GROUP TAKECARE INSURANCE
PART II OF THE POLICY

1. PREAMBLE

This Policy is a contract of insurance issued by ICICI Lombard General Insurance Company Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

2. DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this Policy or related Extensions/Endorsements:

Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

i. STANDARD DEFINITIONS -

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

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

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

Cashless Facility means a facility 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 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.

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

b) External Congenital Anomaly - means 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 claim amount. A co-payment does not reduce the Sum Insured.

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

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

Day care Centre includes 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 healthinsurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Deductible shall be applicable per year, per life or per event as stated in the Policy Certificate and specific deductible to be applied shall be as per the Policy Certificate.

Disclosure to information norm means the policy shall be voidand all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

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 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 Regulations) Act 2010 or under

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enactments specified under the Schedule of Section 56(1) of thesaid Act OR comply with all minimum criteria as under:

i. has qualified nursing staff under its employment round theclock;

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 otherplaces;

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

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

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

Hospital includes Ayush Hosiptal

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

Hospitalization means admission in a Hospital for a minimumperiod of 24 consecutive 'In-Patient Care' hours except for specified procedures/treatments, where such admission could be fora period of less than 24 consecutive hours.

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

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

b) Chronic condition A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests; 2. it needs ongoing or long-term control or relief of symptoms;
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
4. it continues indefinitely;
5. it recurs or is likely to recur;

Injury means accidental physical bodily harm excluding illness ordisease solely and directly caused by external, violent,

visible andevident means which is verified and certified by a MedicalPractitioner.

Intensive Care Unit 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.

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:

- is required for the medical management of the illness or injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a medical practitioner;
- 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 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 the scope and jurisdiction of his license. The term Medical Practitioner would include physician, specialist, anesthetist and surgeon but would exclude the insured and his/her Family Member. A Family Member means an Insured's lawful spouse; children including stepchildren and children legally adopted by the Insured (below 18 years); siblings; parents; sister(s) in law, brother(s) in law; parents-in-law; legal guardian; ward; step-parents.

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 an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

Nominee means the person(s) nominated by You to receive the benefits under this Policy payable on Your death. For the purpose of avoidance of doubt it is clarified that if You are a minor, Your legal guardian shall appoint the Nominee.

Notification of claim means the process of intimating a claim to the insurer or TPA 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 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.

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

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.

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

Surgery or Surgical Procedure means 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 -

Age means the completed years of the Insured Person on his/her last birthday as per the English calendar.

Ambulance Services means procedures that are used to provide immediate care and support to transfer the patient from the pick-up point/location to the nearest Hospital where necessary treatment/care can be initiated depending on the nature of Illness or disorder, presence, severity and cause.

ALS Ambulance means an ambulance which is equipped with Advanced Life Support (ALS) mechanism and is provided in situations where the patient/Insured Person being transported is in a more critical condition. Certified Emergency Medical Technicians (EMTs) and paramedics required to assist in the treatment of the patient/Insured Person before and/or during transport to the emergency facility.

Alternative treatments means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.

BLS Ambulance means an ambulance which is equipped with Basic Life Support (BLS) mechanism and is provided to transport the patient/Insured Person to the emergency facility. Certified Emergency Medical Technicians (EMTs) or/and Paramedic is required to assist in the treatment of the patient/Insured Person before and/or during transport to the emergency facility.

Claim means a demand made by You or on Your behalf for payment of Medical Expenses or any other expenses or benefits, as covered under the Policy.

Extension means an additional insurance cover available under the Policy. An Extension will be in force for the Insured Person only if the due additional premium for the Extension has been received and the Policy Certificate states that the Extension is in force.

Franchise means a minimum amount of loss that must be incurred before insurance coverage applies. Once the Deductible is met, the entire benefit amount is paid, subject to the Policy terms and conditions.

Health Service Provider means any person or entity providing healthcare and medical services in individual capacity, or through aggregation under "Health Service Provider Agreement", and shall include but not be limited to any clinic, diagnostic centre, pharmacy, associated facility for diagnosis, treatment or wellness

services, and health care providers empanelled with Us to provide services specified under the Benefits (including Extensions) to the Insured Person on cashless /reimbursement basis for OPD

Treatment or otherwise. The list of the Health Service Providers is available at our website (https://www.icicilombard.com) and is subject to amendment from time to time.

Healthcare Professional means a qualified/ certified individual/ counsellor/ medical practitioner who provides/creates awareness for preventive, curative, rehabilitative healthcare services.

Health Service Provider Agreement means an agreement prescribing the terms and conditions of the services which may be rendered to the Insured Persons under this Policy, and may be entered into between

a) Health Service Provider and Us; or

b) Health Service Provider, a TPA and Us.

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

Insured Event means any event specifically mentioned as covered under this policy.

Insured Person(s) means the individual(s) covered under the Policy whose name(s) is/are specifically appearing as such in the Policy Certificate and is/are hereinafter referred as "You"/"Your"/ "Yours"/ "Yourself".

Out-patient means the Insured Person who is not Hospitalized but who visits a clinic/ Hospital / or any associated facility like a consultation room for diagnosis or treatment (encompassing but not limited to consultation, diagnostic tests & services, medicines/drugs, vaccination, Medical Procedure, external medical aid). However, any Insured Person undergoing any specified Day Care Treatment will not be considered as an Out-patient.

Period of Cover means the period specified in the Policy Certificate during which the Insured Person is covered under the Policy.

Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or Benefits attaching to or forming part thereof. The Policy contains details of the extent of cover available to the insured, what is excluded from the cover and the terms & conditions on which the Policy is issued to the insured.

Policy Period means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Certificate.

Policy Schedule means the Policy Schedule attached to and forming part of the Policy.

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

Proposal and Declaration Form means any initial or subsequent declaration made by the policyholder and is deemed to be attached and which forms a part of this Policy.

