POLICY WORDINGS

PREAMBLE

You, the Insured/ Policy Holder, have applied to Us, for insurance and this document is the Policy setting out the details of the insurance which You have requested. When drawing up this Policy, We have relied on the information and statements which You have provided in the proposal form. In consideration of the payment of the premium shown in the Schedule, We agree to insure You on happening of covered event during the Policy Period as stated in Schedule, upon which one or more benefits become payable under the Policy, subject to the terms and conditions contained herein or endorsed on this Policy.

1. DEFINITIONS

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

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

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

Admission means Your admission in a Hospital as an in-patient 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

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)

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

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

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

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 is approved.

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

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

Company means ICICI Lombard General Insurance Company Limited.

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 is a cost-sharing requirement under a health insurance Policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

Cumulative Bonus shall mean any increase 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 within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—
--has qualified nursing staff under its employment;
--has qualified medical practitioner/s in charge;
--has a fully equipped operation theatre of its own where surgical procedures are carried out;
--maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

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 hospitalization 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 the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/ hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

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

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

Dependent Child refers to refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income. For the purpose of this policy, child up to age 20 years is considered as dependent child.

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 moved 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 a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

Family would comprise of Your spouse, dependent children, brother(s), sister(s) and dependent parent(s), Grandparents, Grandchildren, Mother-in-law, Father-in-law, Son-in-law and Daughter-in-law, dependent Brother-in-law and dependent Sister-in-law.

Floater Benefit means the amount of Sum Insured mentioned in the Policy Schedule which is common to the whole family covered under the policy which will be the maximum amount payable under this policy for all the covered family members put together, during the policy period if opted to be a Floater policy.

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 Condition/ Disease. 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 Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
a) has qualified nursing staff under its employment round the clock;
b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
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

Hospitalization means admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

a) 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 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 or for you 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.

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

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.

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

Insured/Insured person means the Individual(s) whose name(s) are specifically appearing as such in Part I of the Schedule to this Policy.

Maximum limit of indemnity means the sum total of annual sum insured, additional sum insured (if any,) accrued by the insured

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

Maternity expenses shall include—

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

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

Medical 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 licence.

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).

Medically necessary is defined as an treatment, tests, medication, or stay in hospital which

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

Migration means 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 or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

New Born Baby means baby born during the Policy Period and is upto 90 days,

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

Notification of claim/ Intimation of claims 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.

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

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

Policy Period means the period commencing from the Policy Period Start Date, Time of the Policy 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, as specified in Policy Schedule, and ending on the last day of such twelve month period. For the purpose of subsequent years, the period following the first year of the Period of Insurance, "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 Period of Insurance End Date as specified in the Policy Schedule.

Portability means the right accorded to an individual health insurance policyholder (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

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-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.

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.

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

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.

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

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 mean the ICICI Lombard General Insurance Company Limited

2. WHAT WE WILL PAY (SCOPE OF THE COVER)

At any point of time, our liability for all claims admitted in respect of any/all insured person/s during the period of insurance shall not exceed the Annual Sum Insured (including Additional Sum Insured) stated in the schedule.

A. Basic Cover:

If any insured person suffers an illness or Accident during Policy Period, the Policy provides indemnification of the Medical Expenses incurred by You which is in excess of the Deductible amount. Below mentioned base covers are Indemnity based covers and would be payable for actuals (post deductible and/or Co-Payment as applicable) or up to Annual Sum Insured whichever is lower.

Notwithstanding anything contained herein below, this Benefit shall not apply to any Medical Charges incurred by the Insured in any place or geographical area other than in India.

1. In-patient Treatment

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

We will cover medical expenses for:

- Hospital room rent
- Intensive Care Unit charges
- Medical Practitioners fees
- Nursing Charges
- Diagnostics procedures

- Anesthesia, blood, oxygen, surgical appliances, medicines, drugs and consumables
- Intravenous fluids, blood transfusion, injection administration charges
- Operation theatre charges
- The cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure.

2. Day Care Treatments

We hereby agree subject to terms, conditions and exclusions contained herein or otherwise expressed here on that, if during the Policy Period, You require Hospitalization as an inpatient for less than 24 hours in a Hospital (but not in the outpatient department of a Hospital)on the written advice of a Medical Practitioner, then We will pay You for the Medical Expenses incurred for undergoing such Day Care Procedure/ Treatment or surgery. The indicative list of day care treatments is annexed to this policy.

We will also cover medical expenses for intravenous chemotherapy, radiotherapy, hemodialysis or any other procedure which require a period of specialized observation or care after completion of the procedure where such procedure is undertaken by an Insured person as an In-patient Hospitalization for a continuous period of less than 24 hours.

