Policy Wordings

b) PREAMBLE

ICICI Lombard General Insurance Company Limited ("We / Us"), having received a Proposal and the premium from the Proposer named in Part I of the Policy (hereinafter referred to as the "Policy Schedule") and the said Proposal and Declaration together with any statement, report or other document leading to the issue of this Policy and referred to therein having been accepted and agreed to by Us and the 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 Annual Sum Insured / appropriate benefit amount will be paid by Us.

c) DEFINITIONS PART II OF THE POLICY

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

i. Standard Definitions

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

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

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

a) Central or State government AYUSH hospital; or

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

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

i. Having at least 5 in-patient beds

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

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

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

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

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

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

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

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

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.

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

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

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

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

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

a) has qualified nursing staff under its employment;

b) has qualified medical practitioner(s) in charge;

c) has a fully equipped operation theatre of its own where

surgical procedures are carried out

d) Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

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

a) Undertaken under General or Local Anesthesia in a Hospital/ Day care center in less than 24 hrs because of technological advancement, and

b) Which would have otherwise required a hospitalisation of more than 24 hours.

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

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

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

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

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

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

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

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

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

Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;

Has qualified nursing staff under its employment round the clock;

Has qualified medical practitioner(s) in charge round the clock;

as a fully equipped operation theatre of its own where surgical procedures are carried out Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

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

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

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

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

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

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 expenses shall

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

b) expenses towards lawful medical termination of

pregnancy during the policy period

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

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

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

a. Is required for the medical management of the illness or Injury suffered by the insured

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

c. Must have been prescribed by a Medical practitioner

d. Must conform to the professional standard widely accepted in international medical practice or by the medical community in India

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

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

New born Baby means baby born during the Policy Period and is aged upto 90 days.

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

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

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

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

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

a. diagnose by physician within 48 month prior to the effective date of the policy issued by insurer or its reinstatement or

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

Post Hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

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

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

Pre Hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

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

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

Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

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

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 center by a Medical Practitioner.

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

ii. Special Definitions

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

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

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

Associated Medical Expenses means medical expenses such as Professional fees, OT charges, Procedure charges, etc., which vary based on the room category occupied by the insured person whilst undergoing treatment in some of the hospitals. If Policy Holder chooses a higher room category above the eligibility defined in policy, then proportionate deduction will apply on the Associated Medical Expenses in addition to the difference in room rent. Such associated medical expenses do not include Cost of pharmacy and consumables, Cost of implants and medical devices and Cost of diagnostics.

Proportionate deduction shall not be applicable to "ICU charges" also.

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

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

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

Immediate Family means spouse, dependent children, brother(s), sister(s) and dependent parent(s), Parents-in-law, Son-in-law, Daughter-in-law of the insured.

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

Maximum limit of indemnity means the sum total of annual sum insured, additional sum insured (if any) and super no claim bonus (if opted and accrued by the insured), Sum insured protector (if opted by insured)

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

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

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

Life threatening medical conditions means a medical condition suffered by the insured member which has following characteristics

a) Unstable vital parameters (blood pressure, pulse, temperature and respiratory rate)

b) Acute impairment of one or more vital organ system (involving heart, brain, lungs, liver, kidney and pancreas or)

c) Critical care being provided, which involves high complexity decision making to assess manipulate and support vital organ failures and requires interpretation of multiple physiological parameters and application of advanced technology or

d) Critical care being provided in critical care area such as coronary care unit, intensive care unit, respiratory care unit or the emergency department, and certified by the attending medical practitioner as a life threatening condition.

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

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

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

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

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

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

The list of the Service Providers is available on our digital platform and is subject to amendment from time to time.

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

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

d) WHAT WE WILL PAY (SCOPE OF COVER)

This Policy is a contract of insurance between the Policyholder and Us which is subject to the receipt of premium against each Benefit in full (first instalment in case the customer has opted for Periodic Premium Payment option) in respect of the Insured Persons and the terms, conditions and exclusions of this Policy. Claims made in respect of an Insured Person for any Benefit applicable to the Insured Person shall be subject to the

availability of the Annual Sum Insured, applicable sub-limits (if any) and/or deductible (if any), and / or Co-payment (if any) for the Benefit claimed as specified in the Policy Schedule/Certificate and the terms, conditions and exclusions of this Policy.
All claims shall be made in accordance with the procedures set out in this Policy. Admitted claims will be payable to the Insured Person or the Nominee (as applicable).

A. Base Covers (Mandatory)

1 Hospitalization Expenses

We hereby agree subject to terms, conditions and exclusions herein contained or otherwise expressed hereon that, if during the Policy Year, You require minimum 24 hours Hospitalisation for any Illness or Injury on the written advice of a Medical Practitioner, then We will cover the Medical Expenses so incurred by you for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

In case the group has opted for room rent capping the same shall be applicable to room rent of a hospital room, ICU/ICCU and will be specified in policy schedule/Key Information Sheet against the benefit.
If the insured chooses a higher room category than the category that is eligible as per terms and conditions of the policy then the insured person shall bear the rateable proportion of the total associated medical expenses. However, proportionate deductions shall not be applied in respect of the 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.

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

2 Day Care Treatment /Surgeries

We hereby agree subject to terms, conditions and exclusions herein contained or otherwise expressed hereon that, if during the Policy Year, You require Hospitalisation as an inpatient for less than 24 hours in a Hospital (but not in the outpatient department of a Hospital) on the written advice of a Medical Practitioner, then We will pay You for the Medical Expenses incurred for undergoing such Day Care Procedure/Treatment or surgery.

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

3 Pre-Hospitalisation and Post-Hospitalisation Expenses

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

- Pre-hospitalisation Medical Expenses incurred by You for a period immediately prior to Your Hospitalisation as specified against this benefit in the policy schedule/Key Information Sheet and

- Post-hospitalisation Medical Expenses incurred by You for a period immediately post Hospitalisation, as specified against this benefit in the policy schedule/Key Information Sheet, provided that Your Hospitalisation falls within the Policy Year and

  We have accepted Your Claim under “In-patient Treatment” or “Day Care Procedures” section of the Policy.

4 In Patient AYUSH Hospitalisation

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

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

5 Unlimited Reset Benefit

Reset will be available unlimited times in a policy year in case the annual Sum insured including accrued Additional Sum Insured (if any) and Super No Claim Bonus (if any), Sum insured protector(if any) is insufficient as a result of previous claims in that policy year, provided that:

- The total amount of reset will not exceed the Annual Sum Insured for that policy year
- The reset amount can only be used for all future claims within the same policy year The claim will be admissible under the reset only if the claim is admissible as per terms and conditions of the base policy
- Reset will not trigger for the first claim

- For individual policies, reset Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis
- Any unutilized reset Sum Insured will not be carried forward to subsequent policy year
- The reset amount can only be used for all future claims within the same policy year, not related to the illness/ disease/ injury for which a claim has been paid in that policy year for the same person.
- For any single claim during a policy year, the maximum claim amount payable shall not exceed the sum of
  - The Annual Sum Insured,
  - Additional Sum Insured, and
  - Super No claim Bonus (If opted and accrued)
  - Sum insured protector (If opted and accrued))
- During a Policy Year, the aggregate claim amount payable, shall not exceed the sum of:
  - The Annual Sum Insured
  - Additional Sum Insured
  - Super No claim Bonus(if opted and accrued)
  - Sum insured Protector(if opted and accrued)

6 Additional Sum Insured (Cumulative Bonus)

At the time of renewal of this Policy, We will provide an additional sum insured (hereinafter referred to as "Additional Sum Insured") of 10% of annual sum insured of immediately preceding policy year subject to a maximum of 100% provided that there is no Claim under this Policy during the Policy Year except as an Out-patient (If opted).

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

- In relation to a Floater Benefit cover, the Additional Sum Insured so accrued during the Claim-free Policy Year(s) will also be on floater basis and will only be available to those Insured Person(s) who were insured in such Claim-free Policy Year(s) and continue to be insured in the subsequent Policy Year(s).
- If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated Cumulative Bonus for each Insured Person under the expiring policy, and such expiring policy has been Renewed with Us on a floater policy basis as specified in the Policy Schedule then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.
- In case of floater policies where Insured Persons Renew their expiring policy with Us by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 21 years, the Cumulative Bonus of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
- If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured.
- If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year
- Additional Sum Insured accrued can be utilized only for Inpatient hospitalization, day care treatment and surgeries, pre and post hospitalization expenses, Inpatient AYUSH hospitalization, domiciliary hospitalization and donor expenses.
- Any Additional sum insured (Cumulative bonus) accrued can be utilized within the geographical boundaries of India.

7 Donor Expenses

We will cover you up to the annual sum insured for the Medical Expenses incurred in respect of the donor for any of the organ transplant surgery, provided the organ donated is for your use and the organ donor is an eligible donor in accordance with "The transplantation of Human Organ Act". We have admitted the In-patient Hospitalization Claim under the base plan

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

i. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
ii. Screening expenses of the organ donor.
iii. Any other Medical Expenses as a result of the harvesting from the organ donor.
iv. Costs directly or indirectly associated with the acquisition of the donor's organ. Transplant of any organ/tissue where the transplant is experimental or investigational.
v. Expenses related to organ transportation or preservation.
vi. Expenses incurred by Insured as a donor.
vii. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

8 Domiciliary Hospitalization

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

i. The Domiciliary Hospitalization is for Medically Necessary Treatment.

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

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

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

v. Any Medical Expenses payable shall not in aggregate exceed the maximum limit of indemnity.

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

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

b) Arthritis, gout and rheumatism;

c) Ailments of spine/disc

d) Chronic nephritis and nephritic syndrome;

e) Any liver disease;

f) Peptic ulcer

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

h) Diabetes mellitus and insipidus;

i) Epilepsy;

j) Hypertension;

k) Pyrexia of any origin

B Base Cover (Optional)

Worldwide cover Including India (Hospitalization cover)

We will cover you for hospitalisation expenses including planned hospitalisation, incurred within India and anywhere across the world including USA and Canada, up to the amount specified against this benefit in the policy schedule/Key Information Sheet subject to the terms & conditions specified hereunder:

i. A co-pay of 10% will be applied to every admissible claim over and above to any other co-pay levied, if the treatment is taken outside India

ii. The benefit 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.

iii. The expenses covered under this benefit shall be limited to Inpatient hospitalization expenses, days care treatment/ procedure expenses only.

iv. Expenses incurred for pre and post hospitalization will be covered as specified (number of days) in the policy schedule.

v. Coverage/benefit associated with **Section A Base covers_(Mandatory)** i.e. domiciliary hospitalization, Donor expenses, In-patient AYUSH, unlimited reset and Additional sum insured (cumulative bonus) will be applicable only within the geographical boundaries of India.

vi. We will also cover the expenses associated with the initial treatment plan for reconstructive surgery and surgical implants (excluding dental), provided the same is carried out to restore the function after an accident and the surgery is performed at a medically appropriate stage after the accident.

vii. The benefit is available as cashless facility through a pre-authorization by our service provider subject to availability in the region of loss, as well as reimbursement basis through us. However in case of planned hospitalisation it is mandatory for the customers to seek our approval before undertaking the trip

viii. The payment of any claim under this benefit 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.

