ICICI PRUDENTIAL LIFE INSURANCE

ICICI Lombard Nibhaye Vaade

Get a win-win plan to protect your world.

Life Cover

Health Cover

PRESENTING

i-Shield

A combi product with both health and protection benefits to secure you and your family

Introduction

You strive to provide comfort, happiness, and security to your family and want your and your family's health & future to be secured at all times.

To assist you, ICICI Lombard General Insurance Co. Ltd. & ICICI Prudential Life Insurance Co. Ltd. have come together to bring you iShield, a comprehensive & affordable combi plan with dual benefits of health & life insurance which helps provide a safety net for you and your family so that you can lead a comfortable life without any worries.

Key features/ benefits

Health Insurance

Health AdvantEdge (Base health product)

Cashless hospitalization at any of our network providers/ hospitals. A list of these hospitals/ providers will be sent to You along with Your Policy.

Complimentary Health Check-up at our designated centres^.

Claim Service Guarantee[$]

Tax* deduction: You can avail tax deduction on premiums paid under Health sections of this Policy, as per provisions of section 80D of the Income Tax Act, 1961 and amendments made thereunder.

BeFit (Rider Cover)

The BeFit Rider can only be bought along with the Base Product and cannot be bought in isolation or as a separate product.

Available on cashless basis via IL TakeCare app.

Term Insurance

Enhanced protection: Coverage against death, terminal illness and disability

Comprehensive additional benefits: Option to choose Accidental Death Benefit and Accelerated Critical Illness Benefit

Special premiums rates for non-tobacco users

[**]If You approach us for insurance when You are 45 years of age* or above, You will have to then compulsorily undergo medical tests at our designated diagnostic centres. If we accept Your proposal, we will reimburse at least 50% of the costs incurred by You in undertaking such pre-insurance medical tests.

[*]This age limit may be relaxed for specific channels or plans upon approval from product head.

[^]The Company will cover the cost of health checkup on cashless basis as per plan eligibility as defined in the Policy schedule. Only Insured / Insured Person who has attained minimum age of 18 years at the time of first policy/Renewal shall be eligible for a health check-up.

[$]We provide You Claim Service Guarantee as follows

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

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

   1. Approval, or
   2. Rejection, or
   3. Query seeking further information

In case the request is for enhancement, i.e. request for increase in the amount already authorized, We will respond to it within 2 hours

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

If You are not eligible for 'Claim Service Guarantee' for the reasons stated in the policy conditions, We should inform the same to You, within the 14 days for a) and within 2 hours for b) as specified above.

Need based benefit payout: Choose to receive the benefit amount as a lump sum or as monthly income for 10 years or a combination of both

Flexibility to pay premiums once, for a limited period or throughout the policy term

Tax benefits may be available on premiums paid and benefits received as per the prevailing tax laws

Eligibility criteria

<table>
<tr><th>Eligibility criteria</th><th>Health insurance (Health AdvantEdge)</th><th>Health insurance Rider (BeFit)</th><th>Term insurance (ICICI Pru Life iProtect Smart)</th></tr>
<tr><td>Min. age at entry</td><td>Individual: 6 years
Floater: 91 days</td><td>Individual: 6 years
Floater: 3 months</td><td>18 years</td></tr>
<tr><td>Max. age at entry</td><td>Individual: 60 years for adult and 25 years (for dependent children)</td><td>Individual/Floater: 65 years for adult and 20 years (for dependent children)</td><td>65 years (for PPT: single pay, regular pay, limited pay of 5, 7, 10, PT less 5 years)
55 years (for PPT: 60 years less age at entry)</td></tr>
<tr><td>Policy term</td><td>1/ 2/ 3 years</td><td>1/ 2/ 3 years, same as base cover</td><td>
<table>
<tr><th>Premium Payment Term</th><th>Minimum/ Maximum Policy Term</th></tr>
<tr><td>Single</td><td>5 years / 20 years</td></tr>
<tr><td rowspan="2">Equal to policy term</td><td>5 years / 85 years less age at entry</td></tr>
<tr><td>Whole Life (99 years less age at entry)</td></tr>
<tr><td>5, 7, PT- 5 years</td><td>10 years / 85 years less age at entry</td></tr>
<tr><td rowspan="2">10 years</td><td>15 years / 85 years less age at entry</td></tr>
<tr><td>Whole Life (99 years less age at entry)</td></tr>
<tr><td rowspan="2">60 years less age at entry</td><td>PPT+ 5 years / 85 years less age at entry</td></tr>
<tr><td>Whole Life (99 years less age at entry)</td></tr>
</table>
</td></tr>
<tr><td>Mode of premium payment</td><td>Single (on a renewable basis)</td><td>Single (on a renewable basis)</td><td>Single, Yearly, Half-yearly and Monthly</td></tr>
<tr><td>Min. age at maturity</td><td rowspan="2">Lifelong renewable plan</td><td rowspan="2">Lifelong renewable plan</td><td>23 years</td></tr>
<tr><td>Max. age at maturity</td><td>75 years (Single pay)
99 years (Whole life)
85 years (all others)</td></tr>
</table>

Eligibility criteria	Health insurance (Health AdvantEdge)	Health insurance Rider (BeFit)	Term insurance (ICICI Pru Life iProtect Smart)
Min. Sum Assured	₹2,00,000	Plan A[1]	Subject to a min. premium of ₹2,400 (exclusive of applicable taxes and/or cesses)
Max. Sum Assured	₹3,00,00,000	Plan F[1]	No limit
No. of lives covered	Maximum 5 members can be covered in a single policy*	Maximum 5 members can be covered in a single policy*	1

[1]Plans available under BeFit given under the Befit Section in detail

*You can avail a floater cover and get Your immediate family covered for the same sum insured under a single Policy by paying one premium amount. Any individual between 91 days and 5 years of age can be covered under the Policy provided either parent is getting insured under this Policy.

Under this combi product, it will be ensured that there is no overlap in benefits offered under health insurance cover and term insurance cover to the customers.

Premium calculation (applicable for Health Plans- Health AdvantEdge & BeFit):

i In a family floater policy, the age of the eldest member will be considered while computing premium for all the members covered under the family floater. Other factors determining premium are addition/deletion of any optional covers, change in policy conditions such as tenure, increase or decrease in sum insured opted for and change in any tax laws by the government and health status of the individual being insured.

ii Residents in India shall include all Citizens of India and permanent residents of India as well as expatriates or foreigners who are holding an employment pass, dependant pass or work permit and residing in India.

iii Expatriates or foreigners must provide a copy of either a valid employment pass or work permit, and a bona-fide residential address in India.