Sum Insured means:

(a) If the Policy Certificate specifies that the Policy has been issued on an individual basis: the amount specified in the Policy Certificate against a Benefit or set of Benefits that represents Our maximum, total and cumulative liability for any and all claims made in respect of that Insured Person during the Policy Year under that Benefit/set of Benefits. Any Sum Insured which is not utilized in a particular Policy Year will not be carried over to any subsequent Policy Year in the Period of Cover.

(b) If the Policy Certificate specifies that the Policy has been issued on a family floater basis: the amount specified in the Policy Certificate against a Benefit or set of Benefits that represents Our maximum, total and cumulative liability for any and all claims made in respect of all Insured Persons named in the Policy Certificate during the Policy Year under that Benefit/set of Benefits. Any Sum Insured which is not utilized in a particular Policy Year will not be carried over to any subsequent Policy Year in the Period of Cover.

Third Party Administrators (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.

You / Your means the person named as the policyholder in the Policy Certificate and who is responsible for payment of premium

Waiting Period means a time-bound exclusion period related to condition(s) specified in the Policy Certificate which shall be served before a claim related to such condition becomes admissible.

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

3. BENEFITS COVERED UNDER THE POLICY

This Policy is a contract of insurance between the Policyholder and Us which is subject to the receipt of premium against each Benefit/Cover in respect of the Insured Persons and the terms, conditions and exclusions of this Policy.

Section A: HOSPIFUND BENEFIT

The Policy Certificate will specify which of the following Base Benefits and Extensions are applicable and in force for the Insured Person. Claims made in respect of an Insured Person for any Base Benefit or Extension applicable to the Insured Person shall be subject to the availability of the Sum Insured for the Base Benefit/Extension, and the terms, conditions and exclusions of this Policy.

All Claims shall be made in accordance with the procedures set out in this Policy. Admitted Claims will be payable to the Insured Person or the Nominee (as applicable).

Section A.1: Base Benefits

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

   This Base Benefit shall be payable subject to the following:

   i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

   ii. We shall not be liable to pay the daily amount for more than the maximum number of days as specified in the Policy Certificate for each Insured Person, during the Policy Year.

   iii. Our liability to make any payment under this Base Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.

   iv. We shall not be liable to make any payment under this Base Benefit, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

If We have admitted a Claim under this Base Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Base Benefit is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

2. **Accidental Hospitalization Cash Benefit:** If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Base Benefit for each continuous and completed day of Hospitalization of the Insured Person.

This Base Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

ii. We shall not be liable to pay the daily amount for more than the maximum number of days as specified in the Policy Certificate for each Insured Person, during the Policy Year.

iii. Our liability to make any payment under this Base Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to make any payment under this Base Benefit, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

v. If We have admitted a Claim under this Base Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Base Benefit is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

Section A.2 Extensions To The Base Benefit -

1. **Intensive Care Cash Benefit:** If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized in an Intensive Care Unit, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of confinement of the Insured Person in the Intensive Care Unit.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same Illness/Injury in respect of which the Insured Person was Hospitalized in the Intensive Care Unit.

ii. The Hospitalization in the Intensive Care Unit is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person, during the Policy Year.

iv. Our liability to make any payment under this Extension Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable. However, the Deductible/Franchise will not apply to the extent of days in respect of which the Insured Person has already been admitted in the Hospital in a non- ICU room.

v. We shall not be liable to make any payment under this Extension, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

2. **Cancer Hospitalization Cash Benefit:** If an Insured Person contracts 'Cancer of Specified Severity' during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Cancer of Specified Severity.

For the purpose of this Extension, Cancer of Specified Severity means-

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

The following are excluded -

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3;

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification;

viii. All Gastro-Intestinal Stromal Tumors histologically classified asT1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization. ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible / per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate.

vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

3. **Brain & Stroke Hospitalization Cash Benefit:** If an Insured Person contracts any of the Brain Ailment or Stroke listed below during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount, specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Brain Ailment or Stroke.

For the purpose of this Extension, Brain Ailment and Stroke shall mean the following:

I. BENIGN BRAIN TUMOR:

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies like CT Scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist

a. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

b. Undergone surgical resection or radiation therapy to treat the brain tumor

The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of spinal cord.

II. STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

III. PERMANENT PARALYSIS OF LIMBS

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

IV. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

V. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

I. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis; and

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

Other causes of neurological damage such as SLE are excluded.

VI. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3)of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons.

For the purpose of this Benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

a. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

d. Mobility: the ability to move indoors from room to room on level surfaces;

e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

f. Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

I. Spinal cord injury.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for a Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension Benefit shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

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

4. Organ Transplant Hospitalization Cash Benefit: If an Insured Person undergoes Organ Transplant during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized for the procedure for transplantation, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for transplantation of the organ.

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

The actual undergoing of transplant of:

a. One of the following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end stage failure of the relevant organ;

b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

a. Other stem cell transplants;

b. Where only islets of langerhans are transplanted.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. We shall not be liable to make any payment under this Extension in respect of any organ transplantation that is not carried out in accordance with the Transplantation of Human Organs Act 1994, as amended.

iv. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

v. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

vi. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate, unless due to an Accident.

vii. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

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

For the purpose of this Extension, Heart Ailments mean the following:

I. MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

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

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

II. OPEN CHEST CABG

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

The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

III. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

IV. ANGIOPLASTY

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

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

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

V. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

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

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

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate.

vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

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

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

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

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

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

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization. ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise as stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless such Fracture is due to an Accident).

If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

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

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

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

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

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

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

i. has qualified nursing staff under its employment;

ii. has qualified medical practitioner/s in charge;

iii. has 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.

