Policy wordings – Group Health Assure Super Top-up

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 (Definitions whose wordings are specified by IRDAI)

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

- **"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.

AYUSH treatments refers to the medical aid and / or hospitalisation treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

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

- **"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.

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

- **"Congenital Anomaly"** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
  I. **Internal Congenital Anomaly -** Congenital anomaly which is not in the visible and accessible parts of the body;
  II. **External Congenital Anomaly-** Congenital anomaly which is in the visible and accessible parts of the body.

- **"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.

- **"Day Care treatment"** means medical treatment, and / or surgical procedure which is:
  I. undertaken under general or local anesthesia in hospital/day care centre in less than 24 hours because of technological advancement, and
  II. 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.

- **"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:
  I. has qualified nursing staff under its employment ;
  II. has qualified medical practitioner/s in

charge;

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

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

Day Care Centre includes 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.

- **"Deductible"** means a cost sharing requirement under a health insurance policy that provides that the insurer 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.

- **"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.

- **"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:

A. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

B. the patient takes treatment at home on account of non-availability of room in a hospital.

- **"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.
- **"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.

- **"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:
  i. has qualified nursing staff under its employment round the clock;
  ii. has at least 10 in-patient beds in towns having a population of less than

10,00,000 and at least 15 in-patient beds in all other places;

iii. has qualified medical practitioner(s) in charge round the clock;

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

v. Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Hospital includes 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.

- **"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.

- **"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.

- **"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
  II. immediately before suffering the disease/ illness/ injury which leads to full recovery
  III. **Chronic condition -** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    ii. it needs ongoing or long-term control or relief of symptoms
    iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    iv. it continues indefinitely
    v. it recurs or is likely to recur

- **"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

- **"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.

- **"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.

- **"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.

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

- **"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.
- **"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.

- **"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.

- **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.

- **"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.

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

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

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

- **"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. "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

- **"Specific 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.

- **"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.

- **"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.
  Provided that the definition of the pre- existing disease shall not be applicable for Overseas Travel Policies.

- **"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.

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

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

- **"Renewal"** 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.

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

- **"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.

- **"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.

- **"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.

ii. Specific Definitions (Definitions other than those mentioned under C. i above)

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

- **"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.

- **"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.

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

- **"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.

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

- **"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.

- "**Insured/You/Your**" means the primary Insured who does not qualify as a dependent child or parent as per the policy terms and conditions and 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"**

- **"Insured Person(s)"** means the person(s) named in the Policy Schedule/ Certificate of Insurance.
  • "Parents" means the Primary Insured's natural parents or parents that have legally adopted him or Parents in law

- **"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.

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

- **"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.

- **"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.

- **"Policy Year"** means the duration of each 12 calendar months from the inception date under the policy. E.g. Period of first 12 months shall be termed as First Policy Year, period exceeding 12 months up to 24 months shall be termed as Second Policy Year and period exceeding 24 months up to 36 months shall be termed as Third Policy Year.

- **"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.

- "**Sum Insured**" means the sum shown in the Policy Schedule/ Certificate of Insurance which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

- **"Third Party Administrators or TPA''** means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those

Regulations.

C. BENEFIT COVERED UNDER THE POLICY

- As mentioned in the endorsement wording.

D. EXCLUSIONS

i. Standard Exclusions

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 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- 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.

1. List of specific diseases/procedures
2. Any types of gastric or duodenal ulcers
3. Benign prostatic hypertrophy
4. All types of sinuses
5. Hemorrhoids
6. Dysfunctional uterine bleeding
7. Endometriosis
8. Stones in the urinary and biliary systems
9. Surgery on ears/tonsils/adenoids/ paranasal sinuses
10. Cataracts,
11. Hernia of all types and Hydrocele
12. Fistulae in anus
13. Fissure in anus
14. Fibromyoma
15. Hysterectomy
16. Surgery for any skin ailment
17. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
18. Dialysis required for Chronic Renal Failure.
19. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.
20. Dilatation and curettage
21. Varicose Veins and Varicose Ulcers
22. Non Infective Arthritis and other form arthritis
23. Gout and Rheumatism
24. 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 changeappearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

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 eye sight due to refractive error less than 7. 5 dioptres.