Relationships covered:

BeFit: Self, Spouse, Dependent children, Dependent Grandchildren, Dependent parents, Dependent Parents in law, Siblings and grandchildren. Dependent Child means a child (natural/legally adopted/ step child), who is financially dependent on the primary insured or proposer and does not have His/ Her independent sources of income up to the age of 20 years.

Term insurance (ICICI Pru iProtect Smart)	
Accidental Death Benefit	Minimum: ₹1,00,000 Maximum: Equal to Sum Assured chosen by you, subject to a maximum limit as per the Board Approved Underwriting Policy Accidental death Benefit will be for the policy term or (80-Age at entry), whichever is lower
Critical Illness (ACI) Benefit	Minimum: ₹1,00,000 Maximum: As per the Board Approved Underwriting Policy ACI Benefit is not available for Single Pay policies ACI Benefit would be for policy term or 30 or (75-Age at entry), whichever is lower

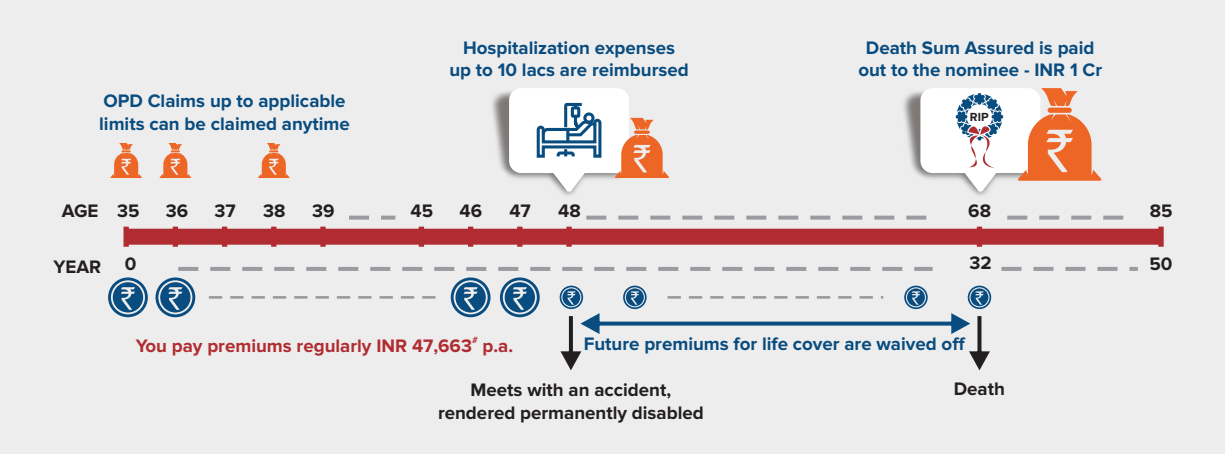
Sample illustration

Shalaj, a 35 year old individual, wants to be well prepared for unforseen circumstances in life. iShield provides the perfect solution for his needs.

Category	Plan option	Sum Assured/ Insured	Premium Payment Term	Policy Term	Annual Premium
Health	Health AdvantEdge Apex Plus	₹10,00,000	Life long yearly renewable		₹9,219
Health	Befit Rider Plan F	Plan F			₹5,558
Term	All in One	₹1,00,00,000	Regular Pay	50 years (till age 85 years)	₹32,886

Total Premiums Paid: ₹47,663
Premiums quoted are exclusive of applicable taxes.

Please refer the illustration below to understand the applicable benefits:



*Apex Plus is a variant under Health AdvantEdge product

#The quoted premium is 1st year premium and is subject to change with age for health insurance

For above example, for term plan –

Accidental Death Benefit cover term: 45 years, Sum Assured: INR 20,00,000; Critical Illness Benefit cover term: 30 years, Sum Assured: INR 10,00,000. Premiums mentioned above are for a healthy male life, non-medical rates and exclusive of applicable taxes and levies.

Section- I: Health insurance cover (Health AdvantEdge)

Basic cover:

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy.

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

Section 2.1) In-patient Treatment:

This benefit provides cover for reimbursement / payment of cashless hospitalization expenses which are reasonably and necessarily incurred by the Insured / Insured Person for treatment of Disease, Illness contracted or Injury sustained by the Insured / Insured Person during the Policy period as specified in the Schedule to this Policy, in a Hospital in India for in- patient care which among other things, includes, Hospital room rent

or boarding expenses, nursing, Intensive Care Unit Charges, Operation Theatre charges, Medical Practitioner's charges, fees of Surgeon, Anesthetist, Qualified Nurse, Specialists, the cost of diagnostic tests, medicines, drugs, blood, oxygen, the cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure.

The Insured/Insured Person should have been hospitalized as an in-patient care for a minimum period of 24 consecutive hours. The benefit under this Section is limited to the Sum Insured specified for this Section in the Schedule of Benefits to this Policy.

Eligibility of room category as per the plan opted

For Insured / Insured Person opting for sum insured options 2Lacs/ 3Lacs/ 4Lacs, the coverage for hospital room and / or boarding and nursing shall be subject to maximum per day capping of 1 % of the Sum Insured and in case of the coverage for Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses shall be subject to maximum per day capping of 2 % of the Sum Insured.

In case of admission to a room at rates exceeding the above limits, the reimbursement/ payment of all other expenses incurred at the Hospital, be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. However, cost of pharmacy and consumables; cost of implants and medical devices and cost of diagnostics shall be reimbursed at actuals. Proportionate deductions are not applicable on ICU charges and on hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on room category.

If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula, this is not applicable if the hospital does not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

Associated Medical Expenses shall include Room Rent excluding ICU charges, nursing charges for Hospitalization as an Inpatient, Medical Practitioners' fees, operation theatre charges and other supply of bill excluding Cost of pharmacy and consumables; Cost of implants and medical devices, Cost of diagnostics

Illustration:

Sum Insured - INR 400,000

Eligible Room Rent - INR 4,000

Room Rent actually incurred - INR8,000

Associated Medical Expenses Incurred-INR 50,000

Associated Medical Expenses Payable-INR 25,000

Basis of Calculation:

4,000/8,000 * 50,000 = INR 25,000

Section 2.2) Pre-hospitalization:

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule of benefits forming part of this Policy, prior to hospitalization or day care treatment for treatment of Disease, Illness contracted or Injury sustained for which

the Insured / Insured Person was hospitalized, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. Pre-hospitalization Medical Expenses can be claimed as reimbursement only.