This Extension shall be payable subject to the following:

i. The Day Care Treatment is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

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

i. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

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

This Extension is payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization. If a Claim is not admitted under the Base Benefit in respect of the Insured Person for the same period of Hospitalization, then no Claim will be admitted under this Extension even if the period of Hospitalization of the Insured Person exceeds 10 days.

ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. We shall not be liable to pay the event amount for more than 5 times specified in the Policy Certificate for each Insured Person during the Policy Year.

iv. We shall be liable to pay the Benefit amount under this extension, only once per hospitalization event.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

9. **Ambulance Cover Benefit:** If an Insured Person contracts an Illness or suffers an Injury that occurs due to an Accident during the Period of Cover and that Illness or Injury solely and directly requires the Insured Person to be transported to a Hospital for Medically Necessary Treatment, We will pay the event amount specified against this Extension in the Policy Certificate in respect of any Ambulance Services used for transportation of the Insured Person from the site of the Accident/ Illness to the nearest Hospital or from the site of first treatment to a higher centre of care.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization. ii. The transportation in case of movement from the site of first treatment to a centre of higher care is recommended in writing by the treating Medical Practitioner.

iii. We shall not be liable to pay the event amount for more than 5 times for each Insured Person during the Policy Year. iv. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

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

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

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

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization. ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability under this Extension shall not increase if the Insured Person has more than one Dependent Child. iv. We shall not be liable to make any payment under this Extension if the Insured Person has no Dependent Children on the date of the Insured Event giving rise to the Claim under this Extension.

v. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/Franchise as stated in the Policy Certificate, if applicable.

vi. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

vii. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

11. **Hospital Attendant Cash Benefit:** If an Insured Person contracts an Illness or suffers an Injury due to Accident during the Period of Cover and which solely and directly requires the Insured Person to

be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Extension in respect of each continuous and completed day of Hospitalization of the Insured Person which requires a Hospital Attendant to be present.

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

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization. ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

12. Compassionate Visit Cash Benefit:

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

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

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

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization. ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

iii. The Insured Person is Hospitalized at a distance of at least 100 kilometres from his place of residence.

iv. The Medical Practitioner treating the Insured Person recommends in writing the personal attendance of an Immediate Family Member.

v. The Insured Person has not be Hospitalized for any planned treatment or Surgery.

vi. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

vii. We shall not be liable to pay the event amount for more than 5 times for each Insured Person within the Policy Year.

viii. We shall be liable to pay the Benefit amount under this extension, only once per Hospitalization event.

ix. Our liability under this Extension shall not increase if more than one Immediate Family Member of the Insured Person travels to the Insured Person's place of Hospitalization.

x. We shall not be liable to make payment of the event amount under this Extension more than once for any period of Hospitalization of the Insured Person.

xi. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

4. EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION A:

We shall not be liable to make any payment for any Claim under Section A of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. STANDARD EXCLUSIONS -

1. Pre-existing Diseases (Code - Excl 01) - (Unless specifically covered and mentioned in the policy certificate)

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.

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

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

iv. Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. 30 day waiting period (Code - Excl 03) - Any hospitalization falling within the initial waiting period as specified in the policy certificate subject to a maximum of 30 days-

i. Expenses related to the treatment of any illness within the initial waiting period shall be excluded except claims arising due to an accident, provided the same are covered.

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

iii. The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

3. Specified disease/procedure waiting period/Specific Waiting Period (Code - Excl 02) - Two Years Exclusions - (Unless the waiting period isspecifically waived off and mentioned in the policy certificate)

a. Expenses related to the treatment of the below listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage

after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific disease/procedures -

i. Deviated Nasal Septum, CSOM-Chronic Suppurative Otitis Media

ii. Stapedectomy, Mastoidectomy, any treatment for conditions related to tonsils, adenoids, sinuses, turbinates/ concha

iii. Fibroids (fibromyoma), Endometriosis, Uterine Prolapse, Polycysyic Ovarian Syndrome(PCOS) iv. Dilatation and curettage (D&C), Myomectomy, Hysterectomy

v. Arthritis, Gout and Rheumatism, Intervertebral disc disorders , Arthroscopy, Spinal and Vertebral Disorders including diagnosis as low back ache, Surgeries for joint replacements

vi. Stones in gall bladder and biliary system; Cholecystitis, Fissure/fistula in anus, hemorrhoids, pilonidal sinus, piles, Esophageal Varices and Gastric Varices, Gastritis, Duodenitis & Pancreatitis

vii. Gastric and Duodenal ulcers, Gastro Esophageal Reflux Disorder (GERD)/Acid Peptic Disease, Ulcerative colitis, Crohn's disease, Irritable Bowel Syndrome, Inflammatory Bowel disease

viii. All forms of cirrhosis, rectal prolapse, Perineal Abscesses, Perianal Abscesses

ix. Cholecystectomy, Endoscopy

x. Stones in urinary system, all prostate diseases, chronic renal failure or end stage renal failure or chronic kidney disease, dialysis

xi. Dysfunctional uterine bleeding, pelvic inflammatory diseases, stress incontinence, Hydrocele, varicocele/ rectocele/ spermatocele

xii. Cataract, Glaucoma, Diseases of the vitreous and retina

xiii. Unless malignant, all internal/ external tumors, cysts, nodules, polyps, sinus, fistula, adenoma, lumps including teratoma, breast lumps, dermoid cyst, ovarian cyst, desmoid tumour, umblical granuloma, mucous cyst of lip/cheek

xiv. Diseases related to thyroid xv.

All skin ailments

xvi. Ulcers of any kind (whether internal or external) including decubitus ulcers

xvii. Varicose veins and varicose ulcers

xviii. All hernias

4. **Cosmetic or plastic surgery (Code - Excl 08) -** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

5. **Refractive Error (Code - Excl 15) -** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

6. **Obesity/Weight Control (Code - Excl 06) -** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

i. greater than or equal to 40 or

ii. 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:

1. Obesity-related cardiomyopathy
2. Coronary heart disease
3. Severe Sleep Apnea
4. Uncontrolled Type2 Diabetes

7. **Rest Cure, rehabilitation and respite care (Code - Excl 05) -** 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.

