Annexure III

ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED.

Corporate Office: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

HEALTH BOOSTER POLICY WORDINGS

PART I OF THE POLICY- POLICY SCHEDULE

Policy No.		**Issued at**		**Stamp Duty**	

Policy details					
Name of the Policyholder			Contact No.		
Mailing address of the Policyholder					
Policy Start Date	DD/ MM/ YY & HH:MM		Policy End Date	DD/ MM/ YY & HH:MM	
Previous Policy details					
Policy number		Policy Period		Claims	

Details of the Insured under the Policy						
Insured's name						
Address for correspondence						
Relationship with the Policy holder						
Date of Birth	MM/ DD/ YY	MM/ DD/ YY	MM/ DD/ YY	MM/ DD/ YY	MM/ DD/ YY	MM/ DD/ YY
Sex	☐ M/ ☐ F	☐ M/ ☐ F	☐ M/ ☐ F	☐ M/ ☐ F	☐ M/ ☐ F	☐ M/ ☐ F
Nominee's name						
Nominee's relationship with the Insured						
Pre-Existing Diseases						
Annual Sum Insured (₹)						
Additional Sum Insured (Cumulative Bonus) (₹)						
Deductible amount (₹)						
Optional covers applicable*						

*As per below table

Optional covers/Extensions under the Policy			
S.No	Extensions	Premium (₹)	Annual Sum Insured (₹)
(i)	Extension 01: Hospital Daily Cash		
(ii)	Extension 02: Convalescence Benefit		
(iii)	Extension03: Personal Accident cover		
(iv)	Extension 04: Temporary Total Disablement (TTD) Rehabilitation Cover (resulting from Accident Extension)		
(v)	Extension 05: Repatriation of Remains		
(vi)	Extension 06: Critical Illness Cover		
(viii)	Extension 07: Midterm Inclusion of Insured Person(s)	-	-

Plan	**Top Up/ Super Top Up**

Geographical Scope	**India**

Premium Details (₹)		
Total Premium	Service/ Sales Tax & Education Cess, as applicable	Net premium

In House Claim Processing Details		
Name	Complete Address	Contact no.

Special Conditions: Any physical, medical condition or treatment or service which is additionally excluded under the Policy.		
Insured's name	Date of Birth	Condition
	DD/ MM/ YY	
	DD/ MM/ YY	

Signed For and on behalf of ICICI Lombard General Insurance Company Limited, at
----------On this Date ----------

Authorized Signatory

COMPANY CONTACT DETAILS:

a) **Toll-free number**: 1800 2666

b) **Registered Office Address:**
ICICI Lombard General Insurance Company Ltd.
ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400025
CIN:U67200MH2000PLC129408

c) **E-mail**: customersupport@icicilombard.com

Agency Details:

Agency name	Agency code	Mobile no.	Landline no.

Premium Certificate for the purpose of Deduction u/ s 80D of Income Tax Act, 1961* (Applicable only for premium paid towards Health Sections under the Policy)

To,

Name of Proposer/ Policyholder,

Subject: Premium certificate for the purpose of deduction under section 80D of Income Tax amendment act, 1961 and any amendments made thereafter.

Dear Customer,

This is to certify that the Company has received the premium dated <Date – "Date format - Month Day, Year"> for Health insurance coverage under "Health Booster" with following details:-

Policyholder's Name		**Policy Number**	
Policy Start Date		**Policy End Date**	
Plan Name		**Total premium paid**	

The product is eligible for deduction u/s 80D of the Income Tax, 1961 and any amendments made there to.

Service tax registration number: <Service tax registration no.>.

Sincerely,
For ICICI Lombard General Insurance Company Ltd

Authorized Signatory

***Note**

- This is subject to the provisions of section 80D of Income Tax Act, 1961 and amendments made thereof.
- Details of the Policy as per the Part II and III of Schedule attached to this Policy.
- This certificate must be surrendered to Us in case of cancellation of the Policy. In the event of incorrect representation of this declaration the liability shall be upon the Policyholder.
- In case You find any variations against Your proposal or any discrepancy in the Policy please contact Us immediately on the numbers available on our website www.icicilombard.com.Or call on our toll free no. 1800 2666

You may also write to us at the following address:

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

PART II OF THE SCHEDULE

PREAMBLE

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

1. DEFINITIONS

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

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

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

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

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.

Alternative treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

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

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

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

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

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

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

Company means ICICI Lombard General Insurance Company Limited.

