PROSPECTUS – Group TakeCare Insurance

Introduction

"Group TakeCare Insurance" is a product designed to cater to the need of all customers who are exposed to the risk of hospitalization and OPD treatment, due to illness or injury. Hospitalization of any kind is unfortunate and can lead to a sudden financial burden. Moreover along with the medical bills, out of pocket expenses like non admissible items, food and travelling puts an additional strain on one's pocket. To mitigate such risks, ICICI Lombard has proposed a group health insurance product – "Group TakeCare Insurance".

Salient features

- Option to choose amongst the covers that offer Daily Hospitalization Cash, OPD cover & Wellness cover.
- No medicals required.
- Tax benefit under Section 80 D of Income Tax Act, 1961, upto the extent of contribution by insured.
- *Flexi premium payment options: Lump sum or in monthly/quarterly/semi-annual/annual installments.

**Subject to Underwriter's approval.*

Eligibility

- Proposer should be 18 years or above
- Min. Entry Age: Child – 91 days
- Adult - 18 years
- Maximum entry age – 65 years
- Policy offers option of covering on both individual and floater basis

Policy Period

The Policy will be issued for 1 year, except for credit linked policies where the term can be extended upto 5 years.

Benefits:

Claims made in respect of an Insured Person for any Base Benefit or Extension applicable to the Insured Person shall be subject to the availability of the Sum Insured for the Base Benefit/Extension, and the terms, conditions and exclusions of this Policy.

Section A: HOSPIFUND BENEFIT

Section A.1: Base Benefits - Insured can avail any one or both of the following base benefits

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

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

Section A.2 Extensions To The Base Benefit - Insured can avail any of the following optional benefits by paying extra premium, under this policy. The benefits opted and their payout in the event of claim would be additive.

The following conditions would be applicable for all the base benefits and extension covers of Section A:

i. The Period of cover for each individual extension benefit cannot be more than the maximum period of cover for base benefit(s),

ii. The Sum Insured under any of the extension benefit cannot be more than five times of the Sum Insured opted under any individual base benefit(s), and

iii. The Sum Insured under any extension opted, cannot be more than the overall maximum Sum Insured available under the base benefit(s) of this Section.

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

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

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

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

The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
v. All Thyroid cancers histologically classified as T1N0M0 (TNMClassification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3;
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification;
viii. All Gastro-Intestinal Stromal Tumors histologically classified asT1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

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

I. BENIGN BRAIN TUMOR:

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies like CT Scan or MRI.
II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist
    a. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
    b. Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded:

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

II. STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extra-cranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
II. The following are excluded:
    a. Transient ischemic attacks (TIA)
    b. Traumatic injury of the brain
    c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

III. PERMANENT PARALYSIS OF LIMBS

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

IV. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and

permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

V. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

I. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis; and
II. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as SLE and HIV are excluded.

VI. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
II. The Accidental Head injury must result in an inability to perform at least three (3)of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:
   a. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   d. Mobility: the ability to move indoors from room to room on level surfaces;
   e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   f. Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

I. Spinal cord injury

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

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

The actual undergoing of transplant of:

a. One of the following human organs: heart, lung, liver, kidney or pancreas that resulted from irreversible end stage failure of the relevant organ;
b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

a. Other stem cell transplants;
b. Where only islets of langerhans are transplanted.

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

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

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

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

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

ii. New characteristic electrocardiogram changes

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

The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

II. OPEN CHEST CABG

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

The following are excluded:

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

III. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

IV. ANGIOPLASTY

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

angiogram (CAG).

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

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

V. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

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

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

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
iii. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

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

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

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

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

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

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

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

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

-undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
-which would have otherwise required a hospitalization of more than 24 hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

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

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

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

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

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

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

XI. Hospital Attendant Cash Benefit: If an Insured Person contracts an Illness or suffers an Injury due to Accident during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this

Extension in respect of each continuous and completed day of Hospitalization of the Insured Person which requires a Hospital Attendant to be present.

