ICICI Lombard
Nibhaye Vaade

Golden Shield
Policy Wording

b. Preamble

This Policy has been issued on the basis of the Disclosure to information Norm, including the information provided by Proposer in respect of the Insured Persons in the Proposal Form, any application for insurance cover in respect of any Insured Person and any other information or details submitted in relation to the Proposal Form. This Policy is a contract of insurance between You and Us which is subject to the receipt of premium in full and accepted by Us in respect of the Insured Persons and the terms, conditions and exclusions as specified in the Policy/ Policy Schedule / Product Benefit Table of this Policy.

c. Definitions

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

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

i. Standard definitions (Definitions whose wordings are specified by IRDAI)

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

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

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

a. Central or State government AYUSH hospital; or

b. Teaching hospital attached to AYUSH college recognized by the central government/Central council of Indian medicine/ Central council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH medical practitioner and must comply with the following criterion:

i. Having at least 5 in-patient beds

ii. Having qualified AYUSH medical practitioner in charge round the clock

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in- patient services and must comply with all the following criterion:

a. Having qualified registered AYUSH Medical Practitioner(s) in charge;

b. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

(Explanation: Medical practitioner referred in the definition of "AYUSH Hospital" and "AYUSH day care center" shall carry the same meaning as defined in the definition of "Medical practitioner" under chapter I of Guidelines)

Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

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

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

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

b. External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body

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

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

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

a. has qualified nursing staff under its employment;

b. has qualified medical practitioner/s in charge

c. has fully equipped operation theatre of its own where surgical procedures are carried out;

d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Day Care 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.

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

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

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

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

a. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

b. the patient takes treatment at home on account of non-availability of room in a hospital.

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

Grace Period means the specified period of time immediately following the premium due date during which 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:

a. has qualified nursing staff under its employment round the clock;

b. 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

c. has qualified medical practitioner(s) in charge round the clock;

d. has a fully equipped operation theatre of its own where surgical procedures are carried out

e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

Hospitalisation means admission in a Hospital for a minimum period of 24 consecutive in-patient care hours except for specified Procedures/Treatments, where such admission could be for a period of less than 24 consecutive hours.

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

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

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

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

   i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

   ii. it needs ongoing or long-term control or relief of symptoms

   iii. it requires your rehabilitation for the patient or for the patient to be specially trained to cope with it

iv. it continues indefinitely

v. It recurs or is likely to recur

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

Intensive Care Unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards

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

Maternity expenses means;

a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation);

b. expenses towards lawful medical termination of pregnancy during the policy period.

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

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

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

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

Migration means the right accorded to health insurance policyholders/proposers (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

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

Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

OPD treatment 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.

Portability means the right accorded to an individual health insurance policyholder/proposers (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer

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

a. That is/ are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

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

a. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and

b. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

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

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

b. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

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

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

Renewal 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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

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

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

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

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

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.

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.

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.

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

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

Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude You and Your spouse, Your children, Your brother(s), Your sister(s) and Your parent(s).

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.

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

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

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

Service Provider means any person, organization, institution, or company that has been empanelled with Us to provide services specified under the Benefits (including add-ons) to The Insured person. These shall also include all healthcare providers empanelled to form a part of network other than hospitals.

The list of the Service Providers is available at our website (https://www.icicilombard.com/content/ilom-en/serviceprovider/search.asp) and is subject to amendment from time to time.

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

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

d. Benefits covered under the policy

The Benefits listed in base cover are in-built benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy wording.

This Policy covers Allopathic and AYUSH treatments taken in India ONLY. Any expenses incurred outside the policy period will NOT be covered.

Any claims made under any of the benefits mentioned below (except Care management program, Care management plus program,) will impact eligibility for Additional Sum Insured.

Any unutilized annual sum insured/tele-consultations/e-consultations/benefits cannot be carried forward to the next policy year.

Base Cover

1. In Patient Treatment

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

i. Room Rent up to Twin sharing room (for Annual Sum Insured below ₹ 10 Lacs and Single private AC room for annual sum insured ₹ 10L and above);

ii. Intensive Care Unit Charges;

iii. Qualified Nurse charges;

iv. Medical Practitioner's Fees ;

v. Anaesthesia, blood, oxygen, operation theatre charges, medicines, drugs and consumables (other than those specified in the list of excluded expenses (non-medical) in Annexure I;

vi. Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure;

vii. Cost of investigative tests or prescribed diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized;

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

i. The Hospitalization is for Medically Necessary Treatment.

ii. The hospitalization warrants inpatient admission in view of active line of treatment.

iii. The Hospitalization commences and continues on the written advice of a Medical Practitioner.

iv. The Medical Expenses incurred are Reasonable and Customary Charges.

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

a. For the purpose of this cover, "Associated medical expenses" shall include room rent, nursing charges, operation theatre charges, fees of medical practitioner including surgeon/ anaesthetist / specialist within the same hospital where the insured person has been admitted and will not include the cost of pharmacy and consumables, cost of implants, medical devices and cost of diagnostics.

b. Proportionate deductions are not applicable for ICU charges

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

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

vii. Any Medical Expenses payable shall not in aggregate exceed the Annual Sum Insured and additional sum insured / cumulative bonus (if any) as specified in the Policy Schedule against this Benefit.

2. Day Care Treatment

We will cover the Medical Expenses incurred in respect of the Day Care Treatment of the Insured Person during the Policy Period provided that:

i. The Day Care Treatment is for Medically Necessary Treatment.

ii. The Day Care Treatment follows the written advice of a Medical Practitioner.

iii. The Medical Expenses incurred are Reasonable and Customary Charges.

iv. We will also cover Medical Expenses incurred for procedures including but not limited to intravenous chemotherapy, radiotherapy, hemodialysis or any other therapeutic procedure which requires a period of specialized observation or medical care after completion of the procedure.

v. We will not cover any Out Patient Treatment or diagnostic services under this Benefit.

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

vii. Any Medical Expenses payable shall not in aggregate exceed the Sum Insured and additional sum insured/ cumulative bonus (if any) specified in the Policy Schedule against this Benefit.

3. Coverage for Modern Treatments

We will cover the Medical Expenses incurred in respect of Hospitalization of the Insured Person for the below mentioned modern treatments during the Policy Period, up to the Annual Sum Insured

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

Robotic surgeries shall be subject to sub-limits as mentioned under d. benefits covered under the policy Base cover 15 Sub-limits applicable

4. Pre Hospitalisation expenses

We will cover the Pre-hospitalization Medical Expenses incurred in respect of the Insured Person for up to 60days immediately before the Insured Person's Admission to Hospital provided that:

i. The Pre-hospitalization Medical Expenses incurred are Reasonable and Customary Charges.

ii. We have accepted the claim under "d. Benefits covered under the policy Base cover 1. Inpatient Treatment" in respect of the Insured Person.

iii. We shall not be liable to make any payment in respect of any Pre-hospitalization Medical Expenses incurred prior to the Policy Period Start Date of the first policy with Us in respect of the Insured Person.

iv. Expenses incurred on nursing care at home are excluded from the scope of pre hospitalization expenses.

v. This Benefit will be provided on a reimbursement basis only.

vi. Any Pre-hospitalization Medical Expenses payable shall not in aggregate exceed the Annual Sum Insured and additional sum insured /cumulative bonus (if any) as specified in the Policy Schedule against this Benefit

5. Post Hospitalisation expenses

We will cover the Post-hospitalization Medical Expenses incurred in respect of the Insured Person for up to 180 days immediately following the Insured Person's discharge from Hospital provided that:

i. The Post-hospitalization Medical Expenses incurred are Reasonable and Customary Charges.

ii. We have accepted the claim under "Inpatient Treatment" in respect of the Insured Person.

iii. We will also consider Post-hospitalization Medical Expenses incurred on Physiotherapy provided that such Physiotherapy is advised in writing by the treating Medical Practitioner and is Medically Necessary Treatment. This service will be provided on a reimbursement and/ or cashless basis where ever applicable.

iv. Expenses incurred on nursing care at home are excluded from the scope of post hospitalization expenses.

v. Any Post-hospitalization Medical Expenses payable during the Policy period shall not in aggregate exceed the Annual Sum Insured and additional sum insured /cumulative bonus (if any) as specified in the Policy Schedule against this Benefit.

