HEALTH SHIELD 360 RETAIL

a. PREAMBLE

ICICI Lombard General Insurance Company Limited ("We / Us"), having received a Proposal and the premium from the Proposer named in Part a of the Policy (hereinafter referred to as the "Policy Schedule") and the said Proposal and Declaration together with any statement, report or other document leading to the issue of this Policy and referred to therein having been accepted and agreed to by Us and the Proposer as the basis of this contract do, by this Policy agree, in consideration of and subject to the due receipt of the subsequent premiums, as set out in the Policy Schedule, and further, subject to the terms and conditions contained in this Policy that on proof to Our satisfaction of the compensation having become payable as set out in the Policy Schedule to the title of the said person or persons claiming payment or upon the happening of an event upon which one or more benefits become payable under this Policy, the Annual Sum Insured/ appropriate benefit amount will be paid by Us.

b. 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:

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.

Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

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

Break in policy means the period of gap that occurs at the end of the existing policy term/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 approved.

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

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

a) **Internal Congenital Anomaly** -Congenital anomaly which is not in the visible and accessible parts of the body
b) **External Congenital Anomaly**- Congenital anomaly which is in the visible and accessible parts of the body

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

Loyalty Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

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 an 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.

Day Care Treatment means medical treatment, and/or Surgical Procedure which is

a) Undertaken under General or Local Anesthesia in a Hospital/Day care centre in less than 24 hours because of technological advancement, and
b) Which would have otherwise required a hospitalisation of more than 24 hours.

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

Deductible means cost sharing requirement under a health insurance policy that provides that provides that the insurer will not be liable for 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.

Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

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

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

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

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

Grace period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period

Hospital 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 enactments specified under the Schedule of Section 56(1) of the said Act **Or** complies with all minimum criteria as under:

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

Hospital includes an AYUSH Hospital:

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

a) Central or State government AYUSH hospital; or
b) Teaching hospital attached to AYUSH college recognized by the central government/Central council of Indian medicine/ Central council for Homeopathy; or
c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH medical practitioner and must comply with the following criterion:
    i. Having at least 5 in-patient beds
    ii. Having qualified AYUSH medical practitioner in charge round the clock
    iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

Hospitalisation means admission in a Hospital for a minimum period of 24 consecutive 'Inpatient Care' hours except for specified Procedures/Treatments, where such admission could be for a 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** - 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:
   i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
   ii. it needs ongoing or long-term control or relief of symptoms
   iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
   iv. it continues indefinitely
   v. It recurs or is likely to recur

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

Inpatient Care means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.

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

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

Maternity expenses shall

a) Include medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation);
b) Expenses towards lawful medical termination of pregnancy during the policy period

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.

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

Medically Necessary Treatment means any treatment, tests medication or stay in hospital or part of a stay in Hospital which

a) Is required for the medical management of the illness or Injury suffered by the insured
b) Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity
c) Must have been prescribed by a Medical practitioner
d) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India

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.

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

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

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.

Pre-existing disease (PED) 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.

Pre-Hospitalisation Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the insured person, provided that:

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

Post-Hospitalisation Medical Expenses means medical expenses incurred during predefined number of days immediately after the Insured Person is discharged from the hospital, provided that:

a) Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
b) The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

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

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

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

Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include associated medical expenses.

Specific waiting period means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

Subrogation shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

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

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

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

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

Annual Sum Insured means and denotes the maximum amount of cover available to You during each Policy Year of the Policy Period, as stated in the Policy Schedule or any revisions thereof based on Claim settled under the Policy.

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

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

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

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

Maximum Limit of Indemnity means the sum total of Annual Sum Insured, Sum Insured accrued as Loyalty Bonus (if accrued), Reset Benefit (If applicable) and Super Loyalty (if applicable/opted and accrued by the Insured) and Sum Insured Protector (if applicable/opted by the Insured),

Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. The term Medical Practitioner would include physician, specialist, anesthetist and surgeon but would exclude You and Your spouse, Your children, Your brother(s), Your sister(s) and Your parent(s).
For the purposes of worldwide cover, Medical practitioner would mean a person who holds a valid registration from the Medical council of the respective country where the treatment is being taken by the Insured

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

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

Proposer/ Policyholder means the person(s) or the entity named in the Policy Schedule who executed the Policy Schedule and is (are) responsible for payment of premium(s).

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 Schedule.

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

Service Provider means any person, organization, institution, or company that has been empaneled with Us to provide services specified under the Benefits (including Add-ons/Optional Cover) to The Insured person. These shall also include all healthcare providers empaneled to form a part of network other than Hospitals.
The list of the Service Providers is available at our website (https://www.icicilombard.com/content/ilom-en/serviceprovider/search.asp) and is subject to amendment from time to time.

You/Your/ Yours/ Yourself means the person(s) that We insure and is/are specifically named as Insured / Insured Person(s) in the Policy Schedule.

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

c. BENEFITS COVERED UNDER THE POLICY

The coverage mentioned below differs between the various plan offerings and the wordings of only the relevant covers opted by the Insured Person and as mentioned in the Policy schedule will be applicable.

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy. The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken during the Policy Period for an Illness, Accident or condition described below if this is contracted or sustained by an Insured Person during the Policy Period and subject always to the Sum Insured, any subsidiary limit specified in the schedule of Benefits, the terms, conditions, limitations and exclusions mentioned in the Policy and eligibility as per the insurance plan opted by Insured and stated in as stated in the Schedule.

A. Basic Cover

The payment under this Basic Cover shall be limited to Maximum Limit of Indemnity.

1. Inpatient Treatment

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

i. Room Rent charges
ii. Intensive Care Unit Charges;
iii. Qualified Nurse charges;
iv. Medical Practitioner's Fees;
v. Anaesthesia, blood, oxygen, operation theatre charges, medicines, drugs and consumables (other than those specified in the list of excluded expenses (non-medical) in Annexure I)
vi. Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure
vii. Cost of investigative tests or prescribed diagnostic procedures directly related to the Injury/Illness for which the Insured Person is hospitalized

We will consider a claim under this Cover, subject to the following:

i. Expenses associated with automation machine for peritoneal dialysis shall not be payable

2. Day Care Procedures/Treatment

We will cover the Medical Expenses incurred in respect of the Day Care Treatment of the Insured Person during the Policy Period up to the Annual Sum Insured as specified in the Policy Schedule provided that:

i. Day Care treatment requires hospitalization as an inpatient for less than 24 hours in a Hospital.
ii. We will also cover Medical Expenses incurred for procedures including but not limited to intravenous chemotherapy, radiotherapy, hemodialysis or any other therapeutic procedure which requires a period of specialized observation or medical care after completion of the procedure.
iii. We will not cover any Out Patient Treatment or diagnostic services under this Cover.
iv. Expenses associated with automation machine for peritoneal dialysis shall not be payable

3. Technological advancements and Treatments

We will cover the Medical Expenses incurred in respect of Hospitalization of the Insured Person for the below mentioned Technological advancements and Treatments during the Policy Period, up to the Annual Sum Insured.

Sr. No	Treatment/Procedure
1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
2	Immunotherapy- Monoclonal Antibody to be given as injection
3	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
4	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
5	Balloon Sinuplasty
6	Oral Chemotherapy
7	Robotic surgeries
8	Stereotactic radio Surgeries
9	Deep Brain stimulation
10	Intra vitreal injections
11	Bronchical Thermoplasty
12	IONM - (Intra Operative Neuro Monitoring)

4. Pre- Hospitalisation Medical Expenses

We will cover the Pre-hospitalization Medical Expenses incurred in respect of the Insured Person immediately before the Insured Person's Admission to Hospital up to the limits as specified in the Policy Schedule provided that:

i. We shall not be liable to make any payment in respect of any Pre-Hospitalization Medical Expenses incurred prior to the Policy Period Start Date of the first policy with Us in respect of the Insured Person.
ii. Expenses incurred on nursing care at home are excluded from the scope of pre hospitalization expenses.
iii. This Cover will be provided on a reimbursement basis only.

5. Post Hospitalisation Medical Expenses

We will cover the Post-Hospitalization Medical Expenses incurred in respect of the Insured Person immediately following the Insured Person's discharge from Hospital up to the limits as specified in the Policy Schedule provided that:

i. We have accepted the claim under "Inpatient Treatment" or "Day Care Procedures" in respect of the Insured Person.
ii. We will also consider Post-Hospitalization Medical Expenses incurred on Physiotherapy provided that such Physiotherapy is advised in writing by the treating Medical Practitioner and is Medically Necessary Treatment. This service will be provided on a reimbursement and/ or cashless basis where ever applicable.
iii. Expenses incurred on nursing care at home are excluded from the scope of Post Hospitalization Medical Expenses.

