ICICI Lombard
Nibhaye Vaade

ELEVATE POLICY WORDING

b. PREAMBLE:

ICICI Lombard General Insurance Company Limited ("We / Us"), having received a Proposal and the premium from the Proposer named in Part a of the Policy (hereinafter referred to as the "Policy Schedule") and the said Proposal and Declaration together with any statement, report or other document leading to the issue of this Policy and referred to therein having been accepted and agreed to by Us and the Proposer as the basis of this contract do, by this Policy agree, in consideration of and subject to the due receipt of the subsequent premiums, as set out in the Policy Schedule, and further, subject to the terms and conditions contained in this Policy that on proof to Our satisfaction of the compensation having become payable as set out in the Policy Schedule to the title of the said person or persons claiming payment or upon the happening of an event upon which one or more benefits become payable under this Policy, the sum insured/ Annual Sum Insured / appropriate benefit amount will be paid by Us.

c. DEFINITIONS:

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing / specified in this Policy or related Add-ons/Optional Covers:

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

i. Standard Definitions

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

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

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

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

"Break in policy" means the period of gap that occurs at the end of the existing policy term / installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

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

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

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

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

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

"Cumulative Bonus" means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in the 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:

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

<u>Day Care Centre includes an AYUSH Day Care Centre as defined below:</u>

"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:

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

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

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

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

a. undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and

b. which would have otherwise required a hospitalization of more than 24 hours.

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

"Deductible" means a cost-sharing requirement under a health insurance Policy that provides, that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured.

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

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

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

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

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

"Emergency care" means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the Insured person's health.

"Grace Period" means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received.

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

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

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

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

ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

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

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

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

<u>Hospital includes an AYUSH Hospital as defined below:</u>

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

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

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

   i. Having at least 5 in-patient beds;

   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

   iii. Having dedicated AYUSH therapy sections as required and/or has equipped

   iv. operation theatre where surgical procedures are to be carried out;

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

"Hospitalization" means admission in a hospital for a minimum period of 24 consecutive "in-patient care" hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

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

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

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests;
2. it needs ongoing or long-term control or relief of symptoms;
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
4. it continues indefinitely;
5. it recurs or is likely to recur

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

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

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

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

"Maternity expense" means

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

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

"Medical Practitioner" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction and is acting within the scope and jurisdiction of license. The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured/ Insured Person's family who includes Father, Mother, Father-in-law, Mother-in-law, Son, Daughter, Son-in-law, Daughter-in-law, Brother or Sister. For the purposes of worldwide cover, Medical practitioner would mean a person who holds a valid registration from the Medical council of the respective country where the treatment is being taken by the Insured

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

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

i. is required for the medical management of the Illness or Injury suffered by the Insured;

ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii. must have been prescribed by a medical practitioner,

iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

"Migration" means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

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

"Newborn Baby" means baby born during the Policy Period and is aged 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" means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

"OPD treatment" means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

"Portability" means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

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

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

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

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

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

"Pre-hospitalization Medical Expenses" means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person provided that:

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

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

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

"Renewal" means the terms on which the contract of insurance can be renewed 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.

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

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

"Specific waiting period" means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break

"Subrogation" means the right of the insurer to assume the rights of the Insured person to recover expenses paid out under the Policy that may be recovered from any other source.

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

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

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

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

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

"Altruistic surrogacy" means the surrogacy in which no charges, expenses, fees, remuneration or monetary incentive of whatever nature, except the medical expenses and such other prescribed expenses incurred on surrogate mother and the insurance coverage for the surrogate mother, are given to the surrogate mother or her dependents or her representative

"Commercial surrogacy" means commercialization of surrogacy services or procedures or its component services or component procedures including selling or buying of human embryo or trading in the sale or purchase of human embryo or gametes or selling or buying or trading the services of surrogate motherhood by way of giving payment, reward, benefit, fees, remuneration or monetary incentive in cash or kind, to the surrogate mother or her dependents or her representative, except the medical expenses and such other prescribed expenses incurred on the surrogate mother and the insurance coverage for the surrogate mother;

"Company" means ICICI Lombard General Insurance Company Limited.

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

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

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

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

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

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

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

"Family Floater Policy" means a Policy in terms of which, two or more persons of a Family are named in the Schedule as Insured Persons.

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

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

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

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

"Maximum Limit of Indemnity" means the sum total of Annual Sum Insured, Sum Insured accrued as Guaranteed Cumulative Bonus (if accrued), Power Booster (if opted and accrued) Reset Benefit (If applicable) and Inflation Protector (if opted and accrued)

"Oocyte" means a developing egg in the ovary

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

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

"Period of Insurance" means the period as specifically appearing in the Policy Schedule and commencing from the Policy Period Start Date of the first Policy taken by You from Us and then, running concurrent to Your current Policy subject to Your continuous renewal of such Policy with Us.

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

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

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

"Single Private Room" means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital.

"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/ilomen/service-provider/search.asp)and is subject to amendment from time to time.

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

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

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

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

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

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

"Twin Sharing Room" means an air conditioned Hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the

most economical of all accommodations available as twin sharing rooms in that Hospital

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

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

d. Benefits covered under the Policy

The coverage mentioned below differs between the various plan offerings and the wordings of only the relevant covers opted by the Insured Person and as mentioned in the Policy schedule will be applicable.

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy. The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken during the Policy Period for an Illness, Accident or condition described below if this is contracted or sustained by an Insured Person during the Policy Period and subject always to the Sum Insured, any subsidiary limit specified in the schedule of Benefits, the terms, conditions, limitations and exclusions mentioned in the Policy and eligibility as per the insurance plan opted by Insured and as stated in the Schedule.

i. Basic cover:

The payment under this Basic Cover shall be limited to Maximum Limit of Indemnity.

1. <u>In-patient Treatment:</u>

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

i. Room Rent charges up to Single Private AC room;

ii. Intensive Care Unit Charges;

iii. Qualified Nurse charges;

iv. Medical Practitioner's Fees;

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

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

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

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

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

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

b. Proportionate deductions are not applicable for ICU charges

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

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

2. <u>Day Care Procedures/Treatment</u>

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

i. Day Care treatment requires hospitalization as an inpatient for less than 24 hours in a Hospital.

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

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

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

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

a. For the purpose of this cover, "Associated

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

b. Proportionate deductions are not applicable for ICU charges

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

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

4. Pre- Hospitalisation Medical Expenses

We will cover the Pre-Hospitalization Medical Expenses incurred in respect of the Insured Person immediately 90 days before the Insured Person's Admission to Hospital provided that:

i. We have accepted the claim under "Inpatient Treatment"/ Daycare Procedures/ Treatment/In-Patient AYUSH hospitalisation" in respect of the Insured Person.

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

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

This Cover will be provided on a reimbursement basis and/or cashless basis wherever applicable.

5. Post Hospitalization Medical Expenses

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

i. We have accepted the claim under "Inpatient Treatment" or "Daycare Procedures/ Treatment" or "In-patient AYUSH Hospitalisation" in respect of the Insured Person.

ii. We will also consider Post-Hospitalization Medical Expenses incurred on Physiotherapy if the treating Medical Practitioner advises such Physiotherapy in writing and the same is Medically Necessary Treatment.

iii. This service will be provided on a reimbursement and/ or cashless basis wherever applicable.

6. In Patient AYUSH Hospitalization

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

i. The Insured person is Hospitalized for AYUSH Treatment at a Government Recognized AYUSH Hospital or AYUSH Day Care Centre.

ii. This Cover will be provided on reimbursement basis and/or on cashless basis wherever applicable

7. Domestic Road Ambulance:

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

i. We have accepted a claim under "Inpatient Treatment" or "Daycare Procedures/Treatment" in respect of the Insured Person for the same Accident/Illness for which road ambulance services were availed.

ii. This Benefit includes and is limited to the cost of the transportation of the Insured Person:

a. To the nearest Hospital with higher medical facilities which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, and only if that transportation has been prescribed in writing by a Medical Practitioner and is for Medically Necessary Treatment.

b. From a Hospital to the nearest diagnostic center during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.

iii. The ambulance / service provider providing the services should be a registered provider with road traffic authority.

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

payable under this Benefit.

8. **Donor Expenses**

We will cover the medical expenses incurred in respect of an organ donor's Hospitalization during the Policy Period for harvesting of the organ donated to the Insured Person up to the Annual Sum Insured specified in the Policy Schedule provided that:

i. The organ donation confirms to the Transplantation of Human Organs Act 1994 (and its amendments from time to time) and the organ is used for the Insured Person

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

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

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

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

ii. Screening expenses of the organ donor.

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

iv. Costs directly or indirectly associated with the acquisition of the donor's organ.

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

vi. Expenses related to organ transportation or preservation.

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

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

9. **Domiciliary Hospitalization**

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

The Domiciliary Hospitalization has commenced on the written advice of a medical practitioner and continues for at least 3 consecutive days in which case we will make payment under this Cover in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization.

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

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

b. Arthritis, gout and rheumatism;

c. Ailments of spine/disc

d. Chronic nephritis and nephritic syndrome;

e. Any liver disease;

f. Peptic ulcer

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

h. Diabetes mellitus and insipidus;

i. Epilepsy;

j. Hypertension;

k. Pyrexia of any origin

10. **Guaranteed Cumulative Bonus:**

We will provide a Cumulative Bonus of 20% of expiring or renewed Annual Sum Insured (whichever is lower) at the end of each Policy Year if the expiring Policy has been claim free and is continuously renewed with the Company. The Cumulative Bonus will not be accumulated for more than 100% of the Annual Sum Insured under any circumstances subject to the following conditions.

i. The Cumulative bonus accumulated will be on floater basis for a floater Policy and on individual basis for an individual Policy.

ii. In case where the Policy is on floater basis, the cumulative bonus will be accrued only if there has been no claim made in respect of all Insured Person(s) in the expiring Policy period.

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

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

v. Cumulative Bonus can only be utilized when the Annual Sum Insured is completely exhausted

vi. If the Policy Period is two or three year(s), any Cumulative Bonus that has accrued for first/second Policy Year will be credited at the end of first/ second Policy Year, as per the Policy Period, and it will be available for claims at the subsequent year.

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

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

Annual Floater Sum Insured	Accumulated GCB	Floater Policy split to Individual policies with Annual Sum Insured of 10 Lacs each	Revised Annual Sum Insured of each Individual Policy	Revised Accumulated GCB of each Individual Policy
20 Lac	20 Lac		10 Lac	4 Lac

ix. The Cumulative Bonus shall be reduced in the same proportion in case of Annual Sum Insured reduction during Renewal.