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

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

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

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

Day care centre A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—
--has qualified nursing staff under its employment;
--has qualified medical practitioner/s in charge;
--has a fully equipped operation theatre of its own where surgical procedures are carried out;
--maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Day Care Treatment refers to medical treatment, and/ or *surgical procedure* which is:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
b) Chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it-it continues indefinitely- it comes back or is likely to come back.

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

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

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

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

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

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

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

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

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

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

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

New Born Baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

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

Notification of claim/ Intimation of claims is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

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

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

Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which the Insured had signs or symptoms, and/ or were diagnosed, and/ or received medical advice/ treatment, within 48 months prior to the first Policy issued by the Company.

Pre-hospitalization Medical Expenses are medical expenses incurred immediately before the insured person is Hospitalised provided that:

a) Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
b) The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

Post-hospitalization Medical Expenses are Medical Expenses incurred immediately after the Insured Person is Hospitalised, 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 Hospitalization claim for such Hospitalization is admissible by the Insurance Company

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

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

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

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

Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

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.

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

Room Rent means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

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

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

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

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

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

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

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

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

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

A. Basic Cover:

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

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

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

   We will cover medical expenses for:

   - Hospital room rent
   - Intensive Care Unit charges
   - Medical Practitioners fees
   - Nursing Charges
   - Diagnostics procedures
   - Anesthesia, blood, oxygen, surgical appliances, medicines, drugs and consumables
   - Intravenous fluids, blood transfusion, injection administration charges
   - Operation theatre charges
   - The cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure.

2. Day Care Treatments

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

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

3. In patient AYUSH Hospitalization

We will reimburse expenses for Alternative treatment only when the treatment has been undergone in a Government Hospital or in any Institute recognised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health.
We will not cover expenses for hospitalization done for evaluation or investigation only. Treatment taken at a healthcare facility which is not a Hospital are also excluded.

4. Domiciliary Hospitalization

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

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

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

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

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

a) Any pre or post hospitalization Medical Expenses ; and
b) Medical Expenses incurred by You for treatment of any of the following diseases:
   - Asthma
   - Bronchitis
   - Chronic Nephritis and Chronic Nephritic/Nephrotic Syndrome
   - Diarrhoea and all types of Dysenteries including Gastro-enteritis
   - Diabetes Mellitus and Insipidus
   - Epilepsy
   - Hypertension
   - Influenza, Cough and Cold
   - All Psychiatric or Psychosomatic Disorders
   - Pyrexia of unknown origin for less than 10 days

- Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
- Arthritis, Gout and Rheumatism

5. Donor expenses:

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

- The organ donated is for Your use and We have admitted Your Hospitalisation Claim under the Policy
- The donation conforms to the "Transplantation of Human Organ Act 1994 (amended)
- You have been Medically Advised to undergo an organ transplant
- We will not pay the donor's pre & post medical expenses or any other medical treatment for the donor consequent on the harvesting

6. Pre-Hospitalization and Post-Hospitalization Expenses

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

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

Cover Under this extension will be provided only if,

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

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

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

7. Domestic Road Emergency Ambulance Cover

We will reimburse You up to 1% of Your Sum Insured, maximum upto 5,000 Rs. per Hospitalization, for the reasonable expenses incurred by You on availing ambulance services offered by a Hospital or by an ambulance service provider for Your necessary transportation to the nearest Hospital in case of a life threatening emergency condition, provided however that, a Claim under this extension shall be payable by Us only when:

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

B. Reset Benefit

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

- The total amount of reset will not exceed the Sum Insured for that policy year
- The reset amount can only be used for all future claims within the same policy year, not related to the illness/disease/injury for which a claim has been paid in that policy year for the same person

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

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

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

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

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

E. Wellness Program- Wellness program intends to promote, incentivize and reward You for Your healthy behavior through various wellness services. All the wellness activities as mentioned below make You earn wellness points which will be tracked by Us. You can redeem these wellness points as per Our redemption terms and conditions.
The wellness services and activities are categorized as below:

A. Manage and track Your health
   - Online Health Risk Assessment (HRA)
   - Medical Risk Assessment
   - Preventive Risk Assessment
B. Disease Management Services
C. Medical Concierge Services
D. Affinity to Wellness

A. Manage & Track Your Health:

Online Health Risk Assessment (HRA)

The Health Risk Assessment (HRA) questionnaire is a tool for evaluation of health and quality of life. It helps You review Your personal lifestyle practices which may impact your health status. You can log

into Your account on Our website www.icicilombard.com and take HRA. This can be undertaken once per policy year per insured person.