6. Donor Expenses

We will cover the Medical Expenses incurred in respect of an organ donor's Hospitalization during the Policy Period for the harvesting of the organ donated to the Insured Person provided that:

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

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

iii. The Medical Expenses incurred are Reasonable and Customary Charges.

iv. Any Medical Expenses payable during the Policy period shall not in aggregate exceed the Annual Sum Insured and additional sum insured /cumulative bonus (if any) as specified in the Policy Schedule against this Benefit subject to an overall limit of ₹ 10,00,000 only

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

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

i. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.

ii. Screening expenses of the organ donor.

iii. Any other Medical Expenses as a result of the harvesting from the organ donor.

iv. Costs directly or indirectly associated with the acquisition of the donor's organ (other than hospitalisation costs involved).

v. Transplant of any organ/tissue where the transplant is experimental or investigational.

vi. Expenses related to organ transportation or preservation.

vii. Expenses incurred by an Insured Person as a donor.

viii. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

7. Domiciliary Hospitalization

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

i. The Domiciliary Hospitalization is for Medically Necessary Treatment.

ii. The Domiciliary Hospitalization commences and continues on the written advice of a Medical Practitioner.

iii. The Medical Expenses incurred are Reasonable and Customary Charges.

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

v. Any Medical Expenses payable shall not in aggregate exceed the Annual Sum Insured and additional sum insured /cumulative bonus (if any) as specified in the Policy Schedule against this Benefit.

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

a) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;

b) Arthritis, gout and rheumatism;

c) Ailments of spine/disc

d) Chronic nephritis and nephritic syndrome;

e) Any liver disease;

f) Peptic ulcer

g) Diarrhea and all type of dysenteries, including gastroenteritis;

h) Diabetes mellitus and insipidus;

i) Epilepsy;

j) Hypertension;

k) Pyrexia of any origin

8. Home Care Treatment

We will cover the medical expenses incurred by the Insured person on home care treatment maximum up to 5% of Annual Sum Insured provided that :

a. The Medical Practitioner advices the Insured Person to undergo treatment at home

b. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.

c. Daily monitoring chart including records of the treatment duly signed by the treating doctor is maintained.

d. The condition of the Insured Person is expected to improve in a reasonable and foreseeable period of time.

e. Prior approval from Us has been taken. The Home care treatment is availed only on a cashless basis, subject to availability of our empanelled service provider(s). Kindly visit our website for cities/locations where such services are available.

f. Treatment availed is not categorized under "AYUSH" or any form of non- allopathic treatment

g. Such treatment cannot be provided on outpatient basis

However in case of unavailability of our empanelled service provider in the insured person's location, in case the insured person intends to avail the services of non-network provider and claims for reimbursement, a prior approval from Us needs to be taken before availing such services.

In case the insured person breaches the conditions of approval or fails to take the prior written approval from Us, we are not liable to settle any claim under this section.

For the purpose of this benefit, Home care treatment shall include:

a. Diagnostic tests underwent at home as advised by medical practitioner

b. Medicines prescribed in writing by a medical practitioner

c. Consultation charges of the medical practitioner

d. Nursing charges if advised by the medical practitioner

Any expenses payable during the Policy period shall not in aggregate exceed the Annual Sum Insured and additional sum insured /cumulative bonus (if any) as specified in the.

9. In Patient AYUSH Hospitalization

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

i. The Medical Expenses incurred are Reasonable and Customary Charges.

ii. The Insured Person is Hospitalized for AYUSH Treatment at a AYUSH hospital or an AYUSH Day-care centre.

iii. The Insured Person's Hospitalization commences and continues on the written advice of the treating Medical Practitioner.

iv. Any Medical Expenses payable during the Policy period shall not in aggregate exceed the Annual Sum Insured and additional sum insured /cumulative bonus (if any) as specified in the Policy Schedule against this Benefit.

v. This Benefit will be provided on a reimbursement and/ or on cashless basis where ever applicable.

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

i. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.

ii. Any expenses incurred for the purpose of evaluation or investigation.

10. Domestic road ambulance cover

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

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

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

11. Air Ambulance

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

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

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

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

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

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

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

12. Base Co-payment

This policy will be subject to 50% base co-payment and He/She shall be liable to pay 50% of admissible claim amount of each and every claim. Base Co-payment once chosen cannot be changed mid-term. Modification of co-payment may happen only during renewal subject to underwriting. In case, base co-payment is reduced during renewal, fresh waiting periods shall be applicable on the modified portion of base co-payment.

i. Base Co-payment shall be applicable to all benefits under the policy except any benefits availed under Care management program, Care management plus program, preventive health check-up,.

ii. Base Co-payment shall not be applicable in case voluntary deductible has been opted for.

13. Cumulative Bonus/ Additional Sum Insured

We will provide a Cumulative Bonus of 10% of the Annual Sum insured at the end of each Policy Year if the expiring Policy has been claim free and is continuously renewed with Us. The Cumulative Bonus will not be accumulated for more than 100% of the Annual Sum insured under any circumstances.

i. In case where the policy is on a floater basis the cumulative bonus will be on floater basis and for individual policy the same will be on an individual basis.

ii. In case where the policy is on a floater basis, the cumulative bonus will be accrued only if no claims have

been made in respect of all Insured Person(s) in the expiring policy period.

iii. In a floater policy as specified in the Policy Schedule, the Cumulative Bonus so accrued during the previous Policy Year(s) will only be available to those Insured Person(s) who were insured in previous Policy Year(s) and continue to be insured with Us in the subsequent Policy Year(s).

iv. Cumulative Bonus will not be added if the Policy is not renewed with Us by the end of the Grace Period.

v. Cumulative bonus can be utilised only when the Annual Sum Insured is completely exhausted.

vi. If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.

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

viii. In case of floater policies where Insured Persons Renew their expiring policy with Us by splitting the Annual Sum Insured in to individual policies the Cumulative Bonus of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Annual Sum Insured of each Renewed Policy as detailed in table below.

Annual Floater Sum Insured	Accumulated Cumulative bonus/ Additional SumInsured (after5claim freeyears)	**Floater policy split to individual policies with Annual Sum Insured of 10 Lacs each**	Revised AnnualSum Insuredof each individual policy	Revised Accumulated Cumulative bonus/ Additional SumInsured ofeach individual policy
20 Lac	10 Lac		10 Lac	5 Lac

ix. If the Annual Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Annual Sum Insured as detailed in table below

Annual Sum Insured	Accumulated Cumulative bonus/ Additional SumInsured (after5claim freeyears)	**Annual Sum Insured reduced to ₹ 10 Lacs**	Revised Annual Sum Insured	Revised Accumulated Cumulative bonus/ Additional SumInsured
20 Lac	10 Lac		10 Lac	5 Lac

x. If the Annual Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Annual Sum Insured of the last completed Policy Year.

xi. In the event of a Claim under the Policy during any subsequent Policy Year, the accrued cumulative bonus shall not be reduced.