Annual Floater Sum Insured	Accumulated GCB	Annual Sum Insured reduced to Rs. 10 Lacs	Revised Annual Sum Insured	Revised Accumulate Guaranteed Cumulative Bonus (GCB)
50 Lac	50 Lac		10 Lac	10 Lac

x. If the Annual Sum Insured under the Policy has been increased during renewal, the Cumulative Bonus shall be calculated on the Annual Sum Insured of the expiring Policy.

Annual Floater Sum Insured	Accumulated GCB	Annual Sum Insured reduced to Rs. 10 Lacs	Revised Annual Sum Insured	Revised Accumulated Guaranteed Cumulative Bonus (GCB)
5 Lac	5 Lac		10 Lac	5 Lac

xi. In the event of Claim, under the Policy during any subsequent Policy Year, the credited Cumulative Bonus will not be reduced.

xii. Guaranteed Cumulative Bonus will not be applicable for policies with Unlimited Sum Insured.

11. Reset Benefit

We will reset up to 100% of the Annual Sum Insured, for any illness/disease/injury for the Insured Person in a Policy Year as stated in the Policy Schedule subject to the following conditions:

I. This benefit will be triggered unlimited times for any illness/disease/injury.

ii. This benefit will not be available for Policies with Unlimited Sum Insured option.

iii. The Annual Sum Insured including Guaranteed Cumulative Bonus, Inflation Protector (if opted and accrued), Power Booster (if opted and accrued) in respect of the Insured Person is insufficient as a result of previous claims paid in that Policy Year.

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

v. The total amount of reset will not exceed the Annual Sum Insured for that Policy Year

vi. The Reset Benefit will be applied only if the claim is made and admissible under “Inpatient Treatment” or “Daycare Procedure/Treatment” "or "in-patient AYUSH Hospitalization""

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

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

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

x. Reset Benefit will not be triggered for claims made outside the geographical limits of India.

12. Bariatric Surgery Cover

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

i. The surgery has to be conducted upon the advice of a Medical Practitioner

ii. The surgery/procedure conducted should be supported by clinical protocols

iii. The Insured Person undergoing the bariatric surgery / procedure has to be 18 years of age or older

iv. Body Mass Index (BMI) of the insured person has to be

a. Greater than or equal to 40 OR

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

1. Obesity-related cardiomyopathy
2. Coronary heart disease
3. Severe Sleep Apnea
4. Uncontrolled Type2 Diabetes

Conditions: -

i. This benefit has a waiting period of 24 months from date of inception of the first policy with Us. However, the waiting period will be reduced to 30 days in case Insured Person has opted for Add ons/Optional Cover 3 Jumpstart.

ii. Any kind of Additional Sum Insured accrued as a part of Guaranteed Cumulative Bonus/Power Booster/Inflation Protector/Reset benefit will not be available for this cover

iii. The Insured Person shall mandatorily obtain cashless approval prior to undergoing the surgery/ treatment

iv. Bariatric surgery/treatment performed for cosmetic reasons is excluded

13. In-patient Hospitalisation for Surrogate mother:

We will cover the Medical Expenses incurred in respect of In Patient Hospitalization of the Surrogate mother appointed by the “Intending Couple”/”Intending woman” for complications arising out of pregnancy and post-partum

delivery complications during the Policy Period, up to a maximum limit of Rs. 5 Lakhs and subject to the following conditions:

i. Initial waiting period of 30 days will be applicable

ii. This benefit is applicable for all female Insured Persons who have opted for 3 years' policy term

iii. The maximum coverage available for a surrogate mother is a period of thirty-six (36) continuous months after the surrogacy procedure has been successful

iv. Any expenses incurred on delivery of the new born (either via normal delivery or caesarean section) are excluded from the scope of this cover

v. This coverage shall only be available if all the provisions as specified in The Surrogacy Regulation Act (2021), and all the rules and regulations made thereunder are fulfilled

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

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

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

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

   b. Proportionate deductions are not applicable for ICU charges

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

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

14. <u>In-patient Hospitalization for Oocyte donor:</u>

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

i. This cover shall be available only for a period of twelve months (12 months) after the oocyte retrieval procedure has been successful

ii. This benefit is applicable to all or any female insured person

iii. Any expenses incurred on delivery of the new born (either via normal delivery or caesarean section) are excluded from the scope of this cover

iv. This coverage shall only be available if all the provisions as specified in The Assisted Reproductive Technology (Regulation) Act, 2021, and all the rules and regulations made thereunder are fulfilled

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

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

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

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

   b. Proportionate deductions are not applicable for ICU charges

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

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

15. <u>Wellness Program</u>

The wellness program provides the Insured Person with the below mentioned benefits

i. Wellness program

ii. Health Assistance [HAT]

iii. Ambulance Assistance

iv. Discounts on services and products

I. Wellness program

Wellness program intends to promote, incentivize and reward the Insured Person(s) for their healthy behavior through various wellness services. The wellness program shall be available to each Adult Insured Person subject to a maximum of 2 Adults in a floater policy. All the wellness activities as mentioned below in Table A enable the Insured Person(s) to earn wellness points which shall be monitored by the Health Coach.

The Health Coach shall only be available to a maximum of 2 Adult Insured Persons. The Health Coach is a personalized service that shall encourage and promote optimal health and physical and mental wellness through a digital platform. The Insured Person shall have access to the health coach on downloading and registering on our mobile application. This activity needs to be done within 30 days of Policy Start Date to ensure adequate utilization of services offered and to redeem the wellness points awarded.

Registered Insured Person(s) on successful completion of Health Risk Assessment [HRA] shall be evaluated by the Health Coach to assess and educate the Insured Person on adapting a healthy lifestyle.

Table A - Journey of earning Wellness points

Category	Policy Tenure	Individual Policy 1 Year	Floater Policy* 1 Year
	Activity Details	Max Points Earned per Insured Person	Max Points Earned per Insured Person
Health Assessment	Health Risk Assessment	500	250
	Undergoing Health check-up & uploading the reports	1,000	500
	Face scan once a quarter	400	200
	First usage of Chat with Health Expert/ Health Coach Service	100	50
Wellness Activities	ICICI Lombard initiated Contest/ health quiz (Any one contest)	200	100
	ICICI Lombard initiated Webinar (Any one webinar)	200	100
Wellness Tasks	Achieving targeted steps per month (10/15/25 points/ day depending on steps completed)	6,000	3,000
Fitness Challenge	Participation and successful completion of fitness challenge In App	500 (250 per challenge)	250 per challenge
Health Events	Participation in Professional sporting events like Marathon/ Cyclathon/Swimathon etc.	500	250
Grand Total		**9,400**	**4,700**

For multi-year policies with policy tenure of 2 years and 3 years, the maximum wellness points that can be accumulated shall be as per table mentioned below

Category	Policy Tenure	Individual		Floater	
	Activity Details	2 Years Max Points Earned per Insured	3Years Max Points Earned per Insured	2 Years Max Points Earned per Insured	3 Years Max Points Earned per Insured
Health Assessment	Health Risk Assessment	1,000	1,500	500	750
	Undergoing Health check-up & uploading the reports	2,000	3,000	1,000	1,500
	Face scan once a quarter	800	1,200	400	600
	First usage of Chat with Health Expert/ Health Coach Service	200	300	100	150
Wellness Activities	ICICI Lombard initiated Contest / health quiz (Any one contest)	400	600	200	300
	ICICI Lombard initiated Webinar (Any one webinar)	400	600	200	300
Wellness Tasks	Achieving targeted steps per month (10/15/25 points/ day depending on steps completed)	12,000	18,000	6,000	9,000
Fitness Challenge	Participation and successful completion of fitness challenge In App	1,000	1,500	500	750
Health Events	Participation in Professional sporting events like Marathon/ Cyclathon/Swimathon etc.	1,000	1,500	500	750
Grand Total		**18,800**	**28,200**	**9,400**	**14,100**

* In case of a floater policy, the wellness points earned by each of the Insured Persons for every completed wellness activities shall be accrued to calculate the renewal discount.

Detailed explanation of Table A has been mentioned below-

"Detailed explanation of Table A (with respect to Individual Policy) has been mentioned below -"

A. Health Assessment

1. Health Risk Assessment

The Health Risk Assessment (HRA) questionnaire is a tool for evaluation of the Insured Person's health and quality of life by reviewing the personal lifestyle practices affecting the Insured Person's health status. The Insured Person shall be awarded a maximum of 500 wellness points per year upon taking the Health Risk Assessment activity within 90 days of Policy Start Date on our mobile application.

2. Undergoing Preventive Health check-up and Uploading the reports

The insured person shall be awarded a maximum of 1,000 wellness points per year upon taking the Health check-up and uploading the reports on our mobile application for verification.

3. Face Scan once a quarter

The Insured Person shall be awarded a maximum of 100 wellness points per quarter for taking Face Scan on our mobile application. The maximum wellness points awarded shall be restricted to 400 (100x4) per policy year.

4. First usage of Chat with Health Expert/ Health Coach Service

The Insured Person shall be awarded a maximum of 100 wellness points per year upon using the chat with Health Expert/Health Coach Service for the first time in a Policy Year on our mobile application. The Insured Person can virtually chat with health experts like physiotherapists, counsellors, dieticians etc. under this service.

B. Wellness Activities

1. ICICI Lombard Initiated contest or health quiz

The Insured Person can earn wellness points by participating in any health related contests or quiz conducted by ICICI Lombard. Maximum of 200 wellness points per policy year can be earned through participating in such activities.

2. ICICI Lombard initiated Webinar

The insured person can earn a maximum of 200 wellness points per policy year on successful completion of any one health related webinar session conducted by ICICI Lombard.

C. Wellness Tasks

The Insured Person shall be awarded wellness points as per the Table B mentioned below for achieving the targeted steps for a minimum of 20 days in a month. Our mobile application has to be downloaded within 30 days of the Policy Start Date to avail this benefit as the average step count completed by an Insured Person would be monitored on this mobile application.

In case the number of active days are insufficient, no wellness points will be accumulated for that month. The steps achieved up to 90 days prior to due date of renewal of the policy shall be considered for wellness points computation. The steps achieved after this time-line, are not lost and shall be considered for the next policy year.

Table B- A Journey of earning Wellness Points by achieving targeted steps

Average Steps achieved per day for 20 days in a month	Maximum Wellness Points per month	Maximum Wellness Points accumulated in a year		
		1 Year	2 Year	3 Year
8,000+ steps	500	6000	12000	18000
6,000 to 7,999 steps	300	3600	7200	10800
4,000 to 5,999 steps	200	2400	4800	7200
<4,000 steps	Nil	Nil	Nil	Nil

D. Fitness Challenge

The Insured Person shall be awarded wellness points on participation and successful completion of a fitness challenge as initiated by the Company from time to time. The Insured Person shall be awarded 250 wellness points per fitness challenge and the maximum wellness points that can be gained by participation and completion of the fitness challenges is 500 per policy year.