Section 2.3) Post-hospitalization:

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule of benefits forming part of this Policy, after discharge from Hospital / day care treatment for continuous and follow up treatment of the Disease, Illness contracted or Injury sustained for which the Insured/Insured Person was hospitalized, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. Post-hospitalization Medical Expenses can be claimed as reimbursement only.

Section 2.4) Organ Donor:

Where the Insured/Insured Person contracts any of the Illness or Injury requiring major Organ Transplantation surgery and undergoes surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible, the hospitalization expenses incurred for harvesting the organ donated for the Insured / Insured Person for this treatment is covered under this benefit, provided the donation conforms to The Transplantation of Human Organs Act 1994. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. This part of benefit is applicable throughout the policy period.

This benefit also covers screening expenses of the donor if he/she is accepted as a donor. Post donation fitness test is also covered under this. Any medical expenses as a result of complications arising because of harvesting from the donor is also covered. However, this benefit does not cover costs directly or indirectly associated with the acquisition of the donor's organ. This part of the benefit is applicable for a period of six months or the policy end date whichever is earlier from the date of organ harvesting from the donor

Section 2.5) Day Care Treatment:

This benefit covers hospitalization expenses towards medical treatment, and/or day care procedure/ treatment/ surgeryincurred by the Insured / Insured Person which is undertaken under General or Local Anesthesia in a Hospital/day care centre (where 24 hours of hospitalization is not required due to technologically advanced treatment) which shall be payable. The benefit under this Section is limited to the available Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

Section 2.6 Ayush Treatment:

This benefit provides reimbursement to the Insured/ Insured Person of Medical Expenses incurred for In-patient treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems provided that:

The treatment is undertaken in lines with definition of Ayush Day Care and Ayush Hospital

Note:

a. The reimbursement under Ayush benefit will be applicable for inpatient hospitalization

claims only;

b. The Insured/ Insured person will not be entitled for Domiciliary Hospitalization;

c. Cashless facility is not available.

The benefit under this Section is available upto the Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

SECTION 3 – OTHER BENEFITS:

Benefits under this Section are payable as additional benefits / in-built benefits upto the limits specified in the Schedule to this Policy. However, the amount under this shall be part of the overall Sum Insured

Section 3.1 Restore Benefit

In case of a situation where the Sum Insured and Guaranteed Cumulative bonus (GCB) are exhausted due to claims made and paid during the Policy Year, and the Insured/Insured Persons have to, incur any hospitalization expenses due to any Accident/ Disease/ Illness / Injury for which a valid claim is admissible under the Policy, then the Sum Insured shall be regained and called Regained Sum Insured which is equal to 100% of SI for the particular Policy year for all members in the Policy, provided that;

I. The Regained Sum Insured will be enforceable only after the first claim during the policy year. The regain benefit will be triggered upon partial or full utilization of Sum Insured. The Regained Sum Insured can be used for claims made by the Insured / Insured Person in respect of the benefits stated in Section 2. Hence making the total Sum Insured available as SI+GCB+Regain – (minus) 1st Claim

II. The Regained Sum Insured shall be available for any Accident / Disease / Illness / Injury or any related Accident / Disease / Illness/ Injury for which a Claim has already been admitted partially or fully for that Insured / Insured person during that Policy Year.

III. The Regain Sum Insured will only be allowed once during a Policy Year;

IV. Regain of Sum Insured is not applicable for Optional benefits.

If the Regain Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

Sample Illustration 1

Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	300000	NA	250000	NA	300000	250000	50000
2	50000	NA	250000	300000	50000 - Main Sum Insured 300000 - Regain Sum Insured	250000	100000

Sample Illustration 2

Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	500000	NA	250000	NA	500000	250000	250000
2	250000	NA	1000000	500000	250000 - Main Sum Insured 500000 - Regain Sum Insured	750000	0

In case of renewal

Sample Illustration 1

Year	Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	No Claim	500000	NA	NA	NA	500000	NA	NA
2	1	500000	100000	500000	NA	500000 - Main Sum Insured 100000 - Cumulative Bonus	500000	100000
	2	0	100000	300000	500000	0 - Main Sum Insured 100000 - GCB 500000 - Regain Sum Insured	300000	300000

Sample Illustration 4

Year	Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	No Claim	500000	NA	NA	NA	500000	NA	NA
2	1	500000	100000	500000	NA	500000 - Main Sum Insured 100000 - Cumulative Bonus	500000	100000
	2	0	100000	300000	500000	0 - Main Sum Insured 100000 - GCB 500000 - Regain Sum Insured	300000	300000
3	1	500000	100000	500000	NA	500000 - Main Sum Insured 100000 - Cumulative Bonus	500000	100000
	2	0	100000	300000	500000	0 - Main Sum Insured 200000 - GCB 500000 - Regain Sum Insured	300000	300000

3.2 Animal Bite (Vaccination)

The Company will cover Medical Expenses of OPD Treatment for vaccinations or immunizations for treatment post an animal bite, up to the limit provided in the Schedule of Benefits. This benefit is available only on reimbursement basis.

3.3 Guaranteed Cumulative Bonus (GCB):

If no claim has been made in a Policy Year by any Insured / Insured Person, then for each such Policy year, the Company will offer a GCB of 20% of Sum Insured maximum uptill 100% of expiring or renewed Policy Sum Insured, whichever is lower

Guaranteed Cumulative Bonus will be provided on the expiring/renewed Policy Sum Insured, whichever is lower, provided that the Policy is renewed continuously.

The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the increase in Guaranteed Cumulative Bonus.

Guaranteed Cumulative Bonus will be calculated on the basis of Sum Insured of the last completed Policy Year.

This will not affect the Sum Insured of the Policy.

Guaranteed Cumulative Bonus will be available only for base cover benefits

Regardless of value of GCB accrued, once accrued GCB shall remain guaranteed for the life (i.e. will not get reduced on subsequent renewals) and shall not get reduced in case of a claim/ Maximum value of GCB that can be accrued is 100% of expiring or renewed policy sum insured, whichever is lower.