Note: The scope of this cover extends to worldwide including India, USA and Canada and the Maximum limit of indemnity would be restricted to the Annual Sum insured for claims within and outside India, in aggregate.

Extension 1 to 5 will be available only when the Base cover (optional) "Worldwide Including India (Hospitalization cover)" is opted by the group. Rest of the extensions/optional covers can also be opted along with it, but the utilization will be limited within the geographical boundaries of India.

C. Extension/Optional Covers

The Benefits listed below shall be available to the Insured Person only if the requisite additional premium has been received by us and the Benefit is specified to be in force for that Insured Person in the Policy Schedule/Key Information Sheet. Benefits under this Section are subject to the terms, conditions,

waiting periods and exclusions of this Policy and in accordance with the applicable Plan as specified in the Policy.

1 Road Emergency Ambulance (worldwide including India)

In consideration of the payment of additional premium to Us it is hereby declared and agreed to cover the expenses incurred on road ambulance services which are offered by a healthcare or ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

a) Our maximum liability under this Benefit for every claim arising during the Policy Year will be restricted to the amount (per hospitalization) specified against this benefit in the policy schedule/Key Information Sheet.

b) We have accepted a claim under worldwide cover including India (hospitalization cover) in respect to you for the same Accident/Illness for which road ambulance services were availed.

c) This Benefit includes and is limited to the cost of the transportation of the Insured Person:

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

II. 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. From one hospital to another hospital for the purpose of providing better medical support to the insured during an emergency

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

Any expenses in relation to transportation of you from Hospital to the your residence while transferring you after you been discharged from the Hospital are not payable under this Benefit

***Note**: On opting this extension, the scope of cover extends to worldwide including India, USA and Canada and the maximum limit of Indemnity would be restricted to the amount as specified against this benefit for claims within and outside India, in aggregate.*

2 International Emergency Medical Assistance (worldwide including India):

a) Air Ambulance

In consideration of the payment of additional premium to Us, We will cover the expenses incurred on air ambulance services in respect to you 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. Our maximum liability under this Benefit for any and all claims arising during the Policy Year will be restricted to the Sum insured as stated in the Policy Schedule/Key Information Sheet;

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

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

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

V. We will not cover:

- Any transportation from one Hospital to another;
- Any transportation of yours from Hospital to your residence after you have been discharged from the Hospital
- Any transportation between two countries.

VI. We have accepted a claim under worldwide cover hospitalization in respect to you for the same Accident/Illness for which air ambulance services were availed.

We shall not be liable if Medically Necessary Treatment can be provided at the Hospital where you are situated at the time of requiring Emergency Care.

b) Repatriation of Mortal Remains: In the event of the death of the insured person oversea/abroad we will pay/reimburse the policyholder up to the amount specified in the policy schedule/Key Information Sheet against this benefit for the cost incurred towards the return of the mortal remains of the insured person to his/her place of residence in India.

Documents to be submitted:

- Death certificate of the deceased providing the details of the place, time, circumstances and cause of death
- Post-mortem certificate, if conducted

- Supporting bills and payment receipts need to be submitted

***Note**: On opting this extension, the scope of cover extends to worldwide including India, USA and Canada and the maximum limit of Indemnity would be restricted to the amount as specified against this benefit for claims within and outside India, in aggregate.*

3 Dependent Accommodation (Worldwide including India):

In consideration of additional premium to us, If you contract an Illness or suffer an Injury due to Accident during the Policy Period and which solely and directly requires you to be Hospitalized, We will pay the daily amount for the accommodation of the dependent in the hospital only as specified in the Policy Schedule/Key Information Sheet against this benefit in respect of each continuous and completed day of Hospitalization of the Insured Person.

For the purpose of this Extension, Dependent means immediate family members

Provided:

a) We have accepted the claim under the worldwide cover in respect to you 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 hospitalised insured member required hospitalization of minimum 3 consecutive days, maximum up to 10 days

d) We will pay for one immediate family member.

***Note**: On opting this extension, the scope of cover extends to worldwide including India, USA and Canada and the maximum limit of Indemnity would be restricted to the amount as specified against this benefit for claims within and outside India, in aggregate.*

4 Convalescence Benefit (Worldwide including India):

In consideration of the payment of additional premium to us. We will pay you an amount as specified against this benefit in the policy schedule/Key Information Sheet. If you are hospitalized under worldwide cover including India (Hospitalization cover) for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy. This benefit is payable only once to an Insured Person during each Policy Year of the Policy Period.

Note**: On opting this extension, the scope of cover extends to worldwide including India, USA and Canada and the maximum limit of Indemnity would be restricted to the amount as specified against this benefit for claims within and outside India, in aggregate.**

5 Worldwide Additional Sum Insured (Cumulative Bonus):

In consideration of payment of additional premium to us, Additional sum insured accrued by You under section A.6 Additional sum insured (Cumulative Bonus) can be utilized by you outside the geographical boundaries of India. The Additional Sum Insured accrued can be utilized only for Inpatient hospitalization, day care treatment and surgeries and pre and post hospitalization expenses.

6 Domestic Road Emergency Ambulance Cover

In consideration of the payment of additional premium to Us it is hereby declared and agreed to 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 you to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

a) Our maximum liability under this Benefit for every claim arising during the Policy Year will be restricted to the amount (per hospitalization event) as specified against this benefit in the policy schedule/Key Information Sheet.

b) We have accepted a claim under hospitalization expenses in respect to you for the same Accident/Illness for which road ambulance services were availed.

c) This Benefit includes and is limited to the cost of the transportation of the you:

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

ii. 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. From one hospital to another hospital for the purpose of providing better medical support to you during an emergency.

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

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

7 Air Ambulance

In consideration of the payment of additional premium to Us, We will cover the expenses incurred on air ambulance services in respect to you which are offered by a healthcare or an air ambulance service provider and which have been used during

the Policy Period to transfer you to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

i. Our maximum liability under this Benefit for any and all claims arising during the Policy Year will be restricted to the Sum insured as stated in the Policy Schedule/Key Information Sheet;

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

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

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

v. We will not cover:

a) Any transportation from one Hospital to another;
b) Any transportation of you from Hospital to the your residence after you have been discharged from the Hospital
c) Any transportation or air ambulance expenses incurred outside the geographical scope of India.

vi. We have accepted a claim under hospitalization expenses in respect to you for the same Accident/Illness for which air ambulance services were availed.

vii. We shall not be liable if Medically Necessary Treatment can be provided at the Hospital where you are situated at the time of requiring Emergency Care.

8 ASI Protector

In consideration of payment of additional premium to Us, you can avail the benefit as mentioned under additional SI protector. Additional sum insured(ASI) accrued by you will not be impacted or reduced at renewal if any one claim or multiple claims admissible in the previous policy year under the policy does not exceed the overall amount of ₹ 50,000.

9 Sum Insured Protector

In consideration of payment of additional premium to Us, you can avail the benefit under sum insured protector. The Sum Insured protector is designed to protect the Sum Insured against rising inflation by linking the Sum Insured under the base plan to the Consumer Price index (CPI).

The 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 Organisation (CSO). Sum Insured protector will be calculated on previous year policy sum insured.

At the time of renewal if the Insured person opts out of this optional cover, then the Sum insured protector accrued up until the expiring policy year will be forfeited

The percentage increase will be applicable only on Annual Sum Insured under the Policy and not on additional sum insured or any other benefit which leads to increase in Sum Insured.

10 Claim Protector

In consideration of payment of additional premium to Us, you can avail the benefit as mentioned under claim protector. If a claim has been accepted under the inpatient hospitalization cover, then the items which are not payable under the claim as per the List of Excluded items released (Part III. 26 List of Non payables) that is related to the particular claim will become payable. The maximum claim payout under this benefit shall be limited to Annual Sum Insured under your policy.

11 Super No Claim Bonus

In consideration of payment of additional premium to us, you can avail the benefit under super no claim bonus. All terms and conditions applicable to the additional sum insured feature will apply to this cover as well, except for the below mentioned terms and conditions:

- If no claims have been paid in the expiring Policy year and the policy is being renewed without any break in period the Insured person will be awarded a super no claim bonus viz. 50% increase in the Sum insured for each completed year, maximum of 100% of Sum insured.
- Super no claim bonus will be over and above the accrued additional sum insured, if any. In the event of a claim in the Policy year, the super no claim bonus will reduce by 50%.
- At the time of renewal if the Insured person opts out of this optional cover, then the Super no claim bonus accrued up until the expiring policy year will be forfeited.
- In case no claims are made in the Policy year, the super no claim bonus will be credited automatically to the subsequent policy year even in the case of multi-year policies (2 & 3 year policy tenure).
- Super no claim bonus will be calculated on the previous policy years Sum insured.
- Additional Sum insured (cumulative bonus) won't be applicable if you opt for super no claim bonus.

12 Maternity Cover

In consideration of the payment of additional premium to us, and subject always to the amount as specified against this benefit in the Policy Schedule/Key Information Sheet, We will cover you for

- Medical Expenses incurred for delivery, including a caesarian section, during Hospitalization or lawful medical termination of pregnancy and pre and postnatal expenses during the Policy Year.

- The cover shall be limited to 2 deliveries/ terminations during the Period of Insurance.
- Pre-natal and postnatal expenses shall be covered.
- Delivery expense for pre- mature baby less than 32 weeks will be covered.

Provided always that;

a) The cover under this extension shall be available after the specified period of time as mentioned in the policy schedule/Key Information Sheet against the benefit has elapsed since the inception of the first Policy with Us.

b) Pre- and Post-Hospitalization expenses under A.3 will not be covered under this extension

c) This benefit is available only under a family floater Policy.

d) This benefit is available for You or Your spouse provided You and Your spouse, both are covered under the same family floater Policy and have served the waiting period.

e) This benefit can be extended to both Individual and floater plans, irrespective of you and your spouse being covered under the same plan, if opted by the group and specified in policy schedule/Key Information Sheet.

f) We will not cover ectopic pregnancy under this benefit (the same shall be covered under In-patient Treatment)

g) We will not cover expenses incurred in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses;

h) On any Renewal, if an enhanced Sum Insured is applied, the condition for specified months of required continuous coverage would apply afresh, but only to the extent of the increased amount available under this Benefit.