14. Reset Benefit

We will reset the Annual Sum insured up to 100% of the Annual Sum insured unlimited times, for all future claims within the same policy not related to the illness / disease / injury for which a claim has been paid for the same insured person in a Policy Year as stated in the Policy Schedule, provided that:

i. The Annual Sum insured including additional sum insured /Cumulative Bonus (if any) in respect of the Insured Person is insufficient as a result of previous claims paid in that Policy Year.

ii. The total amount of reset will not exceed the Annual Sum Insured for that policy year.

iii. The Reset Benefit will be applied only if the claim is made and admissible under “Inpatient Treatment” or “Daycare Procedure”.

iv. The Reset Benefit will not be triggered for the first claim made during the Policy Year.

v. The Reset benefit will be triggered only once and not unlimited times for all future claims within the same policy which are related to the illness/disease/injury for which a claim has already been paid/registered for the same insured person.

vi. For individual policies, reset Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis.

vii. For any single claim during a Policy Year , the maximum claim amount payable shall not exceed the sum of

- The Annual Sum insured;
- additional sum insured /Cumulative Bonus;

viii. The Reset Benefit will not be available for an Illness / Injury or related complications including but not limited to any relapse within 45 days in respect of which a claim has been paid in that Policy Year for the same Insured Person.

ix. Any unutilized Reset Benefit will not be carried forward to any subsequent Policy Years.

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

- The Annual Sum Insured
- additional sum insured /Cumulative Bonus
- Reset Sum Insured

15. Sub-limits applicable

The expenses payable during the entire policy period for treatment of the following diseases/ conditions (either as a day care or as an in-patient exceeding 24hrs of admission in the hospital) shall be maximum up to the amount mentioned in the table below;

Procedures/Medical Conditions/Ailments/Diseases	Annual Sum Insured		
	3L/4L/5L	10L/15L/20L	>20L
Treatment of cataract	Up to ₹ 25,000/ eye	Up to ₹ 50,000/ eye	Up to ₹ 75,000/ eye
Treatment of each and every ailment/procedure mentioned below			
Treatment of cerebrovascular and cardiovascular disorders	₹ 2,00,000	₹ 3,50,000	₹ 5,00,000
Treatment/surgeries for cancer(including chemo/radio/oral)			
Treatment of other renal complications and disorders			
Treatment for breakage of long bones/Joint replacements			
Robotic surgeries for any ailment/condition/disease	₹ 1,00,000	₹ 1,75,000	₹ 2,50,000

Sub-limits will include the expenses incurred on pre hospitalisation and post hospitalisation expenses

16. Enhanced Annual Sum insured for Road Traffic Accidents

If the insured person meets with a Road Traffic Accident resulting in in-patient hospitalization, then the Annual Sum Insured shall be doubled subject to the following:

- It is declared and proven that the insured person was taking due safety precautions such as use of seat-belt/ helmet/ following road traffic signals and was either riding as pillion rider in a two wheeler or travelling in a four wheeler at the time of accident as evidenced by Police record and Hospital record.
- The enhanced(doubled) Sum Insured shall be available only once during the policy period.
- The enhanced (double) Sum Insured shall be available only after exhaustion of the annual sum insured.
- The enhanced Sum Insured can be utilized only for that particular hospitalization following the Road Traffic Accident .
- Reset benefit shall not trigger for claims under this cover.
- This benefit shall not be applicable for day care treatment.
- The unutilized balance of enhanced (doubled) sum insured for road traffic accidents cannot be carried forward for the remaining policy period or for renewal.
- Claims under this benefit will reduce the Cumulative bonus/ additional sum insured

17. Preventive health check-up

Insured Persons can avail a preventive health check-up as per our pre- defined package only at our network providers or empanelled health service providers anytime during the Policy period subject to the below conditions :

- This benefit can be availed only on cashless basis and is limited to once a year per Insured Person.
- This benefit can be availed through our mobile application or via utilisation of health check-up coupons provided with the policy kit
- The Network Provider /Health Service Provider shall be assigned by Us post receiving Insured Person's request to avail a health check-up under this Benefit.
- Utilisation of this preventive health check-up will not impact the Annual Sum Insured or eligibility for additional sum insured /cumulative Bonus.
- Un-utilised health check-up package will not be carried forward to the next policy year and it will be the Insured Person's choice and responsibility to utilise the same with in the designated policy period. We shall not be liable to provide any reminders or notifications for the same.
- In-case of long term policies (2 year or 3 years), the preventive health check-up package for all the policy years shall be provided together in the first policy year itself. It shall be the responsibility of the Insured Person to preserve the same and undergo the check-ups during the designated policy years.

Please Note:

- *We shall not hold any responsibility towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner/ Healthcare professional.*
- *Choosing the services under this Benefit is purely upon the customer's own discretion and at own risk.*
- *The Insured Person should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If the Insured person has any concerns about His/ her health, He/ She may consult His/ her general practitioner.*

18. Incentives associated with Vaccination against pneumococcal disease

We will provide an additional 2.5% discount on premium (fresh or renewal) for Insured Person(s) who have taken the Pneumococcal vaccine or its equivalent vaccine which

helps prevent pneumococcal disease. All the members covered under thepolicy should have be vaccinated in the past one year (1 year) from policy start date to avail this discount. i.e. if policy start date is 1st January 2022, all insured persons under the policy should have been vaccinated against Pneumococcal disease in the period from 1st January 2021 to 31st December 2021. This discount shall be provided lifetime as long as the insured person continues to renew this policy.

Mandatory Extension:

19. Care Management Program

In consideration of payment of additional premium, the insured person can avail benefits of the Care Management Program. The Care Management Program aims to provide solutions which will solve everyday challenges/issues faced by You, promote holistic wellbeing and empower You to lead independent and enriching lives.

Our Care management program focusses on providing You with assistance and support in case of any challenge but at the same time equipping you for the future. Our endeavour is to promote longevity, productivity and incentivise You for your healthy behaviour which will enable dignified living.

The Insured Person shall have access to a host of benefits under the Care management program on downloading and registering on our mobile application. This activity is to ensure adequate utilization of services offered and to redeem the wellbeing points awarded.

1. Tele Consultation(s)

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

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

2. Second E-opinion for Critical Illness

We shall arrange E-opinion on a cashless basis from our empanelled Medical Practitioners in case the Insured Person is diagnosed with any of the below listed critical Illnesses during the Policy Period, and at his/her sole discretion chooses to avail an E-opinion subject to the below mentioned conditions.