Illustration

Let us assume that an individual has opted for a Sum Insured of INR 500,000 and has continuously renewed the policy for next 4 years. The Guaranteed cumulative bonus is as illustrated below:

Year	Sum Insured Available	Guaranteed Cumulative Bonus Available (20% of Sum Insured)	Total Sum Insured Available (Base + GCB)	Claim / No Claim
Year 0	500000	NA	500000	No Claim
Year 1	500000	100000	600000	No Claim
Year 2	500000	200000 (100000 + 100000)	700000	Claim
Year 3	500000	200000 (100000+ 100000 + 0)	700000	Claim
Year 4	500000	200000 (100000+ 100000 +0 +0)	700000	

3.4 Surface Ambulance Charges:

This benefit provides for cashless / reimbursement to the Insured/Insured Person of expenses incurred for his/her surface transport by ambulance to hospital or between hospitals and/or diagnostic center for treatment of Disease, Illness or Injury in a Hospital as an in-patient for which a valid claim under this Policy is admissible.

This benefit is subject to sub limits (per hospitalization claim) as mentioned in Schedule of benefit but within overall limit of the Sum Insured as specified in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to the overall Sum Insured.

3.5 Health Check-up:

The Company will cover the cost of health checkup on cashless basis as per plan eligibility as defined in the Policy schedule. Only Insured / Insured Person who has attained minimum age of 18 years at the time of first policy/Renewal shall be eligible for a health check-up.

3.6 Convalescence Benefit:

In case the Insured / Insured Person is hospitalized for a continuous period of 10 days or more for treatment of any Accident / Disease/ Illness /Injury for which a valid claim is admissible under the Policy, this benefit provides for payment to the Insured / Insured Person of a fixed allowance as mentioned in the Schedule of benefit attached to this Policy.

This benefit is subject to sub limits as mentioned in Schedule of benefits payable only once during the Policy year.

If an insured is taking a coverage for 1 year he is eligible for convalescence benefit only once (i.e. one per policy year), while if he is taking the policy coverage for 3 years, he is then eligible for this benefit once in each and every year (i.e. one per policy year).

3.7: Bariatric Surgery Cover:

If the insured is hospitalized on the advice of a Doctor because of Conditions mentioned below which required insured to undergo Bariatric Surgery during the Policy period, then We will pay the insured, Reasonable and Customary Expenses related to Bariatric Surgery according to the policy schedule and waiting period mentioned in this document.There is no limit on the number of time this cover can be used in a policy year subject to the Sum Insured of the cover as specified in policy schedule.

Eligibility:

For adults aged 18 years or older, presence of severe obesity documented in contemporaneous clinical records defined as any of the following:

BMI greater than and equal to 40 in conjunctions with any of the following severe comorbidities:

1. Coronary heart disease; or
2. Medically refractory hypertension (blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes); or
3. Type 2 diabetes mellitus

Special Conditions applicable to Bariatric Surgery Cover

- Bariatric surgery performed for any other reason not listed above shall not be covered.
- The indication for the procedure should be found appropriate by two qualified surgeons and the insured person shall obtain prior approval of the company for cashless treatment. This optional benefit helps insured in availing bariatric treatment if suggested by attending doctor

3.8) Domiciliary Hospitalization:

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:

1. The condition of the Patient is such that he/she is not in a condition to be removed to a Hospital or,
2. The Patient takes treatment at home on account of non-availability of room in a Hospital.

However, this does not cover

1. Treatment of less than 3 days. (Coverage will be provided for expenses incurred in first three days however this benefit will be applicable if treatment period is greater than 3 days);
2. The following medical conditions:
   a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,
   b. Arthritis, Gout and Rheumatism,
   c. Chronic Nephritis and Nephritic Syndrome,
   d. Diarrhoea and all type of Dysenteries including Gastroenteritis,
   e. Diabetes Mellitus and Insupidus,
   f. Epilepsy,
   g. Hypertension,
   h. Pyrexia of unknown origin.

Domiciliary hospitalization benefits also cover expenses on Qualified nurses engaged on the recommendation of the attending Medical Practitioner.

The benefit under this Section is limited to the available Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

3.9 Zonal Pricing

For the purpose of calculating premium below zones are available:-

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

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

Zone 3:- Rest of India

If you select Zone 1 during proposal inward and if treatment is taken in zone 1 then no copay will be applicable.

If you select Zone 2 during proposal inward and if treatment is taken in zone 1 then 12.5% copay will be applicable.

If you select Zone 3 during proposal inward and if treatment is taken in zone 2 then 12.5% copay will be applicable.

If you select Zone 3 during proposal inward and if treatment is taken in zone 1 then 15% copay will be applicable.

Cities included in the zone	Discount on Premium	Co-pay on claim
Zone 1 – NCR, Mumbai, Thane District, Raigad District (Maharashtra), Navi Mumbai, Gujarat, Kolkata	No Discount	No co-pay on claim anywhere in India
Zone 2 – Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Raigad District (Maharashtra), Navi Mumbai)	Discount on premium – 12.50%	Treatment taken at locations included in Zone 1: 12.5% co-pay Treatment taken at locations included in Zone 2 & 3 – no co-pay
Zone 3 – Rest of India	Discount on premium – 15%	Treatment taken at locations included in Zone 1: 15% co-pay Treatment taken at locations included in Zone 2 – 12.5% co-pay Treatment taken at locations included in Zone 3 – no co-pay

NCR*	Name of the Districts
Haryana	Faridabad, Gurugram, Nuh, Rohtak, Sonepat, Rewari, Jhajjhar, Gurugram, Panipat, Palwal, Bhiwani, Charkhi Dadri, Mahendragarh, Jind and Karnal
Uttar Pradesh	Meerut, Ghaziabad, Noida/ Gautam Budh Nagar, Bulandshahr, Baghpat, Hapur,Shamli and Muzaffarnagar
Rajasthan	Alwar and Bharatpur
Delhi	Whole of NCT Delhi.

Incentives associated with Vaccination against pneumococcal disease

We will provide an additional 1.5% discount on premium (fresh or renewal) for Insured Person who have taken the Pneumococcal vaccine or its equivalent vaccine which helps prevent pneumococcal disease. All the adult members covered under the policy should have been vaccinated in the past one year (1 year) from policy start date to avail this discount. i.e. if policy start date is 1st January 2022, all adult members under the policy should have been vaccinated against Pneumococcal disease in the period from 1st January 2021 to 31st December 2021. This discount shall be provided lifetime as long as the insured person continues to renew this policy

SECTION 4 – OPTIONAL BENEFIT:

Benefits under this Section are payable as optional benefits on payment of additional premium, up to the limits specified in the Schedule to this Policy unless specified otherwise.

