Key Information Sheet

S.No	Title	Description					Refer To Policy Wordings
1.	**Product Name**	**iHealth (ICICI Lombard Complete Health Insurance)**					
2.	What am I covered for	Benefit as per Sum Insured Opted:					Part II of the Schedule Clause 2. Scope of the Cover
		Sum Insured (`)	**2 lacs**	**3 lacs/ 4 lacs/ 5 lacs**	**7 lacs/ 10 lacs**	**15Lacs/ 20Lacs/ 30Lacs 50Lacs**	
		In Patient treatment	Covers Hospital expenses for admission longer than 24 hours				
		Pre & Post Hospitalisation	Medical Expenses incurred due to Illness up to 30 days period immediately before and 60 days immediately after an Insured Person's admission to a Hospital				
		Day Care Procedure	Medical expenses for day care procedures where such procedures are undertaken by an Insured Person as an In-patient in a Hospital for continuous period of less than 24 hours				
		In Patient AYUSH Hospitalisation	Reimbursement of expenses for AYUSH treatment				
		Domestic Road Emergency Ambulance	Ambulance expenses incurred to transfer the Insured Person following an emergency to the nearest Hospital. Maximum amount payable is ` 1,500 per event of emergency hospitalisation				Extension 5 - Domestic Road Emergency Ambulance Cover
		Cover for Pre Existing disease	After 4 Years	After 2 Years			
		Wellness Program	Applicable				Part II of the Schedule Clause 2. Scope of the Cover
		Reset Benefit	Not Applicable	Applicable			
3.	Optional Add On Covers	**Hospital Daily Cash**	Allowance per day for hospital stay of minimum 3 consecutive days or more up to a maximum of 10 consecutive days.				Extension 1 - Hospital Daily Cash
			` 500 per day	` 1,000 per day	` 2,000 per day	` 3,000 per day	
		Convalescence Benefit	` 10,000 provided once for each Policy year during Policy Period, in case of Hospitalisation of minimum 10 consecutive days or more				Extension 2 - Convalescence Benefit
		Critical Illness	Critical Illness cover for specified critical Illnesses/ medical procedures like Cancer of specified severity, open chest CABG, First heart attack, major organ/bone marrow transplant, permanent paralysis of limbs, Kidney failure requiring regular dialysis, end stage liver disease; subject to a maximum of 2 adults.				Extension 7 - Critical Illness Cover
			NA	100% of policy SI		50% of policy SI	
		Donor Expenses	Medical Expenses incurred in respect of the donor for any of the organ transplant surgery, provided the organ donated is for Insured persons, subject to a maximum of 2 adults				Extension 9 - Donor Expenses
			NA		Up to ` 50,000		

