Key Information Sheet

S.No	Title	Description	Refer To Policy Wordings
1.	**Product Name**	**Health Protect (ICICI Lombard Complete Health Insurance)**	
2.	What am I covered for	**(a) In patient treatment -** Covers Hospital expenses for admission longer than 24 hours. **(b) Pre & Post Hospitalisation -** Medical Expenses incurred due to Illness up to 30 days period immediately before and 60 days immediately after an Insured Person's admission to a Hospital. **(c) Day Care Procedures -** Medical expenses for day care procedures where such procedures are undertaken by an Insured Person as an In-patient in a Hospital for continuous period of less than 24 hours. **(d) In Patient AYUSH Hospitalisation -** Reimbursement of expenses for Alternative treatment. **(e) Domestic Road Emergency Ambulance -** Ambulance expenses incurred to transfer the Insured Person following an emergency to the nearest Hospital. Maximum amount payable is ` 1500 per event of emergency Hospitalisation. **(f) Wellness Program** **(g) Reset Benefit**	Part II of the Schedule Clause 2. Scope of the Cover Extension HC 5 - Domestic Road Emergency Ambulance Cover Extension HC 19 - Wellness Program Extension HC 20 - Reset Benefit
3.	Optional Add On Covers	**(a) Hospital Daily Cash -** Allowance of ` 1,000 per day for hospital stay of minimum 3 consecutive days or more up to a maximum of 10 consecutive days. **(b) Convalescence Benefit -** of ` 10,000 provided once for each Policy year during Policy Period, in case of Hospitalisation of minimum 10 consecutive days or more.	Extension HC 2 - Hospital Daily Cash Extension HC 3 - Convalescence Benefit
4.	Value Added Services	* Free health check-up coupon to Insured for every Policy Year, subject to a maximum of 2 coupons per year for floater policies. * Online Chat with Medical Practitioners * Specialist e-Consultation with One Follow-up session * Diet & Nutrition e-consultation * Provide information on offers related to healthcare services like consultation, diagnostics, medical equipments and pharmacy.	Extension HC 17 - Value - Added Services
5.	What are the major Exclusions in the Policy	**Note: Following is an indicative list of the policy exclusions. Please refer to the policy clause for the complete list.** * Naturopathy treatment, acupressure, acupuncture, magnetic and such other therapies * Unproven experimental treatment * Any expenses arising out of Domiciliary Treatment * Treatment taken outside the country * Cosmetic surgery * Sterility, venereal diseases or any sexually transmitted diseases * Dental treatment unless due to accident * Any case directly or indirectly related to criminal acts * Refractive error correction, hearing impairment correction * Substance abuse, self-inflicted injuries, STDs and HIV/ AIDS	Part II of the schedule Clause 3.4 Permanent Exclusions
6	Waiting Period	(a) **Initial waiting period:** 30 days for all illnesses (except Hospitalisation due to injury) (b) **Specific waiting period:** First 24 months, for specific Illness and treatment. (Please refer to the policy clauses for the full listing) (c) **Pre-existing diseases:** Covered after 24 months of continuous coverage	Part II of the schedule Clause3.1 Clause3.2 Clause3.3

7	Payout Basis	* Cashless or Reimbursement of covered medical expenses up to specified Sum Insured as per the scope of cover * Claim Service Guarantee * Cashless Facility available at over 4000+ network hospitals	Part II of the schedule 4. Claim Administration
8	Sub Limit	Cataract, where sub-limit of ` 20,000/- is applicable per eye per Policy year for Plans with Sum Insured up to 5Lacs. Sub-limit options of C available	Part II of the schedule Clause 3.3 Extension HC 15: SubLimit on Medicl Expenses/ Illness/ Surgeries/ Procedures
9	Renewal Condition	(a) **Maximum renewal age -** There will be life-long renewable without any age restriction for the cover. However Premium at the time of renewal is subject to change with change in age band. (b) **Grace Period -** The renewal premium shall be paid to Us on or before the date of expiry of the Policy and in no case later than 30 days (Grace Period) from the expiry of the Policy. (c) **Floater Benefit -** The floater benefit under this policy is available up to lifetime.	Part III of the schedule 18. Renewal notice
10	Renewal Benefits	(a) Cumulative Bonus (Additional Sum Insured) - An Additional Sum Insured of 10% of Annual Sum Insured provided on each renewal for every claim-free year up to a maximum of 50%. In case of a claim under the policy, the accumulated Additional Sum Insured will be reduced by 10% of the Annual Sum Insured in the following year. (b) Complimentary Health Check Up Coupons: One coupon per individual policy and two coupons per Floater policy will be offered.	Part II of the schedule 2. Scope of the Cover Extension HC 17: Value Added Services
11	Cancellation	(a) Disclosure to information norm: The policy shall be void and all premium paid hereon shall be forfeited to the company, in the event of misrepresentation, mis-description or non-disclosure of any material fact. (b) You may cancel this Policy by giving Us 15 days written notice for the cancellation of the Policy by registered post, and then We shall refund premium on short term rates for the unexpired Policy Period.	Part III of the schedule 13. Cancellation/ Termination

Policy Wordings

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

PART II OF THE POLICY

1. DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/ specified in this Policy or related Extensions/ Endorsements: Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

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

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

Alternative treatments are forms of treatments other than treatment

"Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

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.