4.1: Domestic Air Ambulance:

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

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

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

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

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

V. We will not cover:

a. Any transportation from one Hospital to another;

b. Any transportation of the Insured Person

from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital

c. Any transportation or air ambulance expenses incurred outside the geographical scope of India.

VI. We have accepted a claim under Section In patient treatment in respect of the Insured Person for the same Accident/Illness for which air ambulance services were availed.

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

4.2: Maternity Cover:

This optional benefit covers the medical expenses including (after a waiting period of 9 months with the company) up to limits specified in the schedule (over and above Sum Insured mentioned in the Schedule) for the delivery of a baby and / or expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner, limited to maximum of three deliveries or terminations as said herein during the lifetime of an female Insured/Insured Person as the case may be between the ages of 18 years to 45 years in the Policy.

This optional benefit is applicable to all or any female Insured / Insured person who has opted for 3 years Policy term between age 18 to 45 years as selected by proposer.

In case, insured has taken three year policy without maternity optional benefit and would like to opt for maternity optional benefit, then this can be availed only at the time of renewal

Ectopic Pregnancy is not covered under this section. In case the maternity benefit is not claimed, next 3 years maternity premium is waived off. Exclusion No, **'R. Maternity: Code Excl18' will not be applicable to this section**

4.3: New Born Baby Cover:

Medical Expenses for any medically necessary treatment described at 2.1 while the Insured Person (the Newborn baby) is hospitalized during the Policy Period within first 90 days of birth, as an inpatient under this benefit. The coverage is subject to the Policy exclusions, terms and conditions. This Benefit is applicable if Maternity benefit is opted and the Company has accepted a maternity claim under this Policy.

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Maternity sum insured mentioned in the Schedule.

4.4: Vaccinations for new born baby in the first year

Vaccinations for new born baby till one year of age during the policy period - Option of covering vaccination for the new born baby which is upto 1% of Sum Insured or upto ₹10,000 whichever is lesser. This Benefit is applicable if Maternity benefit is opted and the Company has accepted a maternity claim under this Policy.

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Maternity sum insured mentioned in the Schedule

4.5: OPD for Medical and Dental:

This optional cover help you in getting your bill reimbursed upto the limit specified in the schedule. The OPD benefit will cover the following on reimbursement basis

1. In-network Doctor Consultation on submission of consultation papers
2. In-network Pharmacy on submission of

prescription.

3. In-network diagnostics on submission of diagnostic reports
4. In-network Physiotherapy on submission of consultation papers

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Sum Insured mentioned in the Schedule Exclusion No, **'U' will not be applicable to this section**

Illustration

SI	OPD SI Eligibility
1000000	5000
10000000	50000
30000000	100000

4.6: Hospital Cash Benefit:

Daily cash amount will be payable per day up to the specified limits as mentioned in the Schedule to this Policy if the Insured Person is Hospitalized for treatment of any Disease / Illness / Injury for which a valid claim is admissible under the Policy for each continuous and completed period of 24 hours and if the Hospitalization exceeds for more than 24 hours. First continuous and completed period of 48 hours will act as deferment which means minimum hospitalization of 48 hours is required for claims to be payable from the time of hospitalization.

This is paid up to a maximum of 45 days for all Insured Persons.

This benefit is subject to the specified limits as mentioned in Schedule over and above the Sum Insured as mentioned in the Schedule to this policy.

4.7: Personal Accident Cover:

We will pay You or Your nominee a fixed sum insured as mentioned in the policy schedule upon the unfortunate event of Accidental death or Permanent total disablement or permanent partial disablement resulting from an Accident.

This cover can be availed only once during Your lifetime. Once a claim becomes payable under this cover, no benefit will be provided under the same thereafter

4.8: Critical Illness:

After waiting period as specified in the policy schedule (mentioned as Waiting Period), if the Insured is at any time during the Policy period, being diagnosed contracted by any Critical Illness as specified below and surviving for more than such period mentioned in Schedule mentioned as Critical Illness Survival Period, post such diagnosis, (over and above the Sum Insured mentioned in the Schedule), Insured shall be paid Lump Sum amount upto the specified limits as mentioned in Schedule.

In case of diagnosis of multiple illnesses qualified as Critical Illness under the Policy, the payment of compensation under critical illness benefit shall be limited to the limit specified in the schedule and shall be payable only once in the lifetime of Insured/Insured person. Critical Illness benefit will lapse after reporting of and payment of one claim for the claiming Insured/Insured person. Critical Illness limit opted cannot be more than Sum Insured opted for Section In patient Treatment The illnesses qualified as Critical Illnesses and covered in this section are as follows:

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

Kindly refer to the policy wordings for inclusions/coverage/exclusions pertaining to critical illness

4.9 Worldwide Cover:

We will indemnify You for hospitalization expenses including planned hospitalisation incurred outside India and anywhere across the world including USA and Canada, up to the amount specified under against this benefit in the policy schedule subject to the terms & conditions specified hereunder:

i. A co-pay of 10% will be applied to every admissible claim over and above to any other co-pay charged
ii. The benefit is available for 45 consecutive days from the date of travel in a single trip and 90 days in a cumulative bases as a whole in a Policy year
iii. The expenses covered under this benefit will be limited to inpatient hospitalization expenses and days care treatment/ procedure expenses. Expenses incurred for pre and post hospitalization will not be covered under this benefit.
iv. The payment of any claim under this benefit will be based on the rate of exchange as on Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian rupees for payment of claims. If on the insured person's date of loss, if the RBI rates are not published, the exchange rates published next shall be considered for conversion
v. In case of planned hospitalization, prior intimation of the claim and due approval from Us will be necessary

4.10 Tele Consultation

We will arrange consultations and recommendations for routine health issues by a qualified Medical Practitioner or health care professional. For the purpose of this benefit Telephonic/Virtual consultation shall mean consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile app.

4.11 Home Care Treatment

We will cover the medical expenses incurred by You on home care treatment up to 5% of Sum Insured subject to a maximum of ₹25,000 provided the medical practitioner has advised You to undergo treatment at home. Treatments that can be availed on outpatient basis are outside the scope of this cover.

Home care treatment can only be availed on a cashless basis through our empanelled service providers.