6. In Patient AYUSH Hospitalisation

We will cover medical expenses incurred in respect of Insured Person's AYUSH Treatment during the Policy Period up to the Annual Sum Insured specified in the Policy Schedule provided that –

i. The Insured person is Hospitalised for AYUSH Treatment at a AYUSH Hospital or AYUSH Day Care Centre.
ii. This Cover will be provided on reimbursement basis and/or on cashless basis wherever applicable

7. Reset Benefit

We will reset up to 100% of the Annual Sum Insured, once for same illness/disease/injury and Unlimited times for different illness/disease/injury for the same Insured Person in a Policy Year as stated in the Policy Schedule subject to the following conditions:

i. The Annual Sum Insured including Loyalty Bonus, Super Loyalty Bonus (if any) and Sum Insured Protector (if opted by the Insured Person or Applicable) in respect of the Insured Person is insufficient as a result of previous claims paid in that Policy Year.
ii. The Reset Benefit will not be triggered for the first claim made during the Policy Year
iii. The total amount of reset will not exceed the Annual Sum Insured for that Policy Year
iv. The Reset Benefit will be applied only if the claim is made and admissible under "Inpatient Treatment" or "Daycare Procedure/Treatment"
v. For individual policies, reset Annual Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis.
vi. The Reset Benefit will not be available for an Illness /Injury or related complications including but not limited to any relapse within 45 days in respect of which a claim has been paid in that Policy Year for the same Insured Person
vii. Any unutilized Reset Benefit will not be carried forward to any subsequent Policy Years.

8. Domestic Road Ambulance Cover:

We will cover the expenses incurred on road ambulance services which are offered by a healthcare or ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital from the place of Accident/Illness with adequate emergency facilities for the provision of Emergency Care, provided that:

- Our maximum liability under this Benefit for every claim arising during the Policy Year will be restricted to 1% of the Annual Sum Insured maximum up to Rs.10,000 in case the charges of road ambulance are being reimbursed. In case the services of a health care or ambulance service provider are being availed on cashless basis, the charges of road ambulance will be covered as per actuals.
- We have accepted a claim under "Inpatient Treatment" in respect of the Insured Person for the same Accident/Illness for which road ambulance services were availed.
- This Benefit includes and is limited to the cost of the transportation of the Insured Person:
    a) To the nearest Hospital with higher medical facilities which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, and only if that transportation has been prescribed in writing by a Medical Practitioner and is for Medically Necessary Treatment.
    b) From a Hospital to the nearest diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
- The ambulance / service provider providing the services should be a registered provider with road traffic authority.

Any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence while transferring an Insured Person after he/she has been discharged from the Hospital are not payable under this Benefit.

9. Air Ambulance Cover

We will cover the expenses incurred on Air Ambulance services up to the Annual Sum Insured which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

i. It is for a life threatening emergency health conditions of the Insured Person which requires immediate and rapid ambulance transportation from the place where the Insured Person is situated at the time of requiring Emergency Care to a hospital provided that the transportation is for Medically Necessary Treatment, is certified in writing by a Medical Practitioner, and Domestic Road Ambulance services cannot be provided.

ii. Such air ambulance providing the services, should be duly licensed to operate as such by a competent government Authority.

iii. This cover is limited to transportation from the area of emergency to the nearest Hospital only;

iv. We will not cover:
   a. Any transportation from one Hospital to another;
   b. Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital
   c. Any transportation or Air Ambulance expenses incurred outside the geographical scope of India.

v. We have accepted a claim under Inpatient Treatment in respect of the Insured Person for the same Accident/Illness for which air ambulance services were availed.

vi. We shall not be liable if Medically Necessary Treatment can be provided at the Hospital where the Insured Person is situated at the time of requiring Emergency Care.

10. Donor Expenses

We will cover the medical expenses incurred in respect of an organ donor's Hospitalization during the Policy Period for harvesting of the organ donated to the Insured Person up to the Annual Sum Insured specified in the Policy Schedule provided that:

i. The organ donation conforms to the Transplantation of Human Organs and Tissues Act 1994 and the organ is used for the Insured Person

ii. We will cover only those Medical Expenses incurred in respect of an organ donor as an in-patient in the Hospital.

iii. We have accepted a claim under Section "Inpatient treatment" in respect of the Insured Person.

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

i. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
ii. Screening expenses of the organ donor.
iii. Any other Medical Expenses as a result of the harvesting from the organ donor.
iv. Costs directly or indirectly associated with the acquisition of the donor's organ.
v. Transplant of any organ/tissue where the transplant is experimental or investigational.
vi. Expenses related to organ transportation or preservation.
vii. Expenses incurred by an Insured Person as a donor.
viii. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

11. Domiciliary Hospitalization

We will cover the Medical Expenses incurred in respect of the Domiciliary Hospitalization of the Insured Person during the Policy Period provided that:

i. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case we will make payment under this Cover in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization.

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

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

12. Home Care Treatment

We will cover the Medical Expenses incurred by the Insured Person on Home Care Treatment up to 5% of Annual Sum Insured subject to a maximum of Rs.25,000 provided that:

a. The Medical Practitioner advices the Insured Person in writing to undergo treatment at home
b. There is a continuous active line of treatment with monitoring of the health status by a Medical Practitioner for each day through the duration of the home care treatment.
c. Daily monitoring chart including records of the treatment duly signed by the treating Medical Practitioner is maintained.
d. The condition of the Insured Person is expected to improve in a reasonable and foreseeable period of time.
e. Prior approval from Us has been taken. The Home Care Treatment is availed only on a cashless basis, subject to availability of our empaneled Service Provider(s). Kindly visit our website for cities/locations where such services are available.
f. Such treatment cannot be provided on outpatient basis

However in case of unavailability of our empaneled Service Provider in the Insured Person's location, in case the Insured Person intends to avail the services of Non-network Provider and claims for reimbursement, a prior approval from Company needs to be taken before availing such services.
In case the Insured Person breaches the conditions of approval or fails to take the prior written approval from Company, we are not liable to settle any claim under this section.

For the purpose of this Cover, Home Care Treatment shall include:

a. Diagnostic tests underwent at home as advised by Medical Practitioner
b. Medicines prescribed in writing by a Medical Practitioner
c. Consultation charges of the Medical Practitioner
d. Nursing charges if advised by the Medical Practitioner

13. Wellness Program

The wellness program provides the Insured Person with the below mentioned benefits

I. Wellness program
II. Health Assistance [HAT]
III. Ambulance Assistance
IV. Discounts on services and products

I. Wellness program

Wellness program intends to promote, incentivize and reward the Insured Person(s) for their healthy behavior through various wellness services. All the wellness activities as mentioned below in Table A enable the Insured Person(s) to earn wellness points which shall be monitored by the Health Coach.

The Health Coach shall only be available to Insured Persons aged 21 and above. The Health Coach is a personalized service that shall encourage and promote optimal health and physical and mental wellness through a digital platform. The Insured Person shall have access to the health coach on downloading and registering on our mobile application. This activity needs to be done within 30 days of Policy Start Date to ensure adequate utilization of services offered and to redeem the wellness points awarded.

Registered Insured Person(s) on successful completion of Health Risk Assessment [HRA] shall be evaluated by the Health Coach to assess and educate the Insured Person on adapting a healthy lifestyle

Table A- Journey of earning Wellness points

Category	Activity Details	Maximum Wellness Points Earned per Insured Person*
On boarding (mandatory to unlock earnings from other points based slabs)	Addition of Policy Details	500
	E-card Verification	300
Health Assessment	Health Risk Assessment	400
	Advisory on Preventive Health check-up	300
	Medical Vault	300
	First usage of Chat with Health Expert/ Health Coach Service	100
	Tele- consultations	300

Wellness activities	ICICI Lombard initiated Contest/ health quiz (Any one contest)	200
	ICICI Lombard initiated Webinar (Any one webinar)	200
Wellness Tasks	Achieving targeted steps per month	Maximum of 2400 per year
Fitness challenge	Participation and successful completion of fitness challenge In App	250 per challenge, maximum of 500 points
Health Events	Participation in Professional sporting events like Marathon/Cyclothon/ Swimathon etc.	250 per event, maximum of 500 points
Grand Total		6000

* The Wellness Points to be awarded for each activity have been mentioned considering an individual policy for a single adult aged 21 and above. In case of a floater policy with 2 adults aged 21 and above, the wellness points to be awarded shall be doubled, provided, that both the Insured Persons complete their respective wellness activities.

Detailed explanation of Table A has been mentioned below

A. Onboarding

1. Addition of Policy Details

The Insured Person shall be awarded 500 welcome wellness points on downloading our mobile application and registering the policy details.