E. Health Events

The Insured Person shall be awarded wellness points on participation and successful completion of health events as initiated by Us from time to time. The Insured Person shall be awarded 500 wellness points per health event and the maximum wellness points that can be gained by participation and completion of such health events is 500 per policy year.

Redemption of wellness points

The total wellness points earned by the Insured person(s) (as detailed in Table A and Table B) will be redeemed towards availing discount on renewal premium for the subsequent year.

1. For Individual Policies, the maximum discount that can be availed by the Insured Person is 30%.
2. For Floater Policies, the 2 Adult Insured Persons can avail a maximum discount of 15% each. The discount percentage calculated basis the individual Wellness Points earned by each Insured Person in the Floater Policy will be added to provide the renewal discount on the subsequent year. Maximum discount percentage provided shall be 30% on the Policy level.

Table C shows the renewal discount that can be availed against the accumulated wellness points.

Table C- Renewal Discount against Accumulated Wellness Points

Regular fitness related activities Points	Wellness points accumulated per Insured Person*			Individual	Floater (Per Insured Person)
	1 Year	2 Year	3 Year		
Points	2500-3999	5000-7999	7500-11999	2.5%	1.25%
	4000-4999	8000-9999	12000-14999	5%	2.5%
	5000-6999	10000-13999	15000-20999	10%	5%
	7000-8999	14000-17999	21000-26999	20%	10%
	>9000	**>18000**	**>27000**	**30%**	**15%**

*For each consecutive year, an Insured Person has to accumulate a minimum of 9,000 Wellness Points in the first year, 18,000 Wellness Points in the second year, and 27,000 Wellness Points in the third year to avail the discount.

Table D- Illustration showing Redemption Mechanism through the Wellness Discount for Floater Policies

Redemption mechanism	Wellness discount	Fresh Premium	Renewal premium payable
Discount accrued on renewal premium by Insured 1	15%		
Discount accrued on renewal premium by Insured 2	15%		
	Total Discount- 30%	Rs. 25,000	Rs. 25000 - (Rs. 25000x30%) =Rs.17,500

Redemption mechanism	Wellness discount	Fresh Premium	Renewal premium payable
Discount accrued on renewal premium by Insured 1	15%		
Discount accrued on renewal premium by Insured 2	10%		
	Total Discount- 30%	Rs. 25,000	Rs. 25000 - (Rs. 25000x25%) =Rs.18,750

Terms and Conditions for Redemption of Wellness Points

i. Renewal discount will only be applicable on a per year basis upon the subsequent year of the Policy. Points accumulated will be mandatorily redeemed towards renewal discount of the subsequent year and cannot be carried forward to the next Policy Year.

ii. Renewal discount is computed based on the Wellness Points earned on 90 days before the due date of renewal. Residual points will be carried forward to the next Policy Year and accrued with that Policy Year's Wellness Points. Hence, these points are not lost.

iii. Discount is on the individual's premium in Individual plan and on Floater Policy Premium in Floater plans. Discount will be considered only for Insured Persons aged 18 years and above.

iv. In case the insured has opted for a higher Policy Tenure during renewal, the discount will be given : -

a. On the first Policy Year of a 2/3 year Policy Tenure (in case of an existing 1 year Policy Tenure), and

b. On the first and second Policy Year of a 3 year Policy Tenure (in case of an existing 2 year Policy Tenure)

v. In case the insured has opted for a lower Policy Tenure during renewal, flat discount will be applied on all year premium before tenure discount.

Terms and conditions for availing the Wellness Program:

i. For health risk assessment [HRA] services availed through mobile application/online/ digital mode on IL Platform, the Insured Person shall be required to provide the details in order to establish authenticity and validity prior to availing such services. Any such information provided by the Insured Person in this regard shall be used solely for the purpose of providing these wellness services and kept confidential with Us/Our Network Providers/Health Service Providers at all times.

ii. The Insured Person shall notify the Company and submit the relevant documents, reports, receipts as and when required by the Company within 60 days of undertaking any wellness activity.

iii. The Insured Person agrees that choosing to utilize any of the wellness services or any information or advise rendered by Our Health Service Providers or Network Providers or the Company will be solely at the Insured Person's discretion and own risk and should not be, used to diagnose or identify treatment for a medical or mental health condition.

iv. In case of expiry of Policy, the accrued wellness points will not be carried forward

v. There shall not be any cash reimbursement or redemption available against the wellness points accumulated by an Insured Person.

vi. We or Our Health Service Providers or Our Network Providers do not warrant the validity, accuracy, completeness, safety, quality, or applicability of the content or anything said or written or any suggestions provided in the course of providing the wellness services.

vii. We, or our affiliates, their respective directors, officers, employees, agents, vendors, shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person may claim to have suffered, sustained or incurred, as a result of any advice or information obtained by way of the wellness program or any actions chosen by the Insured Person on the basis of such advice or information.

viii. The wellness program offered is subject to revisions based on the insurance regulatory framework from time to time.

Disclaimers

i. Choosing the option is purely on Insured Person's discretion and at own risk.

ii. The wellness program is intended to provide support information to the Insured Person to improve well-being and habits through working towards obtaining a healthy lifestyle, and does not constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.

iii. We reserve the right to remove or reduce wellness points in case the same have been found to be achieved in any unfair manner by manipulation

iv. Availing the service provided by our Health Service Providers / Network Provider is at the sole discretion of the Insured person and We are not liable, responsible or deemed to be liable or responsible for any discrepancy in the information or Medical Advice provided.

II. Health Assistance Team[HAT]:

Our Health Assistance Team (HAT) will assist the Insured Person in understanding his/her health condition better by providing responses to any queries related to health and health care providers.

The services provided under this shall include:

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

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

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

II. We do not accept any liability towards quality of the services made available by our network providers/ service providers and are not liable for any defects or deficiencies on their part

For all services provided under this Cover, our role shall be limited to assistance only and the charges and expenses associated with the actual service shall have to be borne by the Insured Person

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

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

While deciding to obtain such value-added service, the Insured Person expressly notes and agrees that it is entirely for them to decide whether to obtain these services and also to decide the use (if any) to which these services is to be put for.

III. Ambulance Assistance

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

The services under this Cover are subject to the following conditions:

- The medical transportation is for a life threatening health condition of the Insured Person which requires immediate and rapid transportation to the Hospital; as certified in writing by the Medical Practitioner
- The Insured Person is in India and the treatment is in India only;
- The ambulance service is availed within the same city
- This is an assistance service and the expenses for the same will have to be borne by the Insured Person or can be claimed under Domestic Road Ambulance Cover (if Inpatient Treatment claim is found to be admissible)

Process to avail Ambulance Assistance:

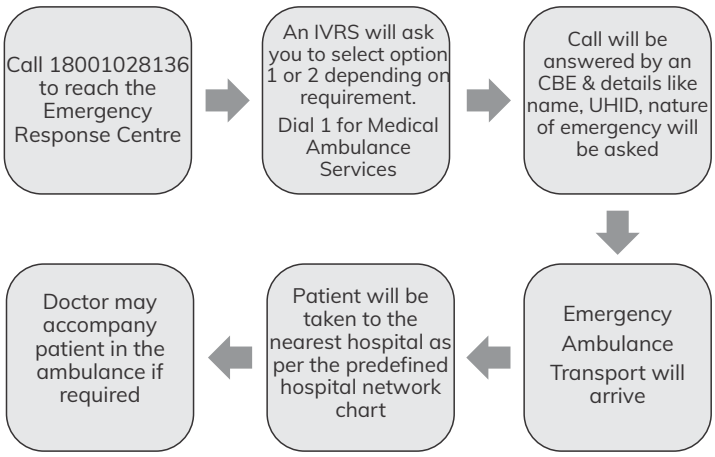
a. On calling Our helpline number provided below, Our trained customer service executive (CSE) will ask the Insured Person relevant questions to assess the situation.

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

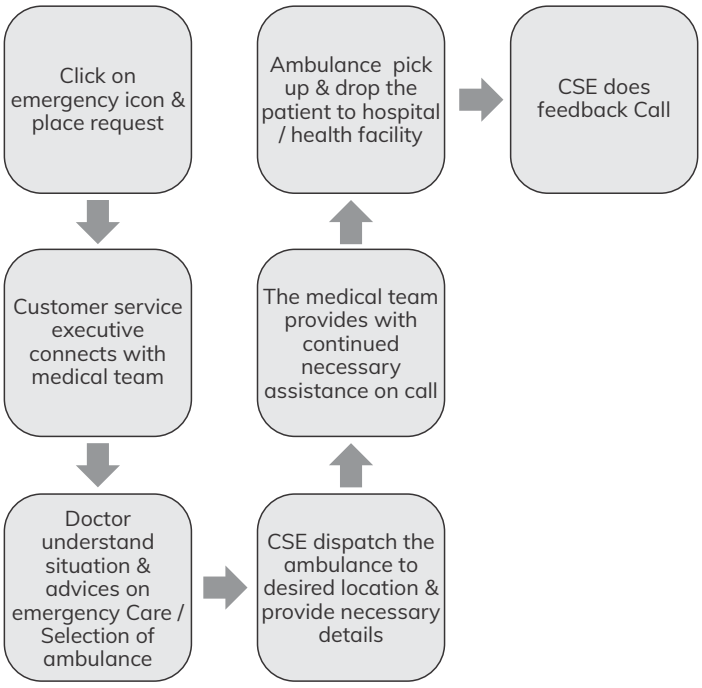
c. The below mentioned details are to be made available for availing the services:

1. UHID of Insured Person, as provided on the Health Card.
2. Contact number of the Insured Person
3. Location of Insured Person

How to Call an Ambulance?



How to Call an Ambulance? (Via Mobile Application)



III. Discounts on services/products

We shall only facilitate the Insured Person in availing discounts on services/products including but not limited to investigations/diagnostic tests/ laboratory tests /health supplements/ medical equipment/homecare services / virtual health & wellness sessions/AYUSH products / Fitness & wellness related activities & products etc. at our empanelled diagnostic centres, drugs/medicines ordered from pharmacies etc. offered by our network providers/ health service providers. These discounts can be viewed on our mobile application and one can avail these discounts depending on terms and conditions and subject to availability.

ii. Add ons/ Optional Covers

The Covers listed below shall be available to the Insured Person only if the additional premium has been received by Us (except Optional Cover 19. Voluntary co-payment, Optional Cover 20. Voluntary Deductible, Optional Cover 29. Network Advantage, and Optional Cover 30. NRI Advantage- Accidental Emergencies Cover for NRI) and the Optional Cover is specified to be in force for that Insured Person in the Policy Schedule.