2. **Change of Gender treatments (Code – Excl 07) -** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

1.

2. **Breach of Law (Code - Excl 10) -** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

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

4. **Investigation & Evaluation (Code - Excl 04) -**

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

5. **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..

6. **Hazardous or Adventure Sport (Code - Excl 09) -** 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.

7. **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.

8. **Excluded Providers (Code - Excl 11) -** Expenses incurred towards treatment in any hospital or by an 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.

9. **Maternity (Code - Excl 18):**

   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

   b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period;

10. 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 - Excl 13)**

11. 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 - Excl 14)**

SPECIFIC EXCLUSIONS -

1. Any dental treatment or dental surgery of any kind unless necessitated due to an Accident or specifically covered and specified in the Policy Schedule/Policy Schedule.
2. Vaccination and inoculation of any kind.
3. Any alternative treatments not covered under AYUSH as instituted in a government hospital or any institutes recognised Board by the government and/or acreddited by Quality Council of India / National Accreditation of Health.
4. Any treatment received outside India unless specifically covered and specified in the Policy Schedule.
5. Circumcision unless necessary for treatment of an underlying Illness.
6. Hormone replacement therapy.
7. Alopecia, baldness, wigs, or toupees and hair fall treatment.
8. Routine medical, eye and ear examinations unless specifically covered and specified in the Policy Schedule.
9. Any medical examination or diagnostics or Hospitalization for the purpose of employment or travel.
10. Treatment of general debility, sterility, venereal disease except HIV.
11. Intentional self-Injury, suicide or attempt to suicide.
12. First Degree Burns where First Degree (superficial) Burns are those which affects only the epidermis, or outer layer of skin.
13. Any External Congenital Anomalies unless specifically covered and specified in the Policy Schedule.
14. Any sexually transmitted diseases..except HIV
15. Treatment by a Family Member and self-medication or any treatment that is not scientifically recognized.
16. Illness or Injury whilst performing duties as a serving member of a military or a police force or any other forces of similar nature.
17. Expenses related to donor screening related to donation of an organ(s).
18. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
19. Domiciliary Hospitalization.
20. Engaging in professional sports unless specifically covered and specified in the Policy Schedule.
21. War, invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion.
22. Nuclear weapon materials or ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission or nuclear fusion.
23. Whilst mounting or dismounting into an aircraft or flying or taking part in aerial activities (including airline crew or cabin crew) except as a fare-paying passenger in a regular scheduled airline or air charter company.
24. Treatment of any sexual problem including but not limited to impotence and Erectile Dysfunction irrespective of the cause; Venereal diseases or any sexually transmitted diseases. except HIV
25. Hospitalization primarily for evaluative and diagnostic purpose for which treatment which is possible in outpatient department is given; Admission only for Holter monitoring/Sleep study.

CLAIM DOCUMENTS AND PROCEDURE APPLICABLE TO SECTION A

On the occurrence of an Insured Event which may give rise to a claim under the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Base Benefit/Extension being claimed within 30 days of the occurrence of the Insured Event:

1. Claim form duly completed and signed by the claimant/Insured Person. The claim form can be downloaded from our website www.icicilombard.com
2. Indoor case papers from the Hospital mentioning the diagnosis, date and time of admission and discharge, past medical and surgical history with duration.
3. Hospital discharge summary filled and attested by Hospital.
4. Original bills from chemists supported by proper prescription.
5. Original investigation test reports and payment receipts.
6. First Information Report (F.I.R.) copy / medico-legal case papers - notarized/ attested by a gazetted officer in case of an Injury. 5. Payment receipt in case an Ambulance Service has been availed, if applicable.
6. KYC Documents of the Insured Person and claimant
7. Age proof of child in case of Child Care Cash Benefit
8. Travel Ticket of the Immediate Family Member in case of Compassionate Visit Cash Benefit
9. Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque)
10. Any other document as required by Us to investigate the claim or Our obligation to make payment for it.

Cashless Facility

Cashless Facility is only available at specific Network Providers (The list of Network Providers is available at Our website). In order to avail of Cashless facility, the following procedure must be followed:

a) Insured Person/claimant must Us or Our in house claimprocessing team accompanied with full particulars namely, Policy Number, Insured Person's name, relationship with Insured Person,
nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital, and any other information that may be relevant to the Illness/ Injury/ Hospitalization.

b) The request must be made at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization.

c) In case, the amount payable under a Benefit/Extension is more than the actual expenses incurred by the Insured Person at the Network Provider, there will be a part payment upto the actual expenses to the Network Provider, and remaining claim payment will be made to the Insured
Person.

d) To avail of Cashless facility, the Insured Person/claimant is required to produce the health card (physical or online), as provided with this Policy, subject to the terms and conditions for the usage of the said health card

Where reimbursement is available:

The Insured Person shall tender to Us all reasonable information, assistance and proofs in connection with any Claim hereunder

(i) In case, Insured Person does not avail Cashless facility, reimbursement, if applicable, may be provided.

(ii) The Insured Person/claimant shall give notice to the TPA in writing or at Our address with particulars as below,:

a) Policy number;

b) Unique health identification number

c) Name of the Insured Person;

d) Relationship with the Insured Person;

e) Nature of Illness or Injury;

f) Name and address of the attending Medical Practitioner and the medical facility;

g) Any other information/ claim related documents as specified, that may be relevant to the Illness/ Injury/ Hospitalization.

