

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

c. DEFINITIONS

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

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

Standard Definitions

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

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

AYUSH treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

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

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

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

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

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

- **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.

loyalty Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

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

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

Day Care Centre includes an AYUSH Day Care Centre as defined below

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

- a) Having qualified registered AYUSH Medical Practitioner(s) in charge;
- b) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- c) Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

- i. Undertaken under General or Local Anesthesia in a hospital/ day care centre in less than 24 hrs because of technological advancement, and
- ii. Which would have otherwise required a hospitalization of more than 24 hours

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

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

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

- a) The condition of the patient is such that he/ she is not in a condition to be moved to a hospital, or
- b) The patient takes treatment at home on account of non-availability of room in a hospital.

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

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

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

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

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

- i. has qualified nursing staff under its employment round the clock;
- ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- iii. has qualified medical practitioner(s) in charge round the clock;
- iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
- v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Hospital includes an AYUSH Hospital as defined below

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

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

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

- a) **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
- b) **Chronic condition** – A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics
 - i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
 - ii. it needs ongoing or long-term control or relief of symptoms
 - iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 - iv. it continues indefinitely
 - v. it recurs or is likely to recur

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

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 means

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

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

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

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

Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in Hospital which

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

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

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

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

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

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

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

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

- a) that is/are diagnosed by a physician not more than 12 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 12 months prior to the date of commencement of the policy.

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

- a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
- b) The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company

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

- a) Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
- b) The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

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

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 means the terms on which the contract of insurance can be renewed as per regulatory prescriptions with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

Specific waiting period/ Specified Disease/Procedure waiting period means a period up to 12 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break

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

Surgery or Surgical Procedure means manual and/ or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a Medical Practitioner.

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

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

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

Company means ICICI Lombard General Insurance Company Limited.

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

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

Dependent Child refers to refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income. For the purpose of this policy, child up to age 25 years is considered as dependent child.

Family would comprise of Your spouse, dependent children, and dependent parent(s), and Mother-in-law, Father-in-law.

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

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

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

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

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

Policy Holder/ 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 of the Policy and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Schedule.

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

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

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

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

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

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

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

d. **BENEFITS COVERED UNDER THE POLICY**

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

A. Basic Cover:

If any insured person suffers an illness or Accident during Policy Period, the Policy provides indemnification of the Medical Expenses incurred towards hospitalization which is in excess of the Deductible amount.

Below mentioned basic covers are Indemnity based covers and would be payable for actuals (post deductible as applicable) or up to Annual Sum Insured whichever is lower.

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

How Deductible works:

Deductible will apply on aggregate basis for all hospitalization expenses during the policy year.

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

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

1. In-Patient Treatment

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

- i. Room Rent charges.
 - a. For Annual Sum Insured options up to Rs. 20 Lakhs – room rent charges shall be capped to a Single Private AC Room
 - b. For Annual Sum Insured options greater than Rs. 20 Lakhs- there will be no room rent capping
- ii. Intensive Care Unit Charges
- iii. Qualified Nurse charges
- iv. Medical Practitioner's Fees
- v. Anaesthesia, blood, oxygen, surgical appliances, medicines, drugs and consumables (other than those specified in the list of excluded expenses (non-medical) in Annexure I
- vi. Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure;
- vii. Cost of investigative tests or prescribed diagnostic procedures directly related to the Injury/Illness for which the Insured Person is hospitalized

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

- i. If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this policy, then the Insured Person shall bear a rateable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred
 - a. For the purpose of this cover, "Associated medical expenses" shall include room rent, nursing charges, operation theatre charges, fees of medical practitioner including surgeon/anesthetist/ specialist within the same hospital where the insured person has been admitted and will not include the cost of pharmacy and consumables, cost of implants, medical devices and cost of diagnostics.
 - b. Proportionate deductions are not applicable for ICU charges
 - c. Proportionate deductions shall not be applicable for hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.
- ii. Expenses associated with automation machine for peritoneal dialysis shall not be payable

2. Day Care Procedures/Treatments

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

- i. Day Care treatment requires hospitalization as an inpatient for less than 24 hours in a Hospital.
- ii. We will also cover Medical Expenses incurred for procedures including but not limited to intravenous chemotherapy, radiotherapy, hemodialysis or any other therapeutic procedure which requires a period of specialized observation or medical care after completion of the procedure.
- iii. We will not cover any Out Patient Treatment or diagnostic services under this Benefit.
- iv. Expenses associated with automation machine for peritoneal dialysis shall not be payable
- v. If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this Policy, then the Insured Person shall bear a ratable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred
 - a. For the purpose of this cover, "Associated medical expenses" shall include room rent, nursing charges, operation theatre charges, fees of medical practitioner including surgeon/anesthetist/ specialist within the same hospital where the insured person has been admitted and will not include the cost of pharmacy and consumables, cost of implants, medical devices and cost of diagnostics.
 - b. Proportionate deductions are not applicable for ICU charges
 - c. Proportionate deductions shall not be applicable for hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