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

Medical Risk Assessment

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

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

Preventive Risk Assessment

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

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

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

B. Disease Management Services

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

C. Medical Concierge Services

You can also contact Us to avail the following services:

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

D. Affinity to wellness

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

List of Fitness initiatives and wellness points

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

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

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

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

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

Redemption of Wellness Points

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

Terms and conditions under wellness services

- Any information provided by You in this regard shall be kept confidential.
- You should notify and submit relevant documents, reports, receipts etc for various wellness activities within 60 days of undertaking such activity.
- For services that are provided through empanelled service provider, We are only acting as a facilitator; hence would not be liable for any incremental costs or the services.

- All medical services are being provided by empanelled health care service provider. We ensure full due diligence before empanelment. However You should consult Your doctor before availing/taking the medical advices/services. The decision to utilize these advices/services is solely at Your discretion.
- There will not be any cash redemption against the wellness points.
- ICICI Lombard, its group entities, or affiliates, their respective directors, officers, employees, agents, vendors, is not responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which a Member claims to have suffered, sustained or incurred, by way of and / or on account of the Program.
- Services offered are subject to guidelines issued by IRDA from time to time.

(F) Claim Service Guarantee-

We provide You Claim Service Guarantee as follows:

a) **For Reimbursement Claims:** We shall make the payment of admissible claim (as per terms & conditions of Policy) OR communicate non admissibility of claim within 14 days after You submit complete set of documents & information in respect of the claim. In case We fail to make the payment of admissible claim or to communicate non admissibility of claim within this time within this time period, We shall pay 1% interest over and above the rate defined as per IRDA (Protection of Policyholder's Interest) Regulations 2002.

b) **For Cashless Claims:** If You notify pre authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will respond within 4 hours of the actual receipt of such pre authorization request with:
a) Approval, or
b) Rejection, or
c) Query seeking further information

In case the request is for enhancement, i.e. Request for increase in the amount already authorized, We will respond to it within 3 hours.
In case of delay in response by Us beyond the time period as stated above for cashless claims, We shall be liable to pay ₹1,000 to You. Our maximum liability in respect of a single hospitalization shall, at no time exceed ₹1,000.

We will not be liable to make any payments under this Claim Service Guarantee in case of any force majeure, natural event or manmade disturbance which impedes Our ability to make a decision or to communicate such decision to You.
This Claim Service Guarantee shall not be applicable for any cases delayed on account of reasonable apprehension of fraud or fraudulent claims or cases referred to/by any adjudicative forum for necessary disposal.
You may lodge claim separately for the hospitalization claim, Pre-Post hospitalization, optional covers, OPD etc. In such scenarios, if delay happens beyond the time period as specified above, the interest amount calculated will be on the net sanctioned amount of respective transaction and not the total amount paid for the entire claim.
If You are not eligible for 'Claim Service Guarantee' for the reasons stated in the policy conditions, We should inform the same to You, within the 14 days for a) and within 4 hours for b) as specified above.
Any amounts paid towards interest under Claim Service Guarantee will not affect the Sum Insured as specified in the Schedule.

How Deductible works:

- **Top Up Plan:**

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

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

- **Super Top Up Plan:**

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

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

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

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

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

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

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

3. **First 30 days waiting Period:** Any diseases contracted and declared during first 30 days of period of insurance start date except those arising out of Accidents. This exclusion shall cease to apply from first renewal of the Policy with Us.

   This will not be applicable if the Insured person(s) was insured continuously and without interruption for at least 1 year under any other health insurance plan with an Indian non-life insurer as per guidelines on portability issued by the insurance regulator.

4. **Pre- Existing Disease waiting period:** Any Pre-existing condition(s) declared by You and accepted by Us, shall not be covered until 24 months of Your continuous coverage, since inception of this policy

   This waiting period will be reduced by number of continuous preceding years of coverage of the insured person under previous health insurance policy by Us or any other health insurance plan with an Indian non-life insurer as per guidelines on portability issued by the insurance regulator.

   If the Policy is renewed for an enhanced Annual Sum Insured, then the benefit in respect of the Pre-existing Condition(s) shall be restricted to the Annual Sum Insured that is lowest under the Period of Insurance.