Section B : OUTPATIENT BENEFIT

The Policy Certificate will specify if the Base Benefit is applicable and in force for the Insured Person. Claims made in respect of an Insured Person for any Base Benefit and any underlying Coverage(s) applicable to the Insured Person shall be subject to the availability of the Sum Insured for the Base Benefit, applicable sub-limits for the Coverage(s) under Base Benefit claimed as specified in the Policy Certificate and the terms, conditions and exclusions of this Policy.

All claims shall be made in accordance with the procedures set out in this Policy. The applicable Base Benefit and Coverage(s) specified under Base Benefit can be availed by the Insured Person on a Cashless facility basis only, unless the Policy Schedule/Policy Certificate specifies that the Base Benefit can also be availed on a reimbursement basis from Network Provider/ Health Service Provider / Non-Network Provider.

Health records in respect of the Insured Person may be made available to the Insured Person on request by digital modes.

Section B. Base Benefit

1. Outpatient Cover:

This Base Benefit can be availed by the Insured Person only during the Policy Year and subject to the terms, conditions and exclusions set out below.We will pay for the Medical Expenses incurred during the Period of Cover for consultations, pharmacy, diagnostics, minor procedures and travel expenses for medical treatment as specified in the Coverage(s) detailed below:

A. Consultation Cover

We will pay for the Medical Expenses incurred during the Period of Cover for any of the following consultations with or second opinions from a Medical Practitioner or Healthcare Professional empanelled with Our Health Service Providers / Network Provider in relation to any Illness contracted or Injury suffered by the Insured Person during the Period of Cover.

Based on the information provided by the Insured Person while availing any of the features under this Coverage, medicines including over the counter medicines or other suggestions may be prescribed or suggested. We shall not be liable or responsible or deemed to be liable or responsible for any discrepancy in the information provided, or Medical Advice provided by such Medical Practitioners/Healthcare Professionals.

Choosing to avail the features under this Coverage is purely on Insured Person's discretion and at his/her own risk. The Insured Person is free to choose whether or not to obtain services under this Coverage, and, if obtained, then whether or not to act on the advice/suggestions received in whole or in part.

By seeking and availing services under this Coverage, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.

The Policy Certificate will specify whether there is any limit on the number of consultations which may be availed under this Coverage and whether any specific specialty consultations are covered/excluded.

1. GP Consult

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

2. Specialist Consult

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

3. Physiotherapy Consult

Consultation with a Medical Practitioner/healthcare professional qualified to treat any Illness, Injury, or deformity by physical methods such as but not limited massage, heat treatment, and exercise.

4. AYUSH Consult

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

5. Dental Consult

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

6. Counseling

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

7. Tele Consult

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

8. Home Consult

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

9. Online / Digital Consult

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

B. Pharmacy Cover

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

We will arrange for delivery of the products purchased under this Coverage at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request for availing this Coverage and only if the Policy Certificate specifies that this option is in force for the Insured Person.

C. Diagnostic Cover

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

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

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

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

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION B:

We shall not be liable to make any payment for any Claim under Section B of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following. Others specific policy related exclusions may be defined in Policy Certificate or any exclusions mentioned below may be covered if mentioned as inclusions in the Policy Certificate.

I. STANDARD EXCLUSIONS

1. 30-day waiting period (Code - Excl 03) -

- Expenses related to the treatment of any illness within the initial waiting period shall be excluded except claims arising due to an accident, provided the same are covered.
- This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

2. **Cosmetic or plastic Surgery (Code - Excl 08) -** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

3. **Hazardous or Adventure Sports (Code - Excl 09) -** 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

4. **Breach of law (Code - Excl 10) -** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

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

7. 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 - Excl 13)**

8. 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 - Excl 14)**

9. **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

10. **Sterility and Infertility (Code - Excl 17) -** Expenses related to Sterility and infertility.

This includes:

- Any type of contraception, sterilization
- Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- Gestational Surrogacy
- Reversal of sterilization

II. SPECIFIC EXCLUSIONS

1. Expenses incurred due to contraction of any Illness necessitating Hospitalization.
2. Personal comfort, cosmetics convenience -
3. Illness, Accident or Injury directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not).
4. Defects or anomalies, venereal disease except HIV, intentional self-injury (whether arising from an attempt to suicide orotherwise)Alternative treatment except AYUSH treatment.
5. All expenses arising out of any condition directly or indirectly caused to or associated with, Human T-Cell Lymphotropic Virus Type III (HTLV -III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any syndrome or condition of a similar kind.
6. Illness, Accident or Injuries directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.
7. Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.
8. Any expenses incurred on instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.), oxygen concentrator for bronchial asthmatic condition,
9. Any sexually transmitted disease. Except HIV
10. Treatment received outside India

CLAIM DOCUMENTS, PROCEDURE, ADMINISTRATION APPLICABLE FOR SECTION B

Upon the discovery or happening of any Illness or Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person shall undertake the following:

1. Claims Procedure

a. For Cashless Settlement

- Cashless treatment is only available at specific Network Providers/ Health Service Providers. The list of Network Providers/ Health Service Providers is available at www.icicilombard.com. In order to avail of Cashless facility, the following procedure must be followed:
- Authorization

Prior to taking treatment and/or incurring Medical Expenses at a Network / Health Service Provider, the Insured person must contact the company or the TPA through online mode or otherwise, accompanied with full particulars namely,

i. Policy Number,
ii. Unique health identification number
iii. Name of the Insured Person,
iv. Relationship with the Insured Person,
v. Nature of Illness or Injury;
vi. Name and Address of the Medical Practitioner/ medical facility / Health Service Provider and any other information that may be relevant to the Illness/ Injury.