13 New-born baby cover

In consideration of the payment of additional premium to Us, and subject to the amount as specified against this benefit in the Policy Schedule/Key Information Sheet. New Born Baby cover- will cover Medical Expenses incurred on the “New born Baby” during Hospitalisation (for a minimum period of consecutive 24 hours) for a maximum period up to 91 days from the date of birth of the baby. This cover will be available only if maternity cover has been opted by you.

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

14 Out Patient Treatment Cover

In consideration of the payment of additional premium to us, as specified against this benefit in the policy schedule/Key Information Sheet. We will cover you for the Medical Expenses incurred by You in outpatient.
For the purpose of this extension, the following shall be covered under this benefit

a) Outpatient consultation by 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.

b) Diagnostics test as recommended/prescribed by the medical practitioner.

c) Pharmacy – Medicines purchased by the Insured Person from a pharmacy, provided that such medicines have been prescribed in writing by a Medical Practitioner.

Note: *Payment of expenses towards outpatient treatment will not prejudice the company's right to deal with a claim in case of non-disclosure of material fact and / or Pre- Existing Diseases in terms of the policy.*

Exclusion applicable to Outpatient Treatment

We shall not be liable to make any payment under this Extension in connection with or in respect of any expenses whatsoever incurred by you in connection with or in respect of:

a) Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)

b) Use, misuse or abuse of intoxicating drugs or alcohol

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

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

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

f) Vaccination procurement and administration

g) External medical aids are not covered under this benefit.

h) Expenses associated with optometric therapy and associated aids like spectacles, contact lenses are also not covered.

i) Dental treatment/ Implants and associated oral and maxillofacial surgical procedures Physiotherapy sessions and counselling

j) Health supplements, Nutraceuticals, foods for special dietary use, foods for special medical purpose, foods with added

probiotics and/or foods with added prebiotics, vaccinations, vitamins, tonics or other related products are excluded from the scope of this cover

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

l) Treatment taken outside the country

m) Any Illness or Injury resulting or arising from or occurring during the commission of continuing perpetration of a violation of law by an Insured with any malafide or criminal intent

n) Any injury or illness caused by or arising from or attributed to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

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

p) Any other benefit except consultation, diagnostic and pharmacy will be excluded from the scope of this cover.

Claim Documents for Extension/Add-on cover 14

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

- Duly completed Claim form
- Bills / invoices raised in Your name
- Test reports and payment receipts
- Any other document as required by Us

15 Hospital Daily Cash

In consideration of the payment of additional premium to Us, If You contract an Illness or suffer an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be hospitalized, then we will pay the daily amount specified in the Policy Certificate for each continuous and completed day of Hospitalization

This Benefit shall be payable subject to the following:

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

b) We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy schedule/Key Information Sheet for each period of Hospitalization within the Period of Cover.

c) Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.

d) We shall not be liable to make any payment under this Benefit, if Hospitalization commenced prior to the commencement of the Period of Cover or within the waiting period specified in the Policy Certificate.

e) The Claim under this extension will be payable only if We have admitted Our liability under “In-patient Treatment” section of the Policy.

16 Daily Cash Benefit for Leave from Job

In consideration of the payment of additional premium to us. We will pay You a daily cash amount for each completed day of hospitalisation for a minimum of 3 days and maximum of 10 days as specified in the policy schedule/Key Information Sheet if You require leave from work, to attend your spouse only. Provided

- A supporting document from the employer verifying that your leave from job is resulting in loss of pay
- You are employed on direct payroll of an organization or entity having a registered office in India.
- Certificate/document stating the reason of absence of the employee from the workplace
- Documents/Discharge summary/hospitalization records of the spouse.

Note: This cover is applicable to full time salaried employees only

17 Compassionate Visit

In consideration of the payment of additional premium to us, as specified against this benefit in the policy schedule/Key Information Sheet. In the 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 reimburse the cost of the economy class air ticket incurred by Your Immediate family from and to the place of origin of such immediate family or the place of residence of the immediate family.

Our liability under this benefit, however, in respect of any one event or all events of Hospitalization during the Policy Year shall not in aggregate exceed the amount (per Policy Year) as specified against this benefit in the policy schedule/Key Information Sheet.

18 Convalescence Benefit

In consideration of the payment of additional premium to us, We will pay You an amount as specified against this benefit in the policy schedule/Key Information Sheet, if You are Hospitalized for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy. This benefit is payable

only once to an Insured Person during each Policy Year of the Policy Period.

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

19 Rehabilitation care

In consideration of the payment of additional premium to us, we will pay You an amount as specified against this benefit in the policy schedule/Key Information Sheet for the post-surgical/operative rehabilitation care for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy. This benefit is payable only once to you during each Policy Year of the Policy Period. Provided

- We have accepted the claim under hospitalization expenses in respect to you for the same Accident/Illness
- The post- surgical/operative care is approved by the treating medical Practitioner/surgeon
- The care is carried out by a medical practitioner/therapist licensed, registered or certified in providing rehabilitation

For the purpose this extension rehabilitation is defined as

Rehabilitation mean a set of interventions needed when a person is experiencing or likely experience limitation in everyday functioning due to surgery/operative procedure done for a health condition.

20 Nursing at Home

In consideration of the payment of additional premium to us. We will pay You for the expenses incurred by You, up to an amount as specified against this benefit in the policy schedule/Key Information Sheet, for each day up to a maximum of 15 days post Hospitalization for the medical services of a Qualified Nurse at Your residence, provided that the nurse is employed in a Hospital/Service provider and the engagement of such Qualified Nurse is certified as necessary by a Medical Practitioner and relates directly to any Illness or Injury, covered under the Policy. The payment under this extension is subject to admissibility of Your Hospitalization Claim under the Policy.
For the purpose of this extension, the term “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.

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

21 Home Health care

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

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

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

In case of unavailability of network provider for cashless claims or non-network provider for reimbursement claims, you will have to avail inpatient hospitalization.
In this benefit, the following would be covered if prescribed by the treating medical practitioner and is related to treatment,

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

Any expenses payable during the Policy period shall not in aggregate exceed the maximum Annual Sum Insured and cumulative bonus (if any) as specified in the Policy Schedule/Key Information Sheet against this Benefit.
Subject to other terms, conditions and exclusions of the policy

22 Dependent Accommodation

In consideration of additional premium to us, If You contract an Illness or suffer an Injury due to Accident during the Policy Period and which solely and directly requires the You to be Hospitalized, We will pay the daily amount for the accommodation of the dependent in the hospital only as specified in the Policy Schedule/Key Information Sheet against this benefit in respect of each continuous and completed day of your Hospitalization.

For the purpose of this Extension, Dependent means immediate family members as defined

Provided:

a) We have accepted the claim under hospitalization expensed in respect to You 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. The medical practitioner certifies that the hospitalised insured member required hospitalization of minimum 3 consecutive days, maximum up to 10 days. We will pay only for one immediate family member.

23 Voluntary Deductible

In case the You have opted for a voluntary deductible, as specified in the Policy Schedule, the Deductible will be applicable on aggregate basis for all Hospitalization expenses during the Policy Year before it becomes payable by Us, subject to terms, conditions and exclusions of the Policy. The deductible will apply on individual basis in case of individual policy and on floater basis in case of floater policy. Voluntary deductible shall not be applicable to any optional covers.

24 Voluntary Co-Payment

In case You have opted for a voluntary co-payment, you will be liable to pay the % of admissible claim amount for each and every claim as specified in the policy schedule.

- Voluntary Co-payment shall be applicable only after the Voluntary Deductible has been exhausted, provided both has been opted by you.
- Voluntary Co-payment applicable shall be in addition to zone based co pay opted.
- Voluntary Co-payment shall not be applicable to any optional covers.

25 Zone wise premium

If opted customer will pay the co-pay as per Zone explained below:

a. Zone 1 : NCR*, Mumbai, Thane District, Raigad District(Maharashtra), Navi Mumbai, Gujarat, Kolkata

b. Zone 2: Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Raigad District (Maharashtra), Navi Mumbai)

c. Zone 3: Rest of India

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

Zone Opted for	**Co-pay for each and every claim in Zone I**	**Co-pay for each and every claim in Zone 2**	**Co-pay for each and every claim in Zone 3**
Zone 1	Nil	Nil	Nil
Zone 2	10%	Nil	Nil
Zone 3	15%	5%	Nil

26 Sub Limits on Illness/ Surgeries / Procedures

In case You have opted for sublimit, our maximum liability to make payment for the Medical Expenses incurred during any Hospitalisation (including its related Pre and Post Hospitalization expenses if applicable) due to the below mentioned Surgeries / Medical Procedures or any medical treatment pertaining to an Illness / Injury shall be limited as per the table below

S. No.	**Particulars**	**Sub-limits (₹)**
1	Cataract per eye	As specified against this benefit in the policy schedule
2	Other Eye Surgeries	
3	ENT	
4	Surgeries for - Tumors/Cysts/Nodule/Polyp	
5	Stone in Urinary System	
6	Hernia Related	
7	Appendectomy	
8	Knee Ligament Reconstruction Surgery	
9	Hysterectomy	
10	Fissures/Piles/Fistulas	
11	Spine & Vertebrae related	
12	Cellulites/Abscess	

27 Health Check-up Cover

Expense incurred towards the cost of Health check-Up will be covered as specified against the benefit in the policy schedule/Key Information Sheet every year. Subject to the conditions below

- Health checkup will be availed only at out empanelled service provider on cashless basis as per the available medical test packages.
- The policy is renewed with us without any break.
- This benefit doesn't not reduce sum insured or impact the accrued bonus (if any)
- Any unutilized test or amount can't be carry forwarded to next policy year.

Note: Payment of expenses towards cost of health check-up will not prejudice the company's right to deal with a claim in case of non-disclosure of material fact and / or Pre- Existing Diseases in terms of the policy.

28 360 Wellbeing Program

On payment of additional premium, You shall be enrolled under the 360 Wellbeing program which aims to empower individuals to manage their lifestyle and prevent complication arising from adverse health conditions. It intends to promote, incentivize and reward You for your healthy behavior through various health and wellbeing activities.

The Health Coach shall only be available, if you are aged 21 and above. The Health Coach is a personalized service that shall encourage and promote optimal health and physical and mental wellbeing through a telephonic / digital connect. The Health Coaches associated with the 360 wellbeing program shall be qualified nutritionist, dietician & physiotherapist with certification on coaching, who will

- Guide & motivate You to follow a healthy lifestyle & promote wellbeing

- Coach You on fitness, diet & nutrition, stress management, weight management & counselling
- Give reminders on blood tests to be done & medications to be consumed

You 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 wellbeing points awarded.