3. In patient AYUSH Hospitalization

We will reimburse expenses for in patient AYUSH treatment only when the treatment has been undergone in a AYUSH Hospital or AYUSH day care centre..
We will not cover expenses for hospitalization done for evaluation or investigation only. Treatment taken at a healthcare facility which is not a Hospital are also excluded.

4. Domiciliary Hospitalization

We will reimburse You for Medical Expenses incurred by You during "Domiciliary Hospitalization" upto an amount as mentioned in the Policy Schedule, subject always to the Maximum Limit of Indemnity

The term "Domiciliary Hospitalisation" for the purpose of this Extension means medical treatment for an Illness/disease/Injury upon the written advice of a Medical Practitioner, for a period exceeding three consecutive days for such Illness or Injury which otherwise is covered under the Policy and in the normal course would require Hospitalisation but is actually undertaken by the patient whilst confined at home (in India) under any of the following circumstances, namely:

- The condition of the patient is such that he/ she cannot be moved to the Hospital; or
- The patient cannot be moved to Hospital for lack of accommodation therein.

And provided that the condition for which the medical treatment is required continues for at least three days, in which case We will pay the Reasonable and Customary charges of any necessary medical treatment for the entire period.

Subject however that Domiciliary Hospitalisation benefits under any circumstances shall not cover:

a) Any pre or post hospitalization Medical Expenses ; and
b) Medical Expenses incurred by You for treatment of any of the following diseases:
   - Asthma

- Bronchitis
- Chronic Nephritis and Chronic Nephritic/Nephrotic Syndrome
- Diarrhoea and all types of Dysenteries including Gastro-enteritis
- Diabetes Mellitus and Insipidus
- Epilepsy
- Hypertension
- Influenza, Cough and Cold
- Pyrexia of unknown origin for less than 10 days
- Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
- Arthritis, Gout and Rheumatism

5. Donor expenses:

We will reimburse You up to an amount not exceeding Annual Sum Insured for the Hospitalization Expenses incurred in respect of the donor for the organ transplant surgery, provided:

- The organ donated is for Your use and We have admitted Your Hospitalisation Claim under the Policy
- The donation conforms to the "Transplantation of Human Organ Act 1994 (amended)
- You have been Medically Advised to undergo an organ transplant

- We will not pay the donor's pre & post medical expenses or any other medical treatment for the donor consequent on the harvesting

6. Pre-Hospitalization and Post-Hospitalization Expenses

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

a) Pre-hospitalization Medical Expenses incurred by You up to 60-days immediately prior to Your Hospitalization; and
b) Post-hospitalization Medical Expenses incurred by You up to 90-days immediately post Hospitalization

Cover Under this extension will be provided only if,

a) The in-patient or day care hospitalization claim is admissible and payable as per terms and conditions of policy
b) Such medical expenses are incurred for the same condition for which insured person is hospitalized

Pre and post hospitalization expenses or screening expenses of the donor or any other medical expenses as a result of harvesting from the organ donor will not be covered.

Expenses under this section will be covered on reimbursement basis only.

7. Domestic Road Emergency Ambulance Cover

We will reimburse You up to 1% of Your Sum Insured, maximum upto 5,000 Rs. per Hospitalization, for the reasonable expenses incurred by You on availing ambulance services offered by a Hospital or by an ambulance service provider for Your necessary transportation

to the nearest Hospital in case of a life threatening emergency condition, provided however that, a Claim under this extension shall be payable by Us only when:

a) Such life threatening emergency condition is certified by the Medical Practitioner
b) We have accepted Your Claim under "In-patient Treatment" or "Day Care Procedures" section of the Policy; and
c) The ambulance service is provided by a healthcare or ambulance service provider

8. Reset Benefit

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

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

9. Additional Sum Insured (Cumulative Bonus)

You will be entitled for Additional Sum Insured (cumulative bonus) as under, for every claim-free Policy Year under the Policy on its renewal Policy.

Tenure	Additional Sum Insured (Cumulative Bonus) as a percentage of Sum insured
For each completed and continuous Policy Year subject to a maximum of 50%	10%

However, in the event of a Claim under the Policy during any subsequent Policy Year, the accrued Additional Sum Insured (cumulative bonus) will be reduced by 10% of the Sum Insured at the time of renewal of this Policy.

10. Complimentary Health Check Up

We will provide Complimentary health check-up coupons to the insured for every Policy Year, on issuance or upon renewal of the Policy, subject to a maximum of 2 coupons per year for floater policies.