- The E-opinion will be arranged on cashless basis and the insured person will not have to bear any expenses on the same.
- The E-opinion will be based only on the information and documentation provided to Us (which will be shared with the Medical Practitioner) and it should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional.
- This E-opinion can be availed only once during the Policy Period for the same illness.
- Appointments to avail this E-opinion may be requested through Our Website or Our mobile application or through calling Our call centre on Our toll free number.
- The E-opinion provided under this Benefit shall be limited to the listed critical Illnesses and will not be valid for any medico legal purposes.
- We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

List of Critical Illness for which Second E-opinion may be requested

Heart and vascular conditions

1. Myocardial Infarction
2. Refractory heart failure
3. Cardiomyopathy

Lung Conditions

4. End stage lung Failure
5. Primary(Idiopathic) pulmonary Hypertension

Liver conditions

6. End stage liver Failure

Neuro/ spinal & psychiatric disease

7. Multiple sclerosis with Persisting symptoms
8. Motor neuron disease with Permanent symptoms
9. Permanent paralysis of limbs
10. Stroke resulting in permanent symptoms
11. Coma of specified severity
12. Alzheimer's Disease before age of 50 years
13. Parkinson's disease before age of 50 years
14. Apallic syndrome
15. Benign brain tumour
16. Creutzfeldt-Jakob disease (CJD)
17. Major head trauma

Renal diseases

18. Kidney failure requiring regular dialysis
19. Medullary cystic disease

Musculoskeletal diseases

20. Muscular dystrophy
21. Poliomyelitis

Bleeding disorders

22. Aplastic Anaemia

Auto immune diseases

23. Systemic Lupus Erythematous with renal involvement
24. Myasthenia gravis
25. Scleroderma
26. Good pastures syndrome with lung or renal involvement
27. Blindness
28. Deafness
29. Cancer of specified severity
30. Third Degree Burns
31. Loss of speech
32. Loss of limbs
33. Loss of Independent Existence

3. Diet and Nutrition e-consultation

We will offer You diet and nutrition e-consultation on a virtual platform via our mobile application to help you achieve your weight and health management goals.

Maximum of 12 sessions will be provided per insured person per policy period.

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

4. E-Counselling

We will offer e-counselling session(s) with a Psychologist via our mobile application for providing assistance in dealing with issues such as but not limited to personal and lifestyle imbalance, anxiety, depression, sleep disorders, stress and problems related to psychological/mental illness/ psychiatric and psychosomatic disorders.

Maximum of 12 sessions will be provided per insured person per policy period.

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

5. Health Management Program

The Health Management Program has been designed to ensure a regular monitoring of the Insured Person's health and timely intervention and a concrete plan for corrective measures in case of any decline in the health status of the Insured Person.

The Health Coach shall guide and motivate the Insured Person to follow the customised Health management program designed for them to achieve their health and fitness goals.

As a part of the Health Management Program, the insured person can avail the following benefits

a. Care Calls

All insured persons shall receive care calls to check up on their well-being and safety by our health coach who understand the issues surrounding senior individuals. The insured person(s) will be encouraged to express their concerns surrounding their well-being (if any) on these calls so that the health coach can address them later.

b. Goal based incentives on outcome of Preventive health check-up

Monitoring of one's health status remains an important step towards becoming more self-aware of one's medical / health conditions.

The insured person shall be subjected to a mid-term assessment via a Wellbeing Risk Assessment [WRA] which will include outcome of certain laboratory tests and questionnaire based assessment covering aspects of lifestyle, current medical history & family history.

The assessment will be carried out using a telephonic/ digital connect with the Health Coach.

The health coach will encourage the insured person to undergo certain laboratory tests (as detailed in Table A) and we will incentivise the Insured Person in case of favourable findings of the laboratory tests.

The insured person will have to undergo the below mentioned laboratory tests as a part of the mid-term assessment from our empanelled diagnostic

centres and will be guided by the health coach for the same.

In case the insured person is desirous of undergoing laboratory tests at a diagnostic centre of their choice which is not empanelled with us, the insured person will have to bear the charges associated with the actual costs of the mid-term assessment diagnostic tests/ visit charges / collection charges etc.

The insured person will also have to provide us with the laboratory reports of the below mentioned medical tests/investigations conducted within the policy period for Us to award the wellness points.

Table A

Medical Tests	Favorable findings	Findings that need improvement
Glycosylated Haemoglobin (HbA1c)	< 6%	>6 and up to7%
Low Density Lipoprotein (LDL)	< 100 mg/dl	>100 and < or = 190 mg/dl
High Density Lipoprotein (HDL)	> or = 40 mg/dl	> 20 mg/dl and <40 mg/dl
Serum cholesterol	< or = 200mg/dl	>200 and < or =300 mg/dl
Serum Triglycerides	<or = 150 mg/dl	> 150 and < = 250mg/dl
S. Creatinine	< or = 1.3 mg/dl	> 1.3 mg/dl

The insured person shall be awarded wellness points as per table B for each laboratory test mentioned below in case the findings of the laboratory test are favourable as detailed in Table A.

Table B

Medical Tests	Wellness points awarded in case of favourable findings
Glycosylated Haemoglobin (HbA1c)	500
Low Density Lipoprotein (LDL)	200
High Density Lipoprotein (HDL)	200
Serum cholesterol	200
Serum Triglycerides	200
Serum Creatinine	200
Total	**1500**

The maximum wellness points that can be awarded under this activity is restricted to 1500 wellness points per insured person per policy year.

Each wellness point will be valued at INR 0.20. Wellness points so earned can be redeemed against deals and discounts on purchase of medicines from our empanelled pharmacies or undergoing recommended diagnostic tests from our empanelled diagnostic centres etc. as listed on our mobile application.

6. Participation in Yoga/Meditation Sessions/ Completion of Targeted Steps

The Insured Person can earn wellness points by participating in yoga sessions or meditation sessions aimed at maintaining physical and mental Wellness. Participation and successful completion of 10 yoga/ meditation sessions in a month will award the insured person 250 wellness points. Each yoga session/ meditation session must last 30 minutes or more and the maximum wellness points that can be accrued under this task is 1500 per insured person per policy year.

Please Note: The insured persons can join a virtual yoga/meditation class or visit an actual yoga/meditation centre. The expenses associated with the class fees/membership fees/tutor or instructor fees etc. will have to be borne by the insured person. Proof of payment of fees and certificate of completion of sessions will have to be provided to us in order for insured person to earn the wellness points.

Alternately, in case the Insured Person is keen to achieve targeted steps instead of participation in yoga sessions/meditation sessions, we will award 250 wellness points per month provided the insured person takes 4000+ steps per day for atleast 15 days in a month. The maximum wellness points that can be accrued by achieving targeted steps is 1500 per insured person per policy year.

Our mobile application will have to be downloaded within 30 days of the policy start date to avail the benefit as the average step count completed by an Insured person would be monitored on this mobile application.

Each wellness point will be valued at INR 0.20. Wellness points so earned can be redeemed against any services under discounts as mentioned in “discounts on services or products” on our mobile application.

Wellness points accumulated	Maximum wellness points awarded per person per policy year	Rupee Value of Accumulated wellness points
Outcome of Preventive health check-ups	1500	300
Participation in Yoga / Meditation / Completion of Targeted steps	1500	300
Total	**3000**	**600**

7. Medical Vault

The insured person can upload His/Her health records in our mobile application so as to protect them from loss or theft. These health records can then be viewed as per need and convenience of the insured person.

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

8. Health Assistance (HAT)

HAT shall assist the Insured Person in understanding their health condition better by providing answers to any queries related to health service providers

The services provided under this shall include:

- Identifying a Physician/ Specialist
- Availability of hospital beds/COVID hubs etc.
- Providing guidance on engaging attendants or nurses
- Facilitation with respect to arrangement of mobility aids, daily living aids, medical equipment etc.

- Scheduling an appointment with any Medical Practitioner empanelled with Us
- Scheduling appointments for a second opinion
- Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
- Scheduling appointments from diagnostic labs empanelled with us.
- Providing information, assistance and facilitation on door step delivery of medicines
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.

