/Healthcare Professional through a clinic or otherwise within the place of work of the Insured Person or elsewhere, and shall include but not be limited to Medical Procedures, vaccinations, First Aid (prescribing and dispensing medicines onsite). The Medical Practitioner/Healthcare Professional will diagnosis, prescribe medications, advice further investigations or refer to a specialist if needed and also schedule follow up session to evaluate the progress. The clinic may be subjected to medical audits and, operational and maintenance services by Us at Our discretion.

63. Wellness Session:

If the Insured Person attends any Wellness Sessions of the type specified in the Policy Schedule/Certificate of Insurance during the Period of Cover, then We shall arrange.

For the purpose of this Section, "Wellness Session" shall mean any off-site or on-site mode of providing awareness/ training/ education on complete wellbeing which includes physical fitness, diet and nutrition, spiritual, occupational, environmental, financial, social and mental wellbeing and safety related parameters by relevant Healthcare Professionals/Health Service Providers.

64. Health Risk Assessment (HRA):

If the Insured Person undertakes Health Risk Assessment (HRA) during the Period of Cover, then We shall arrange.

For the purpose of this Section, "HRA" shall mean any online or hard copy questionnaire tool, as specified in the Policy Schedule/Certificate of Insurance for evaluation of the Insured Person's health and quality of life by reviewing the current lifestyle practices, habits, diet, existing health issues, pathology, family history and others, affecting the Insured Person's health status. Online HRA shall be provided through Our platform. Awareness on health can be provided based on the health status of the Insured Person.

65. Wellness Event:

If the Insured Person attends any Wellness Event of the type specified in the Policy Schedule/Certificate of Insurance during the Period of Cover, then We shall arrange.

For the purpose of this Section, "Wellness Event" shall mean any planned on-site or off-site camp focusing on health parameters such as but not limited to vaccination, eye screening, and dental screening.

discrepancy in the information provided.

66. Telephonic /Virtual Consultation:

If the Insured Person avails any Telephonic/Virtual Consultation of the type or mode specified in the Policy Schedule/Certificate of Insurance during the Period of Cover, then We shall arrange.

For the purpose of this Section, "Telephonic/Virtual Consultation" shall mean any consultations provided by Medical Practitioners/Healthcare Professionals through a virtual mode of communication, such as via audio, video, online portal, chat or mobile application for routine health query or second opinion. This shall also include consulting a professional expert through a dedicated helpline number in relation to any social, mental, emotional, environmental or other issues faced by the Insured Person which affect his/her well-being.

(i) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it;

(ii) Under this Section, We are only providing the Insured Person with access to consultations or opinion and We shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner

We will make available consultation with Medical Practitioners in case of need through Our service provider helpline for assessing the case situation or routine health issues over the phone. Based on the information provided by the Insured Person while availing any of the features under this Section, medicines including over the counter medicines or other suggestions may be prescribed or suggested. We shall not be liable or responsible or deemed to be liable or responsible for any

Section include:

1. 24*7, 365 days a year availability
2. Consultations by Medical Practitioners
3. Over the counter (OTC) medicines may be prescribed/ suggested on case to case basis
4. The Insured can reach the Medical Practitioner by calling on the dedicated helpline number: **xxxxxxxx** Any change in this helpline number shall be updated on Our website **xxxxxxxx**

67. Worksite Wellness Management Program:

If the Insured Person attends any Workplace Wellness Management Program, of the nature specified in the Policy Schedule/Certificate of Insurance, during the Period of Cover, then We shall arrange.

For the purpose of this Section, "Workplace Wellness Management Program" shall mean any of the following:

1. Lifestyle management program with a specific focus such as but not limited to smoking cessation, stress management to educate, empower and engage Insured Persons to become more aware of their health and proactively manage it, each Insured Person shall have access to wellness coach. These programs can be app /web/chat/call based with/without wearable devices.

2. Pregnancy management care program: Customised pregnancy program, online app/web based and telephonic general tips and suggestions to expectant parents on

antenatal support, labour preparation and post-partum support. These services are to educate, empower and engage the expecting parents, which will include but are not limited to customised diet plan, fitness advice, emotional support, educating on changes in the body, caution signs, advises on tests and scans, labour pain management, lactation counselling and counselling on breathing exercises for the expectant mother, baby shoot, maternity shoot with discounts on pharmacy and necessary diagnostics. The services also provide counselling on emotional support and preparation for parenting to the father. These programs can be app /web based with/without wearable devices.