4.	Value Added Services	* Free health check-up coupon to Insured for every Policy Year, subject to a maximum of 2 coupons per year for floater policies. * Online Chat with Medical Practitioners * Specialist e-Consultation with One Follow-up session * Diet & Nutrition e-consultation	Part II of the Schedule Clause 2. Scope of the Cover
5.	What are the major Exclusions in the Policy	**Note: Following is an indicative list of the policy exclusions. Please refer to the policy clause for the complete list.** * Acupressure, acupuncture, magnetic and such other therapies * Unproven experimental treatment * Any expenses arising out of Domiciliary Treatment * Treatment taken outside the country * Cosmetic surgery	Part II of the schedule Clause 3.5 Permanent Exclusions
6.	Waiting Period	(a) **Pre-existing diseases:** Covered after 24 months (48 months, for plans with Sum Insured up to 2Lacs) of continuous coverage. (b) **Specific waiting period:** First 24 months, for specific Illness and treatment. (Please refer to the policy clauses for the full listing) (c) In case of hypertension, diabetes and cardiac conditions, the waiting period will be 90 days unless disclosed as pre-existing (d) **Initial waiting period:** 30 days for all illnesses (except Hospitalisation due to injury).	Part II of the schedule Clause 3.1 Clause 3.2 Clause 3.3 Clause 3.4
7.	Payout Basis	* Cashless or Reimbursement of covered medical expenses up to specified Sum Insured as per the scope of cover * Claim Service Guarantee * Cashless Facility available at over 4000+ network hospitals.	Part II of the schedule 4. Claim Administration
8.	Sub Limit	(a) Cataract, where sub-limit of ` 20,000/- is applicable per eye per Policy year for Plans with Sum Insured up to 5 Lacs. Sub limit of ` 1,00,000 per eye per Policy year will be applicable for cataract treatment for plans with Sum Insured above ` 5Lacs (b) Sub limit options of A and B available for Sum Insured option 2 lacs and Sub limit C option is available for 3 lacs/ 4 lacs/ 5 lacs (c) No Sub limits applicable on Sun Insured 7 lacs/ 10lacs	Part II of the schedule Clause 3.2
9.	Renewal Condition	(a) **Maximum renewal age -** There will be life-long renewable without any age restriction for the cover. However Premium at the time of renewal is subject to change with change in age band. (b) **Grace Period -** The renewal premium shall be paid to Us on or before the date of expiry of the Policy and in no case later than 30 days (Grace Period) from the expiry of the Policy (c) **Floater Benefit -** The floater benefit under this policy is available up to lifetime	Part III of the schedule 17. Renewal
10.	Renewal Benefits	(a) Cumulative Bonus (Additional Sum Insured) - An Additional Sum Insured of 10% of Annual Sum Insured provided on each renewal for every claim-free year up to a maximum of 50%. In case of a claim under the policy, the accumulated Additional Sum Insured will be reduced by 10% of the Annual Sum Insured in the following year. (b) Complimentary Health Check Up Coupons: One coupon per individual policy and two coupons per Floater policy will be offered.	Part II of the schedule 2. Scope of the Cover
11.	Cancellation	a) Disclosure to information norm: The policy shall be void and all premium paid hereon shall be forfeited to the company, in the event of misinterpretation, mis-description or non-disclosure of any material fact. b) 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.	Part III of the schedule 11. Cancellation

Policy Wordings

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

PART II OF THE 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:

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 inpatient for the purpose of medical treatment of an Injury and/or Illness.

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

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

a) Central or State government AYUSH hospital; or
b) Teaching hospital attached to AYUSH college recognized by the central government/ Central council of Indian medicine/ Central council for Homeopathy; or
c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH medical practitioner and must comply with the following criterion:

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
iv. Explanation: Medical practitioner referred in the definition of "AYUSH Hospital" and "AYUSH day care center" shall carry the same meaning as defined in the definition of "Medical practitioner" under chapter I of Guidelines)

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

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

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

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.

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

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

Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured/ proposer will bear a specified percentage of the admissible claims 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.

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

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

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

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 hospitalisation of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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 supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner/s in charge
iii. has 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.

Deductible is a cost sharing requirement under a health insurance policy that provides that We will not be liable for specified rupee amount in case of indemnity policies and for a specified number of days/ hours in case of hospital cash policy, which will apply before any benefits are payable by Us.

This is to clarify that a deductible does not reduce the sum insured.

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

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

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

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

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

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

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

i. Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
ii. Has qualified nursing staff under its employment round the clock;
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 will make these accessible to the Insurance company's authorized personnel.

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

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

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

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

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

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

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

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

Maternity Expenses shall include -

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation);
ii. Expenses towards lawful medical termination of pregnancy during the policy period.

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

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

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

Medically necessary is defined as 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 standard widely accepted in international medical practice or by the medical community in India

Medical Practitioner is a person who holds a valid registration from Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude You and Your Immediate Family. "Immediate Family would comprise of Your spouse, dependent children, brother(s), sister(s) and dependent parent(s).

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

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

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

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

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

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

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

Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to

or forming part thereof. The Policy contains details of the extent of cover available to You, what is excluded from the cover and the terms & conditions on which the Policy is issued to You.

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

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

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

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

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

(a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement

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

Post Hospitalisation Medical Expenses means medical expenses incurred immediately after the Insured Person is discharged from the hospital, provided that:

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

Pre Hospitalisation Medical Expenses means medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:

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

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

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

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.