Covers 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/Pre-Hospitalisation medical expenses/ Post hospitalization medical expenses will not be applicable for this Section. Claims under this Section will not impact the Annual Sum Insured (except Optional cover 10. Claim Protector, Optional Cover 1. Infinite Care, and Optional Cover 22. Durable Medical Equipment Cover) or Guaranteed Cumulative Bonus (except Optional Cover 1. Infinite Care)

The Sum Insured for each of the Optional Covers (except Optional cover 10. Claim Protector, & Optional Cover 22. Durable Medical Equipment Cover)shall be over and above the Annual Sum Insured of the Policy.

1. <u>Infinite Care</u>

We will cover the Medical Expenses incurred in respect of Hospitalization of the Insured Person under in-Patient Treatment / Daycare Procedures/Treatment/ in-Patient AYUSH Hospitalization/ of the Insured Person for any one claim during the lifetime of the Policy without any limits on the Annual Sum Insured subject to the following conditions:

i. The time period to opt for this optional cover shall be limited to 2 Policy Years (irrespective of the Policy Tenure). Such that:

   a. If the Policy Tenure is of single year and is continuously renewed as single year, the Insured Person has to opt for this cover either at the time of Policy Inception or the first renewal. The Optional Cover shall not be applicable in case the Insured Person wishes to opt for this cover at the time of second renewal.

   b. If the Policy Tenure is of 2 or 3 years, the cover has to be opted at the time of Policy inception itself to avail the benefit.

ii. This cover is applicable only for one claim in the lifetime of the Policy, irrespective of Policy Tenure or Policy Type (Individual or Floater), and should be admissible under In-patient Treatment/Daycare Procedures/Treatment/In-patient AYUSH Hospitalization. All the conditions applicable to the above mentioned Basic Covers shall be applicable to this Optional Cover.

iii. Once opted, the optional cover has to be opted continuously by the Insured Person until any one claim is made under this cover. If the Insured Person opts out of this cover during any renewal, the same cannot be opted again.

iv. Once a claim has been made under this Optional Cover, the cover will cease to exist and cannot be opted again upon subsequent renewals.

v. The Total Sum Insured (Annual Sum Insured + Guaranteed Cumulative Bonus (if accrued) + Power Booster (if opted and accrued) + Inflation Protector (if opted and accrued)) shall be utilized as per following sequence in event of a claim under this Optional Cover: -

   1. Annual Sum Insured
   2. Guaranteed Cumulative Bonus
   3. Power Booster
   4. Inflation Protector

vi. After utilization of all the above mentioned Sum Insured, the Total Sum Insured shall be reduced to zero for that Policy Year following the payment of claim under Infinite Care.

vii. Optional Cover 19. Voluntary Co-payment or Optional Cover 20. Voluntary Deductible if opted by the Insured Person shall be applicable under this Optional Cover.

viii. This cover will not be available in case the Insured Person has opted for Optional Cover 9. Worldwide Cover, Basic Cover 13. In-patient Hospitalisation for Surrogate Mothers, Basic Cover 14. In-patient Hospitalization for Oocyte Donors and for policies with Unlimited Sum Insured option.

ix. Room category applicable under this cover shall be capped at Single Private AC room unless the Insured Person has opted for Optional Cover 27 Room Modifier.

2. Power Booster (Guaranteed Super Bonus)

If the Insured Person has opted for this optional cover, We will provide a Cumulative Bonus of 100% of expiring or renewed Annual Sum Insured (whichever is lower) at the end of each Policy Year irrespective of a claim being initiated in the Policy Year, provided that the Policy has been continuously renewed with the Company subject to the conditions mentioned below:

i. The Power Booster can be accumulated up to an Unlimited Sum Insured.

ii. This cover shall not be available to policies with Unlimited Annual sum insured

iii. In case, the Insured Person opts out of this cover at the time of renewal, all the bonus accumulated under Power Booster will be reduced to zero

iv. All conditions applicable under Basic Cover 10. Guaranteed Cumulative Bonus shall be applicable to this cover.

3. Jumpstart

The company shall indemnify Medical Expenses incurred for the hospitalization of the Insured Person(s) admissible under the Basic Cover 1 in-patient Treatment or Basic Cover 2 Daycare Procedures /Treatments or Basic Cover 6. in-patient AYUSH Hospitalization for the below listed diseases / illnesses / conditions from Day 31 of the Policy Start date, provided that:

i. the diseases/illnesses/conditions has been declared by the Insured Person and accepted by Us, or

ii. the diseases/illnesses/conditions has been detected during Pre-policy medical examination and have been accepted by Us.

iii. The above reduced waiting period of 30 days shall be applicable only for specified Insured Persons who have opted and paid additional premium as specified in the policy schedule.

iv. This cover will be available only during inception of the policy and only for the Annual Sum Insured chosen at the time of Policy Inception.

v. Deletion of this Optional cover shall not be permitted upon subsequent policy renewals.

vi. Exclusions Pre-Existing Diseases (Code- Excl01) shall not apply if this Optional Cover has been opted by the Insured Person(s).

vii. This reduced waiting period of 30 days shall not be applicable for claims made under Optional Cover 9. Worldwide Cover.

List of diseases/illnesses/conditions covered under this optional cover-

1. Asthma
2. Diabetes
3. Hypertension
4. Hyperlipidemia
5. Obesity
6. Coronary Artery Disease (PTCA done prior to 1 year)

Specific Definitions for the above listed diseases / illnesses / conditions are mentioned below for ease of understanding and the same will be covered subject that the condition(s) of the Insured Person(s) meet the criteria defined-

1. **Asthma** is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath.
2. **Hypertension** is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.
3. **Hyperlipidemia** is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease.
4. **Diabetes mellitus** is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages every organ in the body, which causes serious health consequences.
5. **Obesity** where Obesity means abnormal or excessive fat accumulation that presents risk to the health (Body Mass Index i.e. BMI is less than or equal to 39.99. This BMI limit will be modified in case of co-morbidities.)
6. **Coronary Artery Disease with PTCA done prior to 1 year:**
   i. Coronary artery disease is the buildup of lipid-rich plaque in the arteries that supply oxygen-rich blood to the heart. Plaque causes a narrowing or
   ii. blockage that could result in a heart attack.
   iii. PTCA (Coronary Angioplasty) is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment
   iv. of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).
   v. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.
   vi. Diagnostic angiography or investigation procedures without angioplasty / stent insertion are excluded from the scope of this definition.

4. Chronic Disease Management Program:

In case the Insured Person(s) has declared any of the listed diseases /illnesses /conditions – Asthma, Diabetes, Hypertension, Hyperlipidemia, Obesity, and/or Coronary Artery Disease (PTCA done prior to 1 year)- and the same have been accepted by Us, the Insured Person(s) shall be enrolled under Our Chronic Disease Management Program.

As a part of this program, we shall provide the below mentioned services to the Insured Person(s)-

i. Assistance to the Insured Person(s) to track their health through Our empaneled medical experts who will guide them in maintaining/ improving their health condition(s).

ii. Assistance to avail Dietician and nutritional counseling as per their health condition(s).

iii. 2 Pre-defined diagnostic Health check-ups for the listed conditions with a gap of six months between the 2 tests. The health checkups are over and above to the Optional Cover 16. Health Check-up if opted.

iv. Assistance to avail Counselling for lifestyle modifications such as quitting tobacco/alcohol etc.

This program shall be subject to the following conditions-

1. The insured person(s) shall be enrolled to this program only if Optional cover 3 Jumpstart has been opted.
2. The health check-up can be availed only on a cashless basis through our mobile application or by calling at our Toll free number: 1800 2666.
3. The Network Provider/Health Service Provider shall be assigned by Us post receiving Insured Person's request to avail a Health Check-up under this cover.
4. Utilization of this Health Check-up will not impact the Annual Sum Insured

5. Maternity Benefit:

i. This optional benefit covers the medical expenses up to 10% of the Annual Sum Insured; subject to a maximum limit of INR 1 Lakh for the delivery of a baby and / or expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner, limited to maximum of three deliveries or terminations as said herein during the lifetime of an female Insured/Insured Person as the case may be between the ages of 18 years to 50 years in the Policy.

ii. Pre-natal (period from conception until delivery of baby) and post-natal (up to 30 days from date of delivery of baby) expenses will be covered within the above mentioned limits (10% of Annual Sum Insured subject to a maximum of INR 1 Lakhs) provided the same have been incurred on in-patient basis

iii. This benefit will have a waiting period of 24 months from the time this cover is opted

iv. This Cover is available only under a family floater Policy

v. This Cover is available for You or Your spouse, provided You and Your spouse, both are covered under the same family floater Policy and the female Insured person is between age 18 to 50 years as selected by proposer.

vi. In case, Insured Person has already taken a policy without maternity benefit and would like to opt for maternity benefit, then this can be availed only at the time of renewal

vii. Any medical Expenses incurred for management of Ectopic Pregnancy shall not be covered under this benefit. The claim for the same can be intimated under Inpatient treatment.

viii. Maternity Benefit shall not be available outside the geographical boundaries of India.

6. New Born Baby Cover:

i. We will cover the Medical Expenses incurred by the Insured Person on Hospitalization of a "New born Baby" during each Policy Year of Policy Period subject to the maximum limit of twice of the maternity sum Insured. This limit is over and above the maternity sum insured.

ii. This add on/ Optional Cover will be provided only if You have opted for the Maternity Cover and We have accepted a claim under Maternity cover under this policy.

iii. This Optional Cover will cover Medical Expenses incurred on the "New born Baby" during Hospitalization (for a minimum period of consecutive 24 hours) for a maximum period up to 90 days from the date of birth of the baby

7. Vaccinations for new born baby in the first year:

i. We will cover the expenses incurred on Vaccinations of the new born baby till one year of age during the policy period up to 1% of the Sum Insured subject to a maximum limit of INR 10,000. This limit is over and above the Maternity Sum Insured

ii. This cover is available only if Optional cover 5. Maternity Cover and Optional cover 6. New Born Baby cover has been opted and We have accepted a maternity claim under this Policy.

8. BeFit:

All benefits under the BeFit cover can be availed only on cashless basis via our mobile application and are subject to the terms, conditions, and exclusions and the availability of Sum Insured under the Cover. BeFit cover can only be opted by Insured Person(s) up to the age of 65 years during first time issuance.

All services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment. There will be a waiting period of 30 days for this cover

Any unutilized Consultations/E- consultations/Sum Insured/ sessions cannot be carried forward to the next Policy Year.