- To avail of Cashless facility, the Insured Person/claimant is required to produce the health card (physical or online), as provided with this Policy, subject to the terms and conditions for the usage of the said health card. The request shall be considered after having obtained accurate and complete information for the Illness or Injury, where applicable, for which Cashless facility is sought and We will confirm the request digitally or in writing.
- In case the services availed exceed the eligibility, the difference will have to be paid directly to the Hospital/Network Provider/Health Service Provider by the Insured person/claimant.

b. For Reimbursement Settlement

(i) For Outpatient cover, Reimbursement of medically necessary expenses incurred on outpatient basis would be done in cases where the member visits a Non-Network provider. In case, Insured person visits a Network / Health Service provider, reimbursement may be done on the basis of actual payment made or limited to the expenses consistent with the prevailing charges agreed between Network / Health Service provider and Us, whichever is lower.

(ii) The Insured Person shall give notice in writing at the Company's address with particulars as below:

1) Policy number;
2) Unique health identification number
3) Name of the Insured Person;
4) Relationship with the Insured Person;
5) Nature of Illness or Injury;
6) Name and address of the attending Medical Practitioner and the medical facility;
7) Any other information that may be relevant to the Illness/ Injury.

(iii) The procedure for lodging the Claim shall be as under:

Upon the happening of any event giving rise or likely to give rise to a Claim under this policy:

a) The Insured Person shall give immediate notice thereof in writing to Us.

b) The Insured Person shall submit the claim documents to Us, within 30 days from the date of completion of treatment, a detailed statement in writing as per the claim form together with bills, vouchers and any other material particular, relevant to the making of such Claim.

c) The Insured Person shall tender to Us all reasonable information, assistance and proofs in connection with any Claim hereunder

2. Basis of assessment of claims

a) The benefit payable shall be such expenses reasonably and necessarily incurred by or on behalf of the Insured Person under the following categories but not exceeding the Sum Insured in respect of such Insured Person as specified in Part I of the Policy.

Heads of compensation payable:

(i) Consultation Expenses,

(ii) Procedure Expenses,

(iii) Diagnostics Expenses,

(iv) Pharmacy Expenses

(v) Minor Procedure Expenses

(vi) Others

b) Claim documents :

The Insured shall be required to furnish the following for or in support of a Claim. The right to waive off as an exception or accept the document in any other format than specified below remains with Us.

(i) Duly completed Outpatient claim form signed by the Insured person along with Aadhaar and PAN copy

(ii) Original bills, receipts and copy of prescription, clinical notes from the Medical Practitioner / medical facility

(iii) Original bills from pharmacy supported by proper prescription

(iv) Copy of investigation test reports and original bills, payment receipts

(v) Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque)

(vi) Any other document as required by Us or the TPA to investigate the Claim or Our obligation to make any payment for it.

Section C: WELLNESS COVER

This Section can only be taken as an Extension to Section A (Hospifund Benefit) or Section B (Outpatient Benefit). This Section will be available and in force for the Insured Person only if either Section A or Section B or both are in force for that Insured Person.

The Insured Person can avail any of the following Benefits on a Cashless Facility basis only. The Policy Certificate will specify the scope of cover, limitations on the number of times or for what periods the Insured Person can avail a particular Benefit during the Period of Cover, sub-limits on any particular Benefit, demography, duration and exclusions applicable to the following Benefits against such Benefit.

Health records in respect of the Insured Person may be made available to the Insured Person on request by digital modes.

C.1. Routine Physical & Preventive Examinations: If the Insured Person undertakes any of the Routine Physical and Preventive Examinations specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred.

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

C.2. Onsite Health Services: If the Insured Person undertakes any Onsite Health Services, during the Period of Cover, then We shall pay the costs incurred.

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

The clinic may be subjected to medical audits and, operational and maintenance services by Us at Our discretion.

C.3. Wellness Session: If the Insured Person attends any Wellness Sessions of the type specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred.

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

C.4. Health Risk Assessment (HRA): If the Insured Person undertakes Health Risk Assessment (HRA) during the Period of Cover, then We shall pay the costs incurred.

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

C.5. Wellness Event: If the Insured Person attends any Wellness Event of the type specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred.

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

C.6. Telephonic /Virtual Consultation: If the Insured Person avails any Telephonic/Virtual Consultation of the type or mode specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred.

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

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

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

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

C.7. Workplace Wellness Management Program: If the Insured Person attends any Workplace Wellness Management Program, of the nature specified in the Policy Certificate, during the Period of Cover, then We shall pay the costs incurred.

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

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

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

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

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

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

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

C.8. Emergency Ambulance Service: If the Insured Person suffers an Illness or sustains an Injury during the Period of Cover which requires the Insured Person to be transported to a Hospital in an emergency for Medically Necessary Treatment to be rendered, We will pay for the charges incurred for ground medical transportation by an ambulance service provider.

This Benefit shall be payable subject to the following:

i. The medical condition of the Insured Person requires immediate on-ground transportation from the place where the Insured Person is Injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Illness or Injury for which the service is called upon.

ii. The ambulance service will be offered by Our Service Providers on a Cashless Facility basis provided that the request has been made by the Insured Person or his Family Members on the dedicated helpline 18001028136 (Toll free) and 01244498770 (Charges applicable helpline number). This number if changed will be updated on Our website.

iii. We will provide this Benefit only for a one way transfer from the place of Injury or Illness to the nearest Hospital where necessary treatment facility is available or from one Hospital to another Hospital having advanced facilities.

iv. We will provide this Benefit only for transportation within the same city.

v. We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital for evaluation purposes only or for any non-emergency services or if there is no active line of treatment.

vi. Ambulance coordination for emergency cases will be provided through the helpline of Our Service Provider on best effort basis from the communicated location by providing a valid identification for validation of coverage. A Medical Practitioner can accompany the ambulance, as and when required and as per availability.

vii. The ambulance coordination is available 24*7, 365 days a year and within the jurisdiction of major cities as listed. The list of cities where this facility will be provided shall be available on Our website.