4.12 Sum Insured Protector

The Sum Insured protector is designed to protect the Sum Insured against rising inflation by linking the Sum Insured under the base plan to the Consumer Price index (CPI).

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

The % increase will be applicable only on Annual Sum Insured under the Policy and not on guaranteed cumulative bonus or any other benefit which leads to increase in Sum Insured.

Sample Illustration 1

Year	Annual Sum Insured	Opted for Sum Insured Protector	Sum Insured Protector at Renewal computation	Overall Sum Insured Protector
0	₹10,00,000	Yes	Not applicable	Not applicable
1	₹10,00,000	Yes	₹10,00,000* 6%	₹60,000
2	₹10,00,000	Yes	₹10,00,000* 6%	₹60,000 + 60,000 = 1,20,000
3	₹10,00,000	Yes	₹10,00,000* 6%	₹1,20,000 + 60,000 = 1,80,000
4	₹10,00,000	No	Nil as Insured has opted out	Nil

*Considering Consumer Price index (CPI) of previous year to be 6%

Sample Illustration 2

Year	Annual Sum Insured	Opted for Sum Insured Protector	Sum Insured Protector at Renewal computation	Overall Sum Insured Protector
0	₹10,00,000	Yes	Not applicable	Not applicable
1	₹10,00,000	Yes	₹10,00,000* 6%	₹60,000
2	₹15,00,000	Yes	₹10,00,000* 6%	₹60,000 + 60,000 = 1,20,000
3	₹15,00,000	Yes	₹15,00,000* 6%	₹1,20,000 + 90,000 = 2,10,000
4	₹15,00,000	No	Nil as Insured has opted out	Nil

*Considering Consumer Price index (CPI) of previous year to be 6%
*Considering Insured has enhanced the Base Sum Insured to ₹15,00,000 in the second renewal year

4.13 Claim Protector

If a claim has been accepted under the inpatient hospitalization cover , then the items which are not payable under the claim as per the List of Excluded items released by IRDAI that is related to the particular claim will become payable. The maximum claim payout under this benefit shall be limited to Annual Sum Insured under your policy.

SECTION 5 – Waiting Periods and Survival Periods:

5.1: Waiting Period for PED:

This optional benefit allows the Insured / Insured Person to opt for 24/36/48 months of waiting period.

5.2: Waiting Period for Named Ailments:

This optional benefit. allows the Insured / Insured Person to opt for 24/12 months of waiting period. This named ailments are listed in **SECTION 7 - EXCLUSIONS: B. Exclusion Name: Specified disease/procedure waiting period- Code- Excl02**

5.3: Waiting period for Bariatric Surgery

This benefit can be availed after a waiting period of 3 years as per advice of Medical Practitioner

5.4: Waiting period for Critical Illness:

This optional benefit allows the Insured / Insured Person to opt for 60 / 90 days of waiting period.

5.5: Survival period for Critical Illness:

This optional benefit allows the Insured / Insured Person to opt for 30 days of survival period.

5.6: Co payment:

Co payment will be applicable as chosen by the Insured. This optional benefit allows the Insured to opt for 10% or 20% co-payment.

5.7: Waiting period for below illnessess

Waiting period

Mental Illness specifically for the following ICD codes:

Schizophrenia (ICD - F20; F21; F25)

Bipolar Affective Disorders (ICD - F31; F34)

Depression (ICD - F32; F33)

Obsessive Compulsive Disorders (ICD - F42; F60.5)

Psychosis (ICD - F 22; F23; F28; F29)

The waiting period chosen for Pre-Existing Diseases will by default apply to this section.

SECTION 6 – Wellness and Value Added Services:

This services will be available to all Insured / Insured persons and this will have no premium and / or Sum Insured impact.

6.1 Health Rewards

Insured can accumulate rewards by opting for an array of wellness programs listed below, that will help assess his/her health status and aid in improving the overall well-being.

There will be no limitation to the number of programs one can enroll however maximum rewards that all the insured person(s) in a single policy period can earn, will be limited to 5% in a year and of the policy premium for the opted tenure on renewal. The Wellness Rewards will get accrued in the following manner:

Wellness Grid

HRA GRID

Services	Points	Limits
Completes Health Risk Assessment	100	1 HRA
Does 2 Health Risk Assessment in a Year	200	Additional points

Basis Investigation Report (upload into our portal)

Services	Points	Limits
Comprehensive health report (Routine Urine Analysis (RUA), Lipid profile, Compete Blood Count (CBC), Kidney Function Test (KFT), Liver Function Test (LFT), Hepatitis B Surface Antigen Test (HBsAg,)	1000	Max 1
2D Echocardiogram	300	Max 1
Magnetic Resonance Imaging (MRI Scan)	300	Max 1
Glycosylated Hemoglobin (Hb1Ac Report)	200	Max 1
Prostate Specific Antigen (PSA)	200	Max 1
Mammography	1000	Max 1
Bone Scan	1000	Max 1
Bone Densitometry test	1000	Max 1

Healthy Initiaitves

Services	Points	Limits
Membership (Gym, Fitness Club, Yoga) for a year	3000	Max. 2
Participation in Walkathon, Marathon, Fitness League, Cycling, Swimming Competition	1000	Max 4

Claim

Services	Points	Limits
Enrollment within 30 Days with our wellness portal for this additional points will be offered	1000	Max 4

Invoices should be uploaded within 60 days from the Date of Invoice date for points redemption
Per Point Value-INR 0.30 Paise

Any member in the policy can avail these facilities and accumulate the above reward points for both Individual and floater.

The accrual shall happen on continuous coverage basis and if the insured fails to continue these activities in subsequent years or fails to redeem these discounts in the subsequent year/ subsequent renewals, the accrual shall fall to zero and the insured will have to start the process again to achieve the maximum discount benefit.

Policy Premium means the premium paid by the proposer to the Company for the renewal policy period, post application of all discounts & loadings excluding any applicable taxes.

i. The Total Accrual rewards earned as reward scale as percentage of the premium paid during the renewal year shall be converted to and accumulated as reward points as mentioned in the Wellness and Value Added Services.

- In case of Multi-year policies, the insured needs to perform all or any of the activities at least once during the tenure of the insurance.
- Rewards can be redeemed in the following manner

Adjustment of renewal year premium, when the insured purchases selected health insurance products from the company post accrual of the wellness rewards points under this policy. However, the total rewards points that can be utilized in a policy tenure shall not exceed 5% of the policy premium for such health policy.

i. Rewards Points earned by an insured cannot be transferred to anyone or rewards points earned under multiple such programs cannot be clubbed together for redemption in any single policy.

