

Health Shield Inclusive

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 sum insured/ 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 Add-ons/Optional Covers:

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 a relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

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

"Break in Policy" means the period of gap that occurs at the end of the existing policy term / installment premium due date, when the premium due for renewal on a given policy

or installment premium due is not paid on or before the premium renewal date or grace period.

"Cashless facility" means a facility extended by the Insurer to the Insured where, the payments of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions are directly made to the network provider by the Insurer to the extent pre-authorization 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 is called Internal Congenital Anomaly.
- b. **External Congenital Anomaly** - Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly.

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

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

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

Day Care Centre includes an AYUSH Day Care Centre as defined below

"AYUSH Day Care Centre" means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health center 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:

- i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iii. 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 hospitalization of more than 24 hours.

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

"Deductible" means a cost-sharing requirement under a health insurance Policy that provides, that the Insurer will not be liable for a specified rupee amount in case of indemnity 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.

"Disclosure to information norm" means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, established fraud or non-disclosure of any material fact.

"Domiciliary hospitalization" means medical treatment for an Illness/Disease/Injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

- i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- ii. 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" - A 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 Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

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

Hospital includes an AYUSH Hospital as defined below:

"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 all 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
 - iv. operation theatre where surgical procedures are to be carried out;
 - v. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

"Hospitalization" means admission in a hospital for a minimum period of 24 consecutive "in-patient 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 a 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:
 1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests;
 2. it needs ongoing or long-term control or relief of symptoms;
 3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
 4. it continues indefinitely;
 5. it recurs or is likely to recur

"Injury" means accidental physical bodily harm excluding Illness 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 treatment expense" means

- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

- b. Expenses towards lawful medical termination of pregnancy during the Policy period.

"Medical 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 license. The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured/ Insured Person's family who includes Father, Mother, Father-in-law, Mother-in-law, Son, Daughter, Son-in-law, Daughter-in-law, Brother or Sister. 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

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

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

- i. is required for the medical management of the Illness or Injury suffered by the Insured;
- ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- iii. must have been prescribed by a medical practitioner,
- iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

"Medical Advise" means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

"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.

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

"Non- Network Provider" means any hospital, day care center 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-hospitalization 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 Hospitalization was required, and
- b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

"Post-hospitalization Medical Expenses" means Medical Expenses incurred during predefined number of days immediately after the Insured Person is discharged from the hospital provided that:

- i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
- ii. The In-patient Hospitalization claim for such Hospitalization 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.

"Pre-existing Disease" means any condition, ailment, injury or disease:

- a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

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

“Renewal” means the terms on which the contract of insurance can be renewed as per applicable regulatory prescriptions 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.

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

“Room rent” means the amount charged by a hospital towards room and boarding expenses and shall include associated medical expenses.

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

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

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

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

“Accidental Emergency” means a traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a person’s health or result in loss of life.

“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.

Age means completed years on last birthday as on Commencement Date.

Ambulance means a motor vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

Associated 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. In case of copayment associated with room rent higher than the entitled room rent limit,

Associated Medical Expenses will not include:

Cost of pharmacy and consumables.

Cost of implants and medical devices

Cost of diagnostics

“Company” means ICICI Lombard General Insurance Company Limited.

“Commissioning couple” means an infertile married couple who approach an assisted reproductive technology clinic or assisted reproductive technology bank for obtaining the services authorized of the said clinic or bank;

“Couple” means the legally married Indian man and woman above the age of 21 years and 18 years respectively;

“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 rate able proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

CD4 cells are a type of white blood cells, also called as CD4 T lymphocytes or ‘helper T cells’ which serve as primary receptor for HIV.

"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.

"Dependent Child" means a child (natural or legally adopted), who is unmarried, aged between 91 days and 30 years, financially dependent on the Insured and does not have his / her independent sources of income.

"Disease" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner.

"Diagnostic Tests" Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

Diagnostic Centre means a place where diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition are done.

HIV means Human Immunodeficiency Virus

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

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

"Intending couple" means a couple who have a medical indication necessitating gestational surrogacy and who intend to become parents through surrogacy;

"Intending woman" means an Indian woman who is a widow or divorcee between the age of 35 to 45 years and who intends to avail the surrogacy;

Life-threatening Emergency shall mean a serious medical condition or symptom resulting from Injury or Illness which is not Pre-Existing Disease, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.

"Maximum Limit of Indemnity" means the sum total of Annual Sum Insured

Material Facts means 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.

Mental Illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary.

demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.

Medical practitioner for treatment of mental illnesses means a medical practitioner possessing apost-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act;

Mental Health Establishment means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends;

“Oocyte” means a developing egg in the ovary

“Oocyte donor” means a person who provides oocyte with the objective of enabling an infertile intending couple or intending woman to have a child

“Oocyte retrieval” means a procedure of removing oocytes from the ovaries of a woman

“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.