2. E-card Verification

The insured person shall be awarded 300 wellness points to view the E-card, verify the details mentioned on the same and confirm to the Company about the same.

The wellness points awarded for onboarding i.e. for addition of Policy details and E-card verification shall only be onetime for the first year of the Policy and not for any subsequent renewals thereof.

B. Health Assessment

1. Health Risk Assessment [HRA]

The Health Risk Assessment (HRA) questionnaire is a tool for evaluation of the Insured Person's health and quality of life by reviewing the personal lifestyle practices affecting the Insured Person's health status. On taking the HRA test on our mobile application, within 90 days of Policy Start Date, the Insured Person can earn a maximum of 400 wellness points under this activity.

2. Advisory on Preventive Health Check-up

The reports of the Preventive Health Check-up of the Insured Person if referred to our tele-consultation platform (example: IL Hello Doctor) for medical advisory and opinion, shall reward the Insured Person with a maximum of 300 wellness points

3. Medical Vault

The Insured Person has to save relevant medical records- diagnostic reports, prescriptions, preventive health check-up reports in the medical vault on the mobile application. This activity shall reward the Insured Person a maximum of 300 wellness points.

4. First usage of Chat with Health Expert/ Health Coach Service

The Insured Person shall be rewarded 100 wellness points on the first time usage of the chat functionality on our mobile application. The Insured Person can virtually chat with health experts like physiotherapists, counsellors, dieticians etc. under this service

5. Tele-consultations

The Insured Person shall be rewarded 150 wellness points for an audio consultation with a Medical Practitioner through the mobile application. Maximum of 300 wellness points can be accrued under Tele-consultations.

C. Wellness Activities

1. ICICI Lombard Initiated contest or health quiz

The Insured Person can earn wellness points by participating in any health related contests or quiz conducted by ICICI Lombard. Maximum of 200 wellness points can be earned through participating in such activities.

2. ICICI Lombard initiated Webinar

The insured person can earn a maximum of 200 wellness points on successful completion of any one health related webinar session conducted by ICICI Lombard.

D. Wellness Tasks

The Insured Person shall be awarded wellness points as per the Table B mentioned below for achieving the targeted steps. The mobile application has to be downloaded within 30 days of the Policy Start Date to avail this benefit as the average step count completed by an Insured Person would be monitored on this mobile application.

Table B

Average Steps achieved per day for 20 days in a month	Maximum Wellness Points per month	Maximum Wellness Points accumulated in a year
8,000+ steps	200	2400
6,000 to 7,999 steps	150	1800
4,000 to 5,999 steps	120	1440
< 4,000 steps	Nil	Nil

E. Fitness Challenge

The Insured Person shall be awarded wellness points on participation and successful completion of a fitness challenge as initiated by the Company from time to time. The Insured Person shall be awarded 200 wellness points per fitness challenge and the maximum wellness points that can be gained by participation and completion of the fitness challenges is 400.

F. Health Events

The Insured Person shall be awarded wellness points on participation and successful completion of health events as initiated by Us from time to time. The Insured Person shall be awarded 200 wellness points per health event and the maximum wellness points that can be gained by participation and completion of such health events is 400.

Redemption of wellness points

Each wellness point is valued at INR 0.25.

The Wellness points earned by the Insured Person (as detailed in Table A) can be redeemed by availing services such as Out-patient Consultations, purchase of Pharmaceutical Drugs/ Medicines, undergoing Diagnostic Tests, purchase of Health Supplements etc. through our mobile application

Terms and Conditions for Redemption of Wellness Points

- The Insured Person has to accumulate minimum 400 wellness points in order to redeem them on our mobile application.
- Alternately, the Insured Person(s) can even choose to carry forward the wellness points for 3 years, in case they do not wish to redeem the same provided the Policy is continuously renewed without any break.

Terms and conditions for availing the Wellness Program:

- For health risk assessment [HRA] services availed through mobile application/online/ digital mode on IL Platform, the Insured Person shall be required to provide the details in order to establish authenticity and validity prior to availing such services. Any such information provided by the Insured Person in this regard shall be used solely for the purpose of providing these wellness services and kept confidential with Us/Our Network Providers/Health Service Providers at all times.
- The Insured Person shall notify the Company and submit the relevant documents, reports, receipts as and when required by the Company within 60 days of undertaking any wellness activity.
- The Insured Person agrees that choosing to utilize any of the wellness services or any information or advise rendered by Our Health Service Providers or Network Providers or the Company will be solely at the Insured Person's discretion and own risk and should not be, used to diagnose or identify treatment for a medical or mental health condition.
- The Wellness Points earned by the Insured person through the Wellness Program can be carried forward for a maximum of 3 years and shall have to be redeemed at the end of the 3rd Policy Year.
- In case, the Insured Person does not wish to redeem the wellness points earned, the same will be forfeited.
- In case of expiry of Policy, the accrued wellness points may be carried forward for a period not exceeding three months
- There shall not be any cash reimbursement or redemption available against the wellness points accumulated by an Insured Person.
- We or Our Health Service Providers or Our Network Providers do not warrant the validity, accuracy, completeness, safety, quality, or applicability of the content or anything said or written or any suggestions provided in the course of providing the wellness services.
- We, or our affiliates, their respective directors, officers, employees, agents, vendors, shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person may claim to have suffered, sustained or incurred, as a result of any advice or information obtained by way of the wellness program or any actions chosen by the Insured Person on the basis of such advice or information.
- The wellness program offered is subject to revisions based on the insurance regulatory framework from time to time.

Disclaimers

- *Choosing the option is purely on Insured Person's discretion and at own risk.*

- *The wellness program is intended to provide support information to the Insured Person to improve well-being and habits through working towards obtaining a healthy lifestyle, and does not constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.*
- *We reserve the right to remove or reduce wellness points in case the same have been found to be achieved in any unfair manner by manipulation*
- *Availing the service provided by our Health Service Providers / Network Provider is at the sole discretion of the Insured person and We are not liable, responsible or deemed to be liable or responsible for any discrepancy in the information or Medical Advice provided.*

II. Health Assistance Team[HAT]:

Our Health Assistance Team (HAT) will assist the Insured Person in understanding his/her health condition better by providing responses to any queries related to health and health care providers

The services provided under this shall include:

- Identifying a Physician/ Specialist
- Availability of hospital beds
- Providing guidance on engaging attendants/ nurses
- Facilitation with respect to arrangement of mobility aids, daily living aids, medical equipment etc.
- Scheduling an appointment with any Medical Practitioner empaneled with Us
- Scheduling appointments for a second opinion
- Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
- Scheduling appointments from diagnostic labs empaneled with Us
- Providing information, assistance and facilitation on door step delivery of medicines
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.

Please note that services provided under this Cover are solely for assistance, and should not be construed to be a substitute for a visit/ consultation to an independent Medical Practitioner. Our role is limited to that of facilitation and Health Assistance Services will not include the charges for any independent Medical Practitioner/nutritionist consulted/ charges incurred on diagnostics/consulted on HAT's recommendation, and such charges are to be borne by the Insured Person.

We do not accept any liability towards quality of the services made available by our network providers/ service providers and are not liable for any defects or deficiencies on their part

For all services provided under this Cover, our role shall be limited to assistance only and the charges and expenses associated with the actual service shall have to be borne by the Insured Person

This service is available on our mobile application or by calling on 040-66274205 (please note that this number is subject to change) from 8am to 8pm from Monday to Saturday except public holidays.

By availing this service, the Insured Person agrees and has no objection to the health records being maintained with Us for internal use only.

While deciding to obtain such value-added service, the Insured Person expressly notes and agrees that it is entirely for them to decide whether to obtain these services and also to decide the use (if any) to which these services is to be put for

III. Ambulance Assistance

We will facilitate ground medical transportation by a Service Provider to transport the Insured Person from the site of Accident/ Illness/ Injury to the nearest Hospital or any clinic or nursing home for medically necessary treatment subject to availability of services in that particular city/location. Kindly visit our website for updated list of cities/locations where the services are provided.