3. Disease management program will cover customized program for Insured Persons with any chronic disease or borderline cases, to educate, empower and engage Insured Persons to become more aware of their health and proactively manage it, each Insured Person shall have access to wellness coach. This program can be app/web/call/chat based with/without wearable devices.

4. Benefits may be earned by the Insured Person under this Section which can be redeemed against any of the benefits available under the Policy, as notified from time to time and subject to our internal eligibility criteria provided on our website. There will be no cash reimbursement or redemption available against the benefits obtained under this Section.

These services are in addition to and are not meant to be availed in replacement of the Medical Advice or treatment provided by a Medical Practitioner. These services are based on general tips and suggestions and may not be suitable for all pregnancies. The Insured Person must not avail or continue if they have received any express instructions from the treating/consulting Medical Practitioner.

68. E-Health Assistance:

Health assistance will be provided through Our dedicated helpline. The health assistance team is dedicated to assist the Insured Person in:

1. Identifying specialist/ Hospital
2. Fixing an appointment with Medical Practitioners wherever applicable on best effort basis
3. Providing options on suitable Network Providers.
4. Providing information on ailments and possible lines of treatment

The facilitation for assistance would be free for the Insured Person. Any service availed by the Insured Person would be on a paid basis and to payment will be borne by the Insured Person and paid directly to the Medical Practitioner or Hospital.

Call Helpline no. **xxxxxxxx** or write to **xxxxxxxx** to avail this facility. Any change in this helpline number shall be updated on Our website **xxxxxxxx** Any information provided through assistance cannot be used as a substitute for physical examination by a Medical Practitioner.

69. International Medical Opinion (Worldwide cover)

The Company shall arrange for a second opinion from a Medical Practitioner Internationally in the event of diagnosis of named critical illness during the policy period.

- It is agreed and understood that the Second Opinion will be based on the

information and documentation provided to the Company which will be shared with the medical practitioner and is subject to the conditions specified below:-

a. This Section can be availed only once by an Insured Person during the policy year for each Critical Illness
b. The Insured Person is free to choose whether or not to obtain the Second Opinion and, if obtained under this Section, then whether or not to act on it
c. This cover is for additional information purposes only and does not and should not be deemed to substitute the insured persons visit or consultation to any independent medical practitioner.
d. The company does not provide a second opinion or make any representation as to the adequacy or accuracy of the same. The insured persons or any other person's reliance on the same or the use to which the second opinion is put.
e. The company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any medical practitioner or any second opinion or for any consequences of actions taken or not taken in reliance thereon.
f. The policyholder/insured person shall hold the company harmless for any loss or damage caused by or arising out of or in relation to any opinion advice, prescription, actual or alleged errors, omissions or representation made by the medical practitioner or for any consequences or any action taken or not taken in reliance thereon.
g. Any second opinion provided under this section shall not be valid for any medico legal purposes.
h. The Second opinion does not entitle insured person to any consultation from or further opinions from that medical practitioner.

- For the purpose of this Section only
  a. Second opinion means an additional medical opinion obtained by the company from a medical practitioner solely on the policy holders or insured persons express request in relationship to a Critical illness which the insured person has been diagnosed with during the policy year.
  b. Unless otherwise specified in the Policy Schedule/Certificate of Insurance, the Company's duty shall be restricted to presentation of the medical records to the Consultant Medical Practitioner opined for under Second Opinion vide any electronic/telephonic medium and medical recommendation thereafter post review of the patients medical facts.
  c. Critical illness means one of the following only:
     1. CANCER OF SPECIFIED SEVERITY
     2. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS
     3. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

4. MAJOR ORGAN / BONE MARROW TRANSPLANT
5. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES
6. OPEN CHEST CABG
7. STROKE RESULTING IN PERMANENT SYMPTOMS
8. PERMANENT PARALYSIS OF LIMBS
9. FIRST HEART ATTACK - OF SPECIFIED SEVERITY
10. COMA OF SPECIFIED SEVERITY
11. PARKINSON'S DISEASE
12. BENIGN BRAIN TUMOUR
13. ALZHEIMER'S DISEASE
14. END STAGE LIVER FAILURE
15. SURGERY TO AORTA
16. DEAFNESS
17. LOSS OF SPEECH
18. MAJOR BURNS
19. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS
20. PRIMARY PULMONARY HYPERTENSION:
21. PULMONARY ARTERY GRAFT SURGERY;
22. MUSCULAR DYSTROPHY
23. SYSTEMIC LUPUS ERYTHEMATOSUS (SLE):
24. PNEUMONECTOMY
25. MEDULLARY CYSTIC DISEASE

70. Wellness Management Services: The insured will have a choice to avail various wellness benefits/services under this Section head provided by the Company through the network of specialists service providers.