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

For all facilitation services provided under this cover, our role shall be limited to assistance only and the charges and expenses associated with the actual service shall have to be borne by the insured person.

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

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

While deciding to obtain the above services, the Insured person(s) expressly notes and agrees that it is entirely for them to decide whether to obtain these services and also to decide the use (if any) to which these services are to be put for.

9. Ambulance Assistance

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

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

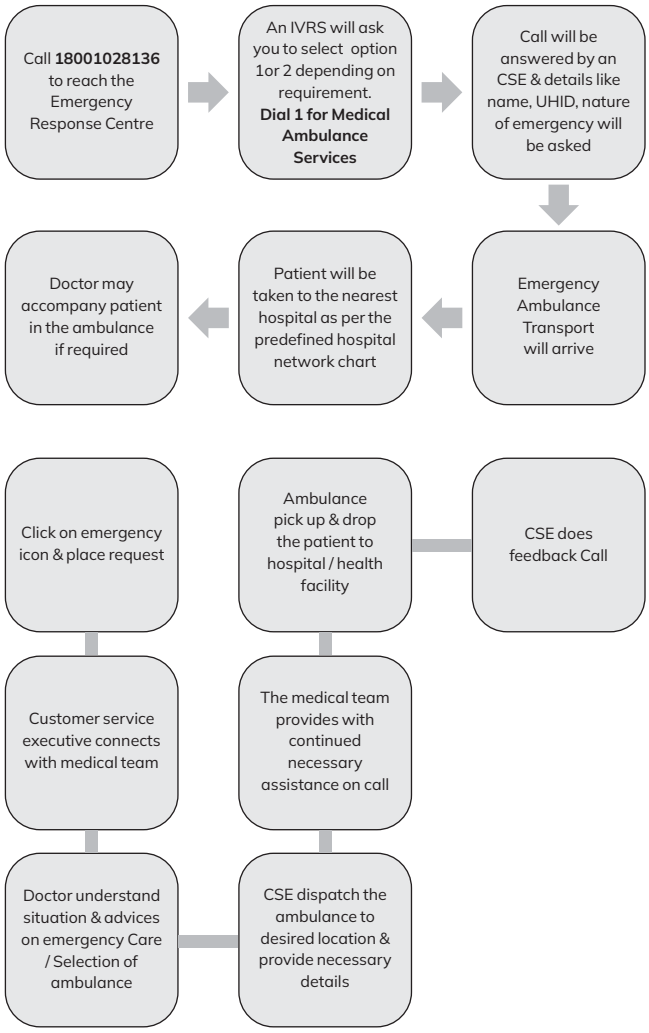
Process to avail Ambulance Assistance:

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

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

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

How to Call an Ambulance? (Via Call)



10. Discounts on services / products

We shall only facilitate the Insured Person in availing discounts on services/ products including but not limited to investigations/ diagnostic tests/ laboratory tests / health supplements/ medical equipment/ homecare services / virtual health & wellness sessions/ AYUSH products / Fitness & wellness related activities & products etc. at our empanelled diagnostic centres, drugs / medicines ordered from pharmacies etc. offered by our network providers/ health service providers. These discounts can be viewed on our mobile application and one can redeem the wellness points earned from Care Management Program (either through favourable findings on health check-up or participation in Yoga/ meditations sessions/ achieving targeted steps per month) for availing discounts as per product terms and conditions and subject to availability.

Terms and Conditions for Care Management Program

- There shall be no minimum wellness points limit for redemption against health related deals and discounts offered on our mobile application.
- The Insured Person(s) can choose to carry forward the wellness points for 3 years, in case they do not wish to redeem the same provided the policy is continuously renewed without any break. The wellness points so accrued shall have to be redeemed at the end of the 3rd Policy year.
- The Insured Person shall notify Us and submit the relevant documents, reports, receipts as and when required by us within 60 days of undertaking any activity for us to reward appropriate wellness points.
- In case of expiry of policy and the policy not being renewed, the accrued wellness points may be carried forward for a period not exceeding three months.
- There shall not be any cash reimbursement or redemption available against the wellness points accumulated by an Insured Person.
- We or Our Health Service Providers or Our Network Providers do not warrant the validity, accuracy, completeness, safety, quality, or applicability of the content or anything said or written or any suggestions provided in the course of providing the wellbeing services.
- We do not accept any liability towards quality of the services made available by our network providers/ health service providers and are not liable for any defects or deficiencies on their part.
- Availability of all Services under the care management program is subject to availability of Health Service provider at the requested location.
- We, Our group entities, or affiliates, their respective directors, officers, employees, agents, vendors, shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person may claim to have suffered, sustained or incurred, as a result of any advice or information obtained by way of the wellness program or any actions chosen by the Insured Person on the basis of such advice or information.
- The care management program offered is subject to revisions based on the insurance regulatory framework from time to time.

Optional Covers

1. Claim Protector

In consideration of payment of additional premium to Us, the insured person can avail the benefit as mentioned under claim protector. If a claim has been accepted under the inpatient hospitalization cover, then the items which are not payable under the claim as per the List of Excluded items released by IRDAI that is related to the particular claim will become payable. The maximum claim pay-out under this benefit shall be limited to Annual Sum Insured under your policy.

Base Co-payment as opted by the Insured Person in the policy shall be applicable for this cover

2. Modification of Base Co-payment

In consideration of payment of additional premium to Us, The insured person will have the option to reduce his base co-payment from 50% to 40% or 30% or 20% and He/She shall be liable to pay the percentage (%) of admissible claim amount of each and every claim.

Base Co-payment once chosen cannot be changed mid-term. Modification of co-payment may happen only during renewal subject to underwriting. In case, base co-payment is reduced during renewal, fresh waiting periods shall be applicable on the modified portion of base co-payment.

3. Voluntary Deductible

In case the Insured person has opted for a voluntary deductible, as specified in the Policy Schedule, the Deductible will be applicable on aggregate basis for all Hospitalization expenses during the Policy Year before it becomes payable by Us, subject to terms, conditions and exclusions of the Policy. The voluntary deductible option available will be 20% of Annual Sum Insured opted by You.

i. In case voluntary deductible has been opted for, base co-payment shall not be chosen. Zone based co-payment shall be applicable in case medically necessary treatment (Except medically necessary treatment for road traffic accidents) has been taken in a zone higher (Zone A being the highest followed by Zone B and then Zone C) than the zone for which premium has been paid on issuance of the policy.

ii. The deductible will apply on individual basis in case of individual policy and on floater basis in case of floater policy.

iii. Deductible once chosen cannot be changed mid-term. Modification of deductible may happen only during renewal subject to underwriting.

4. Care management Plus Program

In consideration of payment of additional premium, Insured Person can avail the benefits associated with care management Plus Program as detailed below

1. Health Care Professional

All insured persons shall be assigned a dedicated Health Care Professional who will act as a first point of contact for any service need. The Health Care professional will be a certified nutritionist who will assist the Insured person(s) with a personalised diet depending on their health concerns. The Health Care Professional shall encourage and promote optimal health and assist on matters pertaining to fitness, diet and nutrition and wellbeing concerns faced by the insured persons. He/She will encourage two way communication, provide reminders on healthy habits and reassure the insured person in times of need.