1. The services under this Cover are subject to the following conditions:
   - The medical transportation is for a life threatening health condition of the Insured Person which requires immediate and rapid transportation to the Hospital; as certified in writing by the Medical Practitioner
   - The Insured Person is in India and the treatment is in India only;
   - The ambulance service is availed within the same city
   - This is an assistance service and the expenses for the same will have to be borne by the Insured Person or can be claimed under Domestic Road Ambulance Cover(if Inpatient Treatment claim is found to be admissible)

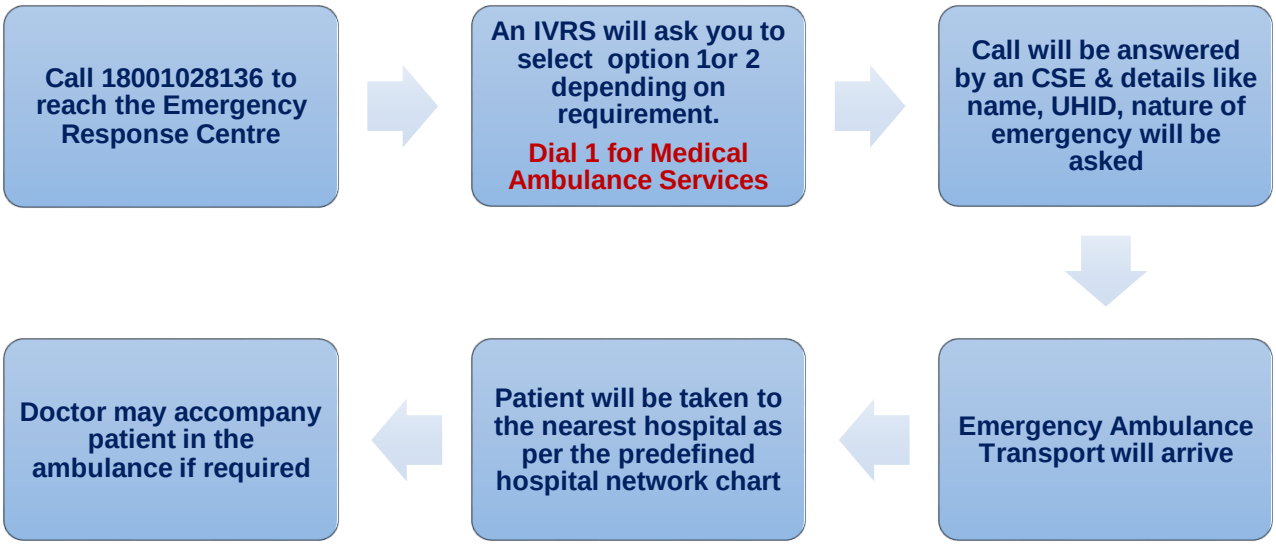
Process to avail Ambulance Assistance:

a) On calling Our helpline number provided below, Our trained customer service executive (CSE) will ask the Insured Person relevant questions to assess the situation.

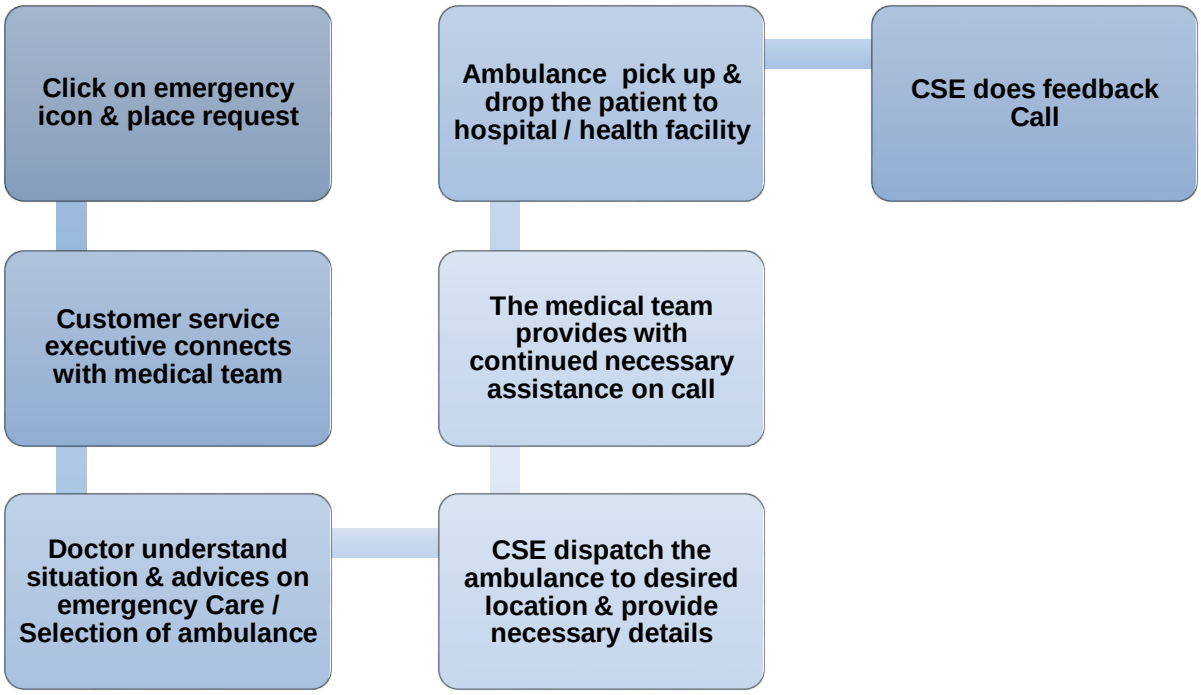
b) The call may be redirected to a qualified Medical Practitioner in order to evaluate the requirement for an ambulance with Advanced Life Support based on the Insured Person's condition.

c) The below mentioned details are to be made available for availing the services:
   1. UHID of Insured Person, as provided on the Health Card.
   2. Contact number of the Insured Person
   3. Location of Insured Person

How to Call an Ambulance? (Via Call)



How to Call an Ambulance? (Via Mobile Application)



IV. Discounts on services/products

We shall only facilitate the Insured Person in availing discounts on services/products including but not limited to investigations/diagnostic tests/ laboratory tests /health supplements/ /medical equipment/homecare services/virtual health & wellness sessions/AYUSH products/Fitness & wellness related activities & products etc. at our empanelled diagnostic centres, drugs/medicines ordered from pharmacies etc. offered by our network providers/ health service providers. These discounts can be viewed on our mobile application and one can avail these discounts depending on terms and conditions and subject to availability.

14. Loyalty Bonus

We will provide a :Loyalty Bonus of 20% of expiring or renewed Annual Sum Insured (whichever is lower) at the end of each Policy Year if the Policy is continuously renewed with the Company. The Loyalty Bonus will not be accumulated for more than 100% of the Annual Sum Insured under any circumstances subject to the following conditions.

i. The Loyalty bonus accumulated will be on floater basis for a floater Policy and on individual basis for an individual Policy.

ii. In a floater Policy as specified in the Policy Schedule, the Loyalty Bonus so accrued in the previous Policy Year(s), will only be available to those Insured Person(s) who were Insured in the previous Policy Year(s) and continue to be Insured with the Company in the subsequent Policy Year(s)

iii. Loyalty Bonus will not be added if the Policy is not renewed with the Company by the end of the Grace Period.

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

v. If the Policy Period is two or three year(s), any Loyalty Bonus that has accrued for first/second Policy Year will be credited at the end of first/ second Policy Year, as per the Policy Period , and it will be available for claims at the subsequent year.

vi. If the Insured Persons in the expiring Policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated Loyalty Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been renewed with the Company on a floater basis as specified in the Policy Schedule then the Loyalty Bonus to be carried forward for credit in such renewed Policy shall be the lowest among all the Insured Persons.

vii. In case of floater Policies where Insured Person renew their expiring Policy with the Company by splitting the Annual Sum Insured in to individual policies the Loyalty Bonus of the expiring policy shall be apportioned to such renewed policies in the proportion of the Annual Sum Insured of each renewed Policy as detailed in table below.

Annual Floater Sum Insured	**Accumulated Loyalty Bonus after 5 year**	**Floater Policy split to 2 Individual policies with Annual Sum Insured of 10 Lacs each**	**Revised Annual Sum Insured of each Individual Policy**	**Revised Accumulated Loyalty Bonus of each Individual Policy**
20 Lac	20Lac		10 Lac	10Lac

viii. The Loyalty Bonus shall be reduced in the same proportion in case of Annual Sum Insured reduction during Renewal.

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

ix. If the Annual Sum Insured under the Policy has been increased during renewal, the Loyalty Bonus shall be calculated on the Annual Sum Insured of the expiring Policy.

Annual Sum Insured	**Accumulated Loyalty Bonus**	**Annual Sum Insured increased to Rs. 10 Lacs**	**Revised Annual Sum Insured**	**Revised Accumulated Loyalty Bonus**
5 Lac	5 Lac		10 Lac	5 Lac

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

15. Tele Consultation(s)

We will arrange Tele Consultations and recommendations for routine health issues by a qualified Medical Practitioner or health care professional. For the purpose of this Cover Tele Consultation shall mean consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile application. The services provided under this Cover will be made available subject to the terms and conditions, and in the manner prescribed below:

- The Medical Practitioner may suggest/recommend/prescribe over the counter medications based on the information provided, if required on a case to case basis. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional*.