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

XII. Compassionate Visit Cash Benefit:

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

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

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

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION A:

We shall not be liable to make any payment for any Claim under Section A of this Policy in respect

of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

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

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

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

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

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

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

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

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

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

3. **Specified disease/procedure waiting period (Code – Excl 02) -Two Years Exclusions** – (Unless the waiting period is specifically waived off and mentioned in the policy certificate)
   a. Expenses related to the treatment of the below listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific disease/procedures -

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

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

iii. Fibroids (fibromyoma), Endometriosis, Uterine Prolapse, Polycysyic Ovarian Syndrome(PCOS)

iv. Dilatation and curettage (D&C), Myomectomy, Hysterectomy

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

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

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

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

ix. Cholecystectomy, Endoscopy

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

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

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

xiii. Unless malignant, all internal/ external tumors, cysts, nodules, polyps, sinus, fistula, adenoma, lumps including teratoma, breast lumps, dermoid cyst,

ovarian cyst, desmoid tumour, umblical granuloma, mucous cyst of lip/cheek

. xiv. Diseases related to thyroid

xv. All skin ailments

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

xvii. Varicose veins and varicose ulcers

xviii. All hernias

4. Permanent Exclusions:

1. Any dental treatment or dental surgery of any kind unless necessitated due to an Accident or specifically covered and specified in the Policy Schedule/Policy Schedule.
2. Vaccination and inoculation of any kind.
3. Any alternative treatments not covered under AYUSH as instituted in a government hospital or any institutes recognised by the government and/or acreddited by Quality Council of India National Accreditation Board of Health.
4. Any treatment received outside India unless specifically covered and specified in the Policy Schedule.
5. Circumcision unless necessary for treatment of an underlying Illness.
6. hormone replacement therapy.
7. Alopecia, baldness, wigs, or toupees and hair fall treatment.
8. Routine medical, eye and ear examinations unless specifically covered and specified in the Policy Schedule.
9. Cosmetic or plastic surgery (Code – Excl 08) - Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and
10. immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
11. Refractive Error (Code – Excl 15) - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres
12. Any medical examination or diagnostics or Hospitalization for the purpose of employment or travel.
13. Treatment of general debility, sterility, venereal disease except HIV.
14. Obesity/Weight Control (Code – Excl 06) - Expenses related to the surgical treatment of

obesity that does not fulfil all the below conditions:

- Surgery to be conducted is upon the advice of the Doctor
- The surgery/Procedure conducted should be supported by clinical protocols
- The member has to be 18 years of age or older and
- Body Mass Index (BMI);

greater than or equal to 40 or

greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

15. Rest Cure, rehabilitation and respite care **(Code – Excl 05**) - Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

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

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

16. Intentional self Injury, suicide or attempt to suicide.
17. First Degree Burns where First Degree (superficial) Burns are those which affects only the epidermis, or outer layer of skin.
18. Any External Congenital Anomalies unless specifically covered and specified in the Policy Schedule.
19. **Change of Gender treatments** (**Code – Excl 07**) -Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

20. Any sexually transmitted diseases except HIV

21. Treatment by a Family Member and self-medication or any treatment that is not scientifically recognized.

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

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

24. Illness or Injury whilst performing duties as a serving member of a military or a police force or any other forces of similar nature.

25. Investigation & Evaluation (Code – Excl 04) -

    a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;

    b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

26. Unproven Treatments (Code – Excl 16) - Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

27. Expenses related to donor screening related to donation of an organ(s).

28. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.

29. Domiciliary Hospitalization.

30. Engaging in professional sports unless specifically covered and specified in the Policy Schedule.

31. War, invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion.

32. Nuclear weapon materials or ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the

purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission or nuclear fusion.

33. Hazardous or Adventure Sport (Code – Excl 09) - Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

34. Whilst mounting or dismounting into an aircraft or flying or taking part in aerial activities (including airline crew or cabin crew) except as a fare-paying passenger in a regular scheduled airline or air charter company.

35. Treatment of any sexual problem including but not limited to impotence and Erectile Dysfunction irrespective of the cause; Venereal diseases or any sexually transmitted diseases.

36. Sterility and Infertility (Code – Excl 17) - Expenses related to Sterility and infertility.

    This includes:

    i. Any type of contraception, sterilization

    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

    iii. Gestational Surrogacy

    iv. Reversal of sterilization.

37. Hospitalization primarily for evaluative and diagnostic purpose for which no active line of treatment/ treatment which is possible in outpatient department is given; Admission only for Holter monitoring/Sleep study.