The following covers will also be available with the Emergency Ambulance Service Benefit:

Tele consultation Benefit: We will make available consultation with Medical Practitioners in case of need through Our service provider helpline for assessing the case situation. Over the counter (OTC) medicines may be prescribed/ suggested on case to case basis. Features under this Benefit include:

a. 24*7, 365 days a year availability

b. Consultations by Medical Practitioners

c. Over the counter (OTC) medicines may be prescribed/ suggested on case to case basis

d. The Insured can reach the Medical Practitioner by calling on the dedicated helpline number: +91 124 4498757. Any change in this helpline number shall be updated on Our website www.icicilombard.com

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

a. Identifying specialist/ Hospital

b. Fixing an appointment with Medical Practitioners wherever applicable on best effort basis

c. Providing options on suitable Network Providers.

d. Providing information on ailments and possible lines of treatment

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

Call Helpline no. 040 - 6627 4205 (9:30 am to 6 pm Mon to Fri, excluding public holidays) or write to healthassistance@icicilombard.com to avail this facility. Any change in this helpline number shall be updated on Our website www.icicilombard.com. Any information provided through assistance cannot be used as a substitute for physical examination by a Medical Practitioner.

GENERAL CONDITIONS APPLICABLE TO SECTION C:

1. Where any of the services provided under this Section are arranged by Us at Our Network Providers/Health Service Providers, We shall not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider/Health Service Provider in relation to the same. Communication around the Benefits, as well as awareness on general health, will be sent through various modes of communication.
2. The Insured Person is free to choose whether or not to obtain services under this Section, and, if obtained, then whether or not to act on the advice received in whole or in part.
3. Based on the information provided by the Insured Person while availing any of the features under this Section, medicines including over the counter medicines or other suggestions may be prescribed or suggested. We shall not be liable or responsible or deemed to be liable or responsible for any discrepancy in the information provided.
4. The Insured Person should seek assistance from a Medical Practitioner/Healthcare Professional when interpreting these material/suggestions received under this Section and applying them to his/her individual circumstances. If the Insured Person has any concerns about his/her health, he/she should consult their general practitioner immediately.

5. By seeking and availing services under this Section, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
6. The services obtained under this Section shall be provided on best effort basis and be limited to defined criteria and shall not be valid for any medico legal purposes.

EXCLUSIONS APPLICABLE FOR SECTION C

No exclusions applicable for Section C.

CLAIM PROCEDURE APPLICABLE TO SECTION C

Claims Procedure For Cashless Settlement

Cashless Facility is only available at specific Network Providers/ Health Service Providers. The updated list of Network Providers/ Health Service Providers is available at Our website. In order to avail of Cashless facility, the following procedure must be followed:

The Insured Person/ group administrator/claimant should notify Us before the usage of the any Benefits under this Section by writing a mail to ihealthcare@icicilombard.com. To avail Cashless facility, the Insured Person/claimant may be required to produce the health card (physical or online), as provided with this Policy, subject to the terms and conditions for the usage of the said health card.

In case the services availed exceed the eligibility, the difference will have to be paid directly to the Health Service Provider/ Network Provider by the Insured person/claimant.

CLAIM ADMINISTRATION APPLICABLE TO ALL SECTIONS

- The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Certificate) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the procedures and requirements in relation to claims, shall be Conditions Precedent to Our liability under this Policy.
- We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full and on time in respect of the Insured Person's cover under the Policy and all payments have been realised.
- On occurrence of an any event that may give rise to a Claim under this Policy, You shall-
  - Notify Us immediately on toll free number 1800 2666 or on our website www.icicilombard.com or also in writing at Our address specified in the Policy Certificate.
  - Along with the completed and signed Claim form, provide all the relevant documents in support of Your Claim within 30 days.
  - Wherever details pertaining to happening of Claim are conveyed by you to Us after reasonable period, You shall provide the reasons of such delay to Us.
- All claims documentation specified within the relevant Section of the Policy for the Base Benefit/Extension being claimed must be submitted in full. The final decision to waive the requirement for any specified claim documents rests with Us.
- We/Our representatives must be given all reasonable co-operation in investigating the Claim in order to assess Our liability and quantum in respect of such Claim. If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's Injury/Illness and treatment and to investigate the facts surrounding the Claim.
- Our medical or other representative shall be allowed to examine the Insured Person on the occurrence of any alleged Injury or disablement when and as often as the same may reasonably be required on behalf of Us Such evidence as We may require from time to time shall be furnished The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed..
- .
- The admissible Claim amount will be calculated post applicability of Deductible, Co-pay, Sub-limit if any and as specifically defined in Policy certificate.

TERMS OF RENEWAL

a. The Policy may be renewed as per regulatory prescriptions and in such event the Renewal premium should be paid to Us on or before the date of expiry ofthe Policy and in no case later than the Grace Period of fifteen days where premium payment mode is monthly and thirty days in all other cases , to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

b. You shall on tendering any premium for the Renewal of this Policy give notice in writing to Us of any Illness, physical defect or infirmity with which any of the Insured Person(s) have become affected since the payment of the expiring Policy start date.

c. There will be life-long renewal without any age restriction for the cover.

Portability:

a. The insured has the choice to port his / her policies from one Insurer to another. An Insured desirous of porting his/her policy to another insurer shall apply to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal.

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

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

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

POLICY RELATED TERMS AND CONDITIONS

- Please inform us immediately of any change in the address, occupation, state of health, or of any other changes affecting the Insured Person (or his Nominee/ legal heir, as the case may be)

- Any change in the policy terms and conditions including but not limited to Sum Insured and/or coverage shall not be permitted within the Period of Cover.
- In case the customer chooses to pay the premium in installments then he/she shall not be able to change the frequency of payments within the Period of Cover.
- In case the customer has opted for auto renewal, the policy shall be Renewed with the same policy terms & conditions including but not limited to the Sum Insured, coverage, premium paying terms and Claim payment terms and policy terms and conditions.
- We shall make payment to assignee/partial assignee/conditional assignee, as the case may be or in the absence of assignee to the Insured Person or the Insured Person's nominee. If there is no assignee or nominee and the Insured Person is incapacitated or deceased, We will pay to the Insured Person's heir, executor or validly appointed legal representative. Any payment We make in this manner will be a complete and final discharge of Our liability towards the Claim.
- The scope of cover shall be within the geographical boundaries on India unless specified otherwise.