11. Wellness Program

Wellness program intends to promote, incentivize and reward You for Your healthy behavior through various wellness services. All the wellness activities as mentioned below make You earn wellness points which will be tracked by Us. You can inform us of the various wellness activities undertaken by You via email or calling our toll free number. You can redeem these wellness points as per Our redemption terms and conditions.
The wellness services and activities are categorized as below:

A. Manage and track Your health
  - Online Health Risk Assessment (HRA)
  - Medical Risk Assessment
  - Preventive Risk Assessment

B. Disease Management Services

C. Medical Concierge Services

D. Affinity to Wellness

A. Manage & Track Your Health:

Online Health Risk Assessment (HRA)

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

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

Medical Risk Assessment

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

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

Preventive Risk Assessment

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

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

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

B. Disease Management Services

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

C. Medical Concierge Services

You can also contact Us to avail the following services:

- Emergency assistance information such as nearest ambulance / hospital / blood bank etc.
- Second opinion provided through electronic mode: E-opinion (Second opinion) of an empanelled medical expert and/or agency.
- Referral for medical service provider, evacuation/ repatriation services, home nursing care etc

D. Affinity to wellness

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

List of Fitness initiatives and wellness points

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

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

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

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

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

Redemption of Wellness Points

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

Terms and conditions under wellness services

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

12. 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 claim. In case We fail to make the payment of admissible claim or to communicate non admissibility of claim within this time within this time period, We shall pay 2% interest over and above the rate defined as per IRDAI (Protection of Policyholder's Interest) Regulations 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 ability to make a decision or to communicate such decision to You.
This Claim 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, optional covers, OPD etc. In such scenarios, 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.
If You are not eligible for 'Claim Service Guarantee' for the reasons stated in the policy conditions, We should inform the same to You, within the 14 days for a) and within 4 hours for b) as specified above.
Any amounts paid towards interest under Claim Service Guarantee will not affect the Sum Insured as specified in the Schedule.

B. Optional Covers

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

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

The Reset Benefit under Section 2.A. 8, will not be applicable for this Section. Claims under this Section will not impact the Sum insured or Cumulative Bonus

1. **Hospital Daily Cash**
   We will pay You a daily cash amount, as stated against this Extension in the Policy Schedule, for each and every completed day of Hospitalization up to a maximum of 30 consecutive days, if such Hospitalization is at least for a minimum of 3 consecutive days and it falls within the Policy Period.

2. **Convalescence Benefit**
   We will pay You an amount as stated against this extension in the Policy schedule, if You are Hospitalized for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy. This benefit is payable only once to an Insured Person during each Policy Year of the Policy Period.

3. **Personal Accident Cover**
   We will pay You or Your Nominee/ legal heir, as the case may be, the sum insured as specified against this Extension in the Policy Schedule, on occurrence of any Insured Event, as specifically described hereunder, arising due to an Injury sustained by You during the Policy Period. This cover is available only for adult members aged maximum up to 60 years. This is a worldwide cover.

a. **Insured Event - Accidental Death**
We will pay Your Nominee/legal heir, as the case may be, the sum insured as specified against this Extension in the Policy Schedule, on the unfortunate event of Your death, provided such death results solely and directly from an Injury sustained within a period of twelve months from the date of Accident provided that the date of occurrence of the Accident falls within the Policy Period.

b. **Insured Event - Permanent Total Disablement (PTD) resulting from Accident**
We will pay You the sum insured as specified against this Extension in the Policy Schedule on the occurrence of any of the following losses, provide such losses are total, permanent and irrecoverable resulting solely and directly from an Injury sustained within a period of twelve months from the date of Accident resulting in such Injury:

a) Loss of use of both eyes, or physical separation/ loss of use of two entire hands or two entire feet, or one entire hand and one entire foot, or of such loss of use of one eye and such physical separation/ loss of use of one entire hand or one entire foot

b) Physical separation/ loss of use of two hands or two feet, or one hand and one foot, or of Loss of Use of one eye and loss of use of one hand or one foot

If such Injury is permanently and totally, disabling the Insured Person from engaging in any employment or occupation of any description whatsoever. Provided that the date of occurrence of the Accident falls within the Policy Period

Notwithstanding anything, We shall not be liable to pay You under this Extension for:

- Compensation under more than one of the categories as specified in the Insured Event, during the Policy Period
- Payment of compensation in respect of Death or Permanent Total Disablement arising from or resulting directly or indirectly from any Illness unless such Illness arose directly as a consequence of an Accident
- Compensation in respect of a death or disablement resulting from, whilst:

i. engaging in aviation or ballooning, or whilst mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airlines in the world, or engaging in any kind of adventure sports for personal gratification
ii. participating in winter sports, skydiving/ parachuting, hang gliding, bungee jumping, scuba diving, mountain climbing, riding or driving in races or rallies using a motorized vehicle or bicycle, caving or pot-holing, hunting or equestrian activities, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), participation in any professional sports, any bodily contact sport or any other hazardous or potentially dangerous sport
iii. working in underground mines or explosives magazines, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in activities like racing on wheels or horseback, big game hunting, mountaineering, winter sports, rock climbing, pot holing, bungee jumping, skiing, ice hockey, ballooning, hang gliding, river rafting, polo and persons whilst engaged in occupation/ activities of similar hazard
iv. serving in any branch of the military or armed forces of any country during war or warlike operations