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.

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

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

The list of the Service Providers is available at c (https://www.icicilombard.com/content/ilom-en/serviceprovider and is subject to amendment from time to time.

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

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

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

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

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

2. WHAT WE WILL PAY (SCOPE OF COVER)

A) In-patient Treatment

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

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

B) Day Care Procedures/Treatment

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

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

C) Pre-Hospitalisation and Post-Hospitalisation Expenses

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

i. Pre-hospitalisation Medical Expenses incurred by You for a 30-day period immediately prior to Your Hospitalisation; and
ii. Post-hospitalisation Medical Expenses incurred by You for a 60-day period immediately post Hospitalisation, provided that Your Hospitalisation falls within the Policy year and We have accepted Your Claim under **"In-patient Treatment"** or **"Day Care Procedures"** section of the Policy. However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Maximum Limit of Indemnity as stated in the Policy Schedule.

D) In Patient AYUSH Hospitalisation - We will reimburse expenses for AYUSHtreatment only when the treatment has been undergone in a AYUSH Hospital or AYUSH Day Care centre.

We will not cover expenses for hospitalisation done for evaluation or investigation only. Treatment taken at a healthcare facility which is not a Hospital are also excluded.

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

E) Reset Benefit

For plans with Sum Insured ` 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 as per section "Scope of cover" in part II of Policy Schedule.
* 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
  1. The Sum Insured, and
  2. Additional Sum Insured
* During a Policy Year, the aggregate claim amount payable, shall not exceed the sum of:
  1. The Sum Insured
  2. Additional Sum Insured
  3. Reset Sum Insured

F) 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:

1. Manage and track Your health
   * Online Health Risk Assessment (HRA)
   * Medical Risk Assessment
   * * Preventive Risk Assessment
2. Disease Management Services
3. Medical Concierge Services
4. Affinity to Wellness

B. 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

C. 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.

D. 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

E. 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

G) Additional Sum Insured (Cumulative Bonus) - It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, at the time of renewal of this Policy, We will provide an additional sum insured (Cumulative Bonus) provided that there is no Claim under this Policy

Tenure	Additional Sum Insured as a percentage of Annual Sum insured
For all insured persons	
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 will be reduced by 10% of the Annual Sum Insured at the time of renewal of this Policy. This extension is also subject to the following:

In relation to a Floater Benefit cover, the Additional Sum Insured so accrued during the Claim-free Policy year(s) will also be on floater basis and will only be available to those Insured Person(s) who were insured in such Claim-free Policy year(s) and continue to be insured in the subsequent Policy year(s).

H) Value-Added Services

Notwithstanding anything to the contrary in the Policy, We at your request will arrange for You or will facilitate You in availing any of the following additional services subject to a limit as specified in the Policy Schedule, on issuance or upon renewal of the Policy for a continuous period from Period of Insurance Start Date, as specified in the Policy Schedule, including but not limited to:-

a) Free health check-up coupons to each insured for every Policy Year, subject to a maximum of 2 coupons per year for floater policies.
b) Vaccination care cover
c) E-opinion (Second opinion) of an expert Medical Practitioner from Our designated centers, with respect to critical Illnesses and procedures
d) Other value added services
   i. Diet & nutrition e-consultation
   ii. Online Chat with Medical Practitioners
   iii. Provide information on offers related to healthcare services like consultation, diagnostics, medical equipment and pharmacy
e) Health assistance: We also provide Health Assistance as a part of Our Value added services, Our Health Assistance Team (HAT) will assist the Insured Person in understanding his/her health condition better by providing answers to any queries related to health and health care providers on Our dedicated helpline. To avail this service, the Insured Person may call Our helpline on 040-66274205 (please note that this number is subject to change).

The services provided under this shall include:

- Identifying a Physician/ Specialist
- Scheduling an appointment with any Medical Practitioner empanelled 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.
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.