38. Excluded Providers (Code – Excl 11) - Expenses incurred towards treatment in any hospital or by an Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

39. Maternity –

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

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

40. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code – Excl 13)

41. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. (Code – Excl 14)

Section B – OUTPATIENT BENEFIT

Base Benefit: Outpatient cover

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

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

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

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

The Policy Certificate will specify whether there is any limit on the number of consultations which

may be availed under this Coverage and whether any specific specialty consultations are covered/excluded.

1. GP Consult

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

2. Specialist Consult

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

3. Physiotherapy Consult

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

4. AYUSH Consult

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

5. Dental Consult

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

6. Counseling

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

7. Tele Consult

   Consultation with a Medical Practitioner through Our Health Service Providers' helpline for

assessing the medical records or routine health issues of the Insured Person over the phone.

8. Home Consult

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

9. Online / Digital Consult

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

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

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

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

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

E. Travel Expenses for Medical Treatment : We will pay the travel costs incurred by an Insured Person during the Period of Cover to purchase medicines prescribed by a Medical Practitioner from a pharmacy or to undergo diagnostic tests provided that We will pay for the costs incurred in such

travel up to a maximum of one time for each prescription from a Medical Practitioner and one visit to Diagnostic center and/or pharmacy for each prescription even if the prescription/diagnostic tests are executed in parts, unless specified otherwise.

STANDARD EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION B:

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

1. Expenses incurred due to contraction of any disease or illness necessitating hospitalization.

2. Personal comfort, cosmetics convenience
3. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **(Code – Excl 14)**
4. Alternative treatment except AYUSH treatment.
5. **Unproven Treatments (Code – Excl 16)** - Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness
6. **30-day waiting period (Code – Excl 03)** - Any hospitalization falling within the initial waiting period as specified in the policy certificate subject to a maximum of 30 days-
    - Expenses related to the treatment of any illness within the initial waiting period shall be excluded except claims arising due to an accident, provided the same are covered.
    - This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
    - The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently
7. Illness, Accident or Injury directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not).
8. Defects or anomalies, venereal disease except HIV, intentional self-injury (whether arising from an attempt to suicide or otherwise)
9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code – Excl 12)**

10. **Sterility and Infertility (Code – Excl 17)** - Expenses related to Sterility and infertility.
    This includes:
    - Any type of contraception, sterilization
    - Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    - Gestational Surrogacy
    - Reversal of sterilization.
11. All expenses arising out of any condition directly or indirectly caused to or associated with , Human T-Cell Lymphotropic Virus Type III (HTLV -III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any syndrome or condition of a similar kind.
12. Illness, Accident or Injuries directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.
13. Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.
14. Any expenses incurred on instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.), oxygen concentrator for bronchial asthmatic condition,
15. Any sexually transmitted disease except HIV.
16. **Cosmetic or plastic Surgery (Code – Excl 08)** - Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner
17. **Change of Gender treatments (Code – Excl 07) -**
    Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
18. **Breach of law (Code – Excl 10)** - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
19. **Hazardous or Adventure Sports (Code – Excl 09)** - Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor

racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving

20. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code – Excl 13)**
21. Treatment received outside India.

Section C- WELLNESS COVER (Optional Section)

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

The Insured Person can avail any of the following Benefits on a Cashless Facility basis only.

1. Routine Physical & Preventive Examinations: If the Insured Person undertakes any of the Routine Physical and Preventive Examinations specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred. For the purpose of this Benefit, 'Routine Physical and Preventive Examinations' shall mean on-site or off-site health check-ups of all health parameters, including any consultations from relevant Medical Practitioners/Healthcare Professionals.

2. Onsite Health Services: If the Insured Person undertakes any Onsite Health Services, during the Period of Cover, then We shall pay the costs incurred. For the purpose of this Benefit, "Onsite Health Consultation' shall mean any consultation, health audit, provided by a Medical Practitioner/Healthcare Professional through a clinic or otherwise within the place of work of the Insured Person or elsewhere, and shall include medical and minor procedures, vaccinations, First Aid (prescribing and dispensing medicines onsite). The Medical Practitioner/Healthcare Professional will diagnosis, prescribe medications, advice further investigations or refer to a specialist if needed and also schedule follow up session to evaluate the progress. The clinic may be subjected to medical audits and, operational and maintenance services by Us at Our discretion.