- Compensation in respect of death or disablement
  i. arising or resulting from You committing any breach of law with a malafide or criminal intent
  ii. directly or indirectly caused by venereal disease
  iii. resulting directly from, or indirectly caused by, or contributed to or aggravated or prolonged by childbirth or pregnancy or in consequence thereof

Claim Documents for optional cover 3:

You or Your Nominee/ legal heir, as the case may be, shall be required to furnish the following for or in support of a claim:

a. In case of Death
   - Policy Copy
   - Claim form duly filled & signed by Nominee
   - Post Mortem Report (certified copies) - as applicable and wherever conducted
   - F.I.R. or Death report or Inquest Panchnama (in original or certified copies)
   - Spot Panchnama (certified copies)- if applicable
   - Death certificate (in original or certified copy)

b. In case of PTD
   - Policy Copy
   - Claim form duly filled & signed by You
   - Disability certificate -by an authorized Medical Practitioner of the district/ units concerned, stating percentage of disablement
   - F.I.R. and Panchnama wherever applicable (original or certified copies)
   - Medical report
   - Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner
   - Original bills from chemists supported by proper prescription

- Investigation reports like laboratory test, X-rays and reports essential of confirmation of the type and percentage of disability and payment receipts
- Photo of Insured Person showing the disability

In addition to above, we may also ask for certain relevant documents as required from case to case basis. If You are covered under any health and accident insurance policy of other insurance company and become entitled to Claim under such policy, then You can submit to Us the copies of the claim documents/ medical records, provided they are duly certified by such insurance company or any hospital where You are getting treated, as applicable.

4. Temporary Total Disablement (TTD) Rehabilitation Cover (resulting from Accident Extension)

We, hereby agree to pay a sum as stated in the Policy Schedule against this extension, per week, on the occurrence of Temporary Total Disablement, which means such loss caused to the Insured Person provided:

a. The temporary total disablement results solely and directly from an Injury sustained within the Policy Period/ Policy Year
b. Such a disablement arises out of an Injury within 7 days from the date of Accident resulting in such Injury.
c. Completely incapacitates the Insured Person from engaging in any employment or occupation of any description whatsoever which he/ she was capable of performing at the time of Accident resulting in such Injury
d. This weekly compensation shall be paid for such time period for which the Insured Person is totally disabled from engaging in any employment or occupation of any description whatsoever.
e. The compensation payable under this Benefit shall not be payable for more than 10 weeks in respect of an Injury, calculated from the date of commencement of disablement
f. Subject to the terms, conditions and exclusions applicable to Extension 03 and the terms, conditions, general exclusions stated in the Policy

This cover is available only for adult members aged maximum up to 60 years.

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible. Only the rehabilitation services provided by a certified practitioner will be considered.

5. Repatriation of Remains

In the unfortunate event of death of the Insured Person whilst travelling within the geographical boundaries of India, during the Policy Period, We will reimburse the legal heir/ Nominee the costs of transporting the remains of such Insured Person back to his/ her place of residence or, up to an equivalent amount, for burial or cremation in the city where the death has occurred. However, Our maximum liability under this cover will not exceed the Annual Sum Insured as specified against this Extension in the Policy Schedule.

6. Critical Illness Cover

We will pay You/ the Nominee, the sum insured as stated against this Extension in the Policy Schedule, in case You are diagnosed as suffering from one or more of the Critical Illnesses for the first time in your life, during the Policy Period.

This cover is available only for adult members aged maximum up to 60 years.

However, We will not make any payment if You are first diagnosed as suffering from a Critical Illness within 90 days of the Period of Insurance Start Date. This benefit can be availed by You only once during Your lifetime. No Claim under this Extension shall be admissible in case any of the Critical Illnesses is a consequence of or arises out of any Pre-Existing Condition(s)/ Disease.