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

Break in Policy occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

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

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

i. Internal Congenital Anomaly - Congenital anomaly which is not in the visible and accessible parts of the body
ii. External Congenital Anomaly - Congenital anomaly which is in the visible and accessible parts of the body

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

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 preauthorization approved.

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

Cumulative Bonus shall mean any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Day Care Treatment refers to medical treatment, and/or Surgical Procedure which is:

i. Undertaken under General or Local Anesthesia in a Hospital/Day care centre in less than 24 hrs because of technological advancement, and
ii. Which would have otherwise required a hospitalisation of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

Day care centre means any institution established for day care treatment of Illness and/or injuries or a medical set-up 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:

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

Deductible is a cost sharing requirement under a health insurance policy that provides that We will not be liable for specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policy, which will apply before any benefits are payable by Us. This is to clarify that a deductible does not reduce the sum insured.

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

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.

Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

Emergency care is management for a severe 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's personal health.

Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of Pre Existing Diseases. Coverage is not available for the period for which no premium is received.

Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulations) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR comply with all minimum criteria as under:

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

Hospitalisation means admission in a Hospital for a minimum period of 24 In patient Care and consecutive hours except for specified Day Care procedures/ Treatments, where such admission could be for a period of less than 24 consecutive hours.

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

Illness means a sickness or disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

i. **Acute condition -** Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. **Chronic condition -** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:-

it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests-it needs ongoing or long-term control or relief of symptoms-it requires your rehabilitation or for you to be specially trained to cope with it-it continues indefinitely-it comes back or is likely to come back.

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

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

Maternity Expenses shall include -

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
ii. Expenses towards lawful medical termination of pregnancy during the policy period.

Medical Advice means any consultation or advice from a Medica Practitioner including the issue of any prescription or repeat prescription.

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

Medically necessary is defined as 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 standard widely accepted in international medical practice or by the medical community in India

Medical Practitioner is a person who holds a valid registration from Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude You and Your Immediate Family. "Immediate Family would comprise of Your spouse, dependent children, brother(s), sister(s) and dependent parent(s).

Newborn Baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

Network Provider means hospitals or health care provider enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility

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

Notification/ Intimation of Claim is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address/ telephone number to which it should be notified.

OPD treatment is 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.

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 the Your continuous renewal of such Policy with Us.

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

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

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

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

Portability means transfer by an individual health insurance policyholder (including Family cover) of the credit gainer for preexisting conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

Pre-existing Disease means any condition, ailment or injury or related condition(s) for which You had signs or symptoms, and/or were diagnosed, and/or received medical advice/ treatment, within 48 months prior to the first policy issued by the insurer.

Post Hospitalisation Medical Expenses means medical expenses incurred immediately after the Insured Person is discharged from the hospital, provided that:

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

Pre Hospitalisation means medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:

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

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

Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of 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 Illness/injury involved.

Room Rent means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

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

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

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

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

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

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

2. WHAT WE WILL PAY (SCOPE OF COVER)

A) In-patient Treatment

We hereby agree subject to terms, conditions and exclusions herein contained or otherwise expressed here on that, if during the Policy - year, You require Hospitalization for any Illness or Injury on the written advice of a Medical Practitioner, then We will indemnify the Medical Expenses so incurred by You.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy - year, shall not exceed the Maximum Limit of Indemnity as stated in the Policy Schedule.

B) Day Care Procedures/Treatment

We hereby agree subject to terms, conditions and exclusions herein contained or otherwise expressed hereon that, if during the Policy - year, You require Hospitalization as an inpatient for less than 24 hours in a Hospital (but not in the outpatient department of a Hospital) on the written advice of a Medical Practitioner, then We will pay You for the Medical Expenses incurred for undergoing such Day Care Procedure/ Treatment or surgery, (as is mentioned in the list of Day Care Procedures/ Treatments annexed to this Policy and also available on our website www.icicilombard.com).

However, Our total liability under this cover for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Maximum Limit of Indemnity as stated in the Policy Schedule.

C) Pre-Hospitalization and Post-Hospitalization Expenses

We hereby agree subject to the terms, conditions and exclusions herein contained or otherwise expressed here on that, We will compensate You for the relevant Medical Expenses incurred by You in relation to:

i. Pre-hospitalization Medical Expenses incurred by You for a 30-day period immediately prior to Your Hospitalization; and
ii. Post-hospitalization Medical Expenses incurred by You for a 60-day period immediately post Hospitalization, provided that Your Hospitalization falls within the Policy year and We have accepted Your Claim under **"In-patient Treatment"** or **"Day Care Procedures"** section of the Policy. However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Maximum Limit of Indemnity as stated in the Policy Schedule.

D) In Patient AYUSH Hospitalization - We will reimburse expenses for Alternate treatment only when the treatment has been undergone in a Government Hospital or in any Institute recosnised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health.

We will not cover expenses for hospitalization done for evaluation or investigation only. Treatment taken at a healthcare facility which is not a Hospital are also excluded.

E) Additional Sum Insured (Cumulative Bonus) - It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, at the time of renewal of this Policy, We will provide an additional sum insured (Cumulative Bonus) provided that there is no Claim under this Policy during the Policy year except as an Out patient.