- There shall be no maximum limit on the count of Tele-Consultations that can be availed by the Insured Person(s) in a policy year
- This service will be available 24 hours a day, and 365 days in a year.
- We/Medical Practitioner/Healthcare professional may refer the Insured Person to another specialist or a general physician, (outside of our empaneled network) if required, and the charges for such specialist or a general physician will have to be borne by the Insured Person.
- We shall not be liable for any discrepancy in the information provided under this Cover.
- Choosing the services under this Cover is purely upon the Insured Person's own discretion and at own risk.
- **The proposer should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If the Insured Person has any concerns about His/ her health, He/ She may consult His/ her general practitioner. We shall not hold any responsibility towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner/ Healthcare professional*

17. Incentives associated with vaccination against pneumococcal disease

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

B. Optional Covers

The Covers listed below shall be available to the Insured Person only if the additional premium has been received by Us and the Optional Cover is specified to be in force for that Insured Person in the Policy Schedule.

Covers under this Section are subject to the terms, conditions, waiting periods and exclusions of this Policy and in accordance with the applicable Plan as specified in the Policy.

The Reset Benefit and Loyalty Bonus will not be applicable for this Section.

The Sum Insured for each of the Optional Covers (except Claim Protector and Worldwide Cover) shall be over and above the Annual Sum Insured of the Policy.

1. Preventive Health Check-up

Insured Person(s) aged 21 years and above can avail a Preventive Health Check-up as per eligibility under the plan opted only at our Network Providers or empaneled Health Service Providers anytime during the Policy Period subject to the below conditions

- This Cover can be availed only on Cashless basis and is limited to once per Policy Year per Insured Person.

- Maximum of 2 Preventive Health Check-up coupons shall be provided per Policy Year for a floater Policy
- This Cover can be availed through our mobile application or via utilization of Health Check-up coupons provided with the Policy kit by calling at our Toll free number: 1800 2666
- The Network Provider /Health Service Provider shall be assigned by Us post receiving Insured Person's request to avail a Health Check-up under this Cover
- Utilization of this Preventive Health Check-up will not impact the Annual Sum Insured or eligibility for Loyalty Bonus and/or Super Loyalty Bonus (if opted and/or available)
- Un-utilized Health Check-up package will not be carried forward to the next Policy Year and it will be the Insured Person's choice and responsibility to utilize the same with in the designated Policy Period. We shall not be liable to provide any reminders or notifications for the same.
- In-case of long term policies (2 year or 3 years), the Preventive Health Check-up package for all the Policy Years shall be provided together in the first Policy Year itself. It shall be the responsibility of the Insured Person to preserve the same and undergo the check-ups during the designated Policy Years.

Please Note:

- *We shall not hold any responsibility towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner/ Healthcare professional*
- *Choosing the services under this Cover is purely upon the customer's own discretion and at own risk.*
- *The Insured Person should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If the Insured Person has any concerns about His/ her health, He/ She may consult His/ her general practitioner.*
- *The Health records in respect of the Insured Person shall be saved with Us in order to award wellness points as a part of the Wellness Program. They may be made available to Insured Person(s) in their medical vault in our mobile application.*

2. Convalescence Benefit

We will pay the Insured Person(s) an amount as specified against this Cover in the Policy Schedule/Key Information Sheet if the Insured Person(s) are Hospitalized for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy. This Cover is payable only once to an Insured Person during each Policy Year of the Policy Period.

3. BeFit

All benefits under the BeFit cover can be availed only on cashless basis via our mobile application and are subject to the terms, conditions, and exclusions and the availability of Sum Insured under the Cover. BeFit cover can only be opted by Insured Person(s) up to the age of 65 years

All services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment. There will be a waiting period of 30 days for this cover

Any unutilized Consultations/E- consultations/ Annual Sum Insured/ sessions cannot be carried forward to the next Policy Year.

Choosing the services under this Cover is purely upon the Insured Person's own discretion and at own risk. The services provided under the various Covers are via third party health Service Providers/ Network Providers/ and We are not responsible for liability arising out of the services provided by these third parties.

The Insured Person(s) should seek assistance from a medical practitioner should they still have any concerns about their health even post availing services from our health service providers/network providers.

i. Physical Consultations

We shall cover the Medical Expenses incurred during the Policy Period for out-patient consultations from a General Medical Practitioner or Specialist Medical Practitioner or Super Specialist Medical Practitioner or AYUSH Medical Practitioner in relation to any Illness contracted or Injury suffered by the Insured Person during the Policy Period subject to the overall maximum number of consultations as specified against this Cover in the Policy Schedule. These services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment.

This Cover shall also include e-consultation given by a General Medical Practitioner or Specialist or Super Specialist Medical Practitioner or AYUSH Medical Practitioner through a virtual mode of communication such as but not limited to chat, email, video, online portal, or mobile application.

Physiotherapy sessions and counselling availed for psychiatric ailments or mental health issues shall be excluded from the scope of this Cover as the same are covered under cover 19 iv. Physiotherapy sessions and cover. 19 v. e-counselling respectively.

ii. Routine Diagnostic and Minor Procedure Cover

We shall cover medical expenses incurred for outpatient diagnostic tests recommended by Medical Practitioner under our cashless network available in the mobile application in relation to any Illness contracted or Injury suffered by the Insured Person during the Policy Period and for listed minor procedures undergone at a general practitioner or specialist/super-specialist medical practitioner by the Insured Person during the Policy Period maximum up to the Annual Sum Insured limit as specified against this Cover in the Policy Schedule. These services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment

The diagnostic tests shall include but will not be limited to histopathology, biochemistry, hematology, immunology, microbiology, serology, pathology, radiology, ultrasound and TMT. Genetic studies shall be excluded from the scope of this cover.

We may even arrange for diagnostic tests 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. This service shall be subject to availability of Our empaneled Health Service provider.

List of Minor Procedures covered under this Cover #

Drainage of abscess
Injection including Intramuscular (Per Injection cost)
Intravenous injection(IV)
Sprain Management (Joint movement/exercise)

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

#This includes only the cost of administration. The actual cost of consumables shall be covered under the pharmacy cover. However, the said cost will have to be borne by the Insured Person in case the Sum Insured under the Pharmacy Cover has been exhausted or is out of scope of the Pharmacy Cover or in case the consumable is a non-payable item as per IRDAI list of non-payables

iii. Pharmacy

We shall cover medical expenses incurred on purchase of medicines, drugs, and medical consumables, as prescribed by a Medical Practitioner under our cashless network available in the mobile application for any Illness contracted or Injury suffered by the Insured Person during the Policy Period, maximum up to the Sum Insured limit as specified against this Cover in the Policy Schedule through our Empaneled Health Service Provider subject to availability on the date of the request.
Health Supplements, Nutraceuticals, foods for special dietary use, foods for special medical purpose, foods with added probiotics and/or foods with added prebiotics, vaccinations, vitamins, tonics or other related products are excluded from the scope of this Cover

iv. Physiotherapy Session

We shall cover medical expenses incurred by the Insured Person for Physiotherapy Sessions with a qualified physiotherapist within our cashless network to treat Illness, injury or deformity suffered as advised by qualified Medical Practitioners during the Policy Period by physical methods such as but not limited to massage, heat treatment, ultrasound, Laser and exercises maximum up to the number of visits/ sessions as specified against this Cover in the Policy Schedule.
These services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment.
The time duration of each physiotherapy session shall be restricted to thirty minutes only.

v. e-Counseling

We shall cover expenses incurred by the Insured Person on e-counseling session(s) with a Psychologist via our mobile application for providing assistance in dealing with issues such as but not limited to personal and lifestyle imbalance, pre-marital counselling, parenting and child care, speech impairment, and problems related to psychological/mental illness/ psychiatric and psychosomatic disorders, stress, anxiety maximum up to the number of sessions as specified against this Cover in the Policy Schedule.

The e-counseling sessions shall be availed only through virtual modes of chat or tele etc. via our mobile application.

vi. Diet and Nutrition e-Consultation

We will cover expenses incurred by the Insured Person on diet and nutrition e-consultation during the Policy Period on a virtual platform via our mobile application for the duration as specified against this Cover in the Policy Schedule.

The e-consultation shall be availed only through virtual modes of chat or tele etc. via our mobile application.

Claim Procedure for BeFit

All claims will be adjudicated only on cashless basis via our mobile application and are subject to the terms, conditions, and exclusions of the Policy and the availability of the Sum Insured. Cashless Facility is only available at specific Network Providers/Health Service Provider available on the mobile application. We reserve the right to modify, add or restrict any Network Provider/Health Service Provider for Cashless facility at Our sole discretion.