Coverage under the policy for any Pre existing diseases is subject to the same being declared at the time of application and accepted by Us without any exclusion.

In the event of non disclosure of Pre existing disease at the time of buying the policy, policy will be null and void and will be cancelled. We will not be liable to pay any claim under such policy.

5. First 2 year exclusion (Specific waiting Period):

For medical diseases/ conditions and treatments/procedures mentioned below, a waiting period of 2 years will be applicable. This will not be applicable only in cases where the procedure is required due to occurrence of cancer.

S.No.	Organ /Organ System	Illness	Treatment/ Procedure
A	ENT	• Sinusitis • Deviated Nasal Septum	• Treatment for conditions related to Tonsils, adenoids, sinuses • Mastoidectomy
B	Gynaecological	• Fibroids (fibromyoma) • Endometriosis • Prolapsed uterus • Polycystic ovarian disorder (PCOD)	• Dilatation and curettage (D&C) • Myomectomy • Hysterectomy
C	Orthopaedic	• Arthritis • Gout and Rheumatism • Osteoarthritis and Osteoporosis • Spinal or Vertebral Disorders	• Surgery for inter vertebral disc • Joint replacement surgeries
D	Gastrointestinal	• Calculus diseases of gall bladder including Cholecystitis • Esophageal Varices • Pancreatitis • Fissure/fistula in anus, hemorrhoids, pilonidal sinus, piles • Ulcer and erosion • Gastro Esophageal Reflux Disorder (GERD) • Perineal Abscesses • Perianal Abscesses	• Cholecystectomy • Procedures for Biliary stones
E	Uro-genital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone etc. • Benign enlargement of Prostate • Chronic Kidney Disease	• Surgery on prostate • Surgery for Hydrocele/ Rectocele • Dialysis
F	Eye	• Cataract	• PHACO emulcification • Any other cataract surgery
G	Other General conditions(Applicable to all organ systems/ organs/ disciplines	• Internal tumors, cysts, nodules, polyps, skin tumors, Lumps, All types of Internal congenital anomalies/illnesses/defects	• Surgery of varicose veins and varicose ulcers • Varicocele • Surgery for any Hernia

	whether or not described above)		

In case the above Illnesses are Pre-Existing Disease at the commencement of this Policy, then these Illnesses shall be covered after 24 months of continuous coverage, since Period of Insurance Start Date.

This waiting period will be reduced by number of continuous preceding years of coverage of the insured person under previous health insurance policy in case of portability.

6. Permanent exclusions

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

i. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.
ii. Cost of routine medical, eye and ear examinations, preventive health check-up, cost of spectacles, laser surgery for correction of refractory errors, contact lenses or hearing aids, dentures and artificial teeth.
iii. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind(like wheelchairs, crutches), instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.), oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively.
iv. Expenses incurred on all dental treatment unless necessitated due to Accident.
v. Personal comfort, cosmetics convenience and hygiene related items and services.
vi. Alternative treatment except AYUSH
vii. Circumcision unless necessary for treatment of a disease or necessitated due to an Accident.
viii. Vaccination and inoculation of any kind unless it is post animal bite.
ix. Sterility, venereal disease or any sexually transmitted disease.
x. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise) and Injury or Illness due to use, misuse or abuse of intoxicating drugs or alcohol.
xi. Any expense incurred on treatment of mental Illness, stress, psychiatric or psychological disorders.
xii. Aesthetic treatment, cosmetic surgery and plastic surgery including any complications arising out of or attributable to these, unless necessitated due to Accident or as a part of any Illness.
xiii. Any treatment/ surgery for change of sex or treatment/ surgery / complications/ Illness arising as a consequence thereof.
xiv. Any expense incurred on treatment arising from or traceable to fertility, infertility, sub fertility or assisted conception treatment or sterilization or procedure, birth control procedures and hormone replacement therapy. However, this exclusion do not apply to ectopic pregnancy proved by diagnostic means and is certified to be life threatening by the Medical Practitioner.
xv. Treatment relating to birth defects and external) congenital Illnesses or defects or anomalies.
xvi. All expenses arising out of any condition directly or indirectly caused to or associated with Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

xvii. Charges incurred at Hospital primarily for evaluative or diagnostic or observation purposes for which no active treatment is given, X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalisation

xviii. Expenses on supplements, vitamins and tonics unless forming part of treatment for Illness as certified by the attending Medical Practitioner.

xix. Weight management services and treatment, vitamins and tonics related to weight reduction programmes including treatment of obesity (including morbid obesity), any kind of weight loss treatment irrespective of the reason for such treatment, any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition and rest cure.