1. **Health Coach**
2. **Chronic Condition Screening**
3. **Condition Specific Care**
   a. Orthopedics Program (Rehabilitation and mobilisation, Nursing attendant, Physiotherapist and medical equipments, etc.).
   b. Oncology Program (Pallaitive care support, Stroma care, Colostomy, Tube feeding, Supportive care, etc.).
   c. Pulmonary Program (Services/programs related to Improving breathing ability. Improving overall strength and exercise tolerence, programs to increase participation in daily physical and social activities)..
   a. Diabetes Management Program (Services such as Personal Health Coach, Personal Nutritionist, Hypo/Hyper Alerts Management, etc may be availed on the basis of need or as recommended by the treating medical practioner).
   b. Internal Medicine Program (Services such as Doctor visits at home, Triage nursing, Medicine delivery, etc. may be availed on the basis of need or as recommended by the treating medical practioner).

71. Home Care Section

Medically necessary reasonable & customary expenses incurred in treatment that can be given at home for an Illness or Injury. These shall include services such as doctor visit, nursing care, investigations, medication (including oral and intravenous),

chemotherapy, dialysis, transfusions, occupational therapy, speech therapy, physiotherapy and postsurgical care.

The Home Health Care Services are covered only if we have accepted Inpatient hospitalization claim and Home Health Care Services are availed immediately after that Hospitalization. If specifically agreed by us and mentioned in the Policy Schedule/Certificate of Insurance, coverage under this section can be extended to cover Domiciliary Hospitalization wherein the below conditions shall stand relaxed.

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

a. The Insured Person is free to choose whether or not to obtain the Services and, if obtained under this Section, then whether or not to act on it
b. The company does not provide or make any representation as to the adequacy or accuracy of the services. The insured persons or any other person shall verify the service levels of the provider before opting for the Care.
c. The company does not assume any liability for and shall not be responsible for any actual or alleged errors, frauds, omissions or representations made by any service provider or for any consequences of actions taken or not taken in reliance thereon.
d. The policyholder/insured person shall hold the company harmless for any loss or damage caused by or arising out of or in relation to any frauds including but not limited to monetary fraud, prescription, actual or alleged errors, omissions or representation made by the service provider or for any consequences or any action taken or not taken in reliance thereon.

72. Wellness and Preventive Care

The Insured member may avail Health Services such as but not limited to Home Care packages, Doctor Consultations, Medicines, Diagnostics, Genetic Health Checkup, Counselling for insured including children for growth and development, Fitness tracker and HRA, Routine Physical & Preventive Examinations, Online Health Services, Wellness Sessions, Health Talks, Wellness Event & Worksite wellness Management Program, Routine Adult Physical Exams, Wellness Tests, Pap Smear, Prostate Cancer Screening, Mammograms For Breast Cancer Screening Or Diagnostic Purposes. The services are available on paid basis and can be electively opted at discounted rates by the Policyholder.

e. The Insured Person is free to choose whether or not to obtain the Services and, if obtained under this Section, then whether or not to act on it
f. The company does not provide or make any representation as to the adequacy or accuracy of the services. The insured persons or any other person shall verify the service levels of the provider before opting for the Care.

g. The company does not assume any liability for and shall not be responsible for any actual or alleged errors, frauds, omissions or representations made by any service provider or for any consequences of actions taken or not taken in reliance thereon.

h. The policyholder/insured person shall hold the company harmless for any loss or damage caused by or arising out of or in relation to any frauds including but not limited to monetary fraud, prescription, actual or alleged errors, omissions or representation made by the service provider or for any consequences or any action taken or not taken in reliance thereon.