On Registration and completion of Health risk assessment [HRA], you will be evaluated by the Health Coach and will be assessed and educated for adapting a healthy lifestyle

a) What we cover under the 360 wellbeing program

The wellbeing program has been designed to ensure a regular monitoring of your health and timely intervention and a concrete plan for corrective measures in case of any decline in the health status.

You shall be subjected to a Periodic assessment via Health Assessment which includes outcomes of medical tests conducted and questionnaire based assessment covering aspects of lifestyle, current medical history & family history. The assessment will be carried out using a telephonic/ digital connect with the Health Coach. In case of any adverse health conditions/life style diseases you shall be shifted to the eligible risk category (green/amber/red) at the time of renewal of the policy by paying the requisite premium for the same. This periodic assessment will be carried out every year to monitor you're the health condition.

The lifestyle/health conditions that shall be considered for 360 wellbeing program will include the below mentioned health conditions but shall not be limited to these conditions. The updated list of health conditions will be uploaded on the mobile application for future reference.

1. Hypertension
2. Diabetes
3. Hyperlipidemia
4. Obesity
5. **Heart and vascular conditions**
   i. Myocardial Infarction
   ii. Refractory heart failure
   iii. Cardiomyopathy
6. **Lung Conditions**
   i. End stage lung Failure
   ii. Primary(Idiopathic) pulmonary Hypertension
7. **Liver conditions**

   End stage liver Failure
8. **Neuro/ spinal & psychiatric disease**
   i. Multiple sclerosis with Persisting symptoms
   ii. Motor neuron disease with Permanent symptoms
   iii. Permanent paralysis of limbs
   iv. Stroke resulting in permanent symptoms
   v. Coma of specified severity
   vi. Alzheimer's Disease before age of 50 years
   vii. Parkinson's disease before age of 50 years
   viii. Apallic syndrome
   ix. Benign brain tumour
   x. Creutzfeldt-Jakob disease (CJD)
   xi. Major head trauma
9. **Renal diseases**
   i. Kidney failure requiring regular dialysis
   ii. Medullary cystic disease
10. **Musculoskeletal diseases**
    i. Muscular dystrophy
    ii. Poliomyelitis
11. **Bleeding disorders**
    i. Aplastic Anemia
12. **Auto immune diseases**
    i. Systemic Lupus Erythematous with renal involvement
    ii. Myasthenia gravis
    iii. Scleroderma
    iv. Good pastures syndrome with lung or renal involvement
    v. Blindness
    vi. Deafness
    vii. Cancer of specified severity
    viii. Third Degree Burns
    ix. Loss of speech
    x. Loss of limbs
    xi. Loss of Independent Existence

b) On-Boarding

Based on your declaration of pre-existing disease and/or results of pre-policy medical check-up (PPMC), You will be categorized in the below mentioned categories (as mentioned in Table A)

Table A: Classification during on-boarding

Medical Tests	Green	Amber
Glycosylated Hemoglobin (HbA1c)	< 6%	>6 and up to7%
Blood Pressure reading	Systolic Up to 120 mm hg Diastolic Up to 80 mm hg	Systolic >120mm and <140 mmhg Diastolic > 80 mm and <90 mm hg
Low Density Lipoprotein (LDL)	< 100 mg/dl	>100 and < or = 190 mg/dl
High Density Lipoprotein (HDL)	> or = 40 mg/dl	> 20 mg/dl and <40 mg/dl
Serum cholesterol	< or = 200mg/dl	>200 and < or =300 mg/dl
Triglycerides	<or = 150 mg/dl	> 150 and <= 250mg/dl

Body Mass Index (BMI)	< or = 32	>32 and < or = 40

- In case of classification in amber category, You will be subjected to a risk based loading and pay the requisite premium for the same.

c) At the time of renewal

Based on the health assessment results parameters, evaluation by the Health Coach and the current health conditions based on outcomes of various health check-ups, You will be categorized into any of the below mentioned categories as mentioned below in Table B

Table B: Classification at the time of renewal:

Medical Tests	**(Green)**	**(Amber)**	**(Red)**
Glycosylated Hemoglobin (HbA1c)	< 6%	>6 and up to7%	>7%
Blood Pressure reading	Systolic Up to 120 mm hg Diastolic Up to 80 mm hg	Systolic >120mm and <140 mmhg Diastolic > 80 mm and <90 mm hg	Systolic >140mm Diastolic > 90 mm
Low Density Lipoprotein (LDL)	< 100 mg/dl	>100 and < or = 190 mg/dl	>190 mg/dl
High Density Lipoprotein (HDL)	> or = 40 mg/dl	> 20 mg/dl and <40 mg/dl	> 40 mg/dl
Serum cholesterol	< or = 200mg/dl	>200 and < or =300 mg/dl	>300 mg/dl
Triglycerides	<or = 150 mg/dl	> 150 and <= 250mg/dl	> 250 mg/dl
Body Mass Index (BMI)	< or = 32	>32 and < or = 40	>40

- In case of deterioration of health condition, you may be moved from green to amber **OR** amber to red category.
- You will have to pay the risk based loaded premium as applicable for the respective category.
- The loading percentage applicable for red category shall be higher than the loading percentage applied for the amber category.
- Once you have been part of amber/red category, you will have to be part of the respective category for a consecutive period of 2 years. Post the successful completion of 2 years in the 360 wellbeing program, your health condition will be reviewed by the health coach. On the basis of the health condition at the time of review, it will be decided whether you needs to continue in the respective amber/ red category or move to green category.

d) 360 Wellbeing Points

Definition

360 Wellbeing points is a platform through which you under 360 wellbeing program will be incentivized and rewarded towards adaption of healthy lifestyle behavior under the guidance of health coach.

Conditions Mandatory to earn 360 wellbeing points across Health category

To earn 360 wellbeing point, health assessment is mandatory. Each point earned values 20 paisa. If you are in green category at the time of on boarding, health assessment is optional, but if you opt for it, as per the outcome you will earn wellbeing points as stated Table C.

Green Category	**Amber category**
For green category, 1st health assessment is conducted within three months from the policy start date if no adverse health parameter is found you will continue in green category and wellbeing points will be unlocked A second health assessment (optional) is also available to you which will help you to earn additional wellbeing points. Those who have adverse outcome in health assessment will be advised to upgraded to 360 wellbeing program.	If you are in Amber Category at the time of on boarding, health assessment is a part of 360 Wellbeing program Health assessment will be done twice a year, post on boarding. · 1st assessment will be done between 5th to 6th month after the policy start date · 2nd assessment will be done between 11th to 12 month after policy start date 360 wellbeing point earned will be as per the outcome values of health assessment

Please Note:

- Health assessment includes Blood test (BP, BMI, WHR, hbA1c, Total cholesterol) followed with an assessment by health coach for scoring
- The assessment will be carried out by ICICI Lombard service providers only.

e) Wellbeing points structure:

Wellbeing points are further categorized into Be-Healthy and Stay-Healthy points. Conditions to earn both these points have been explained in the following sections in detail.

In case of a floater policy, maximum 2 adults aged 21 and above shall be covered in the program and the 360 wellbeing points to be awarded shall be doubled, provided, that both the Insured Persons complete their respective wellbeing activities.

Be-Healthy Points

The Be Healthy points have been designed with the objective to monitor your health at regular intervals. The better the health status as evidenced through various health outcomes as mentioned below in Table C, more of Be-Healthy points will be awarded. You can earn a maximum of 7000 Be-healthy points per insured.

Table C: Be-Healthy points structure as per category

Blood test	Readings	Frequency	Points earned/ activity	Total points
HbA1c	up to 5.99	Twice a year	750	Maximum 1500
	6.00-6.50		300	
	6.51-7.00		100	
Blood pressure	110-120/70-80	Twice a year	750	Maximum 1500
	121-130/80-85		300	
	131-140/86-90		100	
Body mass index	18.00 - 25.00	Twice a year	750	Maximum 1500
	25.01 – 32.00		300	
	32.01 - 40		100	
Total cholesterol (Triglyceride)	up to 150 mg/dl	Twice a year	750	Maximum 1500
	151mg/dl-200mg/dl		300	
	201mg/dl-250mg/dl		100	
Diagnostic test undergone	Preventive check up	Once a year	300	300
	Self-paid advance check up		700	700
Total				7000

Self-paid advance check up

You can also earn wellness points by undergoing certain other diagnostic tests (as suggested by Our empanelled medical experts) at any diagnostic centre at your own expenses. You shall have to submit medical reports of these tests to Us.

Redemption of Be-Healthy Points

- The Be-Healthy points earned by you can be redeemed for discount in renewal premium or towards payment of non-payable items which are deducted as per the list of non-payable items (Part III, 26 List of Non Payable).
- In case, the Health assessment results for any blood test parameter as mentioned in table C, crosses the defined range, then you shall be dis-qualified for the entire reward scheme under Be-Healthy points

Stay-Healthy Points

The Stay-healthy program has been structured to reward You for maintaining good health throughout the year. The points earned as per the engagement activities and their duration has been explained below. The maximum points which can be earned through this program will be 6000 per Insured Person.

Table D: Stay-Healthy points structure:

Parameter	Category	Duration	Frequency	Points earned/activity	Total Points
Advisory on health records	Engagement	Twice a year	2	400	800
Tele-consultation	Engagement	4 times a year	4	150	600

Activity Tracking	Activity	Monthly	12	100	1200
Fitness challenge	Engagement	Twice a year	2	300	600
Sleep tracking	Activity	Monthly	12	100	1200
Health events	Engagement	Once in 2 months	6	100	600
Wellness events	Engagement				1000
Total					6000

Redemption of Stay Healthy points

Stay-Healthy points can be redeemed to avail various health products on ICICI Lombard platform, for payment of OPD expenses, for payment of membership fees in Fitness centers & health supplements as available on ICICI Lombard platform.

Stay Healthy Point Parameters (Table D)

1 Advisory on health records

You will get a medical vault for storing your health records on the mobile application. You can save Your relevant medical records like diagnostic reports, prescriptions, routine and preventive health check-ups in the vault. On seeking advisory or second opinion on health records you can earn maximum of 800 points, basis your consent.

Advisory/Second opinion can be availed using tele-consultation platform on the mobile application only. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute your visit/ consultation to an independent Medical Practitioner/Healthcare professional. We shall not be liable for any discrepancy in the information provided under this Benefit

2 Tele-Consultation

Telephonic/Virtual consultation can be availed from a Medical Practitioner or Health care professional through various mode of communication like audio, video, Chat. Various services will be provided through our empanelled service provider subject to terms and conditions

- 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.
- This service shall be available 24 hours a day, and 365 days in a year.
- We/Medical Practitioner/Healthcare professional may refer you to a specialist medical practitioner or a general physician, if required We shall not be liable for any discrepancy in the information provided under this Benefit

You shall be awarded 150 points for an audio consultation with a medical practitioner and a maximum of 600 points can be accrued under this benefit.