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

xxi. Experimental, unproven or non standard treatment/ device which is not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury.

xxii. Any Illness or Injury resulting or arising from or occurring during the commission of continuing perpetration of a violation of law by You with criminal intent

xxiii. Treatment received outside the country.

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

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

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

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

xxviii. Treatment arising from or traceable to pregnancy (this exclusion does not apply to ectopic pregnancy proved by diagnostic means and is certified to be life threatening by the Medical Practitioner) and childbirth, miscarriage and abortion. This exclusion will not be applicable if any of the maternity complications as listed under 'Maternity complication benefit cover' occurs.

xxix. Expenses attributable to self-inflicted Injury (resulting from suicide, attempted suicide)

xxx. The performance of adventure sports of any kind.

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

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

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

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

Condition based specific exclusion clause:

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

We will give You an intimation by post/ phone call/ e-mail regarding this term & condition. We will issue You a Policy only if You accept this condition based exclusion. You have to revert Us in 15 days for the same. If You do not, it would be considered as non acceptance and Policy will not be issued.

4. CLAIM ADMINISTRATION

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

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

1. Notification of Claim

For Reimbursement

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

For Cashless Services

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

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

2. Claims procedure

i. For Cashless Settlement

Cashless treatment is only available at a Network Provider (List of Network Provider is available at our website. The list is updated as and when there is any change in the Network Provider). In order to avail of cashless treatment, the following procedure must be followed by You:

Pre-authorization

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

To avail of Cashless Hospitalization facility, You are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card. We will consider Your request after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalization facility is sought by You and We will confirm Your request in writing.

ii. For Reimbursement Settlement

a) You shall give notice to Us or Our In house claim processing team by calling the toll free number as specified in the Policy provided to You and also in writing at Our address with particulars as below:

- Policy number
- Your Name
- Your relationship with the Policyholder
- Nature of Illness
- Name and address of the attending Medical Practitioner and the Hospital
- Any other information that may be relevant to the Illness/ Hospitalization

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

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

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

However, in both the above cases i.e. 2 (i) & 2(ii), You must take reasonable steps or measure to minimise the quantum of any Claim that may be covered under the Policy

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

Kindly note that the Company has de-listed few of the hospitals and the Company shall not service any claims including re-imbursement claims for the treatment undertaken at these hospitals. List of de-listed hospitals is available at our website.

3. Claim documents

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

a) Duly completed Claim form signed by You and the Medical Practitioner (Claim form can be downloaded from our website www.icicilombard.com)
b) Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner
c) Original bills from chemists supported by proper prescription.

d) Original investigation test reports and payment receipts.
e) Indoor case papers
f) Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.
g) Any other document as required by Us or Our In house claim processing team to investigate the Claim or Our obligation to make payment for it

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

4. Claim assessment in case of Co payment

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

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

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

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

5. Settlement/ Rejection of Claim

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

Penal interest provision shall be as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2002.

6. Claim falling in two Policy periods

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

SPECIAL CONDITIONS APPLICABLE TO THE POLICY

It is hereby declared and agreed that:

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

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

the Policy Holder / You or Hospital or someone claiming on Your behalf shall be considered as a complete discharge of Our liability against any Claim under the Policy.

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

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

Portability Benefits:

If You were insured continuously and without a break under another Indian retail health insurance policy with any other Indian non-life Insurance company or stand alone Health Insurance company, it is understood and agreed that:

a) You should provide Us Your application and the completed Portability Form with complete documentation at least 45 days before the expiry of Your present period of insurance in case You wish to avail Portability benefits.

b) Portability benefit is available only at the time of renewal of the existing health insurance policy.

c) Portability benefit is available only upto the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

d) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions/waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

e) The portability shall be applicable to the Sum Insured under the previous policy and also to an enhanced Sum Insured, if requested by the insured, to the extent of cumulative bonus acquired from the previous insurer(s) under the previous policies.

For e.g. – If a person had a SI of ₹ 4lacs and accrued bonus of ₹ 40,000 with insurer A, when he shifts with Us, We will offer him SI of ₹ 5lacs by charging the premium applicable for ₹ 5 lacs SI.