SECTION VIII: CULT

73. Room & Boarding expense

The following benefit payable under the Policy shall be subject to the limits as specified which represent maximum liability of the Company for any and all claims made by an Insured Person in respect of that section as specified in the policy schedule/certificate of insurance:

a) Room, boarding expenses shall be restricted for Normal room limit of [X] % of the Sum Insured per day and actuals per day for Intensive Care Unit

Admissibility of all associated medical expenses (Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, except for

1. pharmacy & consumables ,
2. cost of implants & medical devices and
3. cost of diagnostics

shall also be as per the entitled category vis-à-vis room rent. In the event of insured getting admitted in higher room category, room, boarding and all associated medical expenses will be on **proportionate basis** to the eligibility limit as per room rent restriction. Proportionate deductions shall not be applied in respect of hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room rent category.

b) Room, boarding expenses shall be restricted for Normal room limit of [X] % of the Sum Insured per day and for actuals per day for Intensive Care Unit

Admissibility of all associated medical expenses shall be payable on **actuals.**

c) Room, boarding expenses shall be entitled for [X] category of room for Normal Hospitalisation and Intensive Care Unit for emergency Hospitalisation.

Admissibility of all associated medical expenses (Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, except for

4. pharmacy & consumables ,
5. cost of implants & medical devices and
6. cost of diagnostics

shall also be as per the entitled category vis-à-vis room rent. In the event of insured getting admitted in higher room category, room, boarding and all associated medical expenses will be on **proportionate basis** to the eligibility limit as per room rent restriction. Proportionate deductions shall not be applied in respect of hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room rent category.

d) Room, boarding expenses shall be entitled for [X] category of room for Normal Hospitalisation and Intensive Care Unit for emergency Hospitalisation.

Admissibility of all associated medical

expenses shall be payable on **actuals**.

e) Room, boarding expenses shall be restricted for Normal room limit of INR.[X] per day and actuals per day for Intensive Care Unit per day.

Admissibility of all associated medical expenses (Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, except for

7. pharmacy & consumables ,
8. cost of implants & medical devices and
9. cost of diagnostics

shall also be as per the entitled category vis-à-vis room rent. In the event of insured getting admitted in higher room category, room, boarding and all associated medical expenses will be on **proportionate basis** to the eligibility limit as per room rent restriction. Proportionate deductions shall not be applied in respect of hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room rent category.

f) Room, boarding expenses shall be restricted for Normal room limit of INR.[X] per day and actuals per day for Intensive Care Unit per day.

Admissibility of all associated medical expenses shall be payable on **actuals**.

g) There **is no restriction** on the room rent category and admissibility of all associated medical expenses shall be payable on actuals.

74. Waiver of waiting period (30 Days)

On payment of additional premium, the Company agrees to waive off the waiting period of 30 Days for Disease/Illness under the policy.

The waiting period of 30 Days for Disease/ Illness under exclusions to the policy stands deleted under this endorsement.

If the Policy Schedule/ Certificate of Insurance indicate that there shall be a sub-limit of the Sum Insured for 30 Days initial waiting period.

75. Reduction/waiver of specified ailments waiting period

On payment of additional premium, the Company agrees to reduce/waive off the waiting period of 2 Years for Specific Disease/Illness/Procedure/Surgery under the policy.

The waiting period of 2 Years for Specific Disease/Illness/Procedure/Surgery under exclusions to the policy stands modified / deleted (as applicable) under this endorsement to the extent as mentioned below.

If the Policy Schedule/ Certificate of Insurance indicates that there shall be a sub-limit of the Sum Insured for specified ailments waiting period.

76. Reduction/waiver of waiting period (Pre Existing Disease)

On payment of additional premium, the Company agrees to reduce/waive off the waiting period of Pre Existing Disease under the policy.

The waiting period of 36 Months for Pre Existing Diseases under definitions and exclusions to the policy stands modified and / or deleted (as applicable) under this endorsement to the extent as mentioned below.

77. Floater Sum Insured

The Company shall cover the Primary Insured and dependents/anyone related to the Primary Insured under a floater Sum Insured. The definition of “Sum Insured” shall stand replaced with “Floater Sum Insured” as mentioned below

“Floater Sum Insured” represents the Company’s maximum liability for any and all claims made by any one Insured and/or all Insured Person(s) related to Primary Insured together during the Policy Period.

If the Policy Schedule/ Certificate of Insurance indicates that there shall be a sub-limit of the Sum Insured for each insured person under floater Sum Insured, Our maximum liability per Insured Person shall not exceed the specified sub-limit.

78. Co-Payment

a) The Insured Person will bear a co-payment of [XX]% on each and every admissible claim based on the criteria as specified in the Policy Schedule/Certificate of Insurance. Unless otherwise mentioned in the Policy Schedule/Certificate of Insurance, co-payment shall not be applicable on ailments with sublimit/capped ailments.