Choosing the services under this Cover is purely upon the Insured Person's own discretion and at own risk. The services provided under the various Covers are via third party health Service Providers/ Network Providers/ and We are not responsible for liability arising out of the services provided by these third parties.

The Insured Person(s) should seek assistance from a medical practitioner should they still have any concerns about their health even post availing services from our health service providers/network providers.

i. Physical Consultations

We shall cover the Medical Expenses incurred during the Policy Period for out-patient consultations from a General Medical Practitioner or Specialist Medical Practitioner or Super Specialist Medical Practitioner or AYUSH Medical Practitioner in relation to any Illness contracted or Injury suffered by the Insured Person during the Policy Period subject to the overall maximum number of consultations as specified against this Optional Cover in the Policy Schedule. These services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment.

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

Dental treatment shall be excluded from the scope of this cover.

Physiotherapy sessions and counselling availed for psychiatric ailments or mental health issues shall be excluded from the scope of this Optional Cover as the same are covered under optional cover 8 iv. Physiotherapy sessions and optional cover. 8 v. e-counselling respectively.

ii. Routine Diagnostic and Minor Procedure Cover

We shall cover medical expenses incurred for outpatient diagnostic tests recommended by Medical Practitioner under our cashless network available in the mobile application in relation to any Illness contracted or Injury suffered by the Insured Person during the Policy Period and for listed minor procedures undergone at a general practitioner or specialist/super-specialist medical practitioner by the Insured Person during the Policy Period maximum up to the Annual Sum Insured limit as specified against this Optional Cover in the Policy Schedule. These services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment

The diagnostic tests shall include but will not be limited to histopathology, biochemistry, hematology, immunology, microbiology, serology, pathology, radiology, ultrasound and TMT. Genetic studies shall be excluded from the scope of this cover.

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

List of Minor Procedures covered under this Optional Cover #

Drainage of abscess
Injection including Intramuscular (Per Injection cost)
Intravenous injection(IV)
Sprain Management (Joint movement/exercise)
Otoscopic examination (Magnifying otoscopy)
Nasal packing for control of haemorrhage
Nebulizer therapy
Removal of foreign body
Suturing(Staple under LA)
Removal of suture
Stabilization of joint
Syringing ear to remove wax
Application or removal of plaster cast
Laryngoscopy
Minor wound management

#This includes only the cost of administration. The actual cost of consumables shall be covered under the pharmacy cover. However, the said cost will have to be borne by the Insured Person in case the Sum Insured under the Pharmacy Cover has been exhausted or is out of scope of the Pharmacy Cover or in case the consumable is a non-payable item as per IRDAI list of non-payables

iii. Pharmacy

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

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

iv. Physiotherapy Session

We shall cover medical expenses incurred by the Insured Person for Physiotherapy Sessions with a qualified physiotherapist within our cashless network to treat Illness, injury or deformity suffered as advised by qualified Medical Practitioners during the Policy Period by physical methods such as but not limited to massage, heat treatment, ultrasound, Laser and exercises maximum up to the number of visits/ sessions as specified against this Optional Cover in the Policy Schedule.

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

The time duration of each physiotherapy session shall be restricted to thirty minutes only.

v. e-Counseling

We shall cover expenses incurred by the Insured Person on e-counseling session(s) with a Psychologist via our mobile application for providing assistance in dealing with issues such as but not limited to personal and lifestyle imbalance, pre-marital counselling, parenting and child care, speech impairment, and problems related to psychological/mental illness/ psychiatric and psychosomatic disorders, stress, anxiety maximum up to the number of sessions as specified against this Optional Cover in the Policy Schedule.

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

vi. Diet and Nutrition e-Consultation

We will cover expenses incurred by the Insured Person on diet and nutrition e-consultation during the Policy Period on a virtual platform via our mobile application for the duration as specified against this Optional Cover in the Policy Schedule.

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

Claim Procedure for BeFit

All claims will be adjudicated only on cashless basis via our mobile application and are subject to the terms, conditions, and exclusions of the Policy and the availability of the Sum Insured.

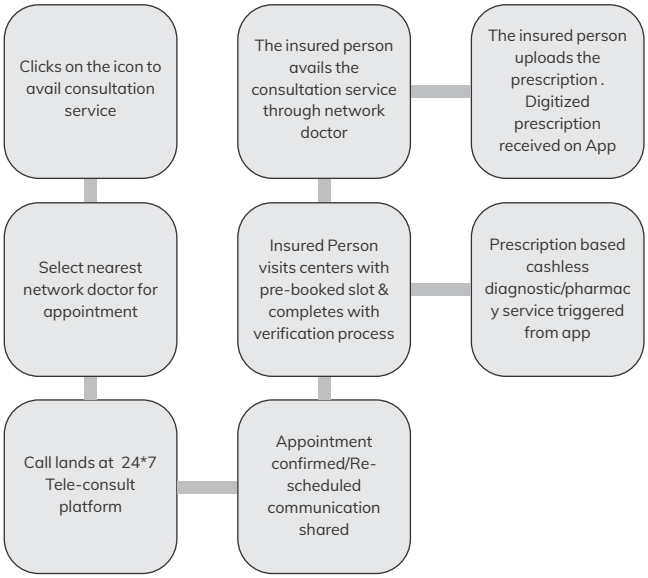
Cashless Facility is only available at specific Network Providers/Health Service Provider available on the mobile application. We reserve the right to modify, add or restrict any Network Provider/Health Service Provider for Cashless facility at Our sole discretion.

- To avail of Cashless Facility at the health Service Provider / Network Provider, the Insured Person/claimant is required to produce information on the health card available on the application for verification and validation. The request shall be considered after having obtained accurate and complete information for the Illness or Injury, where applicable, for which Cashless Facility is sought and We shall confirm the request digitally.
- In case the services availed exceed the eligibility of the Policy, the difference shall have to be paid directly to the Hospital/Network Provider/Health Service Provider by the Insured Person/claimant.
- To avail the benefits and services under this Optional Cover, Insured Person shall need to raise a request through mobile application
- The Routine diagnostic and minor procedure cover /Pharmacy cover services shall only be covered for prescriptions by an empaneled Network Medical Practitioner through the Mobile Application.

How to avail the cashless services under the BeFit cover on the mobile application

1. The Insured Person will have to download the mobile application from the App Store/Play Store. Post download the Insured Person will have to complete the registration process and login to the home page.
2. On the home page, the Insured person will have to go to visit the out-patient service section like consultation, diagnostics and pharmacy

A schematic representation of the claims process is as below



9. <u>Worldwide Cover:</u>

We will cover the Insured Person for Hospitalization expenses including planned Hospitalization incurred outside India and anywhere across the world including USA and Canada, up to the Annual Sum Insured subject to a maximum of INR. 3 Crore, subject to the terms & conditions specified hereunder:

i. The sum insured for this optional cover shall be over and above the Annual Sum Insured

ii. This cover can only be availed by Insured Person(s) up to the age of 65 years and who are resident(s) of India and are within the geographical boundaries of India during Policy issuance. Non- disclosure or mis-representation with respect to the above will impact claims admissibility under this Cover and lead to Policy Cancellation.

iii. There will be a waiting period of 2 years for any claim under this cover. There will be no waiting period for Accidental Emergencies.

iv. In case of addition of any new members to the Policy, they will have to serve the waiting period of 2 years before availing any coverage under Worldwide Cover.

The coverage is available for 45 consecutive days from the date of travel in a single trip and 90 days in a cumulative basis as a whole in a Policy Year. Any expenses incurred beyond 45 days from date of travel shall not be covered in any case

v. The expenses covered under this benefit will be limited to Inpatient Hospitalization Expenses and Daycare Procedures/Treatment Expenses.

vi. Expenses incurred for Pre and Post Hospitalization Medical Expenses, Out- patient Treatment or any other Basic Covers/Optional Covers under this Policy shall not be covered under Worldwide cover.

vii. The payment of any claim will be based on the rate of exchange as on Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian rupees for payment of claims. If on the Insured Person's date of loss, if the RBI rates are not published, the exchange rates published next shall be considered for conversion.

viii. In case of planned hospitalization, prior intimation at least 7 days in advance of the travel and due approval from Us will be necessary.

ix. Any Additional Sum Insured as available under Guaranteed Cumulative Bonus/Power Booster / Inflation Protector (if any) will not be available for worldwide cover and Hospitalization/day care expenses incurred will be covered only up to the Annual Sum Insured under the Policy.

x. Maternity Benefit, Infinite Care, Reset benefit, and Claim Protector will not be available for worldwide cover.

10. Claim Protector:

If a claim has been accepted under the "Inpatient Treatment" or "Daycare Procedures/Treatment" Cover, the items which are included in the List I- Items for which coverage is not available in the Policy of Annexure II, which are non – payable, to the particular claim, will become payable.

i. The maximum claim payable under this add on/Optional Cover shall be limited to Annual Sum Insured under the Policy.

ii. Claims under this add on/Optional Cover shall be limited to treatment taken within the geographical boundaries of India. Hence, this cover is not applicable to Optional Cover 9 Worldwide Cover.

iii. Any Sum Insured accrued under Guaranteed Cumulative Bonus/Inflation Protector/Reset benefit will not be available for Claim Protector Cover.

11. Inflation Protector:

The Inflation Protector Cover is designed to protect the Annual Sum Insured against rising inflation by linking the Annual Sum Insured under the Basic Cover to the Consumer Price index (CPI).

The Annual Sum Insured will be increased on cumulative basis at each Renewal on the basis of inflation rate in previous year. Inflation rate would be computed as the average CPI of the entire calendar year published by the Central Statistical Organization (CSO).

The % increase will be applicable only on Annual Sum Insured under the Policy and not on Guaranteed Cumulative Bonus or any other Covers which leads to increase in Sum Insured.

At the time of renewal, if the insured person opts out of the optional cover, then the sum insured under the Inflation Protector cover accrued up to the expiring policy year will be forfeited.

Year	Annual Sum Insured	Opted for inflation Protector	Inflation Protector at renewal computation#	Overall inflation Protector
0	Rs. 10,00,000	Yes	Not applicable	Not applicable
1	Rs. 10,00,000	Yes	10,00,000 X 6% = 60,000	Rs. 60,000
2	Rs. 15,00,000	Yes	10,00,000 X 6% = 60,000	Rs. 60,000 + Rs. 60,000 = Rs. 1,20,000
3	Rs 15,00,000	Yes	15,00,000 X 6% = 90,000	Rs. 1,20,000 + Rs. 90,000 = Rs. 2,10,000
4	Rs 15,00,000	No	Nil as customer opted out of the Optional Cover	Nil

#Considering Consumer Price Index to be 6%

##Insured Person has enhanced his/her Annual Sum Insured from Rs. 10 Lakhs to Rs. 15 Lakhs

12. Domestic Air Ambulance Cover

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

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

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

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

iv. We will not cover:

a. Any transportation from one Hospital to another;

b. Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital

c. Any transportation or Air Ambulance expenses incurred outside the geographical scope of India.