3. Technological advancements and Treatments

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

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

11	Bronchical Thermoplasty
12	IONM - (Intra Operative Neuro Monitoring)

4. In patient AYUSH Hospitalization

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

- i. The Insured person is Hospitalised for AYUSH Treatment at a AYUSH Hospital or AYUSH Day Care Centre.
- ii. This Cover will be provided on reimbursement basis and/or on cashless basis wherever applicable

5. Domiciliary Hospitalization

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

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

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

- i. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
- ii. Arthritis, Gout and Rheumatism
- iii. Ailments of spine/disc
- iv. Chronic nephritis and nephritic syndrome;
- v. Any liver disease;
- vi. Peptic ulcer
- vii. Diarrhoea and all types of Dysenteries including Gastro-enteritis
- viii. Diabetes Mellitus and Insipidus
- ix. Epilepsy
- x. Hypertension
- xi. Pyrexia of any origin

6. Donor expenses

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

- The donation conforms to the "Transplantation of Human Organ Act 1994 (amendment act, if any) and the organ is used for the Insured Person
- We will cover only those Medical Expenses incurred in respect of an organ donor as an in-patient in the Hospital.
- We have accepted a claim under Section "Inpatient treatment" in respect of the Insured Person.

We shall not be liable to pay for any claim under this Cover which arises 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.
 - v. Transplant of any organ/tissue where the transplant is experimental or investigational.
 - vi. Expenses related to organ transportation or preservation.
 - vii. Expenses incurred by an Insured Person as a donor.
- Any other medical treatment or complication in respect of the donor, consequent to harvesting.

7. Pre-Hospitalization Medical Expenses

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

- i. We shall not be liable to make any payment in respect of any Pre-hospitalization Medical Expenses incurred prior to the Policy Period Start Date of the first policy with Us in respect of the Insured Person.
- ii. Expenses incurred on nursing care at home are excluded from the scope of pre hospitalization expenses.
- iii. This Cover will be provided on a reimbursement basis and/or cashless basis wherever applicable.

8. Post-Hospitalization Medical Expenses

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

- i. We have accepted the claim under "Inpatient Treatment" in respect of the Insured Person.
- ii. We will also consider Post-hospitalization Medical Expenses incurred on Physiotherapy provided that such Physiotherapy is advised in writing by the treating Medical Practitioner and is Medically Necessary Treatment. This service will be provided on a reimbursement and/ or cashless basis where ever applicable.
- iii. Expenses incurred on nursing care at home are excluded from the scope of Post Hospitalization Medical Expenses

9. Domestic Emergency Road Ambulance Cover

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

- i. Our maximum liability under this Benefit for every claim arising during the Policy Year will be restricted to 1% of the Annual Sum Insured maximum up to Rs.10,000 in case

the charges of road ambulance are being reimbursed. In case the services of a health care or ambulance service provider are being availed on cashless basis, the charges of road ambulance will be covered as per actuals. Cashless service can be availed via our mobile application

- ii. We have accepted a claim under "Inpatient Treatment" in respect of the Insured Person for the same Accident/Illness for which road ambulance services were availed.
- iii. This Benefit includes and is limited to the cost of the transportation of the Insured Person:
 - a. To the nearest Hospital with higher medical facilities which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, and only if that transportation has been prescribed in writing by a Medical Practitioner and is for Medically Necessary Treatment.
 - b. From a Hospital to the nearest diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
- iv. The ambulance / service provider providing the services should be a registered provider with road traffic authority.
- v. 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 Cover.

10. Domestic Air Ambulance Cover

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

- i. It is for a life threatening emergency health conditions of the Insured Person which requires immediate and rapid ambulance transportation from the place where the Insured Person is situated at the time of requiring Emergency Care to a hospital provided that the transportation is for Medically Necessary Treatment, is certified in writing by a Medical Practitioner, and Domestic Road Ambulance services cannot be provided.
- ii. Such air ambulance providing the services, should be duly licensed to operate as such by a competent government Authority.
- iii. This cover is limited to transportation from the area of emergency to the nearest Hospital only;
- iv. We will not cover:
 - a. Any transportation from one Hospital to another;
 - b. Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital
 - c. Any transportation or Air Ambulance expenses incurred outside the geographical scope of India.

- v. We have accepted a claim under Inpatient Treatment in respect of the Insured Person for the same Accident/Illness for which air ambulance services were availed.
- vi. We shall not be liable if Medically Necessary Treatment can be provided at the Hospital where the Insured Person is situated at the time of requiring Emergency Care.