P. Unproven Treatments: Code- Excl 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 Exclusions (Exclusions other than those mentioned under e.i above)

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.

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 CONDITIONS

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

I. 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.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

II. **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.

III. **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 repaymenVtI.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:

the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

the active concealment of a fact by the insured person having knowledge or belief of the fact;

any other act fitted to deceive; and

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.

IV. **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.

V. **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.x

VII. **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 ocancellation on grounds of misrepresentation, nondisclosure of material facts or fraud.

VIII. Renewal of Policy

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

- 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.

X 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.

- During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
- 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.

XI. Portability

a. The insured has the choice to port his / her policies from one Insurer to another.

b. The insured is entitled to transfer the credits gained to the extent of the sum insured and the benefits available in the previous policy, subject to the underwriting policy of the Company

c. The company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines .

d. This benefit is not applicable for enhanced sum insured..

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

XII. Migration

n 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.

XIII. Withdrawal of policy

i. 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 periodas per regulatory prescriptions, provided the policy has been maintained without a break."

XIV. 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.

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

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

XVI. 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.

XVII. 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.

XVIII. 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/grievanceredressa.

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 Chattisgarh.
BHUBANESHWAR **Insurance Ombudsman** Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 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 PuducherryTown 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 – 23237539 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 / 3500613 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. Tel.: 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 l 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, Gautambodhana
	gar, 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,	Maharashtra, Area of Navi Mumbai and Thane (excluding Mumbai Metropolitan

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

ii. **Specific General Terms and Clauses (Terms and clauses other than those mentioned above under f.(i) above):**

i. 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.

ii. Deductible :

Unless otherwise specified under the Policy Schedule/Certificate of Insurance for any particular section, an admissible claim shall get paid only when the aggregate of expenses under hospitalisation (single or more than one) exceeds the defined deductible limit opted. Amount payable in only in excess of the defined deductible limit.

iii. Consideration :

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

In the case of annually paid premium - premium is payable before the beginning of each 12 Monthly period when the annual premium is due.

iv. No Constructive Notice:

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

v. 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.

vi. 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.

vii. 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.

viii. 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.

ix. 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.

x. 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.

xi. Forfeiture of claims:

If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any rights whatsoever.

xii. 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.

xiii. 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.

xiv. 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.

xv. 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.

xvi. 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.

xvii. 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.

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 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 Company- customerservice@icicilombard.com
- Post/courier to TPA/Company - Claims, ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032.
- Directly Contacting our Company office but in writing. - ICICI Lombard House, 414 P Balu Marg, Veer Savarkar Road, Prabhadevi, Mumbai – 400025

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

II. 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.

III. 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.

IV. 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).
- 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.

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 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 confirm Your request in writing.

(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@icicilombar d.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. 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 30 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.

v. 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.

List of documents required for Claims processing

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

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

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

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

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 of 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

SECTION – ENDORSEMENT WORDINGS - Group Health Assure Super Top-up

Subject to sum insured, co-payment, sublimits and deductible specified under the policy schedule/certificate of Insurance on an aggregate basis, the policy intends to extend /restrict coverage:-

I. 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 fees
V. Anesthetist, Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Fees
VI. Drugs, Medicines, X-ray & Diagnostic tests.
VII. Physiotherapy
VIII. Cost of Prosthetic devices used intra operatively during the Surgical Procedure.

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

II. Day Care Treatment Expenses - This Section covers hospitalization expenses towards medical treatment, and/or procedure 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 available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy/Certificate of Insurance.

III. 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 however this coverage will be applicable 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 Insupidus,
f. Epilepsy,
g. Hypertension,
h. Psychiatric or Psychosomatic Disorders of all kinds,
i. Pyrexia of unknown origin.

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

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

IV. 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.The 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 available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule/Certificate of Insurance.

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

a) Central and State Government Hospitals
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 sub-limit under **In-Patient Care Expenses** Sum Insured as mentioned in the Schedule/Certificate of Insurance.