Please note that services provided under this Benefit are solely for assistance, and should not be construed to be a substitute for a visit/ consultation to an independent Medical Practitioner. This Benefit does not include the charges for any independent Medical Practitioner/nutritionist 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

While deciding to obtain such value-added service, You expressly note and agree that it is entirely for You to decide whether to obtain these services and also to decide the use (if any) to which these services is to be put for

3. WHAT WE WILL NOT PAY (EXCLUSIONS UNDER THE POLICY)

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

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

3.1 Code-Excl01: Pre-Existing Diseases

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months (48 months for plans with Sum Insured up to 2Lacs) of continuous coverage after the date of inception of the first policy with insurer.

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

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

d) Coverage under the policy after the expiry of 24 months (48 months for plans with Sum Insured up to 2Lacs) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3.2 Code-Excl02: Specified disease/procedure waiting period

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

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

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

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

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

List of specific diseases/procedure:

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

* After two years from the Period of Insurance Start Date, Our maximum liability arising out of any Claim for a cataract treatment shall not exceed ` 20,000 per eye, during each Policy Year of the Policy Period for plans with Sum Insured up to ` 5Lacs. Sub limit of ` 1,00,000 per eye per Policy year will be applicable for Cataract surgery for plans with Sum Insured above ` 5Lacs.

In case the above Illnesses are Pre-existing condition(s) at the commencement of this Policy, then these Illnesses shall be covered after 24 months (48 months for plans with Sum Insured upto 2Lacs) of continuous coverage has elapsed, since Period of Insurance Start Date.

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

i. Hypertension
ii. Diabetes
iii. Cardiac Conditions

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

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

3.4 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 months (48 months for plans with Sum Insured up to 2Lacs)

3.5 Permanent Exclusions

Unless covered by way of an appropriate Extension/ Endorsement, We shall not be liable to make any payment under this Policy in connection with or in respect of any expenses whatsoever incurred by You in connection with or in respect of:

i. Code- Excl04: Investigation & Evaluation

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

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

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

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. Code- Excl06: Obesity/ Weight Control

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

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

iv. Code- Excl07: Change of Gender treatments

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

v. Code- Excl08: Cosmetic or plastic Surgery

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

vi. Code- Excl09: Hazardous or Adventure sports

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

vii. Code- Excl10: Breach of law

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

viii. Code- Excl11: Excluded Providers

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

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

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

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

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

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

xiv. Code- Excl17: Sterility and Infertility: Expenses related to sterility and infertility. This includes:
(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

xv. Code- Excl18: Maternity: Medical treatment expenses tracable 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)

xvi. Any physical, medical or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions

xvii. 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.

xviii. Expenses incurred on dental treatment unless necessitated due to an Accident

xix. Personal comfort, cosmetics, convenience and hygiene related items and services

xx. Acupressure, acupuncture, magnetic and other therapies

xxi. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident.

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

xxiii. Any expenses arising out of Domiciliary Hospitalisation treatment

xxiv. Treatment taken outside the country

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

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

xxvii. 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

xxviii. 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

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 each of 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:

4.1 CLAIMS PROCEDURE

A) For Cashless Settlement

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

Pre-authorization

Prior to taking treatment and/or incurring Medical Expenses at a Network Provider, You must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request preauthorization at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation. To avail of Cashless Hospitalisation facility, you are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card Or You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. We will consider Your request after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalisation facility is sought by You and We will confirm Your request in writing.

B) For Reimbursement Settlement

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

i. 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 However, in both the above cases i.e. 4.1(A) & (B), You must take reasonable steps or measure to minimise the quantum of any Claim that may be covered under the Policy If so requested by Us 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

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 Deductions 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.

4.2 CLAIM DOCUMENTS

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

i. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from our website www.icicilombard.com
ii. Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner
iii. Original bills from chemists supported by proper prescription.
iv. Original investigation test reports and payment receipts.
v. Indoor case papers
vi. Medical Practitioner's referral letter advising Hospitalisation in non-Accident cases.
vii. Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it

4.3 Claim Service Gurantee

We provide You Claim Service Gurantee as follows

a) **For Reimbursement Claims:** We shall make the payment of admissible claim (as per terms & conditions of Policy) OR communicate non admissibility of claim within 14 days after You submit complete set of documents & information in respect of the claims. In case We fail to make the payment of admissible claims or to communicate non admissibility of claim within the time period, We shall pay 2% interest over and above the rate defined as per IRDA (Protection of Policyholder's interest) Regulation 2002.

b) **For Cashless Claims:** If You notify per 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 hospitalisation shall, at no time exceed ` 1,000.