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

availed.

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

13. Convalescence Benefit:

In case the Insured Person is hospitalized for a continuous period of 10 days or more for treatment of any Accident / Disease/ Illness /Injury for which a valid claim is admissible under the Policy, this benefit provides for payment to the Insured / Insured Person of a fixed allowance of INR. 20,000 and is payable only once during the policy year.

If an insured person is opting for a policy tenure of 1 year he/she is eligible for convalescence benefit only once (i.e. one per policy year), while if he/she is opting for policy tenure of 3 years, he/she is then eligible for this benefit once in each and every year (i.e. one per policy year).

14. Nursing at Home:

We will pay You for the expenses incurred by You, up to Rs. 2,000 per day up to a maximum of 10 days post Hospitalization for the medical services of a Qualified Nurse at Your residence, provided that the nurse is employed in a Hospital and the engagement of such Qualified Nurse is certified as necessary by a Medical Practitioner and relate directly to any Illness or Injury, covered under the Policy.

The Claim under this Optional Cover/add on will be payable only if We have admitted Our liability under "In-patient Treatment" section of the Policy.

15. Compassionate Visit:

In event of Your Hospitalization, which in the opinion of the Medical Practitioner attending on You, extends beyond a period of 5 consecutive days, We will indemnify the cost of the economy class air ticket/railway ticket incurred by Your Immediate Family Member from and to the place of origin of such Family Member or the place of residence of the Family Member.

Our liability under this Optional Cover, however, in respect of any one event or all events of Hospitalization during the Policy Year shall not in aggregate exceed Rs. 20,000 per Policy Year of Policy Period.

For the purpose of this extension, the term "Immediate Family member" would mean the Insured's Spouse, Children, Parents, and Parents-in-law.

16. Health Check-up:

Adult Insured Person(s) aged 18 years and above can avail Health Check-up with our Network Providers or empaneled Health Service Providers anytime during the Policy Period subject to the below conditions

i. The coverage shall be up to 0.5% of Annual Sum Insured subject to a maximum of Rs. 5,000 on cashless basis..

ii. Utilization of the above cover shall be via Pre-designed health packages as per sum insured eligibility. Insured person(s) will not be able to modify the pre-designed packages

iii. Health check-up can be availed only once per Policy Year per Adult Insured Person.

iv. The pre-defined health check-up packages maybe modified from time to time without prior notice but the sum insured eligibility will not be changed

v. This Cover can be availed through our mobile application or by calling at our Toll free number: 1800 2666

vi. The Network Provider/Health Service Provider shall be assigned by Us post receiving Insured Person's request to avail a Health Check-up under this cover.

vii. Utilization of this Preventive Health Check-up will not impact the Annual Sum Insured

viii. Unutilized Health Check-up package will not be carried forward to the next Policy Year and it will be the Insured Person's choice and responsibility to utilize the same with in the designated Policy Period. We shall not be liable to provide any reminders or notifications for the same.

ix. In-case of long term policies (2 year or 3 years), the Adult Insured Person(s) are eligible for Preventive Health Check-up once per policy year

Please Note:

a) We shall not hold any responsibility towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner/ Healthcare professional

b) Choosing the services under this Cover is purely upon the customer's own discretion and at own risk.

c) The Insured Person should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If the Insured Person has any concerns about His/ her health, He/ She may consult His/ her general practitioner.

d) The Health records in respect of the Insured Person shall be saved with Us in order to award wellness points as a part of the Wellness Program. They may be made available to Insured Person(s) in their medical vault in our mobile application.

17. Critical Illness:

We will pay You or Your Nominee / legal heir the Annual Sum Insured subject to a maximum limit of Rs.50 Lakhs 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.

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 add on/ Optional Cover can be claimed by You only once during Your lifetime. No Claim under this Optional Cover shall be

admissible in case any of the Critical Illnesses is a consequence of or arises out of any Pre-Existing Condition(s)/Disease.

However, in case of diagnosis of multiple critical illnesses, the payment of critical illness benefit shall be limited to the sum insured as mentioned against this benefit in the policy schedule.

This cover is available only for adult members aged maximum up to 50 years during first time issuance.

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

1. Cancer of Specified Severity
2. Myocardial Infarction (First Heart Attack of Specified Severity)
3. Coronary Artery Disease
4. Open Chest CABG
5. Open Heart Replacement or Repair of Heart Valves
6. Surgery to Aorta
7. Stroke resulting in Permanent Symptoms
8. Kidney Failure requiring Regular Dialysis
9. Aplastic Anaemia
10. End Stage Lung Disease
11. End Stage Liver Failure
12. Coma of Specified Severity
13. Third Degree Burns
14. Major organ /bone marrow transplant
15. Multiple Sclerosis with Persisting Symptoms
16. Fulminant Hepatitis
17. Motor Neuron Disease with Permanent Symptoms
18. Primary Pulmonary Hypertension
19. Terminal Illness
20. Bacterial Meningitis

1. <u>Cancer of Specified Severity</u>

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

The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. <u>Myocardial Infarction (First Heart Attack of specified severity)</u>

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

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

ii. New characteristic electrocardiogram changes

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

The following are excluded

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. <u>Coronary Artery Disease</u>

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery.

4. <u>Open Chest CABG (Coronary Artery By-pass Graft) surgery</u>

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

5. Open heart replacement or repair of heart valve

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.

6. Surgery to Aorta

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures are excluded.

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. 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.

9. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

I. Blood product transfusion;

II. Marrow stimulating agents;

III. Immunosuppressive agents; or

IV. Bone marrow transplantation

The diagnosis must be confirmed by a haematologist.

10. 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.

11. End Stage Liver Failure

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.

12. Coma of specified severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

13. Third Degree Burns

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

14. 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 hematopoietic 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

15. Multiple Sclerosis with persistent symptoms

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

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

16. Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure.

This diagnosis must be supported by all of the following:

I. Rapid decreasing of liver size;

II. Necrosis involving entire lobules, leaving only a collapsed reticular framework;

III. Rapid deterioration of liver function tests;

IV. Deepening jaundice; and

V. Hepatic encephalopathy.

17. Motor Neuron Disease with permanent symptoms

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

18. Primary 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, and any secondary cause are specifically excluded.

19. Terminal Illness

The conclusive diagnosis of an Illness that is expected to result in the death of the insured person within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed Doctor.

20. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

I. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and

II. A consultant neurologist.

18. Personal Accident:

We will pay You or Your Nominee / legal heir, as the case may be, the Annual Sum Insured subject to a maximum limit of Rs.50 Lakhs, on occurrence of any Insured Event, as specifically described hereunder, arising due to an Injury sustained by You during the Policy Year. This cover is available only for adult members aged maximum up to 65 years during first time issuance.

a. Accidental Death

We shall pay 100% of the coverage amount of the Insured / Insured Person, in the event of his / her Death on account of an Accident / Injury, during the Policy Period or within twelve calendar months from the date of occurrence of such Accident / Injury which occurred during Policy Period.

b. Permanent Total Disablement

Sr.	Insured Events	Amount payable = % of the Sum Insured specified in the policy schedule
I	Total and irrecoverable loss of sight of both the eyes or the actual loss by physical separation of two entire hands or feet, or one entire hand and one entire foot, or the total and irrecoverable loss of sight of one eye and loss by physical separation of one entire hand or one entire foot.	100%
II	Total and irrecoverable loss (a) use of two hands or two feet (b) one hand and one foot (c) sight of one eye and use of one hand or one foot	100%
III	Total and irrecoverable loss of sight of one eye or the actual loss by physical separation of one entire hand or one entire foot	50%
IV	Total and irrecoverable loss of use of one entire hand or one entire foot without physical separation	50%
V	Paraplegia or Quadriplegia or Hemiplegia	100%

NOTE: For the purpose of Sr. No. I to IV in the table above, physical separation of a hand or foot shall mean separation of the hand at or above the wrist, and of the foot at or above the ankle.

For the purpose of this Benefit only:

(I) "Hemiplegia" means complete and irrecoverable paralysis of the arm, leg, and trunk on the same side of the body;

(II) "Paraplegia" means complete and irrecoverable paralysis of the whole of the lower half of the body (below waist) including both the legs;

(III) "Quadriplegia" means complete and irrecoverable paralysis of all four limbs.

c. Permanent Partial Disablement

We shall pay up to the coverage amount of the Insured Person as specified below in case of his / her permanent partial disablement on account of any Accident / Injury, during the Policy Period or within twelve calendar months from the date of occurrence of such Accident / Injury which occurred during Policy Period. The payout of the Sum Insured shall be as per table below:

Sr.	Insured Events	Amount payable = % of the Sum Insured specified in the policy schedule
I	Total and irrecoverable loss of hearing in: -	
	a) Both ears	75%
	b) One ear	30%
II	Loss of toes	
	a) All	20%
	b) Both phalanges of great toes bilateral	5%
	c) Both phalanges of one great toe	2%
	d) Both phalanges of other than great than great toes for each	1%
III	III Loss of four fingers and thumb of one hand	40%
IV	Loss of four fingers of one hand	35%
V	Loss of thumb	
	a) Both phalanges	25%
	b) One phalanx	10%
VI	Loss of index finger	
	a) Three phalanges	10%
	b) Two phalanges	8%
	c) One phalanx	4%
VII	Loss of middle finger	
	a) Three phalanges	6%
	b) Two phalanges	4%
	c) One phalanx	2%
VIII	Loss of ring finger	
	a) Three phalanges	5%
	b) Two phalanges	3%
	c) One phalanx	2%
IX	Loss of little finger	
	a) Three phalanges	4%
	b) Two phalanges	3%
	c) One phalanx	2%
X	Loss of metacarpus	
	a) First or second	3%
	b) Third, fourth or fifth	2%
XI	Permanent partial disablement not otherwise provided for under serial no. I to X	Such % of the Sum Insured as determined in accordance with the medical assessment carried out by the Company's Network Hospital that the %age under Insured event Sr. No. XI shall not exceed 50% of the Sum

19. Voluntary Co-Payment:

The Insured Person has the choice to opt for Voluntary Co-payment and avail subsequent discount on premium. In case Voluntary Co-payment is opted as mentioned in the Policy Schedule, the Insured Person will be liable to bear the specified Co-payment percentage of admissible claim amount of each and every claim amount.

i. Voluntary Co-payment once chosen cannot be modified mid-term. Modification of Co-payment may happen only during Renewal subject to underwriting.

ii. Voluntary Co-payment if chosen by the Insured Person(s) shall be applicable to all Basic Cover under the Policy except Wellness Program.

iii. Voluntary Co-payment shall not be applicable to Add Ons/Optional Covers except Optional Cover 1. Infinite Care and Optional Cover 9. Worldwide Cover.

iv. Voluntary co-payment will not be opted in case voluntary deductible has been opted

20. Voluntary Deductible:

The Insured Person has the choice to opt for Voluntary Deductible and avail subsequent discount on premium. In case Voluntary Deductible is opted as mentioned in the Policy Schedule, the Insured Person will be liable to bear the specified Deductible amount.

i. Voluntary Deductible will apply on aggregate basis for

all hospitalisation expenses during the policy year which fall under basic cover.