11. Reset Benefit

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

- i. The Annual Sum Insured in respect of the Insured Person is insufficient as a result of previous claims paid in that Policy Year.
- ii. The Reset Benefit will not be triggered for the first claim made during the Policy Year
- iii. The total amount of reset will not exceed the Annual Sum Insured for that Policy Year
- iv. The Reset Benefit will be applied only if the claim is made and admissible under "Inpatient Treatment" or "Daycare Procedure/Treatment"
- v. For individual policies, reset Annual Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis.
- vi. Any unutilized Reset Benefit will not be carried forward to any subsequent Policy Years.

12. Health Assistance [HAT]

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

The services provided under this shall include:

- Identifying a Physician/ Specialist
- Availability of hospital beds
- Providing guidance on engaging attendants/ nurses
- Facilitation with respect to arrangement of mobility aids, daily living aids, medical equipment etc.
- Scheduling an appointment with any Medical Practitioner empaneled with Us
- Scheduling appointments for a second opinion
- Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
- Scheduling appointments from diagnostic labs empaneled with Us
- Providing information, assistance and facilitation on door step delivery of medicines
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.

Please note that services provided under this Cover are solely for assistance, and should not be construed to be a substitute for a visit/ consultation to an independent Medical Practitioner. Our role is limited to that of facilitation and Health Assistance Services will not include the charges for any independent Medical Practitioner/nutritionist consulted/

charges incurred on diagnostics/consulted on HAT's recommendation, and such charges are to be borne by the Insured Person.

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

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

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

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

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

13. Ambulance Assistance

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

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

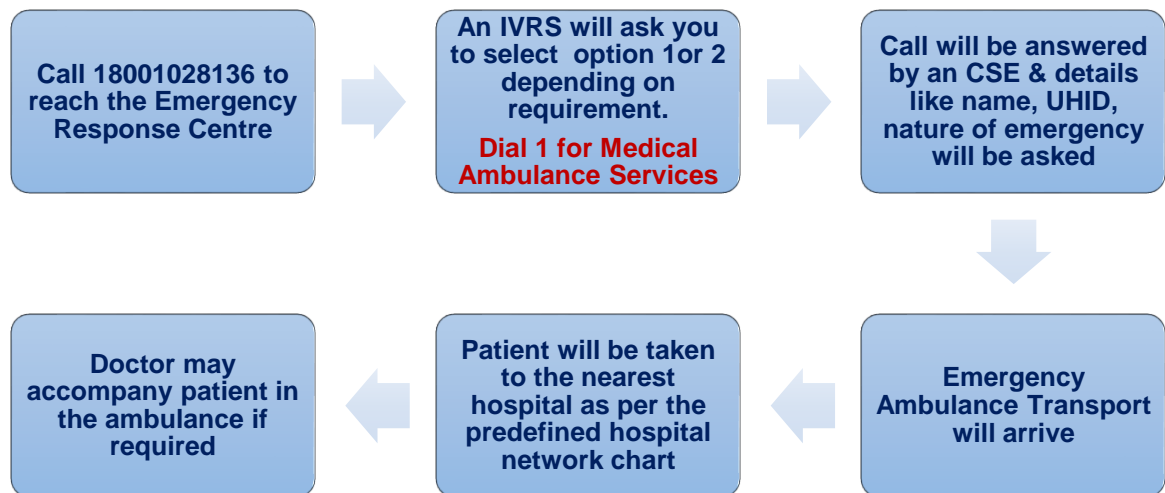
- The medical transportation is for a life threatening health condition of the Insured Person which requires immediate and rapid transportation to the Hospital; as certified in writing by the Medical Practitioner
- The Insured Person is in India and the treatment is in India only;
- The ambulance service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

Process to avail Ambulance Assistance:

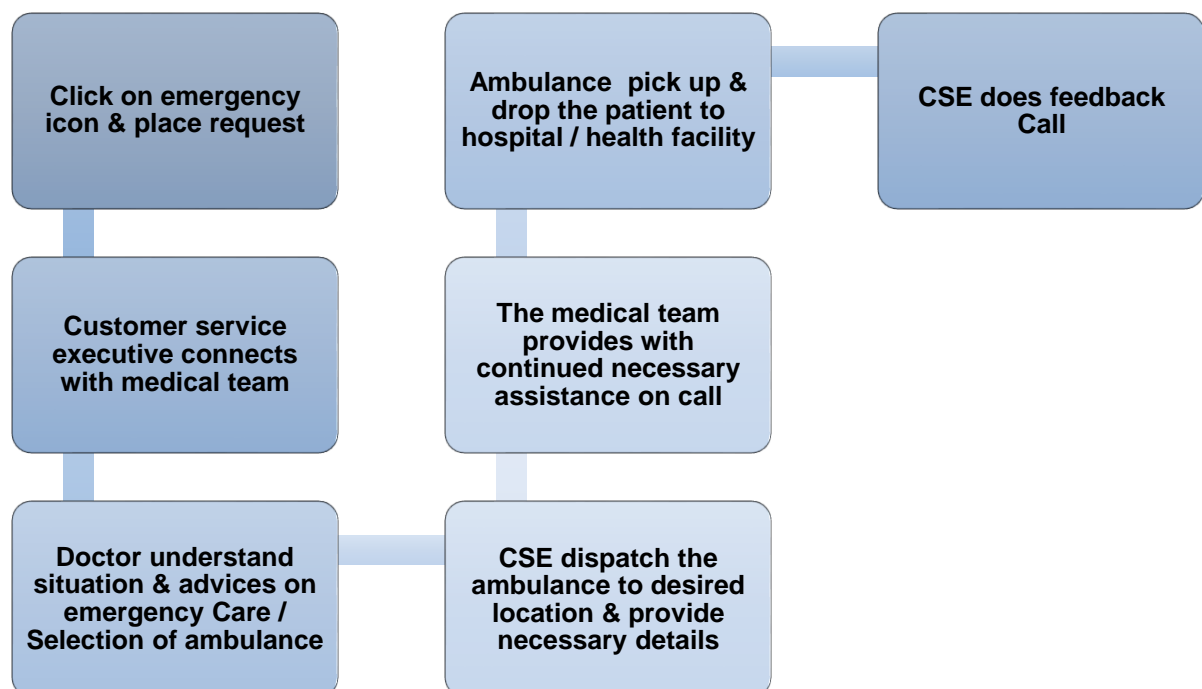
- a) On calling Our helpline number provided below, Our trained customer service executive (CSE) will ask the Insured Person relevant questions to assess the situation.
- b) The call may be redirected to a qualified Medical Practitioner in order to evaluate the requirement for an ambulance with Advanced Life Support based on the Insured Person's condition.
- c) The below mentioned details are to be made available for availing the services:
 1. UHID of Insured Person, as provided on the Health Card.

2. Contact number of the Insured Person
3. Location of Insured Person

How to Call an Ambulance? (Via Call)



How to Call an Ambulance? (Via Mobile Application)



14. Discounts on services/products

We shall only facilitate the Insured Person in availing discounts on services/products including but not limited to investigations/diagnostic tests/ laboratory tests /health supplements/ /medical equipment/homecare services/virtual health & wellness sessions/AYUSH products/Fitness & wellness related activities & products etc. at our empanelled diagnostic centres, drugs/medicines ordered from pharmacies etc. offered by

our network providers/ health service providers. These discounts can be viewed on our mobile application and one can avail these discounts depending on terms and conditions and subject to availability.

15. Tele Consultation(s)

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

- The tele consultations can be availed via our mobile application only
- The Medical Practitioner may suggest/recommend/prescribe over the counter medications based on the information provided, if required on a case to case basis. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional*.
- There shall be no maximum limit on the count of Tele-Consultations that can be availed by the Insured Person(s) in a policy year
- This service will be available 24 hours a day, and 365 days in a year.
- We/Medical Practitioner/Healthcare professional may refer the Insured Person to another specialist or a general physician,(outside of our empaneled network) if required, and the charges for such specialist or a general physician will have to be borne by the Insured Person.
- We shall not be liable for any discrepancy in the information provided under this Cover.
- Choosing the services under this Cover is purely upon the Insured Person's own discretion and at own risk.

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

16. Claim Protector

If a claim has been accepted under the "Inpatient Treatment" or "Daycare Procedure/Treatments" Cover, the items which are included in the

List I- Items for which coverage is not available in the Policy of Annexure II, which are non – payable, to the particular claim, will become payable.

- i. The maximum claim pay-out under this add cover shall be limited to Annual Sum Insured under the Policy.
- ii. Reset benefit will not be available for Claim Protector Cover.

17. Switch

From 6th Policy Year onwards, the Insured Person will have an option to migrate to a base hospitalization policy from the super top up policy, with continuity on waiting periods applicable (up to the deductible amount) under the base Policy subject to underwriting and to the following policy terms and conditions:

- i. In a floater Policy as specified in the Policy Schedule, the Switch will be available to those Insured Person(s) who were Insured in the previous Policy Year(s) and continue to be Insured with the Company in the subsequent Policy Year(s)
- ii. Switch shall not be provided if the Policy is not renewed with Us by the end of the Grace Period.
- iii. This benefit can be exercised only after five subsequent renewals of the policy.
- iv. Continuity benefit under the base product shall be offered on the Sum Insured up to the Deductible amount opted under this Policy.
- v. Continuity on waiting period and guarantee of acceptance will be limited to Sum Insured up to the minimum Deductible opted under the Super Top Up policy for preceding 5 years.
- vi. On opting the base policy, the coverage under existing policy, will cease to be available for the Insured person.