The health care professional will also play a significant role in being the primary point of contact to the Insured Person. The Health Care professional will

- On-board the Insured Person on to our mobile application
- Educate the Insured Person on the pertinent features of our mobile application such as but not limited to availing Tele-consultations, utilising the preventive health check-up, conducting the mid-term assessment, educating about health assistance services, redemption of wellness points etc.
- Give care calls to the Insured Person to understand insured person's issues surrounding fitness, diet & nutrition and wellbeing issues if any and propose solutions for the same

2. Update to family members-

As a part of the enhanced wellness features, your family members will be regularly updated about your health and adherence to prescribed diet(as prescribed under the diet and nutrition e-consultation benefit under Care management program) via messaging platform(s) so that they can motivate and encourage and participate in your efforts to achieve your healthcare goals.

The above update shall be provided only on Your consent and after You provide us with contact details of family member who wishes to receive timely updates about your health and diet regime.

3. Out-patient consultations

We shall cover the Medical Expenses incurred during the Policy period for out-patient consultations from a General Medical Practitioner or Specialist Medical Practitioner or Super Specialist Medical practitioner or AYUSH medical practitioner in relation to any Illness contracted or Injury suffered by the Insured Person during the Policy period subject to the overall maximum number of 4 consultations in a Policy Year.

These services shall be provided through our Empanelled Health Service Provider subject to availability at the time of appointment.

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

Physiotherapy sessions shall be excluded from the scope of this benefit.

Counselling availed for psychiatric ailments or mental health issues shall be excluded from the scope of this benefit but it shall be covered in E-Counseling (section d. Base Cover. 18.4) as per the section d. Benefits covered under the policy.

4. Routine Diagnostics and Minor Procedure cover

We shall cover medical expenses incurred for outpatient diagnostic tests recommended by Medical Practitioner under our cashless network available in the mobile application in relation to any Illness contracted or Injury suffered by the Insured Person during the Policy Period and for listed minor procedures undergone at a general practitioner or specialist / super-specialist medical practitioner by the Insured Person during the Policy period maximum up ₹ 2,000.

These services shall be provided through our Empanelled Health Service Provider subject to availability at the time of appointment. The diagnostic tests shall include but will not be limited to histopathology, biochemistry, hematology, immunology, microbiology, serology, pathology, radiology, ultrasound and TMT. Genetic studies shall be excluded from the scope of this cover.

We may even arrange for diagnostic tests to be carried out at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request. This service shall be subject to availability of Our empanelled Health Service provider.

List of Minor Procedures covered under this benefit #

Sr. No.	Procedure
1	Drainage of abscess
2	Injection including Intramuscular (Per Injection cost)
3	Intravenous injection(IV)
4	Sprain Management (Joint movement/ exercise)
5	Otoscopic examination (Magnifying otoscopy)
6	Nasal packing for control of haemorrhage
7	Nebulizer therapy
8	Removal of foreign body

List of Minor Procedures covered under this benefit #

Sr. No.	Procedure
9	Suturing (Staple under LA)
10	Removal of suture
11	Stabilization of joint
12	Syringing ear to remove wax
13	Application or removal of plaster cast
14	Laryngoscopy
15	Minor wound management

#this includes only the cost of administration. The actual cost of consumables shall be covered under the pharmacy cover. However, the said cost will have to be borne by the insured person in case the annual sum insured under the pharmacy cover has been exhausted or is out of scope of the Pharmacy cover or in case the consumable is a non-payable item.

5. Pharmacy cover

We shall cover medical expenses incurred on purchase of medicines, drugs, and medical consumables, as prescribed by a Medical Practitioner under our cashless network available in the mobile application for any Illness contracted or Injury suffered by the Insured Person during the Policy Period, maximum up to ₹ 2,000 through our Empanelled Health Service Provider subject to availability on the date of the request.

Health supplements, Nutraceuticals, foods for special dietary use, foods for special medical purpose, foods with added probiotics and/or foods with added prebiotics, vaccinations, vitamins, tonics or other related products are excluded from the scope of this cover.

6. Nursing at Home

We shall cover the expenses incurred by You, up to ₹ 2,000 for each day up to a maximum of 15 days post Hospitalization for the medical services of a Qualified Nurse at Your residence, provided that the nurse is employed in a Hospital and the engagement of such Qualified Nurse is certified as necessary by a Medical Practitioner and related directly to any Illness or Injury, covered under the Policy. The payment under this cover is subject to admissibility of Your In-patient treatment Claim under the Policy.

d. Exclusions

We will not be liable for any Voluntary Deductible amount, if applicable and as specifically defined in the Policy Schedule under the Policy.

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

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

1. **Code- Excl01:** Pre-Existing Diseases
   a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
   d. 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. **Code- Excl02:** Specified disease/procedure waiting period
   a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
   d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
   e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific Illness and Surgical Procedures as mention below:

Sr. No.	Organ /Organ System	Illness/ diagnosis (irrespective of treatments medical or surgical)	Surgeries/ Procedures (irrespective of any illness or diagnosis other than cancers)
1	ENT	Deviated Nasal Septum	Septoplasty
		CSOM-Chronic Suppurative Otitis Media	Mastoidectomy
			Tympanoplasty, Myringotomy & Myringoplasty
			Any treatment for conditions related to tonsils, adenoids, sinuses, Turbinates/ concha
2	Gynaecological	Fibroids (fibromyoma)	Dilatation and curettage (D&C)
		Endometriosis, Cervicitis	Myomectomy
		Uterine Prolapse	Hysterectomy (unless due to malignancy
		Dysfunctional uterine bleeding	
		Polycystic Ovarian Syndrome (PCOS)	
3	Orthopaedic	Arthritis	Surgeries for joint replacements
		Gout and Rheumatism	Repairs/ reconstruction of ligaments/ meniscus/ tendons
		Spinal and Vertebral Disorders including diagnosis as low back ache	Spinal & Vertebral Surgeries
		Arthroscopy	
4	Gastrointestinal	Stones in gall bladder & Biliary System, cholecystitis, acalculous cholecystitis	Cholecystectomy, Procedures for biliary stones
		Fissure/fistula in anus, hemorrhoids, pilonidal sinus	Endoscopy
		Esophageal Varices & Gastric Varices	Procedures for Esophageal Varices & Gastric Varices
		All types Hernia	Endoscopy
		Gastrointestinal ulcers including Gastritis & Duodenitis/ Erosions of gastrointestinal tract	
		All forms of Liver cirrhosis	
5	Uro-genital	Stones in Urinary system	Surgeries and procedures related to Stones in Urinary system
		Benign Hyperplasia of prostate	Prostatic Surgeries
		Chronic Renal Failure or end stage Renal Failure or chronic kidney disease including dialysis	Dialysis but not limited to haemodialysis & peritoneal dialysis
		Hydrocele, varicocele/ rectocele/ Spermatocele	
6	Eye	Cataract	
		Retinal detachment	
		Glaucoma	
		Usage of intra vitreal injections including but not limited to avastin & lucentis	

f. List of specific Illness and Surgical Procedures as mention below: *(Contd.)*

Sr. No.	Organ /Organ System	Illness/ diagnosis (irrespective of treatments medical or surgical)	Surgeries/ Procedures (irrespective of any illness or diagnosis other than cancers)
7	Other General conditions (Applicable to all organ systems/ organs/ disciplines whether or not described above)	All internal/ external tumors, cysts, nodules, polyps, sinus, fistula	
		Varicose veins & Varicose ulcers	
		Parkinson's disease/Alzheimer's disease	