Person with Disability/Disability/Disabled means a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others.

“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.

"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 Schedule means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

"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.

Proposal Form means a form to be filled in by the Prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

“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) 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.

Sub-limit means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit. The Sub-limit as applicable under the Policy is specified in the Policy Schedule against the relevant Cover in force under the Policy.

"Sum Insured" or "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.

"Surrogacy" means a practice whereby one woman bears and gives birth to a child for an intending couple with the intention of handing over such child to the intending couple after the birth;

"Surrogacy clinic" means surrogacy clinic, center or laboratory, conducting assisted reproductive technology services, in-vitro-fertilization services, genetic counselling center, genetic laboratory, Assisted Reproductive Technology Banks conducting surrogacy procedure or any clinical establishment, by whatsoever name called, conducting surrogacy procedures in any form;

"Surrogate mother" means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the conditions as specified in the surrogacy (regulation) act, 2021

"Surrogacy procedures" means all gynecological, obstetrical or medical procedures, techniques, tests, practices or services involving handling of human gametes and human embryo in surrogacy

"Third Party Administrator (TPA)" means any organization or institution that is licensed by the IRDA as a TPA and is engaged by the Company for a fee or remuneration for providing Policy and claims facilitation services to the Insured/ Insured Person as well as to the Company for an insurable event.

"Twin Sharing Room" means an air conditioned Hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the most economical of all accommodations available as twin sharing rooms in that Hospital

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.

Waiting Period means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the Waiting Period, diseases/ treatments shall be covered provided the Policy has been continuously renewed without any break.

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

d. BENEFITS COVERED UNDER THE POLICY

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 including HIV/AIDS described below if this is contracted or sustained by an Insured Person including Person With Disabilities 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 up to the limits as mentioned in the Policy Schedule.
- ii. Intensive Care Unit Charges;
- iii. Qualified Nurse charges;
- iv. Medical Practitioner's Fees;
- v. Anesthesia, blood, oxygen, operation theatre charges, medicines, drugs and consumables (other than those specified in the list of excluded expenses (non-medical) in Annexure I; Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure; 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. If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this policy, then the Insured Person shall bear a rateable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred
 - a. For the purpose of this cover, "Associated medical expenses" shall include room rent, nursing charges, operation theatre charges, fees of medical practitioner including surgeon/anesthetist/ specialist within the same hospital where the insured person has been admitted and will not include the cost of pharmacy and consumables, cost of implants, medical devices and cost of diagnostics.
 - b. Proportionate deductions are not applicable for ICU charges
 - c. Proportionate deductions shall not be applicable for hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.
- ii. 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 Benefit.
- iv. Expenses associated with automation machine for peritoneal dialysis shall not be payable
- v. If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this Policy, then the Insured Person shall bear a rateable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred
 - a. For the purpose of this cover, "Associated medical expenses" shall include room rent, nursing charges, operation theatre charges, fees of medical practitioner including surgeon/anesthetist/ specialist within the same hospital where the insured person has been admitted and will not include the cost of

pharmacy and consumables, cost of implants, medical devices and cost of diagnostics.

- b. Proportionate deductions are not applicable for ICU charges
- c. Proportionate deductions shall not be applicable for hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

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 prostate (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	Bronchial Thermoplasty
12	IONM - (Intra Operative Neuro Monitoring)

4. Pre- Hospitalization Medical Expenses

IRDA Reg. No. 115
Mailing Address:
 601 & 602, 6th Floor, Interface 16,
 New Linking Road, Malad (West)
 Mumbai - 400 064

ICICI Lombard General Insurance Company Limited

CIN: L67200MH2000PLC129408
Registered Office Address:
 ICICI Lombard House, 414, P Balu Marg,
 Off Veer Savarkar Road, Nr Siddhi Vinayak Temple,
 Prabhadevi, Mumbai 400 025

UIN: Health Shield Inclusive ICIHLP25045V012425
Toll free no: 1800 2666
Alternate no : 86552 22666 (chargeable)
E-mail: customersupport@icicilombard.com
Website : www.icicilombard.com

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 30 days 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- Hospitalization Medical Expense

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 60 days as specified in the Policy Schedule provided that:

- i. We have accepted the claim under "Inpatient Treatment" 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 Hospitalization

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. Domestic Road 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 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.

8. 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 confirms to the Transportation of Human Organs 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.