B. Add ons/ Optional Covers

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

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

The Sum Insured for each of the Optional Covers shall be over and above the Annual Sum Insured of the Policy.

1. Maternity Benefit

This optional benefit covers the medical expenses up to the amount opted at the time of issuance for the delivery of a baby and / or expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner, limited to maximum of 2 deliveries or terminations as said herein during the lifetime of an female Insured/Insured Person as the case may be between the ages of 18 years to 45 years in the Policy.

- I. This benefit will have a waiting period of 9 months from the time this cover is opted
- II. This optional benefit is applicable to all or any female Insured person whose age is between 18 to 45 years as selected by proposer.
- III. Pre and post natal expenses will be included in the opted Maternity Benefit coverage
- IV. In case, insured person has opted for a policy without maternity benefit and would like to opt for maternity benefit, then this can be availed only at the time of renewal

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

2. BeFit

All benefits under the BeFit cover can be availed only on cashless basis via our mobile application and are subject to the terms, conditions, waiting periods and exclusions and the availability of Sum Insured under the Cover. The BeFit plan opted is as specified in the policy schedule.

- I. All services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment
- II. Any unutilized Consultations/E- consultations/ Annual Sum Insured/ sessions cannot be carried forward to the next Policy Year. There will be a waiting period of 30 days for this cover
- III. Choosing the services under this Cover is purely upon the Insured Person's own discretion and at own risk. The services provided under the various Covers are via third party health Service Providers/ Network Providers/ and the Insurer is not responsible for liability arising out of the services provided by these third parties.
- IV. The Insured Person(s) should seek assistance from a medical practitioner should they still have any concerns about their health even post availing services from our health service providers/network providers.

i. Physical Consultations

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

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

Physiotherapy sessions and counselling availed for psychiatric ailments or mental health issues shall be excluded from the scope of this Optional Cover as the same are covered under clause no. 2 iv. Physiotherapy sessions and clause no. 2 v. e-counselling respectively.

ii. Routine Diagnostic and Minor Procedure Cover

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

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

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

List of Minor Procedures covered under this Optional Cover

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

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

iii. Pharmacy

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

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

iv. Physiotherapy Session

We shall cover medical expenses incurred by the Insured Person for Physiotherapy Sessions with a qualified physiotherapist within our cashless network to treat Illness, injury or deformity suffered as advised by qualified Medical Practitioners during the Policy Period by physical

methods such as but not limited to massage, heat treatment, ultrasound, Laser and exercises maximum up to the number of visits sessions as specified against this Optional Cover in the Policy Schedule.

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

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

v. e-Counseling

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

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

vi. Diet and Nutrition e-Consultation

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

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

Claim Procedure for BeFit

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

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

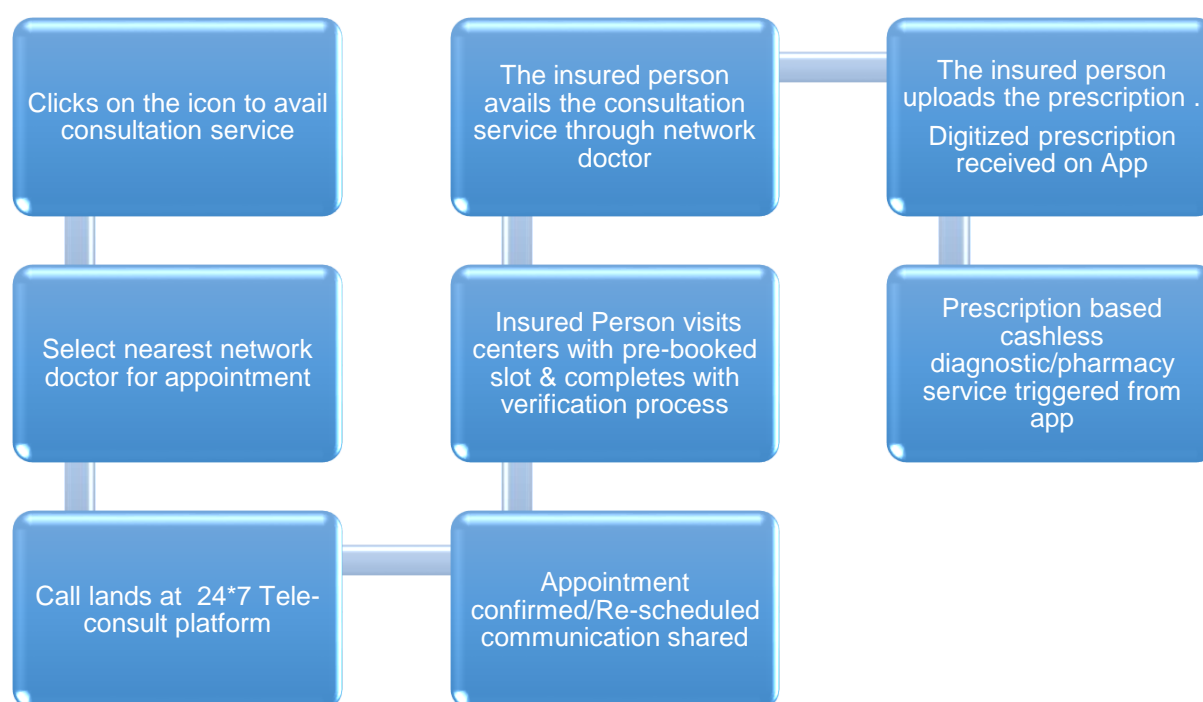
- To avail of Cashless Facility at the health Service Provider / Network Provider, the Insured Person/claimant is required to produce information on the health card available on the application for verification and validation. The request shall be considered after having obtained accurate and complete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