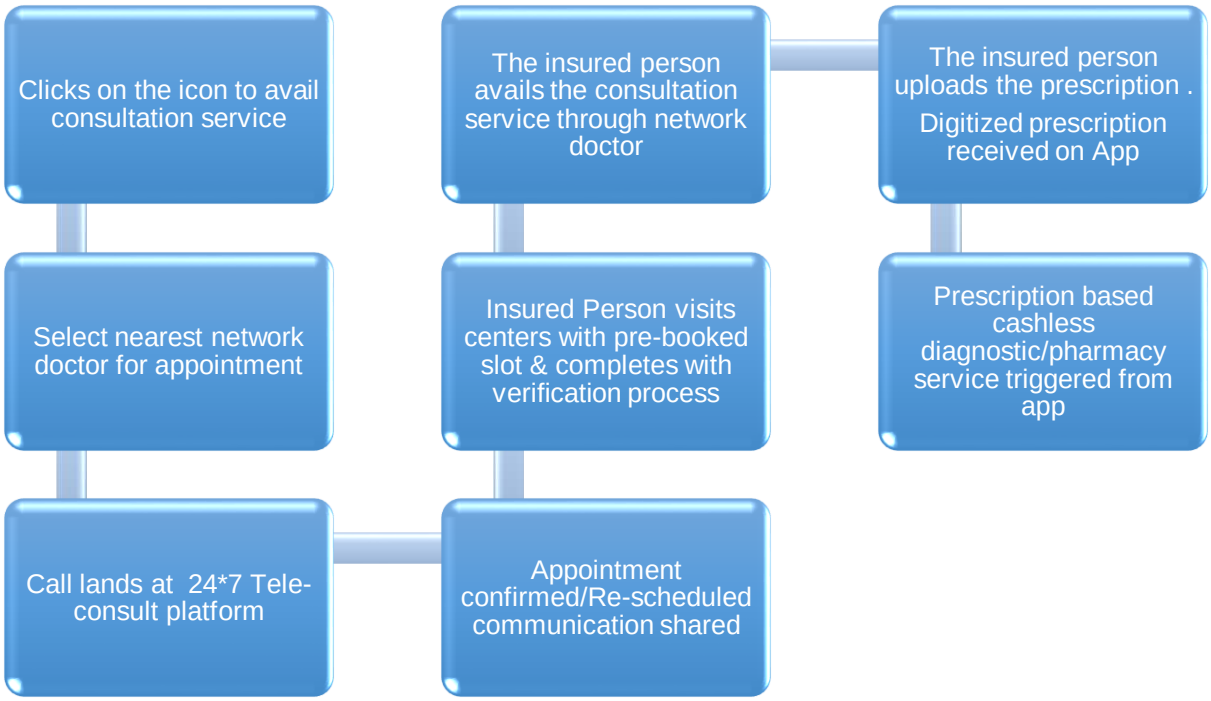
- To avail of Cashless Facility at the health Service Provider / Network Provider, the Insured Person/claimant is required to produce information on the health card available on the application for verification and validation. The request shall be considered after having obtained accurate and complete information for the Illness or Injury, where applicable, for which Cashless Facility is sought and We shall confirm the request digitally.
- In case the services availed exceed the eligibility of the Policy, the difference shall have to be paid directly to the Hospital/Network Provider/Health Service Provider by the Insured Person/claimant.
- To avail the benefits and services under this Cover, Insured Person shall need to raise a request through mobile application
- The Routine diagnostic and minor procedure cover /Pharmacy cover services shall only be covered for prescriptions by an empaneled Network Medical Practitioner through the Mobile Application.

How to avail the cashless services under the BeFit cover on the mobile application

1. The Insured Person will have to download the mobile application from the app store/playstore. Post download the Insured Person will have to complete the registration process and login to the home page.

2. On the home page, the Insured person will have to go to visit the out-patient service section like consultation, diagnostics and pharmacy

   A schematic representation of the claims process is as below



4. Hospital Daily Cash

We will pay You a daily fixed amount, as stated against this Cover in the Policy Schedule, for each and every continuous completed day of Hospitalization up to a maximum of 10 consecutive days, if such Hospitalization is at least for a minimum of 3 consecutive days and it falls within the Policy Year. The Claim under this Cover will be payable only if We have admitted Our liability under "In-patient Treatment" section of the Policy. This Cover is payable only once to an Insured Person during each Policy Year of the Policy Period.

5. Nursing at Home post Hospitalisation

We will pay You for the expenses incurred by You, up to the amount specified against this Cover for each day (as per plan eligibility/depending on annual sum insured) up to a maximum of 15 days post Hospitalization for the medical services of a Qualified Nurse at Your residence, provided that the nurse is employed in a Hospital and the engagement of such Qualified Nurse is certified as necessary by a Medical Practitioner and relate directly to any Illness or Injury, covered under the Policy.

The Claim under this Cover will be payable only if We have admitted Our liability under "In-patient Treatment" section of the Policy.

6. Compassionate Visit

In event of Your Hospitalization, which in the opinion of the Medical Practitioner attending on You, extends beyond a period of 5 consecutive days, We will indemnify the cost of the economy class air ticket incurred by Your Immediate Family Member from and to the place of origin of such Immediate Family Member or the place of residence of the Immediate Family Member.

Our liability under this Cover, however, in respect of any one event or all events of Hospitalization during the Policy Year shall not in aggregate exceed Rs. 20,000 per Policy Year of Policy Period.

7. Maternity Cover and New Born Baby Cover:

I. Maternity Cover:

We will cover the Medical Expenses incurred for delivery of a child, including a caesarean section, during Hospitalization and Pre-natal and post- natal expenses or lawful medical termination of pregnancy during the Policy Year maximum up to the limits as specified in the Policy Schedule.

The cover shall be limited to 2 deliveries/ terminations during the Period of Insurance.

a. The Cover shall be available after 24/36 months (as per the plan opted) of continuous coverage have elapsed since the inception of the first Policy with Us.

b. Pre- and Post-Hospitalization expenses will not be covered under this Cover

c. This Cover is available only under a family floater Policy

d. This Cover is available for You or Your spouse provided You and Your spouse, both are covered under the same family floater Policy

e. We will not cover ectopic pregnancy under this Cover (the same shall be covered under In-patient Treatment)

II. New Born Baby Cover

We will cover the Medical Expenses incurred by You on Hospitalization of a “New born Baby” during each Policy Year of Policy Period subject to the limits as specified in the Policy Schedule. This Cover will be provided only if Maternity Cover is applicable to You.

This Cover will cover Medical Expenses incurred on the “New born Baby” during Hospitalization (for a minimum period of consecutive 24 hours) for a maximum period up to 90 days from the date of birth of the baby

8. Super Loyalty Bonus

All terms and conditions applicable to the Basic Cover ‘Loyalty Bonus’ feature will apply to this cover as well, except for the below mentioned terms and conditions:

- If the Policy is being renewed without any break in period the Insured Person will be given a Super Loyalty Bonus viz. 50% increase in the Annual Sum insured for each completed year, maximum of 100% of Sum insured.
- Super Loyalty Bonus will be over and above the accrued Loyalty Bonus, if any.
- At the time of renewal if the Insured Person opts out of this Cover, then the Super Loyalty Bonus accrued up until the expiring Policy Year will be forfeited.
- The Super Loyalty Bonus will be credited automatically to the subsequent Policy Year even in the case of multi-year policies (2 & 3 year policy tenure)

9. Sum Insured Protector

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

The Annual Sum Insured will be increased on cumulative basis at each Renewal on the basis of inflation rate in previous year. Inflation rate would be computed as the average CPI of the entire calendar year published by the Central Statistical Organisation (CSO).

The % increase will be applicable only on Annual Sum Insured under the Policy and not on Loyalty Bonus or any other Covers which leads to increase in Sum Insured.

In case, an Insured Person(s) opts out of Sum Insured Protector Cover at Renewal, all the accrued amount under the Sum Insured Protector Cover in the Policy till date will be reduced to zero

Illustration – Considering Consumer Price Index to be 6%

*

Year	Annual Sum Insured	Opted for Sum Insured Protector	Sum Insured Protector at renewal	Overall Sum Insured Protector
0	Rs. 10,00,000	Yes	Not applicable	Not applicable
1	Rs. 10,00,000	Yes	6%x 10,00,000 = 60,000	Rs. 60,000
2*	Rs. 15,00,000	Yes	6%x 10,00,000 = 60,000	Rs. 60,000 + Rs. 60,000 = Rs. 1,20,000
3	Rs 15,00,000	Yes	6%x15,00,000=90,000	Rs. 1,20,000 + Rs. 90,000 = Rs. 2,10,000
4	Rs. 15,00,000	No	Nil as customer opted out of the Optional Cover	Nil

*Insured Person has enhanced his/her Annual Sum Insured from Rs. 10 Lacs to Rs. 15 Lacs

10. Claim Protector

If a claim has been accepted under the “Inpatient Treatment” or “Daycare Procedure/Treaments” Cover, the items which are included in the List of Excluded items in clause no.. f (ii) 11 (Please refer List I- Items for which coverage is not available in the Policy) , which are non – payable, to the particular claim, will become payable. The maximum claim payout under this Cover shall be limited to Annual Sum Insured under the Policy.