VI. Pre- Post Hospitalization Expenses - Necessary & Reasonable expenses incurred prior to or following an In-patient Care/ Day Care Treatment (as applicable) shall be covered subject to Pre & Post Hospitalization period specified in the 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.

Pre 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 available Sum Insured under **In-Patient**

Care Expenses of this Policy as mentioned in the Schedule/Certificate of Insurance.

VII. Ambulance Cost:

The Company shall reimburse the expenses incurred on a surface transport 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 claim under the policy
- Ambulance should be from a registered healthcare or ambulance service provider.
- It is for emergency cases only.

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

VIII. 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 shall be in addition to Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule/Certificate of Insurance.

Dental Treatment can be availed as Out-patient or In-Patient Care/ Day care Treatment Basis. Policy deductible shall not be applicable to this section.

IX. 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 X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same, and
- The Company shall not pay for any dental treatment that comprises cosmetic surgery, 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 in addition to Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule/Certificate of Insurance.
- Policy deductible shall not be applicable to this section.

X. Out Patient Treatment

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.
- The coverage under this Section shall be in addition to Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule/Certificate of Insurance
- Policy deductible shall not be applicable to this section.

XI. Extension to Non Payable Items

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 as mentioned in the Annexure – Non Payable items.

The below exclusion stands modified to the extent covered under this policy "Non payable items as per Annexure – Non Payable iterms.I"

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

XII. 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, provided that:

a) The Insured/Insured Persons have maintained an advance deposit, adequate & appropriate for inclusion of the newborn in to the policy (as & when applicable), and
b) The Company's maximum liability under this Section shall be limited to Rs [x] per new born baby.
The definition of Dependent in **Section: Inclusion of Primary Insured's Dependent** will stand modified to this extent.

XIII. Emergency Medical Evacuation (Worldwide cover)

The Company shall indemnify the Insured for the cost incurred for an ambulance or any other Emergency transportation and evacuation services, including necessary medical care en-route, reasonably incurred forming part of the treatment for any Illness contracted or Injury sustained whilst on Trip during the Period of Insurance. These transportation expenses would be limited to transporting the Insured from the place of loss (Worldwide) to the nearest appropriate medical facility or to the Place of Origin or to the City of Residence of the Insured in India, whichever is nearer. Provided that the Company's liability does not exceed the Sum Insured and provided that such cost are certified and authorized by the attending medical practitioner and/or the Company.

1. Extra costs of Medically Necessary and prescribed transportation of the Insured Person from place of loss to his/her permanent place of residence in India provided that -

a. Extra costs in the event of transportation to home are the additional costs arising of the return journey to home as a consequence of the insured event.

b. Additional costs for an accompanying person would be payable, if it is Medically Necessary in the opinion of Company or any agency respresenting the Company, that the Insured/ Insured Person needs to be

accompanied by a Medical Practitioner, nurse, relative, friend or colleague;

c. The payment of any claim under this Section shall be payable in Indian currency.

The extra costs under "Transportation" are:

1. In the event of transportation to home, the additional costs arising for the return journey to home as a consequence of the emergency medical condition for which coverage is not excluded under the policy;

2. In the opinion of the Company or any agency respresenting the Company, the Insured/Insured Person is capable of being transported to Place of Origin or to the City of Residence.

The cover under this Section shall be in addition to Sum Insured under **In-Patient Care Expenses** of this Policy as specified in the Schedule/Certificate of Insurance.

XIV. International Medical Opinion (Worldwide cover)

The Company shall indemnify the Insured for the cost incurred 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 benefit 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, ommissions or representations made by any medical practioner or any second opinion or for any consquences 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, ommissions 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 practioner 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

XV. INTERNATIONAL TREATMENT FOR CRITICAL ILLNESS (INDEMNITY BASIS - WORLDWIDE)

The Company shall indemnify the Insured Person, through Cashless or Reimbursement Facility, for Hospitalisation expenses incurred outside India and anywhere across the world for 25 named critical illness, upto the amount specified against the section in the policy certificate, subject to the conditions specified below:

- The Cover under this section is available for 45 continious 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 otherwise specified to waive off the exclusion, an initial waiting period of 90 days shall be applicable for the insured person from the date of inception or date of joining, whichever is later.
- 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.
- The coverage is applicable for treatment availed by the Insured Person after first diagnosis of Critical Illness. Both treatment and diagnosis should be 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 cover under this Section shall be in addition to Sum Insured under **In-Patient Care Expenses** of this Policy as specified in the Schedule/Certificate of Insurance.
- The definition of the Critical Illness covered under the policy have been mentioned in the Annexure for Critical Illness.