"Critical Illness" for the purpose of this Policy includes the following:

1. Cancer of Specified Severity

I. A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded -

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

2. Coronary Artery Bypass Graft Open Chest CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: i. Angioplasty and/or any other intra-arterial procedures

II. The following are excluded

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

3. First Heart Attack – of Specified Severity (Myocardial infarction)

I. The first occurrence of heart attack or myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial infarction should be evidenced by all of the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

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

4. Open Heart Replacement or Repair of Heart valves

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

5. Kidney Failure Requiring Regular Dialysis

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

6. Major Organ/ Bone marrow Transplant

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that Resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

7. Stroke Resulting in Permanent Symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Permanent Paralysis of Limbs

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

9. Multiple Sclerosis with persisting symptoms

I. The unequivocal diagnosis of definite multiple sclerosis confirmed and evidence by all of the following:
   i. investigations including typical MRI which unequivocally confirm the diagnosis to be multiple sclerosis;
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months,.

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

10. Parkinson's Disease

Unequivocal diagnosis of idiopathic or primary Parkinson's disease (all other forms of Parkinson's are excluded) before age 65 that has to be confirmed by a specialist Medical Practitioner. There is an associated Neurological Deficit that results in Permanent Inability to perform independently at least three of the activities of daily living as defined below

- Transfer: Getting in and out of bed without requiring external physical assistance
- Mobility: The ability to move from one room to another without requiring any external physical assistance
- Dressing: Putting on and taking of all necessary items of clothing without requiring any external physical assistance
- Bathing/Washing: The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by other means
- Eating: All tasks of getting food into the body once it has been prepared

OR

- must result in a permanent bedridden situation and the inability to get up without outside assistance. These conditions have to be medically documented for at least a continuous period of 90 days.

11. Motor Neuron Disease with permanent symptoms

I. Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

12. Benign Brain Tumour (resulting in permanent neurological symptoms)

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

13. **Blindness**

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:
   i. corrected visual acuity being 3/60 or less in both eyes or ;
   ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

14. End Stage Lung Failure

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
   i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
   ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
   iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO2 < 55mmHg$); and
   iv. Dyspnea at rest.

15. Alzheimer's Disease

Unequivocal diagnosis of Alzheihmer's Disease (presenile dementia) before age 65 that has to be confirmed by a specialist Medical Practitioner and evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT Scan, MRI, PET of the brain). The disease must result in a permanent inability to perform independently three or more Activities of Daily Living- bathing (ability to wash in the bath or shower), dressing (ability to put on, take off, secure and unfasten garments), personal hygiene (ability to use the lavatory and to maintain a reasonable level of hygiene), mobility (ability to move indoors on a level surface), continence (ability to manage bowel and bladder functions), eating/ drinking (ability to feed oneself but not to prepare the food) or must result in need of supervision and the permanent presence of care staff due to the disease. These conditions have to be medically documented for at least a continuous period of 90 days

16. Primary (Idiopathic) Pulmonary Hypertension

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

II. The NYHA Classification of Cardiac Impairment are as follows:
    i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
    ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

17. Surgery to Aorta

The actual undergoing of surgery for a chronic disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Traumatic injury of the aorta is excluded.

Realisation of the aortic surgery has to be confirmed by a specialist Medical Practitioner.

18. Aplastic Anaemia

Aplastic Anaemia involving Chronic persistent bone marrow failure which results in anaemia, leucoopenia and thrombocytopenia requiring treatment. The diagnosis has to be confirmed by a specialist medical practitioner and supported by characteristic findings on peripheral blood smear and bone marrow biopsy.

19. Bacterial Meningitis

Bacterial Meningitis involving bacterial infection causing in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks.

The diagnosis of bacterial meningitis must be supported by analysis of cerebrospinal fluid, including culture, showing characteristic bacterial growth. Meningitis due to any other cause will not be covered.

Meningitis occurring in a person with HIV/ AIDS will not be covered.

20. Fulminant Viral Hepatitis

Fulminant Hepatitis involving sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure characterized by

- Permanent jaundice (bilirubin > 2 micromol/ l)
- Moderate ascites
- Albumin <3.5g/ dl
- Prothrombin time <70% of the normal for the age & gender
- Hepatic encephalopathy

The etiology of hepatitis must be viral in origin – limited to Hepatitis A, or B, or C, or D or E or G; it must be evidenced by significant rise in titers of viral DNA/ RNA

The following are excluded:

i. Child-Pugh-Stage A
ii. Liver Disease Secondary to alcohol or drug misuse
iii. Fulminant Viral Hepatitis occurring in a person with HIV/ AIDS will not be covered

21. End Stage Liver Disease

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   i. Permanent jaundice and;
   ii. Ascites; and
   iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

How Deductible works:

- **Top Up Plan:**

Deductible will apply for each and every hospitalisation except for claims made for Any one illness.
(Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.)
In case of an accident where more than one member of a family is hospitalized, Deductible will apply on the aggregate claim amount.

Claim amount under optional covers will not be considered for deductible.