3. Wellness Session: If the Insured Person attends any Wellness Sessions of the type specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred. For the purpose of this Benefit, "Wellness Session" shall mean any off-site or on-site mode of providing awareness/ training/ education on complete wellbeing which includes physical fitness, diet and nutrition, spiritual, occupational, environmental, financial, social and mental wellbeing and safety related parameters by relevant Healthcare Professionals/Health Service Providers.

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

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

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

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

6. Telephonic /Virtual Consultation: If the Insured Person avails any Telephonic/Virtual Consultation of the type or mode specified in the Policy Certificate during the Period of Cover, then We shall pay the costs incurred. For the purpose of this Benefit, “Telephonic/Virtual Consultation” shall mean any consultations provided by Medical Practitioners/Healthcare Professionals through a virtual mode of communication, such as via audio, video, online portal, chat or mobile application for routine health query or second opinion. This shall also include consulting a professional expert through a dedicated helpline number in relation to any social, mental, emotional, environmental or other issues faced by the Insured Person which affect his/her well being.

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

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

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

ii. Pregnancy management care program: Customised pregnancy program, online app/web based and telephonic general tips and suggestions to expectant parents on antenatal support, labour preparation and post-partum support. These services are to educate, empower and engage the expecting parents, which will include but are not limited to customised diet plan, fitness advice, emotional support, educating on changes in the body, caution signs, advises on tests and scans, labour pain management, lactation counselling and counselling on breathing exercises for the expectant mother, baby shoot,

maternity shoot with discounts on pharmacy and necessary diagnostics. The services also provide counselling on emotional support and preparation for parenting to the father. These programs can be app /web based with/without wearable devices.

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

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

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

The following covers will also be available with the Emergency Ambulance Service Benefit (C.1.8.):

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

a. 24*7, 365 days a year availability
b. Consultations by Medical Practitioners
c. Over the counter (OTC) medicines may be prescribed/ suggested on case to case basis
d. The Insured can reach the Medical Practitioner by calling on the dedicated helpline number: +91 124 4498757. Any change in this helpline number shall be updated on Our website www.icicilombard.com

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

a. Identifying specialist/ Hospital
b. Fixing an appointment with Medical Practitioners wherever applicable on best effort basis

c. Providing options on suitable Network Providers.

d. Providing information on ailments and possible lines of treatment

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

EXCLUSIONS APPLICABLE FOR SECTION C

No exclusions applicable for Section C.

ENDORSEMENTS AVAILABLE UNDER THIS POLICY

Endorsement I: Auto Renewal Clause

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

Endorsement II: Premium Installment Clause

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

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

POLICY RELATED TERMS AND CONDITIONS

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

LOADING/ DISCOUNTING :

1. Family Discounting (Applicable to Section A):

Family members	Discount
>=2	5%

2. Sum Insured Loading (Applicable to Section A)

Loading for higher Sum Insured	
Daily Payout (Rs.)	Loading Factor
500	1
1000	2
1500	3
2000	4
2500	5
3000	6
3500	7
4000	8
4500	9

5000	10
6000	12
7000	14
8000	16
9000	18
10000	20

3. Deductible and Franchise Based discount (Applicable to Section A):

Franchise (Days)							
Days\Age	<=20	21-25	26-40	41-50	51-55	56-65	>65
1	0%	0%	0%	0%	0%	0%	0%
2	3%	3%	3%	3%	3%	3%	3%
3	8%	8%	8%	8%	8%	8%	8%
4	25%	25%	25%	25%	25%	18%	18%
5	40%	40%	40%	35%	35%	28%	28%

Deductible (Days)							
Days\Age	<=20	21-25	26-40	41-50	51-55	56-65	>65
1	15%	15%	15%	15%	15%	13%	13%
2	35%	35%	35%	33%	33%	30%	30%
3	55%	55%	55%	50%	50%	43%	43%
4	70%	70%	70%	60%	60%	55%	55%
5	75%	75%	75%	65%	65%	60%	60%