covered for prescriptions by an empaneled Network Medical Practitioner through the Mobile Application.

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

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

A schematic representation of the claims process is as below



3. Guaranteed Deductible Reduction

We will reduce the deductible applicable by 10% of the deductible as applicable to the expiring or renewed Policy as specified in the Policy Schedule at the end of each Policy Year if the expiring Policy has been continuously renewed with Us. The reduction in deductible shall be continued until the deductible is reduced to 50% of the deductible opted during first policy issuance subject to the following conditions. This optional cover is available only for policies with minimum deductible of 5 lakhs.

- i. The guaranteed deductible reduction option has to be chosen at the time of Policy inception. Any modification in the same, will not be permitted
- ii. In a floater Policy as specified in the Policy Schedule, the reduction in deductible will be available to the Insured Person(s) who were Insured in the previous Policy Year(s) and continue to be Insured with the Company in the subsequent Policy Year(s)

- iii. Reduction in deductible shall not be provided if the Policy is not renewed with Us by the end of the Grace Period.
- iv. If the Policy Period is two or three year(s), any reduction in deductible for the policy years shall be provided at the time of renewal of the policy and it will be applicable for claims at the subsequent year.
- v. In case of floater Policies where Insured Person renew their expiring Policy with the Company by splitting the Annual Sum Insured in to individual policies the deductible shall be applicable to such renewed policies.
- vi. Even in the event of Claim, under the Policy during any subsequent Policy Year, the deductible shall continue to reduce until the same is reduced to 50% of the deductible as opted during policy issuance.

Illustration

Year	Annual Sum insured (in INR)	Deductible (in INR)	Claim	Deductible Revised at renewal
1	1 Crore	10 Lakhs	No	Yes
2	1 Crore	9 Lakhs	No	Yes
3	1 Crore	8 Lakhs	No	Yes
4	1 Crore	7 Lakhs	Yes	Yes
5	1 Crore	6 Lakhs	No	Yes
6	1 Crore	5 Lakhs	Yes	No
7	1 Crore	5 Lakhs	No	No

4. No Claim Deductible reduction

We will reduce the deductible applicable to the Policy by 50% at the end of 5 claim free policy years if the policies have been continuously renewed with the Company. The reduction in deductible shall be 50% of the deductible subject to the following conditions.

- i. In case where the Policy is on floater basis, the deductible will be reduced if there has been no claim made in respect of all Insured Person(s) in the expiring Policy period.
- ii. In a floater Policy as specified in the Policy Schedule, the reduction in deductible will be available to those Insured Person(s) who were Insured in the previous Policy Year(s) and continue to be Insured with the Company in the subsequent Policy Year(s)
- iii. The reduction in deductible shall not be provided if the Policy is not renewed with the Company by the end of the Grace Period
- iv. If the Policy Period is two or three year(s), any reduction in deductible for claim free policy years will be provided at the time of renewal of the policy and it will be applicable for claims at the subsequent year.
- v. In case of floater Policies where Insured Person renew their expiring Policy with the Company by splitting the Annual Sum Insured in to individual policies the deductible shall be applicable to such renewed policies.
- vi. In the event of Claim, under the Policy during any subsequent Policy Year, the deductible shall be reset to deductible opted at policy inception.