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

The service gurantee shall not be applicable for any cases delayed o 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 hospitalisation claim, Pre-Post hospitalisation, optional covers, OPD etc. In such scenario, if delay happens beyond the time period as specified above, the interest amount calculated will be on the net sanctioned amount of respective transaction and not the total amount paid for the entire claim.

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

If you are not eligible for 'Claim Service Guarantee' for the reasons stated above, We will inform the same to You, within 14 days in case of a) and within 4 hours in case of b) above.

PART III OF THE POLICY

General Terms and Conditions

1. Disclosure of Information

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

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

2. Claim Settlement (provision for Penal Interest)

I. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2o/o % above the bank rate.

III. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

IV. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2o/o above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

3. Moratorium Period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 eight continuous years would be applicable from date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy contract.

4. 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

5. Material change

You shall notify Us in writing of any material change in the risk in relation to the declarations 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.

6. Records to be maintained

You shall keep an accurate record containing all relevant medical records and shall allow Us to inspect such records. 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.

7. Complete Discharge

Any payment to the policyholder, 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

8. Notice & Communication.

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

9. Territorial Limit

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

10. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the inusred person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurers from whom he/she wants to claim the balance amount.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

11. 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 mis-statement of or suppression of material fact are within the knowledge of the insurer.

Cancellation

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

Cancellation period	Refund % for 1 year tenure Policy	Refund % for 2 year tenure Policy	Refund % for 3 years tenure policy
Within 1 month	80%	80%	80.00%
From 1 month to 3 months	60%	70%	75.00%
From 3 months to 6 months	40%	60%	67.50%
From 6 months to 9 months	20%	50%	60.00%
From 9 months to 12 months	0%	40%	52.50%
From 12 months to 15 months		30%	47.50%
From 15 months to 18 months		20%	40.00%
From 18 months to 21 months		10%	32.50%
From 21 months to 24 months		0%	25.00%
From 24 months to 27 months			20.00%
From 27 months to 30 months			12.50%
From 30 months to 33 months			5.00%
From 33 months to 36 months			0.00%

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

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

12. Automatic change in Coverage under the policy

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

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

ii. Upon exhaustion of sum insured and 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.

13. 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.

14. 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.

15. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 3O days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance producuplan offered by th company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration

For Detailed Guidelines on migration, kinc https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layo

16. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kinc https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layo

17. Renewal of Policy

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

I. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
II. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
III. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
IV. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period
V. No loading shall apply on renewals based on individual claims experience

18. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

19. Policy alignment

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

Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.

20. Premium Payment in Instalments (Wherever applicable)

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

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

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

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

22. Free look period

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

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

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

a) a refund of the premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges; or
b) where the risk has already commenced and the option of return of the Policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
c) where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

23. Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of

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

ii. The proposer may be changed only at the time of renewal. The new proposer must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.
iii. The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.
iv. Mid-term endorsement of addition of member in the policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation

24. Change of Sum Insured

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

25. 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.

26. Redressal of Grievances

In case of any grievance the insured person may contact the company through
Website : www.icicilombard.com
Toll Free : 1800 2666
E-Mail: customersupport@icicilombard.com
Courier: ICICI Lombard General Insurance Company Ltd.
ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai- 400025
Insured person may also approach the grievance cell at any of the company's branches with the details of grievance
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at Manager-Service Quality, Corporate Manager- Service Quality, National Manager- Operations & finally Director-services and Business development at the following address:

ICICI Lombard General Insurance Company Limited,
ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400025
For updated details of grievance officer, kindly refer the link.. .https://www.icicilombard.com/grievance-redressal...
If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Grievance may also be lodged at IRDAI Integrated Grievance Management System https:/ligms.irda.qov.in/