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

iii. Voluntary Deductible once chosen cannot be modified mid-term. Modification of Deductible may happen only during Renewal subject to underwriting.

iv. Voluntary Deductible if chosen by the Insured Person(s) shall be applicable to all Basic Cover under the Policy except Wellness Program.

v. Voluntary deductible will not be opted in case voluntary co-payment has been opted

21. Dependent Accommodation Benefit:

If the Insured Person contract an Illness or suffer an Injury due to Accident during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized, We will pay the daily amount for the accommodation of the dependent in the hospital up to Rs. 1,000 per day, for each continuous and completed day of your Hospitalization, maximum up to 10 consecutive days.

For the purpose of this Optional Cover, Dependent means immediate family members as defined.

Provided:

a. We have accepted the claim under hospitalization expenses in respect of Insured Person for the same Accident/Illness.

b. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

c. The medical practitioner certifies that the hospitalized insured member required hospitalization of minimum 3 consecutive days, maximum up to 10 days

d. We will pay only for one immediate family member.

22. Durable Medical Equipment Cover

We will cover the expenses incurred by the Insured Person towards renting or purchase of any of the listed durable medical equipment during the Policy Year only if the same has been prescribed by the treating Medical Practitioner post Hospitalisation for the same condition for which the Hospitalization claim was admissible.

Conditions:

i. Claim payable shall be paid up to the Annual Sum Insured (within overall basic annual sum insured), maximum up to Rs. 5 Lakhs.

ii. We have accepted the claim under hospitalization expenses (In-patient Treatment/Daycare Procedures / Treatment/In-patient AYUSH Hospitalization) in respect of Insured Person for the same Accident/Illness.

iii. The need for a Durable Medical Equipment has been prescribed by an authorized Medical Practitioner during Hospitalization or within 30 days post discharge of the Insured Person from the Hospital.

iv. The purchase should have been made within 30 days of the medical recommendation.

List of Durable Medical Equipment Covered under this Optional Cover:

1. CPAP Machine
2. Ventilator
3. Wheelchair
4. Prosthetic device
5. Suction Machine
6. Commode Chairs
7. Infusion pump
8. Continuous Passive motion devices in case of Knee Replacement
9. Oxygen concentrator

23. Tele Consulation(s)

We will arrange Tele Consultations and recommendations for routine health issues by a qualified Medical Practitioner or health care professional. For the purpose of this Optional Cover Tele Consultation shall mean consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile application.

The services provided under this Cover will be made available subject to the terms and conditions, and in the manner prescribed below:

i. The Tele Consultation(s) can be availed via Our mobile application only

ii. The Medical Practitioner may suggest / recommend / prescribe over the counter medications based on the information provided, if required on a case to case basis. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional*.

iii. There shall be no maximum limit on the count of Tele-Consultations that can be availed by the Insured Person(s) in a policy year

iv. This service will be available 24 hours a day, and 365 days in a year.

v. We/Medical Practitioner/Healthcare professional may refer the Insured Person to another specialist or a general physician (outside of our empaneled network) if required, and the charges for such specialist or a general physician will have to be borne by the Insured Person.

vi. We shall not be liable for any discrepancy in the information provided under this Cover.

vii. Choosing the services under this Cover is purely upon the Insured Person's own discretion and at own risk.

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

24. Waiting Period Reduction Option (Other than those

listed under JumpStart.)

If the Insured Person has opted for this Optional Cover, the waiting period applicable under Exclusion- Pre-Existing Diseases (Code- Excl01) for any declared and accepted pre-existing diseases shall be reduced from 36 months to 24 months or 12 months as opted. This cover will be available only during inception of the policy and only for the Annual Sum Insured chosen at the time of Policy Inception.

The reduced waiting period shall not be applicable for claims made under Optional Cover 9. Worldwide Cover. Once chosen, this optional cover will have to be opted for a period of 3 continuous policy years.

25. Maternity Waiting Period Reduction Option

If the Insured Person has opted for this Optional Cover, the waiting period applicable under the Add Ons/Optional Cover 5. Maternity Benefit shall be reduced from 24 months to 12 months. This cover will be available only during inception of the policy and only for the Annual Sum Insured chosen at the time of Policy Inception

All the conditions mentioned under the Add Ons/Optional Cover 5. Maternity Benefit shall be applicable to this cover. Once chosen, this optional cover will have to be opted for a period of 2 continuous policy years.

26. Specific Illness Waiting Period Reduction Option

If the Insured Person has opted for this Optional Cover, the waiting period applicable under Exclusion- Specified disease/procedure waiting period (Code- Excl02) shall be reduced from 24 months to 12 months. This cover will be available only during inception of the policy and only for the Annual Sum Insured chosen at the time of Policy Inception.

The reduced waiting period shall not be applicable for claims made under Optional Cover 9. Worldwide Cover. Once chosen, this optional cover will have to be opted for a period of 2 continuous policy years.

27. Worldwide Cover Waiting Period Reduction Option

If the Insured Person has opted for this Optional Cover, the waiting period applicable under the Add Ons/Optional Cover 9. Worldwide cover shall be reduced from 24 months to 12 months. This cover will be available only during inception of the policy and only for the Annual Sum Insured chosen at the time of Policy Inception

All the conditions mentioned under the Add Ons/Optional Cover 9. Worldwide cover shall be applicable to this cover. Once chosen, this optional cover will have to be opted for a period of 2 continuous policy years.

28. Room Modifier

If the Insured Person has opted for this Optional Cover, the Insured Person shall have an option:

A. To Modify the room rent eligibility to any room category without any restriction or

B. To modify the room rent eligibility to twin sharing room or

C. To Modify the room rent eligibility to a room rent capping of 1% of Annual Sum Insured for normal room and 2% of Annual Sum Insured for ICU per day.

This cover shall be available across all Annual Sum Insured options, subject to the following:

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

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

   b. Proportionate deductions are not applicable for ICU charges

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

29. Network Advantage

If the Insured Person has opted for this Optional Cover, the Insured Person shall be entitled for a discount of 10% on premium (including the first year premium), subject to the following conditions

I. The treatment as applicable under In-patient Treatment or Daycare Procedures/Treatment /In-patient AYUSH Hospitalization is taken in a hospital listed under the "Preferred Provider Network" List available on Our website www.icicilombard.com and on Our Mobile Application.

II. A co-payment of 20% will be applicable on each and every claim in case the treatment is taken in a hospital which is not included in the "Preferred Provider Network" List.

30. NRI Advantage- Accidental Emergencies Cover for NRI

We will provide cover to Non Resident Indians/Overseas Citizens of India under this policy only for Accidental Emergencies and no claim will be admissible under any other cover of this policy. Further, we will provide a 25% discount on premium if this cover has been opted, provided that the Insured Person(s)-

i. Provides declaration upon Policy Issuance and subsequent renewals that they are based abroad in entirety for the Policy Year

ii. Provides proof of overseas residence for the upcoming year upon each renewal to continue availing the discount

iii. Possesses and provides other relevant identity proof documents as mandated for Citizenship of India

iv. Has an Indian bank account for premium/claims payment.

If the Insured person ceases to reside outside India, then no further discount shall be applicable upon renewal. This discount can be availed only for a maximum period of five

continuous Policy Years and the same will be applicable on a Policy level. Worldwide cover cannot be availed by Non Resident Indians/Overseas Citizens of India. All waiting periods as per the policy terms and conditions will be applicable for the Insured Persons.

e. EXCLUSIONS:

i. Standard Exclusions

1. Pre-Existing Diseases - Code- Excl01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer as selected by the 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 / migration 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Specified disease/procedure waiting period- Code- Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis
7. Stones in the urinary and biliary systems
8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
9. Cataracts,
10. Hernia of all types and Hydrocele
11. Fistulae in anus
12. Fissure in anus
13. Fibromyoma
14. Hysterectomy
15. Surgery for any skin ailment
16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
17. Dialysis required for Chronic Renal Failure.
18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.
19. Dilatation and curettage
20. Varicose Veins and Varicose Ulcers
21. Non Infective Arthritis and other form arthritis
22. Gout and Rheumatism
23. Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

3. a. Expenses related to the treatment of the below mentioned illness within 90 days from the first policy commencement date shall be excluded unless they are pre-existing and disclosed at the time of underwriting

I. Hypertension

ii. Diabetes

iii. Cardiac Conditions

b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher sum insured subsequently.

4. 30-day waiting period- Code- Excl03

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

5. Investigation & Evaluation- Code- Excl04

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.

6. Rest Cure, rehabilitation and respite care- Code- Excl05

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.

7. **Obesity/ Weight Control: Code- Excl06**

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

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

8. **Change-of-Gender treatments: Code- Excl07**

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

9. **Cosmetic or plastic Surgery: Code- Excl08**

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.

10. **Hazardous or Adventure sports: Code- Excl09**

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.

11. **Breach of law: Code- Excl10**

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

12. **Excluded providers: Code- Excl11**

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

(The list of excluded providers/delisted hospitals is available on our website www.icicilombard.com and is timely updated.)