- vii. This benefit will not be applicable if Guaranteed Deductible Reduction is opted during issuance and vice versa

Illustration

Year	Annual Sum insured (in INR)	Deductible (in INR)	Claim	Deductible Revised at renewal
1	1 Crore	10 Lakhs	No	No
2	1 Crore	10 Lakhs	Yes	No
3	1 Crore	10 Lakhs	No	No
4	1 Crore	10 Lakhs	No	No
5	1 Crore	10 Lakhs	No	No
6	1 Crore	10 Lakhs	No	No
7	1 Crore	10 Lakhs	No	Yes
8	1 Crore	5 Lakhs	No	No

e. 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:

1. Standard Exclusions (Code- Excl01: Pre-Existing Diseases

- Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 months (as applicable at the time of issuance) of continuous coverage after the date of inception of the first policy with insurer.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- If the Insured Person is continuously covered without any break as defined under the portability norms of the relevant prescriptions, then waiting period for the same would be reduced to the extent of prior coverage
- Coverage under the policy after the expiry of 12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Code- Excl02: Specified Disease/Procedure waiting period/ Specific Waiting Period.

- Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 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.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- 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, 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 biliary 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

3. **Code- Excl03:** 30-day waiting period

- a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
 - b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
 - c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.
4. 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
- a. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
 - b. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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: 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:
 - o Obesity-related cardiomyopathy
 - o Coronary heart disease
 - o Severe Sleep Apnea
 - o 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. **Excl10: Breach of law**

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

- viii. **Code- Excl11: Excluded Providers**
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

The list of excluded providers/delisted hospitals is available on our website www.icicilombard.com
- ix. **Code- Excl12: Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.**
- x. **Code- Excl13: Treatments received in health spas, 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 dioptries**
- 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.

This exclusion shall not be applicable if Optional Cover 1. Maternity Benefit Cover is opted.

i. Specific Exclusions (Exclusions other than those mentioned under d.i. above)

- a. Deductible: We shall not be liable for the Deductible amount as specifically defined in Policy Schedule
We are not liable for any payment unless the aggregate medical expenses exceed the deductible.
Deductible shall not be applicable for optional covers, if any.
- b. Any ailment/ illness/ injury/ condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions
- c. Cost of routine medical, eye and ear examinations, preventive health check-up, cost of spectacles, contact lenses or hearing aids, dentures and artificial teeth
- d. Any expenses incurred on Out Patient treatment. This exclusion will not be applicable in case optional cover 2. BeFit has been opted
- e. 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.
- f. Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.
- g. Personal comfort, cosmetics convenience and hygiene related items and services.
- h. Acupressure, acupuncture, magnetic and other therapies
- i. Circumcision unless necessary for treatment of a disease or necessitated due to an Accident.
- j. Expenses for venereal disease or any sexually transmitted disease except HIV.
- k. Screening, counselling or Treatment relating to external birth defects and external congenital illnesses or defects or anomalies
- l. Treatment taken outside the country
- m. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
- 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
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

f. GENERAL TERMS AND CONDITIONS**Standard 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. Complete Discharge

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

4. Multiple Policies

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

5. Fraud

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

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

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

- a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- b. the active concealment of a fact by the insured person having knowledge or belief of the fact;
- c. any other act fitted to deceive; and
- d. any such act or omission as the law specially declares to be fraudulent

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

6. Cancellation

The insured may cancel the policy at any time during the term, by giving 7 days notice in writing. The Company shall

- a) Refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.
- b) Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

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

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

The Company may cancel the Policy at any time on grounds of established fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on the grounds of established fraud.

7. Portability

- a. The insured has the choice to port his / her policies from one Insurer to another. An Insured desirous of porting his/her policy to another insurer shall apply to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal.
- b. The insured is entitled to transfer the credits gained to the extent of the sum insured and the benefits available in the previous policy, subject to the underwriting policy of the Company
- c. The Company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines.
- d. This benefit is not applicable for enhanced sum insured.

8. Migration

In case of migration of this policy with the Company, the insured can transfer the credits gained to the extent of the Sum Insured and benefits available in the previous policy to the migrated policy. The Company may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

9. Renewal of Policy

The policy shall ordinarily be renewable except on ground of established fraud, misrepresentation, non-disclosure by the insured person provided the policy is not withdrawn and also subject to Moratorium conditions.

- I. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- II. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

III. 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

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

10. 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 loyalty bonus, waiver of waiting period, as per regulatory prescriptions, provided the policy has been maintained without a break.

11. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the Company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

12. Premium Payment in instalments

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

- i. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
- ii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
- iii. No interest will be charged if the instalment premium is not paid on due date.
- iv. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vi. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy

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

The Company, , may revise or modify the terms of the policy including the premium rates.

Free look period

Every insured of new health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the

date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the insured and stamp duty charges.