Tenure	Additional Sum Insured as a percentage of Annual Sum insured
For all insured persons	
For each completed and continuous Policy Year subject to a maximum of 50%	10%

However, in the event of a Claim under the Policy during any subsequent Policy year, the accrued Additional Sum Insured will be reduced by 10% of the Annual Sum Insured at the time of renewal of this Policy. This extension is also subject to the following:

In relation to a Floater Benefit cover, the Additional Sum Insured so accrued during the Claim-free Policy year(s) will also be on floater basis and will only be available to those Insured Person(s) who were insured in such Claim-free Policy year(s) and continue to be insured in the subsequent Policy year(s).

3. WHAT WE WILL NOT PAY (EXCLUSIONS UNDER THE POLICY)

We will not be liable for any Deductible 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:

3.1 Any Pre-Existing condition(s) until 24 months of Your continuous coverage has elapsed, since Period of Insurance Start Date.

3.2 Any Illness contracted within 30 days of Period of insurance Start Date, except those incurred as a result of Injury.

3.3 Any Medical Expenses incurred by You on treatment of following Illnesses within the first two (2) consecutive years of Period of Insurance Start Date:

i. Cataract*
ii. Benign Prostatic Hypertrophy
iii. Myomectomy, Hysterectomy unless because of malignancy
iv. All types of Hernia, Hydrocele
v. Fissures &/or Fistula in anus, hemorrhoids/piles
vi. Arthritis, gout, rheumatism and spinal disorders
vii. Joint replacements unless due to accident
viii. Sinusitis and related disorders
ix. Stones in the urinary and billiary systems
x. Dilatation and curettage, Endometriosis
xi. All types of Skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant
xii. Dialysis required for chronic renal failure
xiii. Surgery on tonsils, adenoids and sinuses
xiv. Gastric and Duodenal erosions & ulcers
xv. Deviated Nasal Septum
xvi. Varicose Veins/ Varicose Ulcers
xvii. All types of internal congenital anomalies/ illness/ defects

*After two years from the Period of Insurance Start Date, Our maximum liability arising out of any Claim for a cataract treatment shall not exceed ` 20,000 per eye, during each Policy Year of the Policy Period for plans with Sum Insured up to ` 5 Lacs. Sub limit of ` 1,00,000 per eye per Policy year will be applicable for Cataract surgery for plans with Sum Insured above ` 5 Lacs.

In case the above Illnesses are Pre-existing condition(s) at the commencement of this Policy, then these Illnesses shall be covered after 24 months of continuous coverage has elapsed, since Period of Insurance Start Date.

3.4 Permanent Exclusions

Unless covered by way of an appropriate Extension/ Endorsement, 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. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions

ii. Cost of routine medical, eye and ear examinations, preventive health check-up, cost of spectacles, laser surgery for correction of refractory errors, contact lenses or hearing aids, dentures and artificial teeth

iii. 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 continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively

iv. Expenses incurred on all dental treatment unless necessitated due to an Accident

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

vi. Naturopathy treatment, acupressure, acupuncture, magnetic and such other therapies

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

viii. Vaccination or inoculation of any kind, unless it is post animal bite

ix. Sterility, venereal disease or any sexually transmitted disease

x. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise) and Injury or Illness due to use, misuse or abuse of intoxicating drugs or alcohol

xi. Any expense incurred on treatment of mental Illness, stress, psychiatric or psychological disorders

xii. Aesthetic treatment, cosmetic surgery and plastic surgery including any complications arising out of or attributable to these, unless necessitated due to Accident or as a part of any Illness

xiii. Any treatment/ surgery for change of sex or treatment/ surgery/ complications/ Illness arising as a consequence thereof

xiv. Any expense incurred on treatment arising from or traceable to pregnancy (including voluntary termination of pregnancy, childbirth, miscarriage, abortion or complications of any of these, including caesarean section) and any fertility, infertility, sub fertility or assisted conception treatment or sterilization or procedure, birth control procedures and hormone replacement therapy. However, this exclusion does not apply to ectopic pregnancy proved by diagnostic means and is certified to be life threatening by the Medical Practitioner.

xv. Treatment relating to birth defects and external congenital Illnesses or defects or anomalies

xvi. All expenses arising out of any condition directly or indirectly caused to or associated with Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human TCell Lymphotropic Virus Type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind

xvii. Charges incurred at Hospital primarily for evaluative or diagnostic or observation purposes for which no active treatment is given, X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalisation

xviii. Expenses on supplements, vitamins and tonics unless forming part of treatment for Injury or Illness as certified by the attending Medical Practitioner

xix. Weight management services and treatment, vitamins and tonics related to weight reduction programmes including treatment of obesity (including morbid obesity), any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition and rest cure

xx. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose

xxi. Experimental, unproven or non-standard treatment which is not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury

xxii. Any case directly or indirectly related to criminal acts

xxiii. Any expenses arising out of Domiciliary Hospitalisation Treatment

xxiv. Treatment taken outside the country

xxv. Treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council

xxvi. Any Illness or Injury resulting or arising from or occurring during the commission of continuing perpetration of a violation of law by You with criminal intent

xxvii. Expenses related to donor screening, treatment, including surgery to remove organs from a donor in the case of transplant surgery

xxviii. Any consequential or indirect loss or expenses arising out of or related to Hospitalization

xxix. Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority

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

4. 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.