9. 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

10. Bariatric Surgery Cover:

We will cover medical expenses incurred in respect of Hospitalization of the Insured Person for Surgical Procedure/treatment for Obesity up to Annual Sum Insured, subject to below conditions and Eligibility criteria:

- i. The surgery has to be conducted upon the advice of a Medical Practitioner
- ii. The surgery/procedure conducted should be supported by clinical protocols
- iii. The Insured Person undergoing the bariatric surgery/procedure has to be 18 years of age or older
- iv. Body Mass Index (BMI) of the insured person has to be
 - a) Greater than or equal to 40 **OR**
 - b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 1. Obesity-related cardiomyopathy
 2. Coronary heart disease
 3. Severe Sleep Apnea
 4. Uncontrolled Type2 Diabetes

Conditions: -

- i. This benefit has a waiting period of 24 months from date of inception of the first policy with Us.
- ii. Any kind of Additional Sum Insured accrued will not be available for this cover
- iii. The Insured Person shall mandatorily obtain cashless approval prior to undergoing the surgery/ treatment
- iv. Bariatric surgery/treatment performed for cosmetic reasons is excluded

11. In Patient Hospitalization for Surrogate Mother:

We will cover the Medical Expenses incurred in respect of In Patient Hospitalization of the Surrogate mother appointed by the "Intending Couple"/" Intending woman" for complications arising out of pregnancy and post-partum delivery complications during the Policy Period, up to a maximum limit of Rs. 5 Lakhs and subject to the following conditions:

- i. Initial waiting period of 30 days will be applicable
- ii. The maximum coverage available for a surrogate mother is a period of thirty-six (36) continuous months after the surrogacy procedure has been successful subject to policy renewal
- iii. Any expenses incurred on delivery of the new born (either via normal delivery or caesarean section) are excluded from the scope of this cover
- iv. This coverage shall only be available if all the provisions as specified in The Surrogacy Regulation Act (2021), and all the rules and regulations made thereunder are fulfilled

- v. The terms and conditions of In-patient Treatment shall apply

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

- i. If the Surrogate mother is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this policy, then the intending couple / intending woman shall bear a rateable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred
 - a. For the purpose of this cover, "Associated medical expenses" shall include room rent, nursing charges, operation theatre charges, fees of medical practitioner including surgeon/anesthetist/ specialist within the same hospital where the insured person has been admitted and will not include the cost of pharmacy and consumables, cost of implants, medical devices and cost of diagnostics.
 - b. Proportionate deductions are not applicable for ICU charges
 - c. Proportionate deductions shall not be applicable for hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.
- ii. Expenses associated with automation machine for peritoneal dialysis shall not be payable

12. In-patient Hospitalization for Oocyte donor:

We will cover the Medical Expenses incurred in respect of Hospitalization of the Oocyte donor appointed by the "Intending Couple"/" Intending woman" for complications arising due to oocyte retrieval during the Policy Period, up to the annual sum insured subject to maximum limit of Rs.5 Lakhs and subject to the following conditions:

- i. This cover shall be available only for a period of twelve months (12 months) after the oocyte retrieval procedure has been successful
- ii. This benefit is applicable to all or any female insured person
- iii. Any expenses incurred on delivery of the new born (either via normal delivery or caesarean section) are excluded from the scope of this cover
- iv. This coverage shall only be available if all the provisions as specified in The Assisted Reproductive Technology (Regulation) Act, 2021, and all the rules and regulations made thereunder are fulfilled
- v. The terms and conditions of In-patient Treatment shall apply.

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

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

- a. For the purpose of this cover, "Associated medical expenses" shall include room rent, nursing charges, operation theatre charges, fees of medical practitioner including surgeon/anesthetist/ specialist within the same hospital where the insured person has been admitted and will not include the cost of pharmacy and consumables, cost of implants, medical devices and cost of diagnostics.
- b. Proportionate deductions are not applicable for ICU charges
- c. Proportionate deductions shall not be applicable for hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

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

a. 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

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 36 months of continuous coverage after the date of inception of the first policy with insurer.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If the Insured Person is continuously covered without any break as defined under the portability norms of the relevant regulatory prescriptions, then waiting period for the same would be reduced to the extent of prior coverage.
- d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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 as per relevant regulatory prescriptions, 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 biliary 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

*After two years from the Period of Insurance Start Date, Our maximum liability arising out of any Claim for a cataract treatment shall be restricted to up to 10% of the Annual Sum Insured subject to a maximum of Rs.50,000 per eye.

- 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- 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.
- v. 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.
- vi. Code- Excl11: Excluded Providers**
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim. The list of excluded providers/delisted hospitals is available on our website www.icicilombard.com
- vii. Code- Excl12: Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.**
- viii. Code- Excl13: Treatments received in health 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.