14. Redressal of Grievance

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

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

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

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

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

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

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

- In case of any grievance the insured person may contact the Company through
Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com
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- If Insured person is not satisfied with the redressal of grievance, insured person may contact the grievance officer at the details provided in the below link:
<https://www.icilombard.com/grievanceredressal.com>
- If Insured person is not satisfied with the redressal of grievance, the insured person may also approach Insurance Regulatory and Development Authority (IRDA) through the Bima Bharosa Portal - <https://bimabharosa.irdai.gov.in/> or IRDA Grievance Call Centre (IGCC) at their toll free no. 1800 4254 732 / 155255
- Insured may also approach Insurance Ombudsman, subject to vested jurisdiction, for the redressal of grievance. Details of Insurance Ombudsman offices are available at IRDA website: www.irdaindia.org, or on the Company's website at www.icilombard.com

Note: The Details of Insurance Ombudsman are Available on Annexure A

15. Nomination:

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

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

16. Zone based premium

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

The premium will depend on the city of residence and pin code of the insured person. Please inform us immediately in case of any change in the same. Not doing so, may impact your claim admissibility

Zone	State/District
Zone A	Delhi, Mumbai (including Thane district, Navi Mumbai) , Haryana (excl. Faridabad, Jhajjar, Jind, Nuh, Panipat, Rewari, Mewat, Palwal), Daman & Diu, Dadra Nagar, Ahmedabad, Surat, Noida City, Ghaziabad district, Hapur district, Meerut district, Muzaffarnagar district, Shamali district
Zone B	Pune, Kolkata, Telangana (Incl. Hyderabad), Madhya Pradesh, Goa, Gujarat (excl. Ahmedabad and Surat), Bangalore, Chennai, Andhra Pradesh, Chattisgarh, Pondicherry, Uttarakand

Zone C	Rest of India (Punjab, Rajasthan (excl. NCR region), Chandigarh, Himachal Pradesh, Jammu & Kashmir, Ladakh, Lakshadweep, Kerala, Tamil Nadu (excl. Chennai, Pondicherry), Odisha, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Sikkim, Andaman & Nicobar, Rest of Karnataka, West Bengal (excl. Kolkata), Bihar, Jharkhand, Maharashtra (excl. Mumbai and Pune), UP (excl. NCR Region))
Zone D	Rest of NCR[Alwar, Bagpat, Bharatpur, Bulandshahr, Faridabad, Gautam Buddha Nagar excluding Noida, Jhajjar, Jind, Nuh, Panipat, Rewari, Mewat, Palwal]

17. Material Change

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

18. 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.

19. Notice & Communication

Any notice, direction, instruction or any other communication related to the Policy should be made in writing. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

20. Territorial Limit

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

21. Automatic change in Coverage under the policy

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

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

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

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

22. 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.

23. Policy alignment

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

24. 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. Any change in plan, Optional Covers opted may happen only during Renewal subject to underwriting.
- 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

25. Change of Sum Insured

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

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

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

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

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

28. If You do not comply with the provisions of this Clause or other obligations cast upon You under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at Our option. We may condone the delay on merit for delayed claims where the delay is proved to be for reasons beyond Your control.

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

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

30. Cause of Action/ Currency for payments: No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy Schedu if available under the Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

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

32. 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".

33. Non Payables

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

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

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

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

Sr. No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX I MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/VARMER BLANKET
27	ADMISSION KIT

28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMER CHARGES

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

SI No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV — Items that are to be subsumed into costs of treatments

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE

3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

g. OTHER TERMS AND CONDITIONS

CLAIM ADMINISTRATION

- i. The fulfilment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by 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, – www.icicilombard.com (As the list is dynamic, please refer to the latest list).

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

- i. The deductible shall be applied to aggregate of all claims that are either paid or payable (not excluded) under this policy. Our liability to make payment shall commence only once the aggregate amount of all claims payable or paid exceed the deductible.
- ii. Our liability to make payment shall then be arrived at.

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

1. Annual Sum Insured
2. Reset Sum Insured (if applicable)

1. CLAIMS PROCEDURE

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

- i. Prior to taking treatment and/or incurring Medical Expenses at a Network Provider, You must contact the Company 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-authorization 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. If You notify pre authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will decide on request within 1 hours of the actual receipt of such pre authorization request. Further, we shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital.

(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 collected from the hospital at the time of discharge along with the claim form.. The claim will be processed within 15 days of receipt of claim along with claim form and documents.

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

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

Claim falling in two Policy Periods

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

2. CLAIM DOCUMENTS

You shall be required to furnish the following documents for or in support of a reimbursement claim

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

7. Any other document as required by Us or to investigate the Claim or Our obligation to make payment for it

The relevant documents to be sent to-

ICICI Lombard Health Care,

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

Varun Towers- II , Opp. Hyderabad Public school,

Begumpet, Hyderabad, District Hyderabad, Telangana Pin code -500016

Annexure A

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, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Mr Atul Jerath Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat 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, Sonapat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G. Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry..

KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 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, Sonbhadra, 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 Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.

PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.
THANE Shri Umesh Sinha Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane - 400604 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai , M/East, M/West, N, S and T.

For updated list of ombudsman details kindly visit <https://www.cioins.co.in/Ombudsman>