HRA to be availed by login in on company's portal. All Invoices and reports to be uploaded on company's wellness portal to be elgible for redemption.

6.2 Medical Condition Management Program:

The insured will have a choice to avail various wellness benefits/services under this benefit head provided by the Company through the network of specialists/service providers. The assistance in arranging consultation will be provided on best effort basis. The cost of the services shall be borne by Insured / Insured Person.

1. Health Coach to monitor your day to day well being - The Insured Person will have the facility to connect with a personal coach to motivate the Insured person to achieve his/her personal health goals.
2. Chronic Condition Screening - Customized Health Checks including gene screening to understand the potential health risks the insured(s) may encounter in future or to avail regular screenings for chronic conditions to stay abreast about their on-going health and corrective/precautionary measures can be taken.
3. Condition Specific Care
   a. Orthopedics Program (Rehabilitation and mobilization, Nursing attendant, Physiotherapist and medical equipments, etc.).
   b. Oncology Program (Palliative care support, Stroma care, Colostomy, Tube feeding, Supportive care, etc.).
   c. Pulmonary Program (Services/ programs related to Improving breathing ability. Improving overall strength and exercise tolerance, programs to increase participation in daily physical and social activities).
   d. Diabetes Management Program (Services such as Personal Health Coach, Personal Nutritionist, Hypo/Hyper Alerts Management, etc may be availed on the basis of need or as recommended by the treating medical practitioner).
   e. Internal Medicine Program (Services such as Doctor visits at home, Triage nursing, Medicine delivery, etc. may be availed on the basis of need or as recommended by the treating medical practitioner).

6.3 Video / Tele Consultation

Assistance in arranging consultation with a medical practitioner through Network Service Providers for assessing the medical records or routine health issues of the Insured Person over the phone or Video Chat on best effort basis. The cost of the services shall be borne by

Insured / Insured Person.

6.4 Tele medicine

Assistance in arranging consultation with a medical practitioner through Network Service Providers to evaluate, diagnose and treat patients at a distance using telecommunications technology on best effort basis. Telemedicine involves the use of electronic communications and software to provide clinical services to patients without an in-person visit. The cost of the services shall be borne by Insured / Insured Person.

6.5 Pharmacy and Diagnostic Services

You may purchase medicines and diagnostic services from our Network Service Provider on best effort basis. The cost for the purchase of the medicines or diagnostic services shall be borne by Insured / Insured Person. Assistance in arranging delivery of purchased medicine on best effort basis

6.6 Online Chat with Doctor

The Insured / Insured person can get answers to their health problems by consulting a physician online via an online chat from our panel of doctors available through our network service provider. The cost of the services rendered by the medical practitioner shall be borne by Insured / Insured Person.

6.7 Doctor on Call:

The insured can avail the benefit of doctor on call according to the policy schedule. The insured can avail doctor consultation for any ailment or illness over call upto the limit specified in the schedule to the policy.

6.8 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:

i. Identifying a Physician/ Specialist
ii. Scheduling an appointment with any Medical Practitioner empanelled with Us
iii. Scheduling appointments for a second opinion
iv. Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
v. Providing preventive information on ailments
vi. Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.
vii. 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.
viii. The list of the Service Providers is available at our website (https://www.icicilombard.com/content/ilom-en/serviceprovider/search.asp) and is subject to amendment from time to time.

6.9 Ambulance Assistance:

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

I. This is an assistance service and the expenses for the same will have to be borne by the insured person or can be claimed under surface ambulance cover (if inpatient treatment claim is found to be admissible)

6.10 Discounts on services/products

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

The above benefits will be subject to following conditions:

i. For services that are availed over phone or through online/digital mode, the Insured / Insured Person will be required to provide the details as sought by our Service Provider in order to establish authenticity and validity prior to availing such services.

ii. It is entirely for the Insured / Insured Person to decide whether to obtain these services, the extent to which he/she wishes to avail these services and further to decide whether to use any of these services and if so to which extent.

iii. The services are intended to provide support information to the Insured Person to improve well-being and habits through working towards personalized health goals. These services are not medical advice and are not meant to substitute the Insured / Insured Person's visit/ consultation to an independent Medical Practitioner.

iv. The information services provided under these benefits, including information provided through personalized health coaching services, does not constitute medical advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical condition.

v. The Insured Person shall be free to consider or not consider the suggestions of the health coach and make any lifestyle changes based on information provided through these services. For any change the Insured Person makes to his lifestyle whether or not on the advice of the health coach, we shall in no manner be liable for any harm or injury, whether bodily or otherwise that may occur as a result of such lifestyle changes. The Insured Person must seek immediate medical advice if there is any adverse effect or discomfort on making any lifestyle changes.

vi, The company shall not be liable for any damages sustained by the Insured Person on such information or suggestions provided by Health Coach or any of the service rendered by our service provider.

vii. The company is not responsible for any medical or mental health problems the Insured Person may face as a result of accessing or using these services.

viii. The Insured Person is solely responsible for all information, data, text, music, sound, photographs, graphics, video, messages or other materials that the Insured Person uploads, transmits, posts, publishes or displays on any platform used by the service providers

ix. The Insured Person expressly understands and agrees that we will not be liable for any damages related to services provided by the network service provider

The cost of the services rendered by the medical practitioner/ service provider shall be borne by Insured / Insured Person.

Section 7. POLICY PERIOD:

The Policy will be issued for annual period of 1 year, 2 years and 3 years as per the requirement of customer.