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

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

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

16. **Refractive Error: Code- Excl15**

Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

17. **Unproven Treatments: Code- Excl 16**

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

18. **Sterility and Infertility: Code- Excl 17**

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

The above exclusion part b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI shall not apply to claims which are otherwise admissible under Basic Cover 14 “In-patient Hospitalisation for Oocyte Donor” which pertains to Medical Expenses incurred in respect of Hospitalization of the Oocyte donor for complications arising due to oocyte retrieval process”

The above exclusion part c. Gestational surrogacy shall not apply to claims which are otherwise admissible under Basic Cover 13 “In-patient Hospitalisation for Surrogate Mother” which pertains to Medical Expenses incurred in respect of Hospitalization of the Surrogate mother for complications arising out of pregnancy and post-partum delivery complications”

19. **Maternity: Code Excl18**

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

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

This exclusion will not be applicable in case optional cover 5 Maternity Benefit has been opted

ii. **Specific Exclusions (Exclusions other than those specified under e. I. above)**

20. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

21. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
    a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
    b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
    c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
22. Any expenses incurred on Out Patient treatment. This exclusion will not be applicable in case optional cover 8. BeFit has been opted
23. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively.
24. Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.
25. Treatment taken outside the geographical limits of India. This exclusion shall not be applicable in case optional cover 9. Worldwide cover has been opted
26. Personal comfort, cosmetics, convenience and hygiene related items and services
27. Acupressure, acupuncture, magnetic and other therapies
28. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident.
29. Expenses for venereal disease or any sexually transmitted disease except HIV.
30. Screening, counselling or Treatment relating to external birth defects and external congenital Illnesses or defects or anomalies
31. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
32. Any ailment/ illness/ injury/ condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.

f. GENERAL Terms and CONDITIONS:

i. Standard General Terms and clauses

1. **Disclosure of Information:**

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

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

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

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

3. **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. **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 deceivee; 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.

5. **Multiple policies**

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

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

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose 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.

6. **Free Look Period:**

The Free Look Period shall be applicable only on the new 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 thirty days from date of receipt of the policy documents whether received electronically or otherwise to review the terms and conditions of the policy, and to return the same if not acceptable. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person.

7. **Cancellation:**

a. The policyholder may cancel this policy by giving 15days' 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*	80.00%	80.00%	80.00%
From 1 month to 3 months	60.00%	70.00%	75.00%
From 3 months to 6 months	40.00%	60.00%	67.50%
From 6 months to 9 months	20.00%	50.00%	60.00%
From 9 months to 12 months	0.00%	40.00%	52.50%
From 12 months to 15 months	NA	30.00%	47.50%
From 15 months to 18 months	NA	20.00%	40.00%
From 18 months to 21 months	NA	10.00%	32.50%
From 21 months to 24 months	NA	0.00%	25.00%
From 24 months to 27 months	NA	NA	20.00%
From 27 months to 30 months	NA	NA	12.50%
From 30 months to 33 months	NA	NA	5.00%
From 33 months to 36 months	NA	NA	0.00%

*Not applicable for policies with free look period; Premium refund for cancellations during the free look period will be provided as per the Free look clause.

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

b. The Company may cancel the policy at any time on grounds of 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.

8. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of established fraud, misrepresentation by the insured person provided the policy is not withdrawn and also subject to moratorium conditions.

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

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

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

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

v. For individual products, the loadings on renewal premium shall be at portfolio and not based upon any individual policy claim experience. However, discount in premium may be provided by the Company to individual policyholders for good claims experience.

vi. No fresh underwriting at renewal stage where there is no change in sum insured offered shall be applicable. Provided that where there is an improvement in the risk profile, the company may endeavour to recognize that for removal of loadings at the point of renewal.

9. Premium payment in instalments:

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

i. Grace Period for payment of premiums shall be fifteen days where premium payment mode is monthly and thirty days in all other cases.

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

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 installment premium is not paid on due date.

v. In case of installment 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.

10. 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

11. 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.

The insurer may underwrite the proposal in case of migration, if the insured person is not continuously covered for 36 months

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

12. 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.

13. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium

would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

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

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

15. Nomination

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

16. Grievance Redressal Procedure:

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

Website: www.icicilombard.com
Toll Free: 1800 2666
E-Mail: customersupport@icicilombard.com
Courier: ICICI Lombard General Insurance Company Ltd.
ICICI Lombard House,
414, P Balu Marg, Off Veer Savarkar Road,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai- 400025

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

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance

If Insured person is not .satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at

Manager- Service Quality,

Corporate Manager- Service Quality,

National Manager- Operations & finally

Director-services and Business development at the following address:

ICICI Lombard General Insurance Company Limited,

ICICI Lombard House,

414, P Balu Marg, Off Veer Savarkar Road,

Near Siddhi Vinayak Temple,

Prabhadevi, Mumbai 400025

For updated details of grievance officer, kindly refer the link https://www.icicilombard.com/grievance-redressal.com

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://www.irdai.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo225&mid=14.2

LIST OF INSURANCE OMBUDSMEN

The contact details of the Insurance Ombudsman offices are mentioned as an Annexure I to this policy. These details can also be found at http://www.cioins.co.in/ombudsman.html.

17. 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.

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

18. Zone based premium

For the purpose of premium computation, the country has been divided into 4 zones.

Zone	State/District
Zone A	Delhi, Mumbai (including Thane district, Navi Mumbai) , Gurugram district, Karnal district, Sonipat district, Rohtak district, Bhiwani district, Chakri Dadri district, Mahendragarh district, Daman & Diu, Dadra Nagar, Ahmedabad, Surat, Noida City, Ghaziabad district, Hapur district, Meerut district, Muzaffarnagar district, Shamali district
Zone B	Pune, Kolkata, Telangana (incl. Hyderabad), Madhya Pradesh, Goa, Gujarat (excl. Ahmedabad and Surat), Bangalore, Chennai, Andhra Pradesh, Chhattisgarh, Pondicherry, Uttarakand
Zone C	Meghalaya, Mizoram, Nagaland, Tripura, Sikkim, Andaman & Nicobar, Rest of Karnataka, West Bengal (excl. Kolkata), Bihar, Jharkhand, Maharashtra (excl. Mumbai and Pune), UP (excl. NCR Region), Haryana (excl. NCR region)
Zone D	Rest of NCR (Alwar district, Bagpat district, Bharatpur district, Bulandshahr district, Faridabad district, Gautam Buddha Nagar district excl. Noida, Jhajjar district, Jind district, Nuh district, Panipat district, Rewari district, Mewat district, Palwal district)

The premium will depend on the city of residence and pincode of the insured person. Please inform us immediately in case of any change in the same. Not doing so, may impact your claim admissibility. There shall be no zone-based co-payment applicable.

19. Material Change:

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

20. 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.

21. Notice & Communication

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

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

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

22. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only. unless Optional Cover 9. Worldwide Cover has been opted for.

23. Automatic change in Coverage under the policy

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

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

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

b. Upon exhaustion of Sum Insured and any other additional sum insured (if any), for the Policy Year. However, the Policy is subject to Renewal on the due date as per the applicable terms and conditions.

24. Territorial Jurisdiction

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

25. Arbitration

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

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

26. Policy Alignment

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

b. Such policies will be charged with premium on pro rata basis though the Sum Insured under the Policy shall remain constant.

27. Endorsements (Changes in Policy)

a. 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.

b. Any change in plan, add-ons/Optional Covers opted may happen only during Renewal subject to underwriting.

c. 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.

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

e. 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

28. 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 Sum Insured, the waiting period shall start afresh only for the enhanced portion of the Sum Insured

29. Non Payables

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

g. Other Terms and Conditions

I. Claim Administration

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

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

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

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

i. Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Person availed treatment

ii. Fees charged by surgeon, anesthetist, Medical Practitioner

iii. Investigation expenses

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

iii. Voluntary Co-payment shall be applicable on the amount payable by Us and our liability to make payment shall then be arrived at.

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

1. Annual Sum Insured
2. Guaranteed Cumulative Bonus (if accrued and available)
3. Power Booster (if accrued and available)
4. Inflation Protector (if accrued and available)
5. Reset Sum Insured (if applicable)

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

1. Claims Procedure

A. For Cashless Settlement

Cashless treatment is only available at a Network Provider (List of Network Providers is available at our website). In order to avail of cashless treatment, the following procedure must be followed by You:

Pre-authorization

Prior to taking treatment and/ or incurring Medical Expenses at a Network Provider, You must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request preauthorization at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization.

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

B. For Reimbursement Settlement

i. You shall give notice to Us or Our in house claim processing team by calling the toll free number 1800 2666 or emailing us at 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 or Injury;
- Name and address of the attending Medical Practitioner and the Hospital;
- Any other information that may be relevant to the Illness/ Injury/ Hospitalisation

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

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

iii. You or someone claiming on Your behalf must promptly and in any event within 30 days of Your discharge from a Hospital (for post-hospitalization expenses, within 30 days from the completion of post-hospitalization period) deliver to Us the documentation (written details of the quantum of any Claim along with all original supporting documentation) as more particularly listed in Claim documents section. In case there is a delay beyond 30 days in submission of claim documents, we may condone the delay provided the insured person submits a valid reason justifying the delay to us in writing.

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

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

Claim falling in two Policy periods

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

2. Claim Documents

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

1. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from our website www.icicilombard.com
2. Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner
3. Original bills from chemists supported by proper prescription.
4. Original investigation test reports and payment receipts.
5. Indoor case papers
6. Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.
7. Any other document as required by Us or to investigate the Claim or Our obligation to make payment for it

The relevant documents can be sent to

ICICI Lombard Health Care,

1st, 4th (Half) , 5th and 6th floors,

Varun Towers- II , Opp. Hyderabad Public school,

Begumpet, Hyderabad, District Hyderabad,

Telangana Pin code -500016

3. Claim Service Guarantee

We provide You Claim Service Guarantee as follows

A. For Reimbursement Claims: We shall make the payment of admissible claim (as per terms & conditions of Policy) OR communicate non admissibility of claim within 14 days after You submit complete set of documents & information in respect of the claims. In case We fail to make the payment of admissible claims or to communicate non admissibility of claim within the time period, We shall pay 2% interest over and above the rate defined as per IRDAI (Protection of Policyholder's interest) Regulation 2017.

B. For Cashless Claims: If You notify pre authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will respond within 2 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 2 hours.

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

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

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

You may lodge claim separately for the hospitalization claim, Pre-Post hospitalization. In such scenario, if delay happens beyond the time period as specified above, the interest amount calculated will be on the net sanctioned amount of respective transaction and not the total amount paid for the entire claim.

Any amounts paid towards interest under Claim Service Guarantee will not affect the Annual Sum Insured as specified in the Schedule.

If you are not eligible for 'Claim Service Guarantee' for the reasons stated above, We will inform the same to You, within 14 days in case of A. For Reimbursement claims and within 2 hours in case of B. For Cashless claims above

Annexure I

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: imalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry)
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar

Office Details	Jurisdiction of Office Union Territory, District)
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar , Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

Annexure II

List I- Items for which coverage is not available in the Policy

Sl No.	Item
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 CHARGE)
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

Sl No.	Item
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	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II- Items that are to be subsumed into Room Charges

Sl No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX I MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/VARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE

Sl No.	Item
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER& STRIPS
18	URINE BAG