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:

4.1 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

Prior to taking treatment and/or incurring Medical Expenses at a Network Provider, You must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, 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 preauthorization at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization. To avail of Cashless Hospitalization 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 Hospitalization facility is sought by You and We will confirm Your request in writing.

B) For Reimbursement Settlement

i. You shall give notice to Us or Our in house claim processing team by calling the toll free number 1800 2666 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 Policyholder;
* 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

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

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

iii. You or someone claiming on Your behalf must promptly and in any event within 30 days of Your discharge from a Hospital (for post-hospitalization expenses, within 30 days from the completion of post-hospitalization 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 However, in both the above cases i.e. 4.1 (A) & (B), You must take reasonable steps or measure to minimise the quantum of any Claim that may be covered under the Policy If so requested by Us or Our in house claim processing team, 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

Settlement/Rejection of Claim - The settlement of claims would be done by Us within 30 days, after the receipt of last necessary document, any rejections if done, would be provided with proper reasons by Us. Penal interest provision shall be as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2002.

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 Deductions 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.

4.2 CLAIM DOCUMENTS

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

i. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from our website www.icicilombard.com

ii. Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner

iii. Original bills from chemists supported by proper prescription.

iv. Original investigation test reports and payment receipts.

v. Indoor case papers

vi. Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.

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

4.3 Claim Service Gurantee

We provide You Claim Service Gurantee as follows

a) For Reimbursement Claims: We shall make the payment of admissible claim (as per terms & conditions of Policy) OR communicate non admissibility of claim within 14 days after You submit complete set of documents & information in respect of the claims. In case We fail to make the payment of admissible claims or to communicate non admissibility of claim within the time period, We shall pay 1% interest over and above the rate defined as per IRDA (Protection of Policyholder's interest) Regulation 2002.

b) For Cashless Claims: If You notify per authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will respond within 4 hours of the actual receipt of such pre authorization request with:

a) Approval, or
b) Rejection, or
c) Query seeking further information

In case the request is for enhancement, i.e. Request for increase in the amount already authorized, We will respond to it within 3 hours.

In case of delay in response by Us beyond the time period as stated above for cashless claims, We shall be liable to pay ` 1,000 to You. Our maximum liability in respect of a single hospitalization shall, at no time exceed ` 1,000.

We will not be liable to make any payments under this Claim Service Guarantee in case of any force majeure, natural event or manmade disturbance which impedes Our inability to make a decision or to communicate such decisions to You.

The service gurantee shall not be applicable for any cases delayed o account of reasonable apprehension of fraud or fraudulent claims or cases referred to/by any adjudicative forum for necessary disposal.

You may lodge claim separately for the hospitalization claim, Pre-Post hospitalization, optional covers, OPD etc. In such scenario, if delay happens beyond the time period as specified above, the interest amount calculated will be on the net sanctioned amount of respective transaction and not the total amount paid for the entire claim.
Any amount paid towards interest under Claim Service Guarantee will not affect the Sum Insured as specified in the Schedule.

If you are not eligible for 'Claim Service Guarantee' for the reasons stated above, We will inform the same to You, within 14 days in case of a) and within 4 hours in case of b) above.

5. SPECIAL CONDITIONS APPLICABLE TO THE POLICY

It is hereby declared and agreed that:

i. Any notice or declaration for Your attention shall be deemed served if sent by Us to the Policy Holder at his/her latest known address
ii. Any payment due to You under this Policy shall be paid to the Policy Holder by Us. We shall not be responsible for any liability arising out of the Policy Holder's delay or default in making payment to You. However, We also reserve Our right to pay the Claim directly to You or to the Hospital or to someone on Your behalf. The receipt by the Policy Holder/ You or Hospital or someone claiming on your behalf shall be considered as a complete discharge of our liability against any Claim under the Policy.
iii. We shall have no liability under this Policy, once the Maximum Limit of Indemnity, as stated in the Policy Schedule, is exhausted by You.
iv. For any payment to be made by Us under any Claim arising under this Policy, We shall make the payment in India and in Indian rupees only.

Portability benefits:

If You were insured continuously and without a break under another Indian retail health insurance policy with any other Indian non-life Insurance company or stand alone health insurance company it is understood and agreed that

a) You should provide Us with Your application and completed portability form with complete documentation atleast 45 days before the expiry of the present period of insurance, in case you wish to avail portability benefits
b) Portability benefit is available only at the time of renewal of the existing health insurance policy
c) Portability benefits is available only up to the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.
d) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions/waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.
e) The portability shall be applicable to the Sum Insured under the previous policy and also to an enhanced Sum Insured, if requested by the Insured, to the extent of cumulative bonus acquired from the previous insurer(s) under the previous policies.

For e.g.- If a person had a SI of ` 4lacs and accrued bonus of ` 40,000 with insurer A, when he shifts with US, We will offer him SI of ` 5lacs by charging the premium applicable for ` 5lacs by charging the premium applicable for ` 5lacs SI.

Terms of Renewal

i. The Policy can be renewed under the then prevailing ICICI Lombard Complete Health Insurance product or its nearest substitute (in case the product ICICI Lombard Complete Health Insurance is withdrawn by the Company) approved by IRDA.
ii. A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or noncooperation by the insured.
iii. In case of any change in risk material to the queries raised in the proposal form, medical examination report to be provided on renewal.
iv. **Renewal Premium -** Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDA.
v. **Lifetime Renewability**
vi. In the likelihood that this policy is revised/ modified/ withdrawn in future, we will intimate the insured person regarding the same at least 3 months prior to expiry of the policy. In case of withdrawal, the insured person have the option to migrate to the nearest substitute policy as available with Us at the time of renewal with all the continuity benefits, provided the policy has been maintained without a break as per the IRDA portability guidelines.