3 Activity Tracking

You can also earn Stay-Healthy points by participating in any one of the fitness categories as mentioned in Table E, which will be tracked via our IL digital platform/ mobile Application, provided the application is downloaded within 30 days from the policy start date. Fitness assessment (option3) needs to carried out through our service providers only and it includes

- Flexibility test
- Muscular strength test
- Abdominal/Core strength test
- Body composition test
- Cardiovascular fitness test

Table E: Stay-Healthy points through steps/calories burned/fitness assessment

Options	Fitness category	Grid/month	Maximum Points per month	Maximum Points accumulated in a year
Option 1	Steps taken- Average Steps achieved per day for in a month	8,000+ steps	100	1200
		6,000 to 7,999 steps	90	1080
		4,000 to 5,999 steps	80	960
		< 4,000 steps	Nil	Nil
Option 2	Calories burned- Min 400 calories burned per day for a month	Min 400 calories	100	1200
Option 3	Fitness assessment	Twice in a year. Per assessment - 600 points		1200

4 Fitness Challenge:

You shall be awarded Stay-Healthy points on participation and successful completion of fitness challenges. You shall be awarded 300 points per fitness challenge and a maximum of 600 Stay Healthy points per Insured Person can be gained by participation and completion of the fitness challenges. Fitness

Renewal year	Rupee Value of Wellness Points	Wellness Points	Rupee Value of Wellness Points
First Renewal (2nd Year of policy)	INR 0.21	1000	INR 210
Second Renewal (3rd Year of policy)	INR 0.22	1000	INR 220
Third Renewal (4th Year of policy)	INR 0.23	1000	INR 230
Fourth Renewal (5th Year of policy and onwards)	INR 0.25	1000	INR 250

challenges includes but are not limited to marathon, cyclothon etc.

5 Sleep Tracking:

You can also earn Stay-Healthy points by allowing our mobile application to track Your sleep duration as explained in below table F

Table F: Stay-Healthy points through Sleep Tracking

Average hours of sleep per day for in a month	Maximum Points per month	Maximum Points accumulated in a year
7 hours 1 min-8 hours	100	1200
6 hours 1 min-7 hours	90	1080
< 6 hours	Nil	Nil

6 Health Events:

You will be awarded Stay-Healthy points on participation and successful completion of health events initiated by Us from time to time. You shall be awarded 100 points per health event and a maximum of 600 points per Insured Person can be gained by participation and completion of health events.

Health event can be defined as various events which work towards creating awareness, spreading knowledge about the benefits of a healthy lifestyle which include both physical health and mental health. These include interactive sessions, meditation, fitness videos, health awareness and educational sessions.

7 Wellness events:

You shall be awarded =Stay-healthy points on participation and successful completion of health events initiated by Us from time to time.
Wellness events can be understood as an engagement tool for the customers to make them aware on their individual wellbeing aspects. It also aims to reward them on their level of awareness on various aspects of wellbeing. It includes health quiz, health contest, wellness awareness sessions

- Also, As a Reward for Your loyalty and long association with us, We shall increase the Rupee value of the Wellbeing Points Year on Year as per the Table G below

Table G: Increase in Rupee Value of Wellbeing Points

f) Redemption of 360 wellness points (Stay-Healthy+ Be-Healthy) Points

Conditions on Redemption of 360 wellbeing point

- You have to accumulate a minimum of one thousand wellbeing points during the policy period in order to redeem the same.
- The maximum amount of 360 wellbeing points that You can redeem will be as per the Table H below:

Table H: Maximum 360 wellbeing points

Year	Maximum points that can be redeem under Be-Healthy	Maximum points that can be redeem under Stay-Healthy
1st Year	5500	5000
2nd Year	5500	5000
3rd Year	6000	5500
4th Year	6500	5500
5th Year& onwards	7000	6000

Balance between the maximum points earned and points redeemed can be carried forward for maximum of 3 years, provided policy is active continuously with us and shall have to be redeemed at the end of the 3rd Policy Year. In case, you does not wish to redeem the wellbeing points earned, the same will be forfeited**.**

Illustration for Redemption of wellbeing Points (Policy Tenure 1 year). Below mentioned Table I is a road map journey of 5 years for an individual with 360 wellbeing program.

Table I: Illustration for redemption of wellbeing points

			1	2	3	4	5
	Particulars		Fresh	1st Renewal	2nd Renewal	3rd Renewal	4th Renewal
			1st Year	2nd Year	3rd year	4th Year	5th Year
	Be-healthy points illustration						
A	Maximum points earned under Be-Healthy		7000	7000	7000	7000	7000

B	Maximum points that can be redeemed		5500	5500	6000	6500	7000
C	Balance point that can be carried forwarded	A-B	1500	1500	1000	500	0
D	Total Cumulative Balance Points		1500	3000 Balance Points Of 2nd year (C2) + Carry forward Points of 1st year (D1)	4000 Balance Points of 3rd year (C3) + Carry forward points of 2nd year (D2)	4500 Balance Points of 4th year (C4) + Carry forward points of 3nd year (D3)	3000* Carry forward points of 4th year (D4) – Balance points of 1st year(C1)
E	Value of one 360 wellbeing point		0.2	0.21	0.22	0.23	0.25
F	Value in terms of INR for point that can be availed for benefit as per terms		1100	1155	1320	1495	1750
G	Cumulative INR for carry forward points	D*E	300	630	880	1035	750
	Stay-Healthy points illustration						
H	Maximum points that earned under Stay Healthy		6000	6000	6000	6000	6000
I	Maximum points that can be redeemed the same year		5000	5000	5500	5500	6000
J	Balance point that can be carried forwarded	I-J	1000	1000	500	500	0
K	Total Cumulative Balance Points		1000	2000 Balance Points Of 2nd year (J2) + Carry forward Points of 1st year (K1)	2500 Balance Points Of 3rd year (J3) + Carry forward Points of 2nd year (K2)	3000 Balance Points Of 4th year (J4) + Carry forward Points of 3rd year (K3)	2000* Carry forward points of 4th year (K4) – Balance points of 1st year(J1)
L	Value of one 360 wellbeing point		0.2	0.21	0.22	0.23	0.25
M	Value in terms of INR for point that can be availed towards redemption as per terms	I*L	1000	1050	1210	1265	1500
N	Cumulative INR for carry forward points	K*L	200	420	550	690	500

*****As the balance wellbeing points can be carried forward maximum up to 3 years, after three years they will become zero.

Basic premium refers to the premium charged to the Insured Person (i.e. premium excluding GST) as mentioned on the policy schedule

Terms and conditions for 360 wellbeing program

- For health risk assessment [HRA] services availed through mobile application/online/ digital mode on IL Platform, you will be required to provide the details in order to establish authenticity and validity prior to availing such services. Any such information provided by the you in this regard shall be used solely for the purpose of providing these wellbeing services and kept confidential with Us / Our Network Providers/Health Service Providers at all times.
- You shall notify Us and submit the relevant documents, reports, receipts as and when required by us within 60 days of undertaking any wellbeing activity.
- You agrees that choosing to utilize any of the wellbeing services or any information or advise rendered by Our Health Service Providers or Network Providers or Us will

be solely at your own discretion and own risk and should not be, used to diagnose or identify treatment for a medical or mental health condition.

- In case of expiry of policy, the wellness points may be carried forward for a period not exceeding three months
- The points accrued shall be at periodic intervals at rates/amounts declared upfront at the commencement of the policy and shall not be linked to any dynamic factor such as interest rate.
- All the communication related to the 360 wellbeing program point accrued, its redemption and associated reminders will be through the IL take care application.
- IL take care application is an insurance and wellness application which helps the customers to check their policy details, downloading e-card, intimation and tracking of claims, locating network hospitals etc. It also offers tracking of wellness through various features such as steps, sleep, active hours and stand hours tracking
- There shall not be any cash reimbursement or redemption available against the wellbeing points accumulated by an Insured Person.
- We or Our Health Service Providers or Our Network Providers do not warrant the validity, accuracy, completeness, safety, quality, or applicability of the content or anything said or written or any suggestions provided in the course of providing the wellbeing services.
- We, Our group entities, or affiliates, their respective directors, officers, employees, agents, vendors, shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which you may claim to have suffered, sustained or incurred, as a result of any advice or information obtained by way of the wellbeing program or any actions chosen by you on the basis of such advice or information.
- The 360 wellbeing program offered is subject to revisions based on the insurance regulatory framework from time to time.

Disclaimers

- Choosing the option is purely on Insured Person's discretion and at own risk.
- The wellbeing program is intended to provide supportive information to you to improve well-being and habits through working towards obtaining a healthy lifestyle, and does not constitute medical advice and/or substitute your visit/ consultation to an independent Medical Practitioner.
- We reserve the right to remove or reduce 360 wellbeing points in case the same have been found to be achieved in any unfair manner by manipulation

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

29 Critical illness Cover

If You are first Diagnosed with any one of the Critical Illnesses listed below during the Period of Cover, then We will pay the Sum Insured specified in the Policy schedule/Key Information Sheet against this Benefit as a lump sum amount, in the manner specified in the Policy schedule/Key Information Sheet, provided that the signs or symptoms of such Critical Illness first commence after 90 days from the Risk Inception Date.

On the acceptance of a claim under this Benefit, the cover under this Benefit will terminate in relation to you, and further no subsequent Renewals of this cover in the Policy will be allowed.

International Second Opinion- In the event of your diagnosis with any of the listed critical illness during the policy period, you can avail an E-Consultation second opinion from medical practitioner outside India within our Network with respect to the critical illness only, subject to the following conditions

- It will be based on the medical records submitted by the insured person which should include investigation reports citing the final diagnosis and relevant consultation papers
- The benefit can be availed only once by the insured person for the listed critical illness.
- It should be only for medical reasons and not for medico-legal purposes.
- We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

S. No.	Body system
Heart and vascular conditions	
1	Myocardial Infarction
2	Refractory heart failure
3	Cardiomyopathy
Lung Conditions	
4	End stage lung Failure
5	Primary(Idiopathic) pulmonary Hypertension
Liver conditions	
6	End stage liver Failure
Neuro/ spinal & psychiatric disease	
7	Multiple sclerosis with Persisting symptoms
8	Motor neuron disease with Permanent symptoms
9	Permanent paralysis of limbs
10	Stroke resulting in permanent symptoms
11	Coma of specified severity
12	Alzheimer's Disease

13	Parkinson's disease
14	Apallic syndrome
15	Benign brain tumour
16	Creutzfeldt-jakob disease (CJD)
17	Major head trauma
Renal diseases	
18	Kidney failure requiring regular dialysis
19	Medullary cystic disease
Musculoskeletal diseases	
20	Muscular dystrophy
21	Poliomyelitis
Bleeding disorders	
22	Aplastic Anaemia
Auto immune diseases	
23	Systemic Lupus Erythematosus with renal involvement
24	Myasthenia gravis
25	Scleroderma
26	Good pastures syndrome with lung or renal involvement
Others	
27	Blindness
28	Deafness
29	Cancer of specified severity
30	Third Degree Burns
31	Loss of speech
32	Loss of limbs
33	Loss of Independent Existence

For the purpose of this policy, the Critical Illnesses listed above would have the meaning and exclusions, as specified below:

1. **MYOCARDIAL INFARCTION** (First Heart Attack of specific severity)

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

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

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

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

2. REFRACTORY HEART FAILURE

Refractory heart failure is defined as a systolic dysfunction that does not respond to optimal medical therapy ("triple therapy") and results in permanent physical impairment to the degree of New York Heart Association Classification Class IV, or its equivalent, for at least six months. The diagnosis of refractory heart failure has to be supported by echocardiographic findings of compromised ventricular performance. The diagnosis must be made by a cardiology specialist.