- **Super Top Up Plan:**

Deductible will apply on aggregate basis for all hospitalisation expenses during the policy year. The deductible will apply on individual basis in case of individual policy and on floater basis in case of floater policy.

Claim amount under optional covers will not be considered for deductible.

3. WHAT WE WILL NOT PAY (EXCLUSIONS APPLICABLE TO POLICY)

1. Deductible: We shall not be liable for the Deductible amount as specifically defined in Part I of the Schedule.
We are not liable for any payment unless the medical expenses exceed the deductible. Deductible shall not be applicable for optional covers, if any.

2. Co-Payment: We are not liable to pay twenty percent (20%) of admissible claim amount above the Deductible applicable under the Policy, for insured(s) above 60 years of age. This does not apply if insured is 60 years of age or below.

However, this condition will not be applicable if You were aged 45 years or below at the time of buying this policy first time with Us and have renewed it continuously after that.

Co payment will not be applicable for optional covers, if any.

3. **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.

4. 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.

5.

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.

6. 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.

S.No.	Organ /Organ System	Illness	Treatment/ Procedure
A	ENT	• Sinusitis • Deviated Nasal Septum	• Treatment for conditions related to Tonsils, adenoids, sinuses • Mastoidectomy
B	Gynaecological	• Fibroids (fibromyoma) • Endometriosis • Prolapsed uterus • Polycystic ovarian disorder (PCOD)	• Dilatation and curettage (D&C) • Myomectomy • Hysterectomy
C	Orthopaedic	• Arthritis • Gout and Rheumatism • Osteoarthritis and Osteoporosis • Spinal or Vertebral Disorders	• Surgery for inter vertebral disc • Joint replacement surgeries
D	Gastrointestinal	• Calculus diseases of gall bladder including Cholecystitis • Esophageal Varices • Pancreatitis • Fissure/fistula in anus, hemorrhoids, pilonidal sinus, piles • Ulcer and erosion • Gastro Esophageal Reflux Disorder (GERD) • Perineal Abscesses • Perianal Abscesses	• Cholecystectomy • Procedures for Biliary stones
E	Uro-genital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone etc. • Benign enlargement of Prostate • Chronic Kidney Disease	• Surgery on prostate • Surgery for Hydrocele/ Rectocele • Dialysis
F	Eye	• Cataract	• PHACO emulcification • Any other cataract surgery
G	Other General conditions(App licable to all organ systems/ organs/ disciplines whether or not described above)	• Internal tumors, cysts, nodules, polyps, skin tumors, Lumps, All types of Internal congenital anomalies/illnesses/defects	• Surgery of varicose veins and varicose ulcers • Varicocele • Surgery for any Hernia

7. Permanent exclusions

Unless covered by way of an appropriate Extension/optional covers, We shall not be liable to make any payment under this Policy in connection with or in respect of

i. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.
ii. Cost of routine medical, eye and ear examinations, preventive health check-up, cost of spectacles , contact lenses or hearing aids, dentures and artificial teeth.
iii. **Code- Excl15:** Refractive Error: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres
iv. **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.
v. **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/proposers 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.
vi. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind(like wheelchairs, crutches), instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.), oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively.
vii. Expenses incurred on all dental treatment unless necessitated due to Accident.
viii. Personal comfort, cosmetics convenience and hygiene related items and services.
ix. Circumcision unless necessary for treatment of a disease or necessitated due to an Accident.
x. Vaccination and inoculation of any kind unless it is post animal bite.
xi. **Code- Excl17:** Sterility and Infertility: Expenses related to, sterility and infertility. This includes:

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

xii. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
xiii. **Code- Excl12**: Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

.
xiv. **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.

xv. **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.

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

xvii. **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.

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

xix. **Code- Excl06:** Obesity/ Weight Control
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
5) greater than or equal to 40 or
6) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   - Obesity-related cardiomyopathy
   - Coronary heart disease
   - Severe Sleep Apnea
   - Uncontrolled Type2 Diabetes

xx. **Code- Excl05**: Rest Cure, rehabilitation and respite care

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   I. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   II. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

xxii. **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.

xxiii. **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.

xxiv. Treatment received outside the country.

xxv. Treatment by a family member and self-medication or any treatment that is not scientifically recognized. Treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical Council

xxvi. Any travel or transportation expenses excluding ambulance charges, unless specifically covered.

xxvii. Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemies, hostilities (whether declared or not), civil war, commotion, confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

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

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

xxx. **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.

xxxi. Any Injury or Illness sustained or contracted due to flying other than as a passenger on a scheduled regular carrier.

xxxii. Any losses directly or indirectly due to contamination caused by any act of terrorism, regardless of any contributory causes

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

xxxiv. If Policy is issued to You as per condition based exclusion clause, that particular condition and its related complications will be permanent exclusion for that insured.