Following extensions are being offered to You as optional covers under this product. These benefits are available w.r.t. the members, for whom these optional covers have been opted by You by paying additional premium.

<Extensions / Endorsements.....>

PART III OF THE POLICY SCHEDULE

General Terms and Conditions

1. **Incontestability and Duty of Disclosure:** The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or on non-disclosure in any material particular in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or devices being used by You or any one acting on Your behalf to obtain any benefit under this Policy.

2. **Reasonable Care**: You shall take all reasonable steps to safeguard Your interests against Accidental loss or damage that may give rise to the Claim.

3. **Observance of terms and conditions:** The due observance and fulfilment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by You, shall be a condition precedent to Our liability to make any payment under this Policy.

4. **Material change**: You shall notify Us 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 We may, adjust the scope of cover and / or premium, if necessary, accordingly.
5. **Records to be maintained**: You shall keep an accurate record containing all relevant medical records and shall allow Us to inspect such record. You shall exercise all necessary co-operation in obtaining the medical records from the Hospital, and furnish them as We may require in relation to the Claim within reasonable time limit and within the time limit specified in the Policy.

6. **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.

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

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

9. **Your duties on occurrence of loss**: On the occurrence of any loss, within the scope of cover under the Policy, You shall:
   Forthwith file/ submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in Part II of the Policy.
   Assist and not hinder or prevent Us or any of Our representative from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.
   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.

10. **Subrogation:** You and any claimant under this Policy shall at no cost or expense to Us do whatever is necessary to enable Us to enforce any rights and remedies or obtain relief or indemnity from other parties to which We would become entitled or subrogated upon Us paying for or making good any Claim or loss under this Policy whether such acts and things shall be or become necessary or required by Us or otherwise before or after Your indemnification by Us. However, this condition shall not be applicable for all the benefit based covers under the Policy, as applicable.

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

12. **Fraudulent Claims:** If any Claim 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 You or anyone acting on Your behalf to obtain any benefit under this Policy, or if a Claim is made and rejected and no court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

13. **Terms of renewal**

a) A health insurance Policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured
b) **Renewal Premium** - Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDA.
c) **Lifetime renewability**
d) **Grace Period** - Grace Period of 30 days from the expiry of the Policy is provided. We will not be liable for any Claim which occurs during the Grace Period.
e) In the likelihood that this Policy is revised/ modified/withdrawn in future, we will intimate the insured person regarding the same at least 3 months prior to expiry of the Policy. In case of withdrawal, the insured person have the option to migrate to the nearest substitute Policy as available with Us at the time of renewal with all the continuity benefits, provided the Policy has been maintained without a break as per the IRDA portability guidelines.
f) If a claim becomes payable under Critical Illness optional cover, it will not be offered on subsequent renewal.
g) In case of any change in risk material to the queries raised in proposal form, medical examination report to be provided on renewal.

Sum Insured Enhancement – You can enhance Your sum insured under the Policy, for the same deductible, only upon renewal, subject to underwriters' approval. If the Policy is renewed for an enhanced Annual Sum Insured, then fresh waiting period will be applicable to this enhanced limit from the effective date of such enhancement.

14. **Automatic Termination of Policy:**

The coverage for the Insured Person shall automatically terminate if:

a) You no longer reside in India, or in the case of Your demise. However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case, the 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 You) must be given to Us along with the application.

b) Upon exhaustion of Policy Sum Insured

In case of individual Sum Insured Policy, where no claim has been made, and automatic termination takes place on account of death of the insured person, pro-rate refund of premium of the deceased Insured Person for the balance period of the Policy will beeffected.

In case of floater policy no refund shall be made on account of death of any one or more insured person/s, unless the entire policy is cancelled.

15. Cancellation/ termination of the policy

a) **Disclosure to information norm:** The Policy shall be void and premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
b) You may cancel the Policy during free look period (15 days from the date you receive the Policy) in which case we will refund the premium paid subject only to a deduction of the expenses incurred by Us on medical examination of the Insured Person(s) and the stamp duty charges.
c) You may cancel this Policy by giving Us 15 days written notice for the cancellation of the Policy by registered post, and then We shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below, provided no claim has been payable on Your behalf under the Policy:

Cancellation Period	Refund % for 1 year tenure policy	Refund % for 2 years tenure policy	Refund % for 3 years tenure policy
Within 1 month	80%	80%	80%
From 1 month to 3 months	60%	70%	70%
From 3 months to 6 months	40%	60%	65%
From 6 months to 9 months	20%	50%	60%
From 9 months to 12 months	0%	40%	55%
From 12 months to 15 months	NA	30%	45%
From 15 months to 18 months	NA	20%	40%
From 18 months to 21 months	NA	10%	35%
From 21 months to 24 months	NA	0%	25%
From 24 months to 27 months	NA	NA	20%
From 27 months to 30 months	NA	NA	10%
From 30 months to 33 months	NA	NA	5%
From 33 months to 36 months	NA	NA	0%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Policy/ Certificate of Insurance where any claim has been admitted by Us or has been lodged with Us or any benefit has been availed by the You under the Policy.

d) We may cancel the policy on grounds of mispresentation, fraud, non-disclosure or non- cooperation of the insured, by giving You 15 days notice for the cancellation. There would be no refund of premium on cancellation by Us on grounds of mispresentation fraud or non-disclosure. In case of non-cooperation of insured, policy will be cancelled with premium refund on pro rata basis.

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

17. **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.

18. **Arbitration clause:** If any dispute or difference shall arise as to the quantum to be paid under this 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 to the dispute/ difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of 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. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

    It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as herein before provided, if We have disputed or not accepted liability under or in respect of this Policy.

19. **Free Look Period:** You would be given a period of 15 days (Free Look Period) from the date of receipt of the Policy to review its terms and conditions. Where the Policy Holder disagrees to any of the terms or conditions of the Policy, he has the option to return the Policy stating the reasons for his objection.

    If insured has not made any claim during free look period, insured will be entitled to:
    - A refund of premium paid less any expenses incurred by Us on medical examination of the Insured Person(s) and the stamp duty charges, or;
    - Where the risk has already commenced and the option of return of policy is exercised by You, a deduction towards the proportionate risk premium for period on cover or;
    - Where only a part of risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

In case the request for cancellation is done 15 days after the receipt of Policy by You, we would refund premium on short term rates to You.

20. **Renewal notice:**
    a) We shall ordinarily renew the Policy except on grounds of moral hazard, misrepresentation or fraud or non cooperation by the Insured. We shall not be bound to give notice that the renewal premium is due. However renewal intimation will be made available as required. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to You that may result to enhance Our risk under the guarantee hereby given. Any change in the risk will be intimated by You to Us.
    b) The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to Us on or before the date of expiry of the Policy and in no case later than Grace Period of 30 days from the expiry of the Policy.

21. **Notices:** Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post:

    To You, at Your last-known address

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

In addition, we may send You other information through electronic and telecommunications means with respect to Your Policy from time to time.

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

22. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified, during normal business hours. You can also call at Our toll free No.

23. Grievances

In case You are aggrieved in any way, You should do the following

1. For resolution of any query or grievance, Insured may contact the respective branch office of The Company or may call us at toll free no. 1800 2666 or email us at customersupport@icicilombard.com or write to us at ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai- 400025.

2. If you are not satisfied with the resolution provided, you may approach us at the sub section "Grievance Redressal" on our website www.icicilombard.com (Customer Support section).

3. In case Your complaint is not fully addressed by the insurer, You may use the Integrated Greivance Management System (IGMS) for escalating the complaint to IRDA. Through IGMS You can register your complain online and track its status. For registration please visit IRDA website www.irda.gov.in .If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.

   The details of Insurance Ombudsman are available below:-

Jurisdiction	Ombudsman office
Dadra & Nagar Haveli, Daman and Diu	2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014.
Karnataka	Jeevan Soudha Building,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru.
Madhya Pradesh, Chattisgarh	Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.
Orissa	62, Forest park, Bhubneshwar – 751 009.
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh	S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017.
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)	Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI 600 018.
Delhi	2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh,	Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).

Nagaland and Tripura	
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry	6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.
Rajasthan	Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur
Kerala, Lakshadweep, Mahe-a part of Pondicherry	2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.
West Bengal, Sikkim, Andaman & Nicobar Islands	Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.
Uttar Pradesh	6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.
State of Uttaranchal, Uttar Pradesh	Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, G.B. Nagar, Noida.
Bihar, Jharkhand	1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006.
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan	Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.

The updated detail of Insurance Ombudsman is available at IRDA website: www.irda.gov.in , on the website of General Insurance Council: www.generalinsurancecouncil.org.in or Our website www.icicilombard.com and can be obtained from the any of Our offices.