3. a. Expenses related to the treatment of the below mentioned illness within 90 days from the first policy commencement date shall be excluded unless they are pre-existing and disclosed at the time of underwriting
   I. Hypertension
   ii. Diabetes
   iii. Cardiac Conditions
   b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
   c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.
4. Code- Excl03: 30-day waiting period
   a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
   c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

   Unless covered by way of an appropriate extensions / optional covers, We shall not be liable to make any payment under this Policy in connection with or in respect of
5. Permanent Exclusions
   i. Code- Excl04: Investigation & Evaluation
      a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
      b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
   ii. Code - Excl05: Exclusion Name: Rest Cure, rehabilitation and respite care-

   Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   a. 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.
   b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs
   iii. Code- Excl06: Obesity/ Weight Control

   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1. Surgery to be conducted is upon the advice of the Doctor
   2. The surgery/Procedure conducted should be supported by clinical protocols
   3. The member has to be 18 years of age or older and
   4. Body Mass Index (BMI);
      a. greater than or equal to 40 **or**
      b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy
         ii. Coronary heart disease
         iii. Severe Sleep Apnea
         iv. Uncontrolled Type2 Diabetes
   iv. Code- Excl07: Change of Gender treatments

   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
   v. Code- Excl08: Cosmetic or plastic Surgery

   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or

Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

vi. Code- Excl09: Hazardous or Adventure sports

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

vii. Code- Excl10: Breach of law

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

viii. Code- Excl11: Excluded Providers

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim. The list of excluded providers/delisted hospitals is available on our website www.icicilombard.com

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

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

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

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

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

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

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

xv. Code- Excl18: Maternity: Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

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

6. Any ailment/ illness/ injury/ condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions
7. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, instruments used in treatment of sleep apnoea syndrome or cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively.
8. Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.
9. Expenses incurred on dental treatment unless necessitated due to an Accident
10. Personal comfort, cosmetics, convenience and hygiene related items and services
11. Acupressure, acupuncture, magnetic and other therapies
12. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident.
13. Expenses for venereal disease or any sexually transmitted disease (except HIV/AIDS)
14. Any Treatment or medical services taken outside the geographical boundaries of India.
15. Any expenses incurred on out-patient (OPD) treatment. (This exclusion shall not be applicable in case care management plus program has been opted for by payment of additional premium)
16. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
17. Any injury or illness caused by or arising from or attributed to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority
18. Any Illness or Injury caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel

19. Treatment for any condition / illness which requires hormone replacement therapy.
20. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:
    a. Deep coma and unresponsiveness to all forms of stimulation; or
    b. Absent pupillary light reaction; or
    c. Absent oculo-vestibular and corneal reflexes; or
    d. Complete apnea.

e. General Terms and Clauses

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

1. Disclosure of Information

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

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

2. Condition Precedent to Admission of Liability

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

3. Claim Settlement (provision for Penal Interest)

I. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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

III. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

IV. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

4. Complete Discharge

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

5. Multiple Policies

i. 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 obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurers from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

6. Fraud

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

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

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

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

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

7. Cancellation

a) The policyholder may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium for the unexpired Policy Period as detailed below.

Cancellation Period	Refund % for 1 year tenure policy	Refund % for 2 years tenure policy	Refund % for 3 years tenure policy
From 16 days to 1 month	75%	80%	80%
From 1 month to 3 months	60%	70%	75%
From 3 months to 6 months	40%	60%	70%
From 6 months to 9 months	20%	50%	60%
From 9 months to 12 months	0%	40%	55%
From 12 months to 15 months	-	30%	45%
From 15 months to 18 months	-	20%	40%
From 18 months to 21 months	-	10%	35%
From 21 months to 24 months	-	0%	25%
From 24 months to 27 months	-	-	20%
From 27 months to 30 months	-	-	10%
From 30 months to 33 months	-	-	5%
From 33 months to 36 months	-	-	0%

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

b) The Company may cancel the Policy at any time on grounds of mis-representation, 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 mis-representation, non-disclosure of material facts or fraud.

8. Migration:

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/ plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

9. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

11. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

12. Moratorium Period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract

13. Premium Payment in Instalments (Wherever applicable)

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. Grace Period of 15 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. 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.

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

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

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

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

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

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

15. Free look period

The Free Look Period of fifteen days (thirty days in case of distance marketing) from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable. It shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the Policy documents to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

a) a refund of the premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges; or

b) where the risk has already commenced and the option of return of the Policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

c) where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

16. Redressal of Grievances

In case of any grievance the insured person (including senior citizen) may contact the company through

Website : www.icicilombard.com

Toll Free: 1800 2666

E-Mail : customersupport@icicilombard.com

Courier : **ICICI Lombard General Insurance Company Ltd.**
ICICI Lombard House,
414, P Balu Marg, Off Veer Savarkar Road,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai- 400025.

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.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at :
Manager- Service Quality,
Corporate Manager- Service Quality,
National Manager- Operations &
finally Director-services and Business development at the following address:
ICICI Lombard General Insurance Company Limited,
ICICI Lombard House,
414, P Balu Marg, Off Veer Savarkar Road,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai - 400 025.

For updated details of grievance officer, kindly refer the link

https://www.icicilombard.com/grievance-redressal

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman

Rules 2017. Grievance may also be lodged at IRDAI Integrated Grievance Management System https://igms.irda.gov.in/

17. Nomination:

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

ii. Specific terms and clauses (terms and other clauses other than those mentioned above under f. I. above)

18. Zone based Premium

This Policy only covers medical treatment taken within India arising during the Policy Period. All payments under this Policy will only be made in Indian Rupees within India.

The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law.

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

- Zone A- NCR*, Mumbai, Thane District,, Navi Mumbai, Gujarat, Kolkata
- Zone B- Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Navi Mumbai)
- Zone C- Rest of India

NCR* includes Includes Delhi and the following districts: Faridabad, Gurgaon/Gurugram, Mewat, Rohtak, Sonipat, Panipat, Jhajjhar, Palwal, Karnal, Ghaziabad, Noida/Gautam Budh Nagar, Bulandshahr, Baghpat, Hapur, Shamli, Muzaffarnagar

Additional zone based Co-Payment would be levied on each and every claim (over and above the base co-payment opted by the Insured person) in case medically necessary treatment has been taken in a zone higher (Zone A being the highest followed by Zone B and then Zone C) than the zone for which premium has been paid on issuance of the policy. Zone based co-payment shall not be applicable in case of medically necessary treatment taken for road traffic accidents.

The additional zone based co-payment that will be levied will be as per tables mentioned below

Additional zone based Co-Payment Grid			
Treatment taken in Zone	Zone opted at policy issuance		
	A	B	C
A	0%	15.0%	25.0%
B	Nil additional co-payment	0%	12.0%
C	Nil additional co-payment	Nil additional co-payment	0%

Please refer to the claim illustrations as detailed in g. other terms and conditions 1. Claim Administration for further understanding

19. Conditional Underwriting

Risk based loading:

We may apply a risk loading on the premium payable (based on the declarations made in the proposal form and the health status of the persons proposed for insurance) at the Commencement Date or on any renewal of the Policy with Us or on the receipt of a request for enhancing the Annual Sum Insured. The maximum risk loading applicable for an individual will not exceed 100% per diagnosis / medical condition and an overall risk loading of 200% per individual.

We will send You the applicable risk loading in writing via a counter offer letter. You shall give Us Your consent and the additional premium (if any), within 15 days of the issuance of Our Counter offer letter.

If You neither accept Our letter nor revert to Us within 15 days, We will cancel Your application and refund the premium paid within the next 7 days.