Any Sum Insured as available under Loyalty Bonus Super Loyalty Bonus (if any)/ Sum Insured Protector (if any) will not be available for Claim Protector Cover.

11. Worldwide cover (Outside India)

I. Hospitalization cover

We will cover the Insured Person for Hospitalization expenses including planned Hospitalization incurred outside India and anywhere across the world including USA and Canada, up to the Annual Sum Insured subject to the terms & conditions specified hereunder:

i. This cover can only be availed by Insured Person(s) up to the age of 65 years and who are resident(s) of India and are within the geographical boundaries of India during Policy issuance. Non- disclosure or mis-representation with respect to the above will impact claims admissibility under this Cover and lead to Policy Cancellation
ii. A Co-payment of 10% will be applied to every admissible claim
iii. The coverage is available for 45 consecutive days from the date of travel in a single trip and 90 days in a cumulative basis as a whole in a Policy Year.
    a. The expenses covered under this cover will be limited to Inpatient Hospitalization Expenses and Day Care Treatment/ Procedure Expenses.
    b. Expenses incurred for Pre and Post Hospitalization Medical Expenses, Out- patient Treatment or any other Basic Covers/Optional Covers under this Policy shall not be covered.
iv. The payment of any claim will be based on the rate of exchange as on Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian rupees for payment of claims. If on the Insured Person's date of loss, if the RBI rates are not published, the exchange rates published next shall be considered for conversion.
v. In case of planned hospitalization, prior intimation at least 7 days in advance of the travel and due approval from Us will be necessary.
vi. Any Sum Insured as available under Loyalty Bonus / Super Loyalty Bonus (if any)/ Sum Insured Protector (if any) will not be available for worldwide cover and Hospitalization/day care expenses incurred will be covered only up to the Annual Sum Insured under the Policy.
vii. Reset benefit will not be available for worldwide cover

II. Road Emergency Ambulance

We will cover the expenses incurred on road ambulance services which are offered by a healthcare or ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital from the place of Accident/Illness with adequate emergency facilities for the provision of Emergency Care, provided that:

- Our maximum liability under this Benefit for every claim arising during the Policy Year will be restricted up to Rs.35,000 per hospitalization.
- We have accepted a claim under Worldwide Cover (Hospitalization cover) in respect of the Insured Person for the same Accident/Illness for which road ambulance services were availed.
- This Benefit includes and is limited to the cost of the transportation of the Insured Person:
    a) To the nearest Hospital with higher medical facilities which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, and only if that transportation has been prescribed in writing by a Medical Practitioner and is for Medically Necessary Treatment.

b) From a Hospital to the nearest diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.

- The ambulance / service provider providing the services should be a registered provider with road traffic authority.

Any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence while transferring an Insured Person after he/she has been discharged from the Hospital are not payable under this cover.

III. Air Ambulance

We will cover the expenses incurred on Air Ambulance services up to the Annual Sum Insured which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

i. It is for a life threatening emergency health conditions of the Insured Person which requires immediate and rapid ambulance transportation from the place where the Insured Person is situated at the time of requiring Emergency Care to a hospital provided that the transportation is for Medically Necessary Treatment, is certified in writing by a Medical Practitioner, and Domestic Road Ambulance services cannot be provided.

ii. Such air ambulance providing the services, should be duly licensed to operate as such by a competent government Authority.

iii. This cover is limited to transportation from the area of emergency to the nearest Hospital only;

iv. We will not cover:

d. Any transportation from one Hospital to another;

e. Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital

f. Any transportation between two countries.

v. We have accepted a claim under Worldwide Cover (Hospitalization cover) in respect of the Insured Person for the same Accident/Illness for which air ambulance services were availed.

We shall not be liable if Medically Necessary Treatment can be provided at the Hospital where the Insured Person is situated at the time of requiring Emergency Care.

12. Dependent Accommodation

If the Insured Person contract an Illness or suffer an Injury due to Accident during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized, We will pay the daily amount for the accommodation of the dependent in the hospital only as specified in the Policy Schedule/Key Information Sheet against this benefit in respect of each continuous and completed day of your Hospitalization.

For the purpose of this Optional Cover, Dependent means immediate family members as defined

Provided:

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

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

c) The medical practitioner certifies that the hospitalised insured member required hospitalization of minimum 3 consecutive days, maximum up to 10 days

d) We will pay only for one immediate family member.

d. EXCLUSIONS UNDER THE POLICY

We will not be liable for any Deductible amount or Co-payment amount, if applicable and as specifically defined in the Policy Schedule under the Policy

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

i. Standard Exclusion (Exclusions for which standard wordings are specified by IRDAI)

1. Code- Excl01: Pre-Existing Diseases

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 12/24 months (as per the plan opted) of continuous coverage after the date of inception of the first policy with insurer.

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

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

d) Coverage under the policy after the expiry of 12/24 months (as per the plan opted) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

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

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

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

List of specific diseases/procedure:

- Cataract

- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy unless because of malignancy
- All types of Hernia, Hydrocele
- Fissures &/or Fistula in anus, hemorrhoids/piles
- Arthritis, gout, rheumatism and spinal disorders
- Joint replacements unless due to accident
- Sinusitis and related disorders
- Stones in the urinary and billiary systems
- Dilatation and curettage , Endometriosis
- All types of Skin and internal tumors/ cysts/nodules/ polyps of any kind including breast lumps unless malignant
- Dialysis required for chronic renal failure
- Surgery on tonsils, adenoids and sinuses
- Gastric and Duodenal erosions & ulcers
- Deviated Nasal Septum
- Varicose Veins/ Varicose Ulcers

3. Expenses related to the treatment of the below mentioned illness within 90 days from the first policy commencement date shall be excluded unless they are pre-existing and disclosed at the time of underwriting

i. Hypertension
ii. Diabetes
iii. Cardiac Conditions

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

4. Code- Excl03: 30-day waiting period

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

5. Permanent Exclusions

i. Code- Excl04: Investigation & Evaluation

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

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

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

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

iii. **Code- Excl06:** Obesity/ Weight Control

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
5) greater than or equal to 40 or
6) 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:
   - Obesity-related cardiomyopathy
   - Coronary heart disease
   - Severe Sleep Apnea
   - Uncontrolled Type2 Diabetes

iv. **Code- Excl07:** Change of Gender treatments

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

v. **Code- Excl08:** Cosmetic or plastic Surgery

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

vi. **Code- Excl09:** Hazardous or Adventure sports

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

vii. **Code- Excl10:** Breach of law

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

viii. **Code- Excl11:** Excluded Providers

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

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

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

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

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

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

xiv. **Code- Excl17:** Sterility and Infertility: Expenses related to, sterility and infertility. This includes:

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

xv. **Code- Excl18:** Maternity:

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

Note: This exclusion shall not be applicable in case Optional Maternity Cover has been opted for.

ii. **Specific Exclusion (Exclusions other than those mentioned under e.i above)**

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

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

c. Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

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

e. Acupressure, acupuncture, magnetic and other therapies

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

g. Expenses for venereal disease or any sexually transmitted disease except HIV.

h. Screening, counselling or Treatment relating to external birth defects and external congenital Illnesses or defects or anomalies

i. Treatment taken outside the country, unless Worldwide Cover has been opted for.

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

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

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

e. GENERAL TERMS AND CONDITIONS

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

1. Disclosure of Information

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

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

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. Complete Discharge

Any payment to the policyholder, 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

4. Multiple Policies

In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a

settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be treated as the primary Insurer and shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

5. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s) who has made that particular claim,who shall be jointly and severally liable for such repayment to the insurer

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:—

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

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

6. Cancellation

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

i. 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.

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

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

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.

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

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

8. **Portability**

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

9. **Renewal of Policy**

   The policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured person provided the policy is not withdrawn and also subject to moratorium conditions.
   The Company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.

I. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
II. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
III. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of thirteen 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
IV. No loading shall apply on renewals based on individual claims experience

   The Company shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy. -

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 loyalty bonus, waiver of waiting period as per regulatory prescription, provided the policy has been maintained without a break.