The following is excluded:

1. Reversible causes of heart failure such as hypocalcemia, alcohol abuse, thyroid, anaemia.

3. CARDIOMYOPATHY

An impaired function of the heart muscle, which is unequivocally diagnosed as Cardiomyopathy by a registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV, or its equivalent, for at least six (6) months based on the following classification criteria:

Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity discomfort will be experienced. The diagnosis of Cardiomyopathy has to be supported by Echographic findings of compromised ventricular performance.
Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

4. END STAGE LUNG FAILURE

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

1. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
2. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
3. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
4. Dyspnoea at rest.

5. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

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

degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

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

1. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
2. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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

6. END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
1. Permanent jaundice; and
2. Ascites; and
3. Hepatic encephalopathy.

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

7. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

1. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
2. 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. Neurological damage due to SLE is excluded.

8. 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.

9. PERMANENT PARALYSIS OF LIMBS

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

10. 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:

1. Transient ischemic attacks (TIA)
2. Traumatic injury of the brain
3. Vascular disease affecting only the eye or optic nerve or vestibular functions.

11. 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:

1. No response to external stimuli continuously for at least 96 hours;
2. Life support measures are necessary to sustain life; and
3. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

12. ALZHEIMER'S DISEASE

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardised questionnaires and cerebral imaging.

The diagnosis of Alzheimer's Disease must be confirmed by an appropriate consultant and supported by a Medical Practitioner appointed by Us. There must be significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. There must also be an inability of the Insured Person to perform (whether aided or unaided) at least three of the Activities of Daily Living, for a continuous period of at least 3 months:

For the purpose of this clause, Activities of Daily Living are defined as:

1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding – the ability to feed oneself once food has been prepared and made available.
6. Mobility - the ability to move from room to room without requiring any physical assistance.

The following are excluded:

- Any other type of irreversible organic disorder/dementia
- Alcohol-related brain damage.

13. PARKINSON'S DISEASE

I. The occurrence of Parkinson's Disease where there is an associated Neurological Deficit that results in permanent inability to perform independently at least three of the Activities of Daily Living, for a continuous period of at least 3 months:

For the purpose of this clause, Activities of Daily Living are defined as:

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

The following is excluded:

- Parkinson's Disease accompanied with drug and/or alcohol abuse.

14. APALLIC SYNDROME

Universal non-functioning of the brain cortex, with the brain stem intact. Diagnosis of Apallic Syndrome must be definitely confirmed by a registered Medical Practitioner who is also a neurologist and substantiated by clinical and investigation findings. This condition must be documented for a continuous period of at least one month.

15. BENIGN BRAIN TUMOR

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

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

1. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
2. Undergone surgical resection or radiation therapy to treat the brain tumor.

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

16. CREUTZFELDT-JAKOB DISEASE (CJD)

A diagnosis of Creutzfeldt Jakob Disease must be made by a specialist Medical Practitioner who is a neurologist and the diagnosis must be substantiated by CSF examination, EEG, CT Brain and MRI of the brain. There must be permanent clinical loss of the ability in mental, physical and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required

17. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this Benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

I. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
II. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
III. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

IV. Mobility: the ability to move indoors from room to room on level surfaces;
V. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
VI. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following is excluded:
i. Spinal cord injury;

18. 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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

19. MEDULLARY CYSTIC DISEASE

I. Medullary Cystic Disease where the following criteria are met:
i. The presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
ii. Clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
iii. The diagnosis of Medullary Cystic Disease is confirmed by renal biopsy along with specialist Medical Practitioner opinion.

II. The following are excluded

i. Isolated or benign kidney cysts are specifically excluded from this Benefit
ii. Any condition is which cysts are absent

20. MUSCULAR DYSTROPHY

Diagnosis of muscular dystrophy by a registered Medical Practitioner who is a neurologist based on the presence of following conditions:

1. Clinical presentation including weakness and loss of muscle mass, absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
2. Characteristic electromyogram
3. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform (whether aided or unaided) at least three of the Activities of Daily Living, for a continuous period of at least 6 months.

For the purpose of this clause, Activities of Daily Living are defined as:

1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding – the ability to feed oneself once food has been prepared and made available.
6. Mobility - the ability to move from room to room without requiring any physical assistance

21. POLIOMYELITIS

The occurrence of Poliomyelitis, where the following conditions are met:

I. Poliovirus is identified as the cause through laboratory investigation
II. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

The diagnosis of Poliomyelitis must be confirmed by a registered Medical Practitioner who is a neurologist.

22. APLASTIC ANAEMIA

Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

1. Blood product transfusion;
2. Marrow stimulating agents;
3. Immunosuppressive agents; or
4. Bone marrow transplantation.

The diagnosis of Aplastic anaemia must be confirmed by a bone marrow biopsy. Atleast two of the following values should be present:

1. Absolute Neutrophil count of 500 per cubic millimetre or less;
2. Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
3. Platelet count of 20,000 per cubic millimetre or less.

23. Systemic lupus erythematosus (SLE) with renal involvement

I. Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "SLE" under this policy is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy.

Diagnosis by a nephrologist, supported by renal biopsy report is mandatory. There must be positive antinuclear antibody test

II. The following are excluded

i. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.
ii. Class I - Minimal mesangial lupus nephritis
iii. Class II - Mesangial proliferative lupus nephritis

24. MYASTHENIA GRAVIS

I. An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatigability, where all of the following criteria are met:

1. Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and
2. The diagnosis of Myasthenia Gravis and categorization are confirmed by a registered Medical Practitioner who is a neurologist.

Myasthenia Gravis Foundation of America Clinical Classification is as follows:

Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere.
Class II: Eye muscle weakness of any severity, mild weakness of other muscles.
Class III: Eye muscle weakness of any severity, moderate weakness of other muscles.
Class IV: Eye muscle weakness of any severity, severe weakness of other muscles.
Class V: Intubation needed to maintain airway.

II. The following are excluded:

1. Congenital myasthenic syndrome
2. Transient neonatal or juvenile myasthenia gravis

25. SCLERODERMA

A systemic collagen-vascular Illness causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following conditions are excluded:

1. Localised scleroderma (linear scleroderma or morphea);
2. Eosinophilic fascitis; and
3. CREST syndrome.

26. GOOD PASTURES SYNDROME with lung or renal involvement

Goodpastures Syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for continuous period of at least 30 days. The diagnosis must be proven by kidney biopsy and confirmed by a specialist Medical Practitioner who is a rheumatologist.

27. BLINDNESS

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

II. The Blindness is evidenced by:

1. Corrected visual acuity being 3/60 or less in both eyes or ;
2. The field of vision being less than 10 degrees in both eyes.

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

28. DEAFNESS

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means “the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing” in both ears.

29. CANCER OF SPECIFIED SEVERITY

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

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

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

vi. Chronic 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;

30. THIRD DEGREE BURNS

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.

31. LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, throat (ENT) specialist.

32. LOSS OF LIMBS

The physical separation of two or more limbs, at or above the wrist or ankle level as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

33. LOSS OF INDEPENDENT EXISTENCE

Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three of the Activities of Daily Living, with no hope of recovery

For the purpose of this clause, Activities of Daily Living are defined as:

1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding – the ability to feed oneself once food has been prepared and made available.
6. Mobility - the ability to move from room to room without requiring any physical assistance.

Exclusions

We shall not be liable to make any payment for any claim under Critical illness cover of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. Any Critical Illness where the symptoms indicative of such Critical Illness have first manifested or first occurred prior to the Risk Inception Date or arisen within first 90 days of commencement of the Period of Cover.
2. Any Critical Illness arising on account of or in connection with any Pre-Existing Disease(s).
3. Any Critical Illness arising out of any Congenital Anomaly of the Insured Person.
4. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy schedule under the head "Special Conditions".
5. Any claim made without a medical certificate from the treating Medical Practitioner evidencing the diagnosis of such Critical Illness.
6. Any Critical Illness traceable to pregnancy, childbirth, abortion, or related consequences.

On the occurrence of an Insured Event which may give rise to a claim under this Benefit, We shall be provided with the necessary and mandatory information specified in "A" for all claims, and additional documentation specified in "B" in relation to the particular Critical Illness being claimed, within 30 days of occurrence of the Insured Event:

A: Common documents required for all claims under this Benefit:	
	Claim Form duly filled and signed by Insured Person/Nominee/claimant
	EMS Paper
	Discharge Card/Summary papers
	Indoor Case papers
	Hospital Bills
	All Investigation Reports – blood, pathology, radiology, etc.
	Certificate by treating Medical Practitioner confirming diagnosis
	Current and past consultation papers
	Certificate of Medical Cause of Death issued by last attending Medical Practitioner (wherever applicable)
	Certificate from last attending Medical Practitioner /medical authority for underlying medical condition/s leading to death of the Insured Person
	Post Mortem Report, FSL Report, Viscera and Chemical Analysis Report, Histopathoilogy Report (wherever applicable)
	Any other specific investigation / document to support the diagnosis of such Critical Illness, as may be reasonably

	required by Us in addition to the documents specified under this Section.

B: Specific documentation for specified Critical Illnesses,

(To be furnished in addition to the common documents specified in A above.)