Condition based specific exclusion clause:

Subject to our underwriting guidelines, for specific conditions and illnesses, we may provide Policy but with terms that any expenses directly or indirectly related to this condition / illness, including its complications will be considered permanent exclusion for that insured under this Policy.

We will give You an intimation by post/ phone call/ e-mail regarding this term & condition. We will issue You a Policy only if You accept this condition based exclusion. You have to

revert Us in 15 days for the same. If You do not, it would be considered as non acceptance and Policy will not be issued.

4. CLAIM ADMINISTRATION

The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by You shall be conditions precedent to admission of Our liability.

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

1. Notification of Claim
   For Reimbursement

Treatment/ Procedure	You should inform Us
Any Planned Hospitalization for which claim can be made	At least 48 hours prior to admission in hospital
Any Emergency Hospitalization for which claim can be made	Within 24 hours of hospitalization
For all other cases/benefits	Within 7 days of completion of such treatment or procedure

For Cashless Services

Treatment/ Procedure	Taken at	We must be notified along with full particulars
Any Planned treatment/ Hospitalization	Network hospital	At least 48 hours before the treatment/ hospitalization
Any Emergency treatment/ Hospitalization	Network hospital	Within 24 hours of the treatment/ hospitalization

In case of covered Hospitalization, the cost of which were not initially estimated to exceed the deductible but were subsequently found likely to exceed the deductible, the intimation should be submitted along with a copy of intimation made to the other insurer immediately.

2. Claims procedure

i. For Cashless Settlement

Cashless treatment is only available at a Network Provider (List of Network Provider is available at our website. The list is updated as and when there is any change in the Network Provider). 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/ Hospitalisation. You must request pre-authorisation 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 claims 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.

ii. For Reimbursement Settlement

a) You shall give notice to Us or Our In house claim processing team by calling the toll free number 1800 2666 or emailing us at customersupport@icicilombard.com as specified in the Policy provided to You and also in writing at Our address with particulars as below:
   - Policy number
   - Your Name
   - Your relationship with the Policyholder
   - Nature of Illness
   - Name and address of the attending Medical Practitioner and the Hospital
   - Any other information that may be relevant to the Illness/ Hospitalization

   The above information needs to be provided to Us or Our In house claim processing team immediately within 24 hours of Hospitalization in case of an emergency situation or at least 48 hours before a planned hospitalization, failing which We will have the right to treat the Claim as inadmissible, as We may deem fit at Our sole discretion.

b) You must immediately consult a Medical Practitioner and follow the advice and treatment that he/she recommends.

c) You or someone claiming on Your behalf must promptly and in any event within 30 days of Your discharge from a Hospital (for post-hospitalization expenses, within 30 days from the completion of post-hospitalization period) deliver to Us the documentation (written details of the quantum of any Claim along with all original supporting documentation) as more particularly listed in CLAIM DOCUMENTS section

   However, in both the above cases i.e. 2 (i) & 2(ii), 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.

3. Claim documents

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

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

In case of multiple health policies, the customer has to provide attested photocopy of the claim documents duly stamped by the hospital along with the Claim settlement letter from the other insurer who has paid the claim. In case certain documents which were not considered by the previous insurer are required, those have to be provided in original to the company for claim processing.

4. Claim assessment in case of Co payment

If the insured in respect of whom, claim is made, is aged above 60 years, 20% co pay will be applicable. Claim shall be assessed in following order:

a. Deductible will be applied as per cover on admissible claim amount
b. Co payment will be applied on admissible claim amount over and above deductible
c. Balance amount will be the claim payable

However, this condition will not be applicable if You were aged 45 years or below at the time of buying this policy first time with us and have renewed it continuously after that.

No co payment is applicable for optional covers, if any.

5. Settlement/ Rejection of Claim

The Settlement of claims including its rejection would be done by Us within 30 days after receipt of last necessary documents, any rejections if done, would be provided with proper reasons by Us.

Penal interest provision shall be as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2017.

6. Claim falling in two Policy periods

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

SPECIAL CONDITIONS APPLICABLE TO THE POLICY

It is hereby declared and agreed that:

a) Any notice or declaration for Your attention shall be deemed served if sent by Us to the Policy Holder at his/ her latest known address

b) Any payment due to You (insured) under this Policy shall be paid to the Policy Holder by Us. We shall not be responsible for any liability arising out of the Policy Holder's delay or default in making payment to You (insured). However, We also reserve Our right to pay the Claim directly to You or to the Hospital or to someone on Your behalf. The receipt by the Policy Holder / You or Hospital or someone claiming on Your behalf shall be considered as a complete discharge of Our liability against any Claim under the Policy.

c) We shall have no liability under this Policy, once the Annual Sum Insured (including Additional Sum Insured) as stated in the Policy Schedule, is exhausted by You.

d) For any payment to be made by Us under any Claim arising under this Policy, We shall make the payment in India and in Indian rupees only.