Sum Insured Enhancement- You can enhance Your sum insured under the Policy only upon renewal, subject to underwriters' approval. If the Policy is renewed for an enhanced Annual Sum Insured, then fresh waiting period will be applicable to this enhanced limit from the effective date of such enhancement.

PART III OF THE POLICY

General Terms and Conditions

1. Incontestability and Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or on non-disclosure in any material particular in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or devices being used by You or any one acting on Your behalf to obtain any benefit under this Policy.

2. Reasonable Care

You shall take all reasonable steps to safeguard Your interests against any Injury or Illness that may give rise to the Claim.

3. Observance of terms and conditions

The due observance and fulfilment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by You, shall be a condition precedent to any of Our liability to make any payment under this Policy.

4. Material change

You shall notify Us in writing of any material change in the risk in relation to the declarations made in the proposal form or medical examination report at each renewal and We may, adjust the scope of cover and/or premium, if necessary, accordingly.

5. Records to be maintained

You shall keep an accurate record containing all relevant medical records and shall allow Us to inspect such records. You shall exercise all necessary co-operation in obtaining the medical records from the Hospital, and furnish them, as We may require in relation to the Claim within reasonable time limit and within the time limit specified in the Policy.

6. No constructive Notice

Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our officials shall not be the notice to or be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

7. Notice of charge etc.

We shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by Us to You or Your legal representative of any compensation or benefit under the Policy shall in all cases be an effectual discharge to Us.

8. Overriding effect of Part II of the Policy

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

9. Your duties on occurrence of loss

On the occurrence of any loss, within the scope of cover under the Policy You shall:

i. Forthwith file/submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in Part II of the Policy.
ii. Assist and not hinder or prevent Us or any of Our representative from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

If You do not comply with the provisions of this Clause or other obligations cast upon You under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at Our option.

10. Subrogation

You and any claimant under this Policy shall at no cost or expense to Us do whatever is necessary to enable Us to enforce any rights and remedies or obtain relief or indemnity from other parties to which We would become entitled or subrogated upon Us paying for or making good any Claim or loss under this Policy whether such acts and things shall be or become necessary or required by Us or otherwise before or after Your indemnification by Us. However, this condition shall not be applicable for all the benefit based covers under the Policy, as applicable.

11. Contribution

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

12. Fraudulent Claims

If any Claim 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 You or anyone acting on Your behalf to obtain any benefit under this Policy, or if a Claim is made and rejected and no court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

13. Cancellation/ termination

(a) **Disclosure to information norm**
The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

(b) You may cancel the Policy during free look period (15 days from the date you receive the Policy) in which case we will refund the premium paid subject only to a deduction of the expenses incurred by Us on medical examination of the Insured Person(s) and the stamp duty charges.

(c) You may cancel this Policy by giving Us 15 days written notice for the cancellation of the Policy by registered post, and then We shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below, provided no claim has been payable on Your behalf under the

Cancellation period	Refund % for 1 year tenure Policy	Refund % for 2 year tenure Policy
Within 1 month	80%	80%
From 1 month to 3 months	60%	70%
From 3 months to 6 months	40%	60%
From 6 months to 9 months	20%	50%
From 9 months to 12 months	0%	40%
From 12 months to 15 months	NA	30%
From 15 months to 18 months	NA	20%
From 18 months to 21 months	NA	10%
From 21 months to 24 months	NA	0%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Policy/ Certificate of Insurance where any claim has been admitted by Us or has been lodged with Us or any benefit has been availed by You under the Policy.

We may cancel the policy on grounds of mispresentation, fraud, non-disclosure or non- cooperation of the insured, by giving You 15 days notice for the cancellation. There would be no refund of premium on cancellation by Us on grounds of mispresentation fraud or non-disclosure. In case of non-cooperation of insured, policy will be cancelled with premium refund on pro rata basis.

14. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy Schedule. The cause of action can arise anywhere in the world in case of Personal Accident Cover (Extension HC 11), if available under the Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

15. Policy Disputes

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

16. Arbitration Clause

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/ difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of 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.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

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

17. Free Look Period

You would be given a period of 15 days (Free Look Period) from the date of receipt of the Policy to review its terms and conditions. Where the Policy Holder disagrees to any of the terms or conditions of the Policy, he has the option to return the Policy stating the reasons for his objection-

If the insured has not made any claim during free look period, insured will be entitled to :

* A refund of premium paid less any expenses incurred by Us on medical examination of the Insured Person(s) and the stamp duty charges, or;

* Where the risk has already commenced and the option of return of policy is exercised by You, a deduction towards the proportionate risk premium for period on cover or;
* Where only a part of risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

In case the request for cancellation comes 15 days after the receipt of Policy by You, we would refund of premium would be paid to You on short term basis.

18. Renewal notice

a) We shall ordinarily renew the policy except on grounds of moral hazard, misrepresentation or fraud or non cooperation by the Insured. We shall not be bound to give notice that the renewal premium is due. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to You that may result to enhance Our risk under the guarantee hereby given. Any change in the risk will be intimated by You to Us.

b) The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to Us on or before the date of expiry of the Policy and in no case later than Grace Period of 30 days from the expiry of the Policy.