	S. No.	Name of Critical Illness	CI specific documents
	Heart and vascular conditions		
	1	Myocardial Infarction	All ECGs, Stress Test, 2D Echo, X-Ray Chest, Cardiac Enzymes (Trop. T, Trop. I, CPK, CPK-MB, LDH, S. Electrolytes), Thallium Scan
	2	Refractory heart failure	
	3	Cardiomyopathy	
	Lung Conditions		
	4	End stage lung disease	All Pulmonary Function Tests, Chest CT Scan (HRCT), Bronchoscopy, ABG, ECGs, Stress Test, 2D Echo, X-Ray Chest
	5	Primary pulmonary Hypertension	
	Liver conditions		
	6	End stage liver disease	Reports pertaining to all Liver Function Tests, USG Abdomen, CT Scan of Abdomen, Liver Biopsy, all other pathological tests, Ascitic Tapping report,
	Neurological / spinal disease		
	7	Multiple sclerosis	CT Scan(s) and MRI(s), Visual Evoked Potentials report, EEG, EMG, nerve conduction studies, CSF evaluation , , , , Certificate from Neurologist confirming diagnosis
	8	Motor neuron disease	CT Scan(s) and MRI(s), EEG, EMG, pathological tests, Nerve Conduction studies CSF evaluation, Muscle Biopsy, Certificate from Neurologist confirming diagnosis
	9	Permanent paralysis of limbs	CT Scan(s) and MRI(s), EEG, EMG, , Certificate from Civil Surgeon confirming disability, Consultation papers from the Treating Neurologist stating the Neurological deficit and the degree/current neurological status and duration of the Paralysis, Consultation papers from the Treating Neurologist stating the Neurological deficit and the degree/current neurological status at the end of 3 months of date of diagnosis
	10	Stroke with neurological deficit	CT Scan(s) and MRI(s), EEG, EMG, pathological tests, Certificate of diagnosis from treating Neurologist Consultation papers from the Treating Neurologist stating the Neurological deficit and the degree/current neurological status, Consultation papers from the Treating Neurologist stating the Neurological deficit and the degree/current neurological status at the end of 3 months of date of diagnosis
	11	Coma of specified severity	CT Scan(s) and MRI(s), EEG, EMG, pathological tests, Certificate of diagnosis from treating Neurologist, Consultation papers from the Treating Neurologist stating the Neurological status, Consultation papers from the Treating Neurologist stating the Neurological status at the end of 96 hours of date of diagnosis
	12	Alzheimer's Disease	CT Scan(s) and MRI(s), EEG, EMG, pathological tests, Neuropsychological Tests, Certificate of diagnosis and neurological status from treating Neurologist
	13	Parkinson's disease	CT Scan(s) and MRI(s), EEG, EMG, pathological tests, Certificate of diagnosis and neurological status from treating Neurologist
	14	Apallic syndrome	CT Scan(s) and MRI(s), EEG, EMG, pathological tests, PET Scan, Certificate of diagnosis and neurological status from treating Neurologist
	15	Benign brain tumour	CT Scan(s) and MRI(s), pathological tests, Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports, Certificate of diagnosis from treating Neurologist / Neurosurgeon stating neurological deficit, Subsequent details of the treatment with the consultation papers from the inception of ailment
	16	Creutzfeldt-Jakob disease (CJD)	Electroencephalography, CSF Analysis, MRI Certificate of diagnosis from treating Neurologist, brain biopsy / histopathological examination of brain tissue at the time of autopsy
	17	Major head trauma	CT Scan(s) and MRI(s), EEG, EMG, pathological tests, Certificate of diagnosis and neurological status from treating Neurologist, Consultation papers from the Treating Neurologist stating the Neurological deficit and the degree/current neurological status at the end of 3 months of date of diagnosis
	Renal diseases		

	18	Kidney failure requiring regular dialysis	Complete Renal Profile, S. Uric Acid, Urine Routine, S. creatinine, creatinine clearance, Urine Microscopy, 24 hour Urine Analysis, USG Abdomen Pelvis, CT Scan Abdomen Pelvis, Renal Biopsy, Dialysis Papers/Receipts done in recent past
	19	Medullary cystic disease	
	Musculoskeletal diseases		
	20	Muscular dystrophy	Creatinine Kinase, ECG, 2D Echo Pulmonary Function Tests, EMG, nerve conduction studies, Muscle Biopsy, Certificate of diagnosis and neurological status from treating Neurologist
	21	Poliomyelitis	Throat Sawb / Stool / CSF Examination for Poliovirus, Certificate from Civil Surgeon certifying Diagnosis and Disability
	Bleeding disorders		
	22	Aplastic Anaemia	CBC, Renal Function Test, Liver Function Test, S Electrolytes, Thyroid Function Test, Vitamin B12, Folic Acid levels, Bone Marrow Aspiration Biopsy, Autoimmune workup, certificate from hematologist confirming the diagnosis
	Auto immune diseases		
	23	SLE with renal involvement	ANA Antibodies, Anti-ENA Antibodies, Complete Renal Profile, S. Uric Acid, Urine Routine, Urine Microscopy, 24 hour Urine Analysis, USG Abdomen Pelvis, CT Scan Abdomen Pelvis, Renal Biopsy
	24	Myasthenia gravis	Nerve stimulation tests, Tensilon test, Autoimmune workup, X Ray Chest, High resolution CT , EMG, Certificate of diagnosis from treating physician
	25	Scleroderma	Autoimmune workup, ANA, Renal Function Test, Urine Routine & Microscopy, USG Abdomen Pelvis, Renal Biopsy, Pulmonary Function Tests, X ray Chest/HRCT, Lung Biopsy, ECG, 2D Echo, CAG
	26	Good pastures syndrome with lung or renal involvement	Autoimmune workup, Anti-GBM antibody testing, ANCA, Renal Function Test, Urine Routine & Microscopy, USG Abdomen Pelvis, Renal Biopsy, Pulmonary Function Tests, X ray Chest/HRCT, Lung Biopsy
	Others		
	27	Complete loss of vision(Blindness)	Visual Field Testing, Vision Acuity Testing, Certificate from Civil Surgeon confirming the diagnosis and disability
	28	Complete loss of hearing ability(Deafness)	Audiometry Tests, Certificate from Civil Surgeon confirming the diagnosis and disability
	29	Cancer of specified severity	All histology/cytology/FNAC/Biopsy/Immuno-chemistry reports, X-ray, CT Scan, MRI, PET Scan, Bone Marrow Test, Cancer Markers, all other pathological tests
	30	Burns	MLC, FIR, Panchnama, Police Final Charge sheet, Post Mortem report, Certificate from attending physician certifying degree of burns along with the percentage of body surface involved
	31	Loss of speech	Bronchoscopy/Laryngoscopy, Certificate from Civil Surgeon confirming the diagnosis and disability
	32	Loss of limbs	MLC, FIR, Panchnama, in case of accidental injury Certificate from civil surgeon confirming the diagnosis and disability
	33	Loss of Independent Existence	Certificate from Medical Practitioner confirming Illness/injury and in ability to perform activities of Daily living

30 Personal Accident Cover

a) Death Benefit

We will pay You or Your Nominee / legal heir, as the case may be, the Annual Sum Insured as specified against this benefit in the Policy Schedule/Key Information Sheet if you suffer an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's death within 365 days from the date of the Accident.

On the acceptance of a claim under this Benefit and any other applicable Benefit pertaining to the same event, all cover under this Policy shall immediately and automatically cease in respect of that Insured Person

Claims Document required

- Claim Form duly filled and signed by Nominee
- MLC or FIR
- Cause of Death Certificate and death certificate by municipal corporation
- Post Mortem Report (certified copies) as applicable and wherever conducted
- Viscera / Chemical Analysis / Forensic Report
- Police Final Charge Sheet / Court Final Order
- Spot / Inquest Panchnama certified copies
- Indoor case papers
- Any other document as may be required by Us

b) Permanent Total Disablement (PTD) Benefit

We will pay You or Your Nominee / legal heir, as the case may be, the Annual Sum Insured as specified against this benefit in the Policy Schedule/Key Information Sheet if you suffer from an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the

Permanent Total Disablement of the Insured Person within 365 days from the date of the Accident.

This Benefit shall be payable subject to the following

i. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be considered under Death benefit, if in force for the Insured Person.
ii. If the Insured Person suffers Injuries resulting in more than one of the Permanent Total Disablements, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.
iii. If We have admitted a claim for Permanent Total Disablement in accordance with this Benefit, then We shall not be liable to make any payment under the Policy under Death Benefit on the death of the Insured Person, if the Insured Person subsequently dies. However, any other applicable Benefits which may get triggered will be considered in accordance with the terms and conditions of the applicable Benefits.
iv. We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease.

On the acceptance of a claim under this Benefit, insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

Claims Document Required

- Claim form duly filled and signed by You
- MLC or FIR
- Police Final Charge Sheet / Court Final Order
- Spot / Inquest Panchnama
- Disability Certificate issued by civil or government hospital
- Indoor case papers
- Medical Certificate/Reports
- Discharge certificate, Original bills and receipts form the hospital/Medical Practitioner
- Photo of Insured Person showing the disability
- Any other document as may be required by Us.

c) Permanent Partial Disablement Benefit (PPD)

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Schedule/Key Information Sheet in the manner which is specified in the table below if you suffer an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Partial Disablement of the Insured Person (which is of the nature specified in the table below) within 365 days from the date of the Accident.

For the purpose of this Benefit, Permanent Partial Disablement means total and/or partial irrecoverable loss of use or the actual loss by physical separation of the body parts as specified in the table below:

SR No.	LOSSES COVERED	% OF SUM INSURED payable
1	Loss of one entire hand	70
2	Loss of one entire foot	70
3	Loss of use of one eye	50
4	Loss of all toes	20
5	Loss of great toe - both phalanges	5
6	Loss of great toe - one phalanx	2
7	Other than great toe if more than one toe lost each	5
8	Loss of use of both ears	75
9	Loss of use of one ear	30
10	Loss of four fingers and thumb of one hand	40
11	Loss of four fingers	35
12	Loss of thumb - both phalanges	25
13	Loss of thumb - one phalanx	10
14	Loss of index finger - three phalanges	10
15	Loss of index finger - two phalanges	8
16	Loss of index finger - one phalanx	4
17	Loss of middle finger - three phalanges	6
18	Loss of middle finger - two phalanges	4
19	Loss of middle finger - one phalanx	2
20	Loss of ring finger - three phalanges	5
21	Loss of ring finger - two phalanges	4
22	Loss of ring finger - one phalanx	2
23	Loss of little finger - three phalanges	4
24	Loss of little finger - two phalanges	3
25	Loss of little finger - one phalanx	2
26	Loss of metacarpus - first or second (additional)	3
27	Loss of metacarpus - third, fourth or fifth (additional)	2

This Benefit shall be payable subject to the following:

i. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be considered under Death Benefit
ii. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum,

total and cumulative liability under any and all such claims will be limited to the annual Sum Insured.

iii. On the acceptance of a claim under this Benefit, the Insured Person's insurance cover under this Benefit and the Policy shall continue, subject to the availability of the Annual Sum Insured and the terms, conditions and exclusions of this Policy.