11. Moratorium Period

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

12. Premium Payment in installments

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

i. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
ii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iii. No interest will be charged If the instalment premium is not paid on due date.
iv. In case of instalment premium due not received within the grace period, the policy will get cancelled.
v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vi. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

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

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

14. Free look period

Every insured of new individual health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the insured and stamp duty

15. Redressal of Grievances

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

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

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

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

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

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

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

Note: The Details of Insurance Ombudsman are Available on Annexure A

16. Nomination:

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

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

iii. Specific Terms and Clauses (Terms and clauses other than those mentioned above under f.(i) above)

16. Zone based premium

For the purpose of policy issuance, the premium will be computed basis the zone chosen by Insured Person in the proposal form. The premium that would be applicable zone wise and the areas defined in each zone are as under

Zone	State/District
Zone A	Delhi, Mumbai (including Thane district, Navi Mumbai) , Haryana (excl. Faridabad, Jhajjar, Jind, Nuh, Panipat, Rewari, Mewat, Palwal), Daman & Diu, Dadra Nagar, Ahmedabad, Surat, Noida City, Ghaziabad district, Hapur district, Meerut district, Muzaffarnagar district, Shamali district

Zone B	Pune, Kolkata, Telangana (Incl. Hyderabad), Madhya Pradesh, Goa, Gujarat (excl. Ahmedabad and Surat), Bangalore, Chennai, Andhra Pradesh, Chattisgarh, Pondicherry, Uttarakand
Zone C	Rest of India (Punjab, Rajasthan (excl. NCR region), Chandigarh, Himachal Pradesh, Jammu & Kashmir, Ladakh, Lakshadweep, Kerala, Tamil Nadu (excl. Chennai, Pondicherry), Odisha, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Sikkim, Andaman & Nicobar, Rest of Karnataka, West Bengal (excl. Kolkata), Bihar, Jharkhand, Maharashtra (excl. Mumbai and Pune), UP (excl. NCR Region))
Zone D	Rest of NCR[Alwar, Bagpat, Bharatpur, Bulandshahr, Faridabad, Gautam Buddha Nagar excluding Noida, Jhajjar, Jind, Nuh, Panipat, Rewari, Mewat, Palwal]

Additional zone based Co-Payment as per table below would be levied on each and every claim (over and above any other co-payment as applicable in the policy) in case medically necessary treatment has been taken in a zone higher (Zone D being the highest followed by Zone A, followed by Zone B and Zone C being the lowest) than the zone for which premium has been paid on issuance of the policy.

Zone	State/District	Treatment taken in Zone	Zone based co-payment
Zone A	Delhi, Mumbai (including Thane district, Navi Mumbai) , Haryana (excl. Faridabad, Jhajjar, Jind, Nuh, Panipat, Rewari, Mewat, Palwal), Daman & Diu, Dadra Nagar, Ahmedabad, Surat, Noida City, Ghaziabad district, Hapur district, Meerut district, Muzaffarnagar district, Shamali district	Zone A	Nil
		Zone B	Nil
		Zone C	Nil
		Zone D	Nil
Zone B	Pune, Kolkata, Telangana (Incl. Hyderabad), Madhya Pradesh, Goa, Gujarat (excl. Ahmedabad and Surat), Bangalore, Chennai, Andhra Pradesh, Chattisgarh, Pondicherry, Uttarakand	Zone A	8%
		Zone B	Nil
		Zone C	Nil
		Zone D	8%
Zone C	Rest of India (Punjab, Rajasthan (excl. NCR region), Chandigarh, Himachal Pradesh, Jammu & Kashmir, Ladakh, Lakshadweep, Kerala, Tamil Nadu (excl. Chennai, Pondicherry), Odisha, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Sikkim, Andaman & Nicobar, Rest of Karnataka, West Bengal (excl. Kolkata), Bihar, Jharkhand, Maharashtra (excl. Mumbai and Pune), UP (excl. NCR Region))	Zone A	16%
		Zone B	8%
		Zone C	Nil
		Zone D	16%
Zone D	Rest of NCR[Alwar, Bagpat, Bharatpur, Bulandshahr, Faridabad, Gautam Buddha Nagar excluding Noida, Jhajjar, Jind, Nuh, Panipat, Rewari, Mewat, Palwal]	Zone A	Nil
		Zone B	Nil
		Zone C	Nil
		Zone D	Nil

There will be No zone based co-payment for Zone A and for Zone D i.e. Insured Persons(s) who have opted for Zone A or Zone D can take treatment anywhere in India without any additional zone based co-payment

Material Change

18. The Insured Person shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and/or premium, if necessary, accordingly.

19. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Proposer or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

20. Notice & Communication

Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

21. Territorial Limit

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

22. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

a. In the case of his/ her (Insured Person) demise.

i. However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case, the other Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the Insured Person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy will be effective.

b. Upon exhaustion of Sum Insured and any other additional sum insured (if any), for the Policy Year. However, the Policy is subject to Renewal on the due date as per the applicable terms and conditions.

23. Territorial Jurisdiction

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

24.Arbitration

If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015.
It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability

under or in respect of the policy, iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

25. Policy Alignment

a. Policy Alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the Policy Start Dates. We can align the policies by extending the coverage of one Policy till the end date of the other Policy.
b. Such policies will be charged with premium on pro rata basis though the Sum Insured under the Policy shall remain constant.

26.Endorsements (Changes in Policy)

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped. Any change in plan, Optional Covers opted may happen only during Renewal subject to underwriting.

The proposer may be changed only at the time of Renewal. The new proposer must be the legal heir/immediate family member. Such change would be subject to acceptance by the Company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

Mid- term endorsement of addition of member in the Policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation

27. Change of Sum Insured or Change of Plan

Change of Sum insured or Change of Plan can be done only at the time of Renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the Sum Insured

28. Non Payables

Below are the non-payable items applicable in the policy. The list may be updated as per the direction of Authority, for updated list please visit Our website: www.icicilombard.com

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

List of Non Payable Items	
Sr. No	**Items**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS

11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets

54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	RECOVERY KIT, ETC]ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT,
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sr. No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX I MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/VARMER BLANKET
27	ADMISSION KIT

28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

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

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

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

f. Other Terms and Conditions

I. CLAIM ADMINISTRATION

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

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

1. Annual Sum Insured
2. Loyalty Bonus (if accrued and available)
3. Super Loyalty Bonus (if accrued and available)
4. Sum Insured Protector (if accrued and available)
5. Reset Sum Insured (if applicable)

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

1 CLAIMS PROCEDURE

(A) For Cashless Settlement

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

Pre-authorization

i. Prior to taking treatment and/or incurring Medical Expenses at a Network Provider, You must contact the Company or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Proposer, nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request pre-authorisation at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation. To avail of Cashless Hospitalisation facility, you are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card Or You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. If You notify pre authorization request for cashless facility through any of our empanelled network hospitals along with complete set of documents & information, We will decide on request within 1 hours of the actual receipt of such pre authorization request and We will confirm Your request in writing. Further, we shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital."

(B) For Reimbursement Settlement

i. You shall give notice to Us or Our In house claim processing team by calling the toll free number 1800 2666 or emailing us at customersupport@icicilombard.com as specified in the Policy provided to You and also in writing at Our address with particulars as below:

- Policy number;
- Your Name;
- Your relationship with the Proposer;
- Nature of Illness or Injury;
- Name and address of the attending Medical Practitioner and the Hospital;
- Any other information that may be relevant to the Illness/ Injury/ Hospitalisation

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

ii. You must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.

iii. You or someone claiming on Your behalf must promptly and in any event within 30 days of Your discharge from a Hospital (for post-hospitalisation expenses, within 30 days from the completion of post-hospitalisation period) deliver to Us the documentation (written details of the quantum of any Claim along with all original supporting documentation) as more particularly listed in CLAIM DOCUMENTS section collected from the hospital at the time of discharge along with the claim form In case there is a delay beyond 30 days in submission of claim documents, we may condone the delay provided the insured person submits a valid reason justifying the delay to us in writing. The claim will be processed within 15 days of receipt of claim along with claim form and documents.

iv.

However, in both the above cases i.e. g. Claim Administration I.1(A) & (B)You must take reasonable steps or measures to minimise the quantum of any Claim that may be covered under the Policy

If so requested by Us, You will have to undergo a medical examination from Our nominated Medical Practitioner, as and when We or Our In house claim processing team considers reasonable and necessary. The cost of such examination will be borne by Us.

Claim falling in two Policy Periods

If the claim event falls within two Policy periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Periods, including the Deductibles for each Policy Period. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the Renewal/due date of premium of health insurance Policy, if not received earlier.

2. CLAIM DOCUMENTS

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

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

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

Annexure A

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, 7th 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 Uttaranchal 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.

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