19. Notices

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

In Your case, at Your last known address. In Our case:
ICICI Lombard General Insurance Company Limited,
ICICI Lombard House, 414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400025

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

20. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified, during normal business hours.

21. Grievances

In case You are aggrieved in any way, You should do the following

i. For resolution of any query or grievance, Insured may contact the respective branch office of The Company or may call us at toll free no. 1800 2666 or email us at customersupport@icicilombard.com or write to us at
ICICI Lombard General Insurance Company Ltd.
ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai - 400025.

ii. If you are not satisfied with the resolution provided, you may approach us at the sub section "Grievance Redressal" on our website www.icicilombard.com (Customer Support section).

iii. In case Your complaint is not fully addressed by the insurer, You may use the Integrated Greivance Management System (IGMS) for escalating the complaint to IRDA. Through IGMS You can register your complain online and track its status. For registration please visit IRDA website www.irda.gov.in. If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.

Extensions/ Endorsements available under ICICI Lombard Complete Health Insurance

Mandatory Extensions/ Endorsements under the Plan

Extension HC 1: Floater Benefit

Floater Benefit means that the aggregate Maximum Limit of Indemnity, as specified in the Policy Schedule, is available to You or Your Immediate Family members, as covered under this Policy at the Policy Start Date, for any and all Claims made in aggregate during each Policy Year of the Policy Period.

It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay You or Your Immediate Family members, for any and all Claims subject to the Maximum Limit of Indemnity, made in aggregate by You or Your Immediate Family members under the Floater Benefit, provided such Claim is admissible under the Policy.

For the purpose of this extension the term "Immediate Family" will include Your spouse, dependent children, brothers, sisters, and dependent parents, whose name(s) are specifically appearing as Insured Person(s) in the Policy Schedule.

Subject otherwise to the terms, conditions and exclusions of the Policy

Extension HC 5: Domestic Road Emergency Ambulance Cover

In consideration of the payment of additional premium to Us, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy and subject always to the Annual Sum Insured for this Extension, We will reimburse You up to a maximum of `1500/- per Hospitalization, for the reasonable expenses incurred by You on availing ambulance services offered by a Hospital or by an ambulance service provider for Your necessary transportation to the nearest Hospital in case of a life threatening emergency condition, provided however that, a Claim under this extension shall be payable by Us only when:

(i) Such life threatening emergency condition is certified by the Medical Practitioner, and

(ii) We have accepted Your Claim under "In-patient Treatment" or "Day Care Procedures" section of the Policy.

Subject otherwise to the terms, conditions and exclusions of the Policy

Extension HC 17: Value-Added Services

Notwithstanding anything to the contrary in the Policy, We at your request will arrange for You or will facilitate You in availing any of the following additional services subject to a limit as specified in the Policy Schedule, on issuance or upon renewal of the Policy for a continuous period from Period of Insurance Start Date, as specified in the Policy Schedule, including but not limited to:-

* Free health check-up coupons to each insured for every Policy Year, subject to a maximum of 2 coupons per year for floater policies.
* Online Chat with Medical Practitioners
* Specialist e-consultation with One Follow-up session
* Diet & nutrition consultation
* Provide information on offers related to healthcare services like consultation, diagnostics, medical equipments and pharmacy

While deciding to obtain such value-added service, You expressly note and agree that it is entirely for You to decide whether to obtain these services and also to decide the use (if any) to which these services is to be put for

Extension HC 19: Wellness Program

Wellness program intends to promote, incentivize and reward You for Your healthy behavior through various wellness services. All the wellness activities as mentioned below make You earn wellness points which will be tracked by Us. You can redeem these wellness points as per Our redemption terms and conditions

The wellness services and activities are categorized as below:

1. Manage and track Your health
   * Online Health Risk Assessment (HRA)
   * Medical Risk Assessment
   * Preventive Risk Assessment
2. Disease Management Services
3. Medical Concierge Services
4. Affinity to Wellness

A. Manage & Track Your Health:

Online Health Risk Assessment (HRA)

The Health Risk Assessment (HRA) questionnaire is a tool for evaluation of health and quality of life. It helps You review Your personal lifestyle practices which may impact your health status. You can log into Your account on Our website www.icicilombard.com and take HRA. This can be undertaken once per policy year per insured person.

On taking online HRA test, You can earn 250 wellness points per insured, maximum up to 500 points per floater policy.

Medical Risk Assessment

We will reward You with wellness points on undergoing medical checkup, using complimentary checkup coupons provided with policy, anytime during the policy period. We will help You in getting the appointment fixed at Our empanelled centers or We will arrange home visit wherever necessary. You will be awarded 1,000 wellness points per insured, maximum up to 2,000 points per floater policy on undergoing these tests.

Second year onwards, if Your medical test results are in normal limits, additional 1,000 wellness points per insured, maximum up to 2,000 points per floater policy will be awarded for maintenance of health. We will communicate the findings of this assessment to You and advice You appropriately.

Preventive Risk Assessment

You can also earn wellness points by undergoing certain other diagnostic and preventive health check up (Specified in list given below or as suggested by Our empanelled medical experts) at any diagnostic centre at Your own expenses. You shall have to submit medical reports of these tests to Us.