XVI. Enhanced Accidental Hospitalisation

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.

Our maximum liability shall be beyond the policy deductible specified in the policy schedule.

XVII. Domestic 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.

There shall be an admissible hospitalization that requires admission in the hospital as In-Patient. The cover under this Section shall be on per hospitalization event basis and in addition to Sum Insured under **In-Patient Care Expenses** of this Policy maximum upto the Sum Insured specified in the Schedule/Certificate of Insurance.

XVIII. Corporate Floater

- Beyond a Policy deductible, 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 benefit is restricted by sublimit.

- 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 benefit is restricted by sublimit.

- 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/illnessinjury 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 benefit is restricted by sublimit.

- 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 benefit is restricted by sublimit.

- 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 benefit is restricted by sublimit.

- 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 benefit is restricted by sublimit.

- 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, beyond an aggregate limit of deductible 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.

XIX. Home Nursing Coverage

The Company, on a reimbursement basis, 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 available Sum Insured under **In-Patient Care Expenses** of this Policy asspecified in 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 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 shall apply.

XX. Terrorism

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

XXI. 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.

XXII. 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 schedule/certificate of insurance:

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

Admissibility of all related expenses (Surgeon, Anaesthetist, Medical Practitioner,Consultants, Specialists Fees Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, , relevant laboratory / diagnostic tests, X-ray, and similar expenses except for medicine / pharmacy bills and body implants, 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 related expenses will be on **proportionate**

basis to the eligibility limit as per room rent restriction.

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

Admissibility of all related expenses (Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees, Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, cost of prosthetic devices like Pacemaker implanted during surgical procedures, relevant laboratory / diagnostic tests, X-ray, and similar 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 related expenses (Surgeon, Anaesthetist, Medical Practitioner,Consultants, Specialists Fees Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, , relevant laboratory / diagnostic tests, X-ray, and similar expenses except for medicine / pharmacy bills and body implants, 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 related expenses will be on **proportionate basis** to the eligibility limit as per room rent restriction.

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 related expenses (Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees, Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, cost of prosthetic devices like Pacemaker implanted during surgical procedures, relevant laboratory / diagnostic tests, X-ray, and similar expenses shall be payable on **actuals**.

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

Admissibility of all related expenses (Surgeon, Anaesthetist, Medical Practitioner,Consultants, Specialists Fees Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, , relevant laboratory / diagnostic tests, X-ray, and similar expenses except for medicine / pharmacy bills and body implants, 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 related expenses will be on **proportionate** basis to the eligibility limit as per room rent restriction.

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

Admissibility of all related expenses (Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees, Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, cost of prosthetic devices like Pacemaker implanted during surgical procedures, relevant laboratory / diagnostic tests, X-ray, and similar expenses shall be payable on **actuals**.

g) There **is no restriction** on the room rent category and admissibility of all related expenses (Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees, Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances,

Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, cost of prosthetic devices like Pacemaker implanted during surgical procedures, relevant laboratory / diagnostic tests, X-ray, and similar expenses shall be payable on actuals.

XXIII. 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 including specified Critical illnesses as specified in the policy schedule/Certificate of Insurance. The definition for Critical Illness is available in Annexure – Critical Illness

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. TYPHOID
27. MALARIA
28. DENGUE FEVER
29. TUBERCULOSIS
30. MATERNITY COMPLICATIONS - GESTATIONAL DIABETES
31. MATERNITY COMPLICATIONS - ECTOPIC PREGNANCY
32. KIDNEY STONES
33. TETANUS
34. MENINGITIS

XXIV. Co-Payment

a) The Insured Person will bear a co-payment of Rs. [XXX] on each and every admissible claim. Co-payment shall not be applicable on ailments with sublimits/capped ailments.