PART III OF THE POLICY SCHEDULE

GENERAL TERMS & CLAUSES :

i. STANDARD GENERAL TERMS AND CLAUSES -

1. Disclosure of Information

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

("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)

2. Condition Precedent to Admission of Liability

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

3. Claim Settlement (provision for Penal Interest)

i. The Company shall processa claim, as the case maybe, within 15 days of receipt of claim along with claim form.

- In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate
- .
- 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

4. 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.

5. Fraud

- If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
- Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
- For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
  - a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true; b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
  - c) any other act fitted to deceive; and
  - d) any such act or omission as the law specially declares to be fraudulent
- The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer

6. Cancellation

a) The policyholder may cancel this policy by giving 7 days' written notice. The insurer shall

1. Refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period
2. Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

Note: - *Above 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

Full refund may be given based on underwriter's discretion.

For any cancellation initiated by the company, refund shall be done on a pro rata basis.

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.

b) The Company may cancel the policy at any time on grounds of,established fraud by the insured person by giving 7 days' written notice. Therewould be no refund of premium on cancellation on grounds established fraud.

7. Migration

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

8. Portability

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

9. d. This benefit is not applicable for enhanced sum insured..Renewal of Policy

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

- 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 f thirty days..Coverage is not available during the grace period.
- No loading shall apply on renewals based on individual claims experience

10. 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.

ii. 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."

11. Moratorium Period

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

12. Premium Payment in Instalments

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

i. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the company shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

ii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iii. No interest will be charged If the instalment premium is not paid on due date

i. In case of instalment premium due not received within the grace period, the policy will get cancelled.

ii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending instalments, from the claim amount due under the policy.

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

The Company, , may revise or modifythe terms of the policy including the premium rates. 14 Free look period

Every insuredof 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. In the event a policyholder disagrees to any of the policy terms or conditions, or otherwise and has not made any claim, he shall have the option to return the policy to the insurer for cancellation, stating the reasons for the same. Irrespective of the reasons mentioned, the policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges

14. Redressal of Grievance

n case of any grievance the insured person may contact the Company through

Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com

ICICI Lombard General Insurance Co. Ltd. Ground floor- Interface 11, Sixth floor- Interface 16 ,

Office no 601 & 602, New linking Road, Malad (West), Mumbai – 400064

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

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

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

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

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

Insured may also approach Insurance Ombudsman, subject to vested jurisdiction, for the redressal of grievance. Details of Insurance Ombudsman offices are available at IRDA website: www.irdai.gov.in , or on the Company's website at www.icicilombard.com or on https://www.cioins.co.in/Ombudsman"redressal of grievance as per Insurance Ombudsman Rules 2017.

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.

CHANDIGARH Mr Atul Jerath Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI **Insurance Ombudsman** **Office of the Insurance Ombudsman,** **10th Floor, Jeevan Prakash,LIC Building,** **Opp to Maharaja's College Ground,M.G.Road,** **Kochi - 682 011.** **Tel.: 0484 – 2358759** Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7nth Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.
THANE Shri Umesh Sinha Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane – 400604 Email: bimalokpal.thane@cioins.co.in	Jurisdiction :Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."

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

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15. 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 thelegal heirs or legal representatives of the policyholder whosedischarge shall be treated as full and final discharge of its liability under the policy.

ii. SPECIFIC TERMS AND CLAUSES

1. Material Change

The Insured Person shall immediately notify Us in writing ofany material change in the risk and cause at his own expense such additional precautions to be taken as circumstances may require to ensure safe operation, trade or businesspractices thereby containing the circumstances that maygive rise to the Claim and We may, adjust the scope of cover and / or premium, if necessary, accordingly.

2. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant particulars and shall allow Us to inspect suchrecord.

3. Notice of Charge

We shall not be bound to take notice or be affected by anynotice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by Us to the

Insured Person, Nominee, assignee or his legal heirs of any amount under the Policy shall in all cases be an effectual discharge to Us.

4. Overriding effect of Part II of the Schedule

The terms and conditions contained herein and in Part II of the Schedule to this Policy shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Schedule to this Policy, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in Part II of the Schedule to this Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

5. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be adjudicated or interpreted in accordance with Indian Laws and only competent Indian courts shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

6. 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 Insured Person, at the address specified in the Policy Certificate.

In case of Us: ICICI Lombard General Insurance Company Limited, ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

7. Customer Service

If at any time the Insured Person (or his Nominee/ legal heir, as the case may be) requires any clarification or assistance, they may contact Our offices at the address specified below, during normal business hours.

ICICI Lombard General Insurance Company Limited ICICI Lombard House 414, Veer Savarkar Marg, Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025.

OTHER TERMS AND CONDITIONS -

1. ENDORSEMENTS AVAILABLE UNDER THIS POLICY

Endorsement I: Auto Renewal Clause

Under this Endorsement, We will automatically renew the Policy for the Policy Period as opted by the policyholder. However, after completing its entire auto Renewal period on expiry of the Policy on the Policy End Date, We shall not be bound to accept any Renewal premium nor give notice that such Renewal premium is due. Any change in the risk will be intimated to the Company by the Policyholder/ Insured Person.

Endorsement II: Premium Installment Clause

a. We will accept payment of the premium applicable taxes, charges, cess etc. in monthly/quarterly/semi-annual/annual installments as specified in the Policy Certificate provided that the Policyholder continues to perform and observe all their obligations hereunder.