Extensions/ Endorsements available under ICICI Lombard Complete Health Insurance

Mandatory Extensions/ Endorsements under the Plan

Extension 5: Domestic Road Emergency Ambulance Cover

In consideration of the payment of additional premium to Us, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy and subject always to the Annual Sum Insured for this Extension, We will reimburse You up to a maximum of `1500/- per Hospitalisation, 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:

(i) Such life threatening emergency condition is certified by the Medical Practitioner, and
(ii) We have accepted Your Claim under "In-patient Treatment" or "Day Care Procedures" section of the Policy.

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

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.

Extension 1: Hospital Daily Cash

In consideration of the payment of additional premium to Us, it is hereby declared and agreed that notwithstanding

anything to the contrary in the Policy and subject always to the Annual Sum Insured for this Extension, We will pay You a daily cash amount, as stated against this Extension in the Policy Schedule, for each and every completed day of Hospitalisation up to a maximum of 10 consecutive days, if such Hospitalisation is at least for a minimum of 3 consecutive days and it falls within the Policy Year. The Claim under this extension will be payable only if We have admitted Our liability under "In-patient Treatment" section of the Policy.

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

Extension2: Convalescence Benefit

In consideration of the payment of additional premium to Us, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay You an amount of ` 10,000 if You are Hospitalized for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy. This benefit is payable only once to an Insured Person during each Policy Year of the Policy Period.

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

Extension 9: Donor Expenses

In consideration of the payment of additional premium to Us, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will indemnify You up to an amount not exceeding ` 50,000 for the Medical Expenses incurred in respect of the donor for any of the organ transplant surgery, provided the organ donated is for Your use and We have admitted Your Hospitalisation Claim under the Policy.

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

Extension 7: Critical Illness Cover

In consideration of the payment of additional premium to Us, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay You the sum insured as stated against this Extension in the Policy Schedule, in case You are diagnosed as suffering from one or more of the Critical Illnesses for the first time in your life, during the Policy Period.

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

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

1) Cancer of specified severity

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

The following are excluded -

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

2) Open chest CABG

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graph (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

The following will be excluded:

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

3) First heart attack - of specified severity

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

i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
ii. new characteristic electrocardiogram changes
iii. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris.

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

4) Kidney failure requiring regular dialysis

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

5) Major organ/ bone marrow transplant

The actual undergoing of a transplant of:

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

The following are excluded:

i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

6) Stroke resulting in permanent symptoms

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

The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain

Vascular disease affecting only the eye or optic nerve or vestibular functions.

7) Permanent paralysis of limbs

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

8) Open heart replacement or repair of heart valves

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

9) End stage liver disease

Permanent and irreversible failure of liver function that has resulted in all three of the following:

a) Permanent jaundice; and
b) Ascites; and
c) Hepatic encephalopathy.
d) Liver failure secondary to drug or alcohol abuse is excluded

Note: In the event of a Claim arising out of any of the Critical Illness or medical procedures as covered under this Extension, You should intimate Us within thirty (30) days from the date of first diagnosis of such Illness or from the date of surgical procedure or from date of occurrence of the medial event as the case may be (irrespective of Your coverage under any other health insurance policy).

Further, You should arrange for submission of the Claim Documents* as stated in the Policy including the confirmation from the Medical Practitioner that the Critical Illness or medical procedure or medical event for which a Claim has been lodged under this Extension, does not relate to any Pre-Existing Condition/Disease(s) or any Illness or Injury which existed within the first 3 months of the Period of Insurance Start Date.

* In case You are covered under any health policy of other insurance company and become entitled to a Claim under such policy, then for this Extension, You may submit to Us the copies of such Claim Documents provided they are duly certified by such insurance company or any hospital where You are getting treated, as applicable

The cover under this extension shall terminate in the event of Your Claim becoming admissible hereunder. In consequence thereof no benefit shall be payable to You under this extension of the policy thereafter.