XXV. 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 indicates that there shall be a sub-limit of the Sum Insured for 30 Days initial waiting period, Our maximum liability per Insured Person shall not exceed the specified sub-limit.

XXVI. 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, Our maximum liability per Insured Person shall not exceed the specified sub-limit.

XXVII. 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.

If the Policy Schedule/ Certificate of Insurance indicates that there shall be a sub-limit of the Sum Insured for Pre-Existing Diseases, Our maximum liability per Insured Person shall not exceed the specified sub-limit.

XXVIII. 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.

XXIX. Wellness and Value Added Services

I. Wellness Rewards- Insured can accumulate rewards by opting for an array of wellness programs listed below, that will help assess his/her health status and aid in improving the overall well-being. Each specific program can be opted only once by a particular Insured Person in a policy year.

There will be no limitation to the number of programs one can enroll however maximum rewards that all the insured person(s) in a single policy period can earn, will be limited to 5% in the first year and 10% of the policy premium in the subsequent years and multi-year policies subject to continuous utilization of these programs. The Wellness Rewards will get accrued in the following manner:

Program Type	**Rewards Scale#**	
	Activization Year 1	**Activization Year 2 & above***
Health Awareness – Health risk assessment	Upto 1% of the Policy Premium	Upto 2% of the Policy Premium
Health Action – Voluntary Health Checkup undergone by the Insured/Insured persons in the last 6 months from the date of renewal and their readings • CBC • ESR • Urine Routine • General Physical Examination- Pulse, BP, Height, Weight, Eyesight, Chest & abdominal conditions	Upto 2.50% of the Policy Premium	Upto 5% of the Policy Premium

• Blood Sugar- Fasting Blood Sugar & Post Prandial Blood Sugar • Triglycerides • Serum Cholesterol • Chest X Ray • ECG		
Health Affinity – Active Membership for any programs which keeps you moving like (on Annual membership basis) Gym membership, Yoga, Swimming, Zumba, etc. Also participation in Professional sporting events like Marathon, Walk for a cause, etc.	Upto 1.5% of the Policy Premium	Upto 3% of the Policy Premium
Total Accrual	Upto 5% of the Policy Premium	Upto 10% of the Policy Premium

#The reward scale percentages are applicable basis the proposer covered under the policy. While these can be availed by family members also but the accrual shall happen based on activities availed/performed by the primary member onlyproposer covered under the policy.

*Activization year means the year in which the insured performs all or any of the activities as mentioned in the above program types. The accrual shall happpen on continuous coverage basis and if the insured fails to continue these activities in subsequent years or fails to redeem these discounts in the subsequent year/subsequent renewals, the accrual shall fall to zero and the insured will have to start the process again to achieve the maximum discount benefit.

** Policy Premium means the premium payable by the proposer to the Company for the period post application of all discounts & loadings excluding any applicable taxes.

- The Total Accrual rewards earned as reward scale percentage of the premium paid during the activization year shall be converted to and accumulated as reward points.
- In case of Multi-year policies, the insured is required to perform all or any of the activities at least once during the tenure of the insurance.
- The value of each earned rewards point is worth Re.1 and can be redeemed in the following manner

:

1. Adjustment of 1st year premium when the insured purchases selected health products from ICICI Lombard General Insurance Co Ltd. Post accrual of the wellness rewards points under this policy. However, the total rewards points that can be utilized shall not exceed 10% of the policy premium for such health policy. The rewards points can be redeemed on selected health insurance products offered by ICICI Lombard General Insurance Co. Ltd.
2. This accrued discount can also be adjusted while paying the renewal contribution under the same coverage.
3. The equivalent value of the accrued total discount can be redeemed against any OPD (Doctor consultation, Dietician/Nutrionist consultation, purchase of Pharmacy (allopathy/ayurvedic/homeopathy medicines), 2nd Medical Opinion, Diagnostics, etc.) services offered by ICICI Lombard General Insurance network of service providers.

- Rewards Points earned by an insured cannot be transferred to anyone or rewards points earned under multiple such program cannot be clubbed together to avail redemption in any single policy.

II. Wellness Management Services: The insured will have a choice to avail various wellness benefits/services under this benefit 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).

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).