4. Tenure Discount (Applicable to all sections)

Tenure	Discount
1	0%
2	10%
3	15%
4	22%
5	28%

Note: Discount is available only on the respective year premium. For eg. If 1 year premium is 100 then premium for 2 year policy will be 100 (1st year premium)+100*0.90 (2nd year premium with 2nd year discount) = 190

5. Loading on Premium Payment Installments (Applicable to all sections)

Policy Tenure (months)	Loading Factor			
	Premium Payment Installments			
	Annual	Half Yearly	Quarterly	Monthly
12	0%	3%	5%	7%
24	7%	11%	13%	14%
36	14%	18%	20%	22%
48	22%	26%	28%	30%
60	30%	34%	37%	38%

6. Group Size Discount

Group Size Discount	
Criteria	**Discounting Factor**
Up to 100	0.00%
101 – 500	2.00%
501 – 1000	3.00%
1001 – 2500	5.00%
2501 – 5000	7.00%
5001 – 10000	10.00%
10,001 - 25,000	15.00%
25,001 - 50,000	20.00%
50,001 - 75,000	20.00%
75,001 - 100,000	20.00%
100,001 - 125,000	20.00%
125,001 - 150,000	20.00%
> 150,000	20.00%

TERMS OF RENEWAL

a. The Policy may be renewed as per regulatory prescriptions and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of thirty days

b. Renewals will not be denied except on grounds of established fraud, of material facts. We may, revise the Renewal premium payable under the Policy or the terms of cover,. Renewal premium will not alter based on individual Claims experience.

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

d. If this product is withdrawn, then the Policy may be renewed under the nearest substitute product offered by the Company

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

STANDARD TERMS AND CONDITIONS

1. **Disclosure of Information**

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

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

2. **Condition Precedent to Admission of Liability**

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

- 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

3. **Complete Discharge**

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. **Fraud**

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

5. **Cancellation/ Termination**

a) The policyholder may cancel this policy by giving 7 days' written notice. The insurer shall
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
Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

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

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

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

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

6. Migration

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

7. Portability

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

8. Renewal of Policy

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

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

9. Withdrawal of Policy

- In the likelihood of this product being withdrawn in future, the Company will intimate the

insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting periodas per regulatory prescriptions, provided the policy

10. **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

11. **Premium Payment in Instalments**

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

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

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

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

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

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

vi The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

12. **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.

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

14. Redressal of Grievance

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

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

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

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

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

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

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

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

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	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.

Email: bimalokpal.chandigarh@cioins.co.in	
CHENNAI Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.

KOCHI **Insurance Ombudsman** **Office of the Insurance Ombudsman,** **10th Floor, Jeevan Prakash,LIC Building,** **Opp to Maharaja's College** **Ground,M.G.Road,** **Kochi - 682 011.** **Tel.: 0484 – 2358759** Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7nth Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar,	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,

U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	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

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.

16. **Material Change**

The Insured Person shall immediately notify Us in writing of any material change in the risk and cause at his own expense such additional precautions to be taken as circumstances may require to

ensure safe operation, trade or business practices thereby containing the circumstances that may give rise to the Claim and We 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 particulars and shall allow Us to inspect such record.

18. Notice of Charge

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

19. Overriding effect of Part II of the Schedule

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

20. Policy Disputes

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

21. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to: In case of the Insured Person, at the address specified in the Policy Certificate.

In case of Us:

ICICI Lombard General Insurance Company Limited, ICICI Lombard House, 414, Veer Savarkar

Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025

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

22. Customer Service

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

ICICI Lombard General Insurance Company Limited ICICI Lombard House 414, Veer Savarkar

Marg, Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025.

Tax Benefit - Tax Benefits would be applicable only to covers under Section A & B, if availed, as per the provisions of Income Tax Act, 1961 Section 80D and amendments made thereto.

Note: Policy terms & conditions and Premium rates are subject to change with prior approval from IRDAI. Tax benefits are subject to changes in tax laws. Please consult your financial/tax advisor for more details.

Prohibition on Rebates - Section 41 of the Insurance Ac 1938 stipulates as follows:

"(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the

premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

(2) Any person making default in complying with the provisions of this Section shall be liable for a penalty which may extend to ten lakh rupees.

Disclaimer: The foregoing is only an indication of the cover offered. For complete details on coverage, terms, conditions and exclusions, please read the Policy document or seek the advice of your insurance advisor before concluding sale.