Extension 15: Sub Limits on Medical Expenses/ Illness/ Surgeries/ Procedures

Notwithstanding anything to the contrary in the Policy and subject to the Maximum Limit of Indemnity, Our maximum liability to make payment for the Medical Expenses incurred during any Hospitalisation (including its related Pre and Post Hospitalisation expenses if applicable) due to the below mentioned Surgeries/ Medical Procedures or any medical treatment pertaining to an Illness/ Injury shall be limited as per the table below:

S. No.	Surgeries/ Medical Procedures	Sub-limits (Rs.)

		A	B	C
1	Cataract per eye	10,000	15,000	20,000
2	Other Eye Surgeries	15,000	22,000	35,000
3	ENT	15,000	22,000	35,000
4	Surgeries for - Tumors/ Cysts/ Nodule/ Polyp	20,000	30,000	60,000
5	Stone in Urinary System	20,000	30,000	40,000
6	Hernia Related	20,000	30,000	60,000
7	Appendisectomy	20,000	30,000	40,000
8	Knee Ligament Reconstruction Surgery	40,000	60,000	90,000
9	Hysterectomy	20,000	30,000	60,000
10	Fissures/ Piles/ Fistulas	15,000	22,000	35,000
11	Spine & Vertebrae related	40,000	60,000	90,000
12	Cellulites/ Abscess	15,000	22,000	35,000
	All Medical Expenses for any treatment not involving surgery/ medical procedure	10,000	15,000	25,000

Any complications resulting from or arising out of any surgery or medical procedure shall be subject to the overall sub-limit, as applicable

No Sub-limits shall be applicable on any Major Medical Illness & Procedures and Joint Replacement Surgery. Major Medical Illness & Procedures for the purpose of this Policy shall mean and include the following:

1) Cancer of Specified Severity
2) Kidney Failure Requiring Dialysis
3) Major Organ/ Bone marrow Transplant
4) All cardiac surgeries/ conditions including but not limited Open Chest CABG
5) Multiple Sclerosis
6) Stroke Resulting in Permanent Symptoms
7) Permanent Paralysis of Limbs
8) All brain related surgeries

The sub-limits mentioned above shall be applicable for each Hospitalisation. For the purpose of applicability of the said sub-limits, multiple Hospitalisations pertaining to the same Illness or medical procedure/ surgery occurring within a period of 45 days from the date of discharge of the first Hospitalisation shall be considered as one Hospitalisation.

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

Non Payables

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

List of Non Payable Items as per IRDAI	
Sr. No	**Items**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical

	pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	RECOVERY KIT, ETC]ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT,
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

ANNEXURE

The IRDAI has taken several proactive measures and granted relaxations for the benefit of policyholders to respond to the outbreak of Covid-19 situation within the Country. The Company is offering the below mentioned benefits without any additional cost as an aiding gesture to all the policyholders of the Company for this financial year. These benefits shall be available for all our customers until 31st March 2021

1. **Additional Sum Insured (Cumulative bonus)**
   - Currently, we provide an additional sum insured (Cumulative Bonus) of 10% for every claim free year maximum up to 50% of annual sum insured. In the event of any Claim (except out-patient treatment claim) during any subsequent Policy year, the accrued Additional Sum Insured is reduced by 10% of the Annual Sum Insured.
   - As a benefit, the additional sum insured shall not be reduced in case of any claim on hospitalization due to COVID-19.
2. **30 day Waiting Period**
   - Currently, expenses related to the treatment of any illness within 30 days from the first policy commencement date are excluded except claims arising due to an accident
   - As a benefit, this waiting period of 30 days shall be reduced to 15 days for in patient claims of COVID-19 illness.
3. **Home Healthcare**

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

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

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

   In case of unavailability of network provider for cashless claims or non-network provider for reimbursement claims, the insured person will have to avail inpatient hospitalization.

   In this benefit, the following would be covered if prescribed by the treating medical practitioner and is related to treatment,

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

   Any expenses payable during the Policy period shall not in aggregate exceed the maximum Sum Insured and cumulative bonus (if any) as specified in the Policy Schedule against this Benefit.

   Subject to other terms, conditions and exclusions of the policy