5. General Terms and Conditions

1. Disclosure of Information

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

(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. 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

6. 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.

7. 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.

8. 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.

9. 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 member in the policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation

10. Change of Sum Insured

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

11. 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 insurer 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.

12. 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 misstatement of or suppression of material fact are within the knowledge of the insurer.

13. Cancellation

i. 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
Within 1 month	80%	80%	80%
From 1 month to 3 months	60%	70%	70%
From 3 months to 6 months	40%	60%	65%
From 6 months to 9 months	20%	50%	60%
From 9 months to 12 months	0%	40%	55%
From 12 months to 15 months	NA	30%	45%
From 15 months to 18 months	NA	20%	40%
From 18 months to 21 months	NA	10%	35%
From 21 months to 24 months	NA	0%	25%
From 24 months to 27 months	NA	NA	20%
From 27 months to 30 months	NA	NA	10%
From 30 months to 33 months	NA	NA	5%
From 33 months to 36 months	NA	NA	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.

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

14. 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

15. 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

16. Renewal of Policy

The policy shall ordinarily be renewable except on misrepresentation by the insured person.

grounds of fraud,

i. The Company shall endeavour 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.

17. 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.

18. Moratorium Period

After completion of eight continuous years under the policy no look back to 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 sums 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.

19. Premium Payment in instalments

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

i. 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 installments from the claim amount due under the policy.

20. 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.

21. Free look period

The Free Look Period 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 document to review the terms and conditions of the policy, and to return the same if not acceptable.

i. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to 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
ii. 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
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

22. Redressal of Grievance

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

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

Email: customersupport@icicilombard.com

- 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, Veer Savarkar Marg,
  Near Siddhi Vinayak Temple,
  Prabhadevi, Mumbai 400025

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. The contact details of the ombudsman have been provided as an annexure to the policy wordings

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/ligms. irda.qov. in/

23. 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

24. No constructive Notice: Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our officials shall not be the notice to or be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

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

26. Overriding effect of Part II of the Policy: The terms and conditions contained herein and in Part II of the Policy shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Policy, then the term(s) and condition(s) contained herein shall be read *mutatis mutandis* with the scope

of cover/ terms and conditions contained in Part II of the Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

27. Your duties on occurrence of loss: On the occurrence of any loss, within the scope of cover under the Policy, You shall:

Forthwith file/ submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in Part II of the Policy.

Assist and not hinder or prevent Us or any of Our representative from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

28. If You do not comply with the provisions of this Clause or other obligations cast upon You under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at Our option. We may condone the delay on merit for delayed claims where the delay is proved to be for reasons beyond Your control.Subrogation: You and any claimant under this Policy shall at no cost or expense to Us do whatever is necessary to enable Us to enforce any rights and remedies or obtain relief or indemnity from other parties to which We would become entitled or subrogated upon Us paying for or making good any Claim or loss under this Policy whether such acts and things shall be or become necessary or required by Us or otherwise before or after Your indemnification by Us. However, this condition shall not be applicable for all the benefit based covers under the Policy, as applicable.

29. Contribution: Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a ratable proportion of Sum Insured.

This clause shall not apply to any Benefit offered on fixed benefit basis.

30. Cause of Action/ Currency for payments**:** No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy Schedule. The cause of action can arise anywhere in the world in case of Personal Accident Cover (Extension HC 05), if available under the Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

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

.

Office Details	Jurisdiction of Office Union Territory,District)
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@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah 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@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava 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@ecoi.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@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman,	Punjab, Haryana,

Office Details	**Jurisdiction of Office Union Territory,District)**
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@ecoi.co.in	Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI - Shri M. Vasantha Krishna 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@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
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@ecoi.co.in	Delhi.
GUWAHATI - Shri Kiriti .B. Saha 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@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu 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 - 67504123 / 23312122	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.

Office Details	Jurisdiction of Office Union Territory,District)
Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.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@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
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@ecoi.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@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, 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,

Office Details	Jurisdiction of Office Union Territory,District)
	Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat 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@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
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.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - 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@ecoi.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.	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Office Details	**Jurisdiction of Office** **Union Territory,District)**
Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	

The updated details of Insurance Ombudsman are also available on IRDA website: www.irda.gov.in on the website of General Insurance Council: www.generalinsurancecouncil.org.in, website of the company www.icicilombard.com or from any of the offices of the Company

32. 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.iciciclombard.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
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