Claims Document required

- Claim form duly filled and signed by You
- MLC or FIR
- Police Final Charge Sheet / Court Final Order
- Spot / Inquest Panchnama
- Disability Certificate issued by civil or government hospital
- Indoor case papers
- Medical Certificate
- Photo of Insured Person showing the disability
- Any other document as may be required by Us.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO DEATH BENEFIT, PERMANENT TOTAL DISABLEMENT AND PERMANENT PARTIAL DISABLEMENT.

We shall not be liable to make any payment for any claim under this cover in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1 War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft

2 Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution.

3 Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world.

4 Breach of law or while being involved in any unlawful activity.

5 Any Injury / Illness arising from intentional self- Injury, suicide or attempted suicide.

6 Any Injury / Illness arising whilst under the influence of alcohol or intoxicating drugs or substance abuse of any kind.

7 Any Injury / Illness occurring whilst working in underground mines or explosives magazines, or involving electrical installation with high tension supply, or as jockeys or circus personnel

8 Any Accidental Injury / Illness directly or indirectly caused by venereal disease

9 Injury sustained whilst engaging in Adventure Sports

10 Any Injury that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought

11 Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization of the Insured Person resulting directly from, or indirectly caused by, or contributed to or aggravated or prolonged by, childbirth or pregnancy or in consequence thereof.

12 Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization of Insured Person due to animal or insect or reptile attack.

13 Death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

31 Recovery Benefit

In consideration of the payment of additional premium to us .We will pay the you 1% of Sum insured maximum up to ₹ 50,000 as specified against this Benefit in the Policy Schedule/Key Information Sheet, if you suffer an Injury due to an Accident that occurs during the Period of Cover and that solely and directly results in your hospitalization for at least 7 continuous days.

This Benefit shall be payable subject to the following:

i. We will accept multiple claims under this Benefit during the Period of Cover in respect of you. However Our maximum, total and cumulative liability for claims arising in respect to you under this Benefit during the Period of Cover shall be 1% of Sum Insured maximum up to ₹ 50,000 as specified against this Benefit in the Policy Certificate.

ii. We have accepted a claim under hospitalization expenses in respect to you for the same Accident for which this benefit is being availed.

32 Mobility Benefit

In consideration of the payment of additional premium to us .We will pay you 1% of sum insured maximum up to ₹50,000 under this Benefit to you towards modification of home, office and / or vehicle or towards purchase of an Artificial Limb or any prosthesis or any other expenses because of Permanent Total Disablement or Permanent Partial Disablement (which is only of the nature specified in the table below) covering the disabilities mentioned in the table below suffered by the Insured Person. However, Our liability for payment of all claims under this Benefit in aggregate for Period of Cover shall in no case exceed

the Sum Insured for this Benefit as specified in the Policy schedule/Key Information Sheet.

For the purpose of this Benefit, Permanent Partial Disablement means total and/or partial irrecoverable loss of use or the actual loss by physical separation of the body parts as specified in the table below:

Permanent Partial Disablement: LOSSES COVERED
One entire hand
One entire foot
Loss of Use of one eye
Loss of Use of both ears
Loss of four fingers and thumb of one hand

This Benefit shall be payable subject to the following:

a) We have accepted Your claim under PTD or PPD.

b) We will only accept only one claim under this Benefit in your lifetime. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect to you shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

c) The Modification of the house or vehicle are carried out to facilitate your activities of daily living.

d) The modification is carried out in the house where you resides after injury.

e) The vehicle should be the one which was being used by you before the occurrence of the injury

f) The expenses are not related to the repair, renovation or improvisation of the existing establishment or vehicle

g) The modification is carried out within three months form your intimation of claim.

e) WHAT WE WILL NOT PAY (EXCLUSIONS UNDER THE POLICY)

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

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

i. Standard Exclusions

3.1 Code- Excl01: Pre-Existing Diseases

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

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

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage

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

3.2 Code- Excl02: Specified disease/procedure waiting period

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of specified 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.

List of specific diseases/procedure:

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy unless because of malignancy
- All types of Hernia, Hydrocele
- Fissures &/or Fistula in anus, hemorrhoids/piles
- Arthritis, gout, rheumatism and spinal disorders
- Joint replacements unless due to accident
- Sinusitis and related disorders
- Stones in the urinary and billiary systems
- Dilatation and curettage , Endometriosis
- All types of Skin and internal tumors/ cysts/nodules/ polyps of any kind including breast lumps unless malignant
- Dialysis required for chronic renal failure
- Surgery on tonsils, adenoids and sinuses

- Gastric and Duodenal erosions & ulcers
- Deviated Nasal Septum
- Varicose Veins/ Varicose Ulcers
- All types of internal congenital anomalies/ illness/defects such as but not limited to congenital heart disease like VSD, ASD, TOF,PDA, Cryptorchidism, Congenital hernia, Achalasia cardia, Spinal defects like spina bifida

3.3

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.

3.4 Code- Excl03: 0 or 30-day waiting period

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

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

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

3.5 Permanent Exclusions

i. Code- Excl04: Investigation & Evaluation

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

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

ii. Code- Excl05: Exclusion Name: Rest Cure, rehabilitation and respite care

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.

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

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

iv. Code- Excl07: Change of Gender treatments

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

v. Code- Excl08: Cosmetic or plastic Surgery

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

vi. Code- Excl09: Hazardous or Adventure sports

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

vii. Code- Excl10: Breach of law

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

viii. Code- Excl11: Excluded Providers

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders/proposers are not admissible. However, in case of life threatening

situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

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

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

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

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

ii. Specific Exclusions

a) Any ailment / illness, injury, condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.

b) 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.

c) Expenses incurred on all dental treatment unless necessitated due to an Accident

d) Personal comfort, cosmetics, convenience and hygiene related items and services

e) Acupressure, acupuncture, magnetic and other therapies

f) Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident. Expenses for venereal disease or any sexually transmitted disease

g) Treatment relating to birth defects and external congenital Illnesses or defects or anomalies such as but not limited to Cleft lip, Combination of cleft lip and cleft palate, Tongue Tie, CTEV (Club foot), Congenital Torticollis, Morphological abnormalities like congenital kyphosis, congenital scoliosis etc., and Phimosis

h) Any expenses arising out of Domiciliary Hospitalisation treatment

i) Treatment taken outside the country

j) Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)

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

l) Any injury or illness caused by or arising from or attributed to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority

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

**some of the exclusion will be waived off if the add on cover is opted for the same.*

PART III OF THE POLICY

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. Complete Discharge

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

5. Multiple Policies

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

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

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

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

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

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

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 knowledgeor belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

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

7. Cancellation

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

Cancellation	Refund	Refund	Refund	Refund	Refund

Period	% for 1 year tenure policy	% for 2 years tenure policy	% for 3 years tenure policy	% for 4 years tenure policy	% for 5 years tenure policy
From 16 days to 1 month	77.5%	80.0%	82.5%	82.5%	82.5%
From 1 month to 3 months	62.5%	72.5%	77.5%	77.5%	80.0%
From 3 months to 6 months	42.5%	62.5%	70.0%	72.5%	75.0%
From 6 months to 9 months	20.0%	52.5%	62.5%	67.5%	70.0%
From 9 months to 12 months	0.0%	42.5%	55.0%	62.5%	67.5%
From 12 months to 15 months		30.0%	47.5%	57.5%	62.5%
From 15 months to 18 months		20.0%	42.5%	52.5%	57.5%
From 18 months to 21 months		10.0%	35.0%	47.5%	55.0%
From 21 months to 24 months		0.0%	27.5%	42.5%	50.0%
From 24 months to 27 months			20.0%	35.0%	45.0%
From 27 months to 30 months			12.5%	30.0%	42.5%
From 30 months to 33 months			5.0%	25.0%	37.5%
From 33 months to 36 months			0.0%	20.0%	32.5%

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

b) The Company may cancel the Policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

8. Migration:

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

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

9. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

10. Renewal of Policy

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

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

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

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

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

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

11. Withdrawal of Policy

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

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

12. Premium Payment in installments

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

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

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

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

14. Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

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

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

15. Redressal of Grievances

In case of any grievance the insured person 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, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai- 400025

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at Manager-Service Quality, Corporate Manager- Service Quality, National Manager- Operations & finally Director-services and Business development at the following address:

ICICI Lombard General Insurance Company Limited,
ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400025

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

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/ligms. irda.qov. in/

The Details of Insurance Ombudsman are Available Below:

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	Karnataka.

Email: bimalokpal.bengaluru@cioins.co.in	
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: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
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 Union Territory of Puducherry.
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.
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.

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

16. Nomination:

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

ii. Specific Terms and Clauses

1. 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.

2. Notice & Communication

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

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

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

3. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only unless worldwide cover has been opted for.

4. 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.

5. Arbitration

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

ii. It is clearly agreed and understood that no difference or

dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy, iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

6. Policy alignment

Policy Alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy.
Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.

7. Endorsements (Changes in Policy)

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

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

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

iv. Mid- term endorsement of addition of member in the policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation

8. Change of Sum Insured

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

9. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:
In Your case, at Your last known address.

In Our case:
ICICI Lombard General Insurance Company Limited
ICICI Lombard House
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400025

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

10. Non Payables

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

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

42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	RECOVERY KIT, ETC]ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT,
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

g) Other Terms and Conditions

CLAIM ADMINISTRATION

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

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

4.1 CLAIMS PROCEDURE

(A) For Cashless Settlement

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

Pre-authorization

Prior to taking treatment and/or incurring Medical Expenses at a Network Provider, You must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Proposer, 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 pre-authorisation at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation. To avail of Cashless Hospitalisation 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 Hospitalisation 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 Proposer;
- 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 Hospitalisation, 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-hospitalisation expenses, within 30 days from the completion of post-hospitalisation 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. 4.1 (A) & (B), You must take reasonable steps or measure to minimise the quantum of any Claim that may be covered under the Policy
If so requested by Us, You will have to undergo a medical examination from Our nominated Medical Practitioner, as and when We or Our In house claim processing team considers reasonable and necessary. The cost of such examination will be borne by Us.

Settlement/Rejection of Claim
The settlement of claims would be done by Us within 30 days, after the receipt of last necessary document, any rejections if done, would be provided with proper reasons by Us.
Penal interest provision shall be as per Regulation 15(10) of (Protection of Policyholders' Interests) Regulations 2017

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.
Claims settlement will follow the below mentioned order in case you have opted for super no claim bonus and sum insured protector

1) Sum Insured
2) Additional Sum insured
3) Super No Claim Bonus (if opted and accrued)
4) Sum Insured Protector (if opted and accrued)

4.2 CLAIM DOCUMENTS

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

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