20. Material Change

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

21. Records to be Maintained

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

22. Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

23. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

24. Automatic change in Coverage under the policy

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

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

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

ii. Upon exhaustion of sum insured and additional sum insured (if any), for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

25. Territorial Jurisdiction

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

26. Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy, iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator / arbitrators of the amount of expenses shall be first obtained.

27. Policy alignment

Policy Alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy.

Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.

28. Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

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

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

iv. Mid- term endorsement of addition of members in the policy shall not be permitted

29. Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

30. Non Payables

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

List of Non Payable Items as per IRDAI

Sr. No.	Items
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT

List of Non Payable Items as per IRDAI (Contd.)

Sr. No.	Items
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	RECOVERY KIT, ETC]ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT,
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

f. Other Terms and Conditions

1. Claim Administration

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

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

i. If a room/ICU accommodation has been opted for where the room rent or category is higher than the eligible limit as applicable for the Insured Person, then the associated medical expenses payable shall be pro-rated as per applicable limits.

ii. Associated medical expenses means those expenses as listed below which vary in accordance with the room rent or room category or ICU Charges in a hospital:

a. Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the insured person availed treatment

b. Intensive care unit (ICU) Charges

c. Fees charged by surgeon, anesthetist, medical practitioner
d. Investigation expenses

iii. Zone based co-payment shall be applicable in all cases (Except medically necessary treatment for road traffic accidents) where treatment is taken in a zone higher than for which premium was paid for

iv. The voluntary deductible shall be applied to aggregate of all claims that are either paid or payable (not excluded) under this policy. Our liability to make payment shall commence only once the aggregate amount of all claims payable or paid exceed the voluntary deductible. Base Co-payment shall not be applied incase voluntary deductible has been opted for.

v. Base Co-payment shall be applicable on the amount payable by Us and our liability to make payment shall than be arrived at.

vi. In case, the claim is for a Procedure/Medical Condition/Ailment/Disease which is subject to sub-limits as per policy terms and conditions, the claim will be settled to the extent of amount which is lesser of the three amounts – i.e. claimed amount or maximum amount as per sub-limits applicable or ICICI Lombard Liability after deduction of base co-payment/ voluntary deductible.

Illustrations for claim settlement

Illustration 1 - Insured Person opted for base co-payment

Heading	Particulars	Scenario 1	Scenario 2	Scenario 3
A.	Annual Sum Insured	₹ 10,00,000	₹ 10,00,000	₹ 10,00,000
B.	Base Co-payment opted at time of policy issuance	20%	20%	20%
	Zone opted	B (Goa)	B (Goa)	B (Goa)
	Hospitalization Diagnosis	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease
	Treatment taken in	Goa (Zone B)	Mumbai (Zone A)	Guwahati (Zone C)
C.	Hospitalisation expenses Amount	₹ 4,00,000	₹ 5,00,000	₹ 3,00,000
D.	Pre and Post hospitalisation expenses	₹ 35,000	₹ 50,000	₹ 20,000
E.	Total claimed Expenses*[C+D]	₹ 4,35,000	₹ 5,50,000	₹ 3,20,000
F.	Zone based co-payment	0%	15%	0%
G.	Claimed amount after application of zone based co-payment [E*F]	₹ 4,35,000	₹ 4,67,500	₹ 3,20,000
H.	Sub-limit for cardiovascular diseases	₹ 3,50,000	₹ 3,50,000	₹ 3,50,000
I.	Insured Person liability after application of base co-payment [G*B]	₹ 87,000	₹ 93,500	₹ 64,000
J.	ICICI Lombard Liability after deduction of co-payment [G-I]	₹ 3,48,000	₹ 3,74,000	₹ 2,56,000
K.	Final payable amount to Insured Person [lesser amount out of G, H, J]	₹ 3,48,000	₹ 3,50,000	₹ 2,56,000
L.	Balance Annual Sum Insured [A-K]	₹ 6,52,000	₹ 6,50,000	₹ 7,44,000

*It has been assumed that total claimed expenses are same as total payable expenses. i.e. there are no deductions in the claimed amount.

Illustration 2 - Insured person opted for voluntary deductible

Heading	Particulars	Scenario 1	Scenario 2	Scenario 3
A.	Annual Sum Insured	₹ 20,00,000	₹ 20,00,000	₹ 20,00,000
B.	Voluntary deductible opted at time of policy issuance	₹ 4,00,000	₹ 4,00,000	₹ 4,00,000
C.	Base Co-payment applicable	NA	NA	NA
	Zone opted	B (Goa)	B (Goa)	B (Goa)
	Hospitalization Diagnosis	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease
	Treatment taken in	Goa (Zone B)	Mumbai (Zone A)	Guwahati (Zone C)

Illustrations for claim settlement *(Contd.)*

Illustration 2 - Insured person opted for voluntary deductible *(Contd.)*

Heading	Particulars	Scenario 1	Scenario 2	Scenario 3
D.	Hospitalisation expenses Amount	₹ 4,00,000	₹ 5,00,000	₹ 3,00,000
E.	Pre and Post hospitalisation expenses	₹ 35,000	₹ 50,000	₹ 20,000
F.	Total claimed Expenses*[D+E]	₹ 4,35,000	₹ 5,50,000	₹ 3,20,000
G.	Zone based co-payment	0%	15%	0%
H.	Claimed amount after application of zone based co-payment [F*G]	₹ 4,35,000	₹ 4,67,500	₹ 3,20,000
I.	IL Liability after application of voluntary deductible [H-B]	₹ 35,000	₹ 67,500	NA as expenses have not crossed voluntary deductible amount
J.	Sub-limit for cardiovascular diseases	₹ 3,50,000	₹ 3,50,000	₹ 3,50,000
K.	Final payable amount to Insured Person [lesser amount out of I,J]	₹ 35,000	₹ 67,500	-
L.	Balance Annual Sum Insured [A-K]	₹ 19,65,000	₹ 19,32,500	₹ 20,00,000

*It has been assumed that total claimed expenses are same as total payable expenses. i.e. there are no deductions in the claimed amount.

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

1. Annual Sum Insured
2. Additional Sum Insured/Cumulative Bonus (if accrued and available)
3. Reset Sum Insured (If applicable)

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

1.1 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 or emailing us at as customersupport@icicilombard.com 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

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.

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. In case there is a delay beyond 30 days in submission of claim documents, we may condone the delay provided the insured person submits a valid reason justifying the delay to us in writing. However, in both the above cases i.e. g.1.1.1(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.

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.

1.2 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

1.3 Claim Service Guarantee

We provide You Claim Service Guarantee 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 2% interest over and above the rate defined as per IRDAI (Protection of Policyholder's interest) Regulation 2017.

B. **For Cashless Claims:** If You notify pre authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will 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 guarantee shall not be applicable for any cases delayed on 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. 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 Annual 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. For Reimbursement claims and within 4 hours in case of B. For Cashless claims above.

Annexure A

Jurisdiction of Office Union Territory, District)	Office Details
AHMEDABAD - Shri Kuldip Singh 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, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17-D, Chandigarh - 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI 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 - Shri Sudhir Krishna 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.

Jurisdiction of Office Union Territory, District)	Office Details
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.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th 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 - Shri Justice Anil Kumar Srivastava 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.

Annexure A *(Contd.)*

Jurisdiction of Office Union Territory, District)	Office Details
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

Jurisdiction of Office Union Territory, District)	Office Details
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah 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.