List of Additional tests and corresponding wellness points per Policy Year:

Test	For whom	Wellness Points
Heart related screening tests (2D echo/ TMT)	Above 45 years	500
HbA1c / Complete lipid profile	Any age	500
PAP Smear	Females above age 45	500
Mammogram	Females above age 45	500
Prostate Specific Antigen (PSA)	Males above age 45	500
Any other test as suggested by Our empanelled Medical expert	As suggested	500

B. Disease Management Services

In case Your medical tests indicate any health irregularities, We will help You track Your health through Our empanelled medical experts who will guide You in maintaining/ improving Your health condition. We may also provide Dietician and nutritional counseling as per Your health condition.

C. Medical Concierge Services

You can also contact Us to avail the following services:

* Emergency assistance information such as nearest ambulance/ hospital/ blood bank etc.

* Second opinion provided through electronic mode: E-opinion (Second opinion) of an empanelled medical expert and/or agency.
* Referral for medical service provider, evacuation/ repatriation services, home nursing care etc

D. Affinity to wellness

We will provide You information on health and wellness training, online fitness portals, sporting events, various sports and health related applications, latest fitness accessories through periodic communications like e-mailers, blogs, forums etc. and will reward You for undertaking any of the fitness & health related activities as given below.

List of Fitness initiatives and wellness points

Initiatives	Wellness Points
Gym/ Yoga membership for 1 year	2,500
Participation in Professional sporting events like Marathon/ Cyclothon/ Swimathon etc.	2,500
Participation in any other health & fitness activity/ event organized by Us	2,500

You have to provide Us relevant receipts/ bills and/or certificates indicating participation and completion of these activities. These fitness centers, gym, yoga centers etc and the companies organizing these fitness initiatives should be legally registered entities as per rules, regulations as applicable by governing law.

As per the above mentioned activities, You can earn maximum 5,000 wellness points per insured, and maximum 10,000 wellness points per floater policy.

You can also earn 100 wellness points for each of the following activities:

* Quit smoking - based on Self declaration
* Share Your fitness success story
* On winning any Health quiz organized by Us

Redemption of Wellness Points

Each wellness point will be equivalent to ` 0.25. Wellness points not redeemed in the given policy year can be carry forwarded maximum up to 3 years from the date of awarding of these points, provided the policy is renewed continuously for subsequent 3 years. You can redeem these wellness points against outpatient medical expenses like consultation charges, medicine & drugs, diagnostic expenses, dental expenses, wellness & preventive care and other miscellaneous charges not covered under any medical insurance, through our Network providers, the list of which will be updated on our website www.icicilombard.com from time to time. In case cashless facility is not available for wellness points' redemption at these network centres, You can avail reimbursement by submitting relevant documents with Us.

Terms and conditions under wellness services

* Any information provided by You in this regard shall be kept confidential.
* You should notify and submit relevant documents, reports, receipts etc for various wellness activities within 60 days of undertaking such activity.
* For services that are provided through empanelled service provider, We are only acting as a facilitator; hence would not be liable for any incremental costs or the services.
* All medical services are being provided by empanelled health care service provider. We ensure full due diligence before empanelment. However You should consult Your doctor before availing/ taking the medical advices/ services. The decision to utilize these advices/ services is solely at Your discretion.
* There will not be any cash redemption against the wellness points.
* ICICI Lombard, its group entities, or affiliates, their respective directors, officers, employees, agents, vendors, is not responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which a Member claims to have suffered, sustained or incurred, by way of and/or on account of the Program.

Services offered are subject to guidelines issued by IRDA from time to time.

Extension HC 20: Reset Benefit:

For plans with Sum Insured ` 3lacs and above, We will reset up to 100% of the Sum insured once in a policy year in case the Sum insured including accrued Additional Sum Insured (if any) is insufficient as a result of previous claims in that policy year, provided that:

* The total amount of reset will not exceed the Sum Insured for that policy year
* The reset amount can only be used for all future claims within the same policy year, not related to the illness/ disease/ injury for which a claim has been paid in that policy year for the same person
* The claim will be admissible under the reset only if the claim is admissible as per section "Scope of cover" in part II of Policy Schedule.
* Reset will not trigger for the first claim
* For individual policies, reset Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis
* Any unutilized reset Sum Insured will not be carried forward to subsequent policy year
* Such reset will be available only once during a Policy year to each insured in case of individual policy and can be utilized by insured persons who stand covered under the Policy before the Sum Insured was exhausted.
* For any single claim during a policy year, the maximum claim amount payable shall not exceed the sum of
  1. The Sum Insured, and
  2. Additional Sum Insured

* During a Policy Year, the aggregate claim amount payable, shall not exceed the sum of:

    1. The Sum Insured
    2. Additional Sum Insured
    3. Reset Sum Insured

Following extensions are being offered to You as optional covers under this product. These benefits are available w.r.t. the members, for whom these optional covers have been opted by You by paying additional premium.

Extension HC 2: Hospital Daily Cash

In consideration of the payment of additional premium to Us, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy and subject always to the Annual Sum Insured for this Extension, We will pay You a daily cash amount, as stated against this Extension in the Policy Schedule, for each and every completed day of Hospitalization up to a maximum of 10 consecutive days, if such Hospitalization is at least for a minimum of 3 consecutive days and it falls within the Policy Year. The Claim under this extension will be payable only if We have admitted Our liability under "In-patient Treatment" section of the Policy.