- ix. **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.
- x. **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.
- xi. **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

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

- a. 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.
- b. 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.
- c. Personal comfort, cosmetics, convenience and hygiene related items and services
- d. Acupressure, acupuncture, magnetic and other therapies

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Prabhadevi, Mumbai 400 025

UIN: Health Shield Inclusive ICIHLP25045V012425
Toll free no: 1800 2666
Alternate no : 86552 22666 (chargeable)
E-mail: customersupport@icicilombard.com
Website : www.icicilombard.com

- e. Circumcision unless necessary for treatment of an illness or necessitated due to an Accident.
- f. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
- g. 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
- h. 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

b. GENERAL TERMS AND CONDITIONS

i. Standard General Terms and Clauses

1. Disclosure of Information

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

(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

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Prabhadevi, Mumbai 400 025

UIN: Health Shield Inclusive ICIHLP25045V012425
Toll free no: 1800 2666
Alternate no : 86552 22666 (chargeable)
E-mail: customersupport@icicilombard.com
Website : www.icicilombard.com

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,

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

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

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

- 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 30 days 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.
- v. 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

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

11. Moratorium Period

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

12. Premium Payment in 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).

The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

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

- i. 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.
- ii. No interest will be charged If the instalment premium is not paid on due date.
- iii. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- iv. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- v. 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 health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the insured and stamp duty charges.

Redressal of Grievances

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

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

customersupport@icicilombard.com

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

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

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

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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>

15. Nomination:

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

16. Material Change

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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. 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 (No. 3 of 2016).

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.

23. 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.

24. 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.

25. Change of Sum Insured

Sum insured can be changed (increased/ decreased) 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

26. 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

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Registered Office Address:
 ICICI Lombard House, 414, P Balu Marg,
 Off Veer Savarkar Road, Nr Siddhi Vinayak Temple,
 Prabhadevi, Mumbai 400 025

UIN: Health Shield Inclusive ICIHLP25045V012425
Toll free no: 1800 2666
Alternate no : 86552 22666 (chargeable)
E-mail: customersupport@icicilombard.com
Website : www.icicilombard.com

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

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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	PULSEOXYMER CHARGES

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

Sr 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

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

SI 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

c. 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. (As the list is dynamic, please refer to the latest list.)

The claim pay-out would be adjudicated in following sequence:

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 Prabhadevi, Mumbai 400 025

UIN: Health Shield Inclusive ICIHLP25045V012425
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Alternate no : 86552 22666 (chargeable)
E-mail: customersupport@icicilombard.com
Website : www.icicilombard.com

- i. If a room accommodation has been opted for where the room rent or category is higher than the eligible limit as applicable for the Insured Person, then the associated medical expenses payable shall be pro-rated as per applicable limits.
 - a. Associated medical expenses means those expenses as listed below which vary in accordance with the room rent or room category or ICU Charges in a Hospital:
 - i. Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Person availed treatment
 - ii. Fees charged by surgeon, anesthetist, Medical Practitioner
 - iii. Investigation expenses
- ii. Zone based Co-payment shall be applicable in all cases where treatment is taken in a zone higher than for which premium was paid for
- iii. Voluntary Co-payment shall be applicable on the amount payable by Us and our liability to make payment shall than be arrived at.
- iv. In case, the claim is for a Procedure/Medical Condition/Ailment/Disease which is subject to sub-limits as per Policy terms and conditions, the claim will be settled to the extent of amount which is lesser of the three amounts – i.e. claimed amount or maximum amount as per sub-limits applicable or ICICI Lombard liability after deduction of voluntary co-payment

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-authorization at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation. To avail of Cashless Hospitalisation facility, you are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card Or You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. We will consider Your request after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalisation facility is sought by You and We will confirm Your request in writing.

If You notify pre-authorization request for cashless facility through any of Our empaneled network hospitals along with complete set of documents & information, We will respond within 1 hour of the actual receipt of such pre-authorization request. Further, we shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital

(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.

- 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

ICICI Lombard General Insurance Company Limited**IRDA Reg. No. 115****Mailing Address:**

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Mumbai - 400 064

CIN: L67200MH2000PLC129408**Registered Office Address:**

ICICI Lombard House, 414, P Balu Marg,
Off Veer Savarkar Road, Nr Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400 025

UIN: Health Shield Inclusive ICILIP25045V012425**Toll free no:** 1800 2666**Alternate no :** 86552 22666 (chargeable)**E-mail:** customersupport@icicilombard.com**Website :** www.icicilombard.com

hospital as the time of discharge along with the claim form. The claim will be processed within 15 days of receipt of the claim along with claim form and documents.

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

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

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 reimbursement 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 to be sent to -

ICICI Lombard Health Care,
1st, 4th (half), 5th and 6th floor,
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, Sonapat 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, Sonapat & 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, 7 th 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	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.

Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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