Subject otherwise to the terms, conditions and exclusions of the Policy

Extension HC 3: Convalescence Benefit

In consideration of the payment of additional premium to Us, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay You an amount of ` 10,000 if You are Hospitalized for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy. This benefit is payable only once to an Insured Person during each Policy Year of the Policy Period.

Subject otherwise to the terms, conditions and exclusions of the Policy

Extension HC 15: Sub Limits on Medical Expenses/ Illness/ Surgeries/ Procedures

Notwithstanding anything to the contrary in the Policy and subject to the Maximum Limit of Indemnity, Our maximum liability to make payment for the Medical Expenses incurred during any Hospitalisation (including its related Pre and Post Hospitalization expenses if applicable) due to the below mentioned Surgeries/ Medical Procedures or any medical treatment pertaining to an Illness/ Injury shall be limited as per the table below:

S. No.	Surgeries/ Medical Procedures	Sub-limits (Rs.)
		C
1	Cataract per eye	20,000
2	Other Eye Surgeries	35,000
3	ENT	35,000
4	Surgeries for - Tumors/ Cysts/ Nodule/ Polyp	60,000
5	Stone in Urinary System	40,000
6	Hernia Related	60,000
7	Appendisectomy	40,000
8	Knee Ligament Reconstruction Surgery	90,000
9	Hysterectomy	60,000
10	Fissures/ Piles/ Fistulas	35,000
11	Spine & Vertebrae related	90,000
12	Cellulites/ Abscess	35,000
	All Medical Expenses for any treatment not involving surgery/ medical procedure	25,000

Any complications resulting from or arising out of any surgery or medical procedure shall be subject to the overall sub-limit, as applicable

No Sub-limits shall be applicable on any Major Medical Illness & Procedures and Joint Replacement Surgery. Major Medical Illness & Procedures for the purpose of this Policy shall mean and include the following:

1) Cancer of Specified Severity
2) Kidney Failure Requiring Dialysis
3) Major Organ/ Bone marrow Transplant
4) All cardiac surgeries/ conditions including but not limited Open Chest CABG
5) Multiple Sclerosis
6) Stroke Resulting in Permanent Symptoms
7) Permanent Paralysis of Limbs
8) All brain related surgeries

The sub-limits mentioned above shall be applicable for each Hospitalization. For the purpose of applicability of the said sub-limits, multiple Hospitalizations pertaining to the same Illness or medical procedure/ surgery occurring within a period of 45 days from the date of discharge of the first Hospitalization shall be considered as one Hospitalization.

Subject otherwise to the terms, conditions and exclusions of the Policy

ANNEXURE

The IRDAI has taken several proactive measures and granted relaxations for the benefit of policyholders to respond to the outbreak of Covid-19 situation within the Country. The Company is offering the below mentioned benefits without any additional cost as an aiding gesture to all the policyholders of the Company for this financial year. These benefits shall be available for all our customers until 31st March 2022

1. **Additional Sum Insured (Cumulative bonus)**
   - Currently, we provide an additional sum insured (Cumulative Bonus) of 10% for every claim free year maximum up to 50% of annual sum insured. In the event of any Claim (except out-patient treatment claim) during any subsequent Policy year, the accrued Additional Sum Insured is reduced by 10% of the Annual Sum Insured.
   - As a benefit, the additional sum insured shall not be reduced in case of any claim on hospitalization due to COVID-19.
2. **30 day Waiting Period**
   - Currently, expenses related to the treatment of any illness within 30 days from the first policy commencement date are excluded except claims arising due to an accident
   - As a benefit, this waiting period of 30 days shall be reduced to 15 days for in patient claims of COVID-19 illness.
3. **Home Healthcare**

   In this benefit we will cover the medical expenses incurred by the Insured person on availing treatment at home provided that:

   a) The insured person has been advised non-emergency hospitalization by a Medical practitioner and the Insured person out of his own will, opts to undergo treatment at home.
   b) The condition of the Insured Person is expected to improve in a reasonable and foreseeable period of time.
   c) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
   d) Treatment that can be availed on Outpatient basis will not be qualified to be covered under this clause.
   e) Insured can avail the services as prescribed by the medical practitioner on cashless basis which would be arranged by the Insurer through designated network provider.

   However under special circumstances in case the insured intends to avail the services of non-network provider and claims for reimbursement, a prior approval from the Insurer needs to be taken before availing such services. In case insured breach the conditions of approval or fails to take the prior written approval the insurer is not liable to settle any claim under this section.

   In case of unavailability of network provider for cashless claims or non-network provider for reimbursement claims, the insured person will have to avail inpatient hospitalization.

   In this benefit, the following would be covered if prescribed by the treating medical practitioner and is related to treatment,

   a. Diagnostic tests undergone at home or at diagnostics centre
   b. Medicines prescribed in writing
   c. Consultation charges of the medical practitioner
   d. Nursing charges related to medical staff
   e. Medical procedures limited to parenteral administration of medicines

   Any expenses payable during the Policy period shall not in aggregate exceed the maximum Sum Insured and cumulative bonus (if any) as specified in the Policy Schedule against this Benefit.

   Subject to other terms, conditions and exclusions of the policy