Section 8. SUM INSURED:

Sum Insured that can be opted upto the age at entry of 65 years on Individual and/or Floater basis are as follows:

Plan	Sum Insured
Prime	2/3/4 lacs
Prime Plus	3/4 / 5/7.5/10/15/20/25/30/40/50/ 75/100/150/200/300 lacs
Royal	5/7.5/10/15/20/25/30/40/50
Royal Plus	3 /4 / 5/7.5/10/15/20/25/30/40/50/ 75/100/150/200/300 lacs
Apex	75/100/150/200/300 lacs
Apex Plus	3 /4 / 5/7.5/10/15/20/25/30/40/50/ 75/100/150/200/300 lacs

SECTION 9- EXCLUSIONS:

a. Pre-Existing Diseases - Code- Excl01

1. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48/36/24 months of continuous coverage after the date of inception of the first policy with insurer as selected by the Insurer.
2. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
3. If the Insured Person is continuously covered without any break as defined under the portability / migration norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
4. Coverage under the policy after the expiry of 48/36/24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

1. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
2. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

3. 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.
4. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
5. 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.
6. List of specific diseases/procedures
    1. Any types of gastric or duodenal ulcers
    2. Benign prostatic hypertrophy
    3. All types of sinuses
    4. Hemorrhoids
    5. Dysfunctional uterine bleeding
    6. Endometriosis
    7. Stones in the urinary and biliary systems
    8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
    9. Cataracts,
    10. Hernia of all types and Hydrocele
    11. Fistulae in anus
    12. Fissure in anus
    13. Fibromyoma
    14. Hysterectomy
    15. Surgery for any skin ailment
    16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
    17. Dialysis required for Chronic Renal Failure.
    18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.
    19. Dilatation and curettage
    20. Varicose Veins and Varicose Ulcers
    21. Non Infective Arthritis and other form arthritis
    22. Gout and Rheumatism
    23. Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

c. 30-day waiting period- Code- Excl03

1. 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.
2. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
3. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

d.Investigation & Evaluation- Code- Excl04

1. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
2. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

1. 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.

f. Obesity/ Weight Control: Code- Excl06

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

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

g. Change-of-Gender treatments: Code- Excl07

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

h. Cosmetic or plastic Surgery: Code- Excl08

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

I. Hazardous or Adventure sports: Code- Excl09

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

j. Breach of law: Code- Excl10

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

k. Excluded providers: Code- Excl 11

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

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

Treatments received in heath hydros, nature cure clinics, spas or similar establishments or

private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code- Excl13**

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

o. Refractive Error: Code- Excl15

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

p. Unproven Treatments: Code- Exel 16

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

q.Sterility and Infertility: Code- Excl 17

Expenses related to sterility and infertility. This includes:

1. Any type of contraception, sterilization
2. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
3. Gestational Surrogacy
4. Reversal of sterilization

r. Maternity: Code Excl18

1. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
2. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

   This exclusion will stand modified to the effect to cover **4.2: Maternity Cover**

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

t. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

1. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
2. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
3. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

u. Any expenses incurred on and OPD treatment. This exclusion will stand modified to the effect to cover **Section 4.5: OPD for Medical and Dental**

v. Treatment taken outside the geographical limits of India This exclusion will stand modified to the effect to cover Section 4.9: Worldwide cover

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

SECTION 10- GENERAL CONDITIONS:

i) Standard General Terms and clauses

1. Disclosure of Information:

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

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

2.Condition Precedent to Admission of Liability:

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

3.Claim Settlement (provision for Penal Interest)

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

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

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

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

4. Fraud:

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

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

insurer.

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

a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b. the active concealment of a fact by the insured person having knowledge or belief of the fact;

c. any other act fitted to deceivee; and

d. any such act or omission as the law specially declares to be fraudulent

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

5. Multiple policies

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

b. 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.

c. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

d. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

6. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

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

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

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

4. 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.

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

7. Premium payment in instalments:

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

1. For Yearly and single payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.
2. 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.
3. 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
4. No interest will be charged If the installment premium is not paid on due date.
5. In case of installment premium due not received within the grace Period, the Policy will get cancelled.
6. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
7. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

8. Portability

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

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

9. Migration

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

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

10. Withdrawal of Policy

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.

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.

11. Moratorium Period

After completion of eight continuous years under the policy no look back to 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 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim 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, deductibles as per the policy contract.

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

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

13. 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.

14. Grievance Redressal Procedure:

In case of any grievance You may contact the company through

- Website: www.icicilombard.com
- Email: customersupport@icicilombard.com
- Phone: 1800 2666

Courier: ICICI Lombard House, 414, P Balu Marg, Off Veer Savarkar Road, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

You may also approach the grievance cell at any of the company's branches with the details of grievance.

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

ICICI Lombard General Insurance Company Limited,

ICICI Lombard House, 414, P Balu Marg, Off Veer Savarkar Road, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

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

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also

approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

LIST OF INSURANCE OMBUDSMEN

The contact details of the Insurance Ombudsman offices are as below. These details can also be found at http://www.cioins.co.in/ombudsman.html.

15. Complete Discharge

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

ii) Specific terms and clauses

16. Floater Policy:

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all other Insured Persons. However, the Sum Insured shall be the overall limit including Optional Sum Insured unless otherwise specified, if opted and guaranteed GCB, if any for the entire period of Insurance/Policy period including all members/Insured persons and all claims.

17. Material Change:

The Insured / Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business, partial disclosure of the medical history at Insured / Insured person own expense. The Company may, adjust the scope of cover and / or the premium, if necessary, accordingly.

18. No Constructive Notice:

The Company shall not take notice of any information relating to the Insured person unless such information is submitted in writing by the Insured, even if such information was available with the Company.

19. Notice of Charge:

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to the Policy. However, any payment by the Company to Insured or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

20. Special Provisions:

Any special provisions subject to which this Policy has been entered into and endorsed on the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

21. Electronic Transaction:

The Insured / Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele service operations (whether voice, video, data or combination thereof) or

by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDA regulations for protection of Policy holder's interests.

22. Duty of the Insured on occurrence of loss/event leading to claim

On the occurrence of loss/event/claim within the scope of cover under the Policy resulting in a claim, the Insured / Insured Person shall:

a. Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.

b. Allow the Medical Practitioner or any agent of the Company to inspect the medical and hospitalization records and to examine the Insured / Insured Person

c. Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties

In case the Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Insured / Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

23. Right to Inspect:

If required by the Company, an agent/ representative of the Company including a physician appointed in that behalf in case of any loss/event/claim or any circumstances that have given rise to a claim to the Insured / Insured Person, be permitted at all reasonable times to examine into the circumstances of such loss/event leading to claim. The Insured / Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss/event or such circumstance in his/her possession including presenting himself/herself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or shall assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

The Company shall bear all cost of examination required under this section.

24. Position after a claim:

As from the day of receipt of the claim amount by the Insured / Insured Person, the Sum Insured for the remainder of the Policy year of insurance shall stand reduced by a corresponding amount.

25. Forfeiture of claims:

If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any rights whatsoever.

26. Cause of action/Currency of payment:

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India in Indian

Rupees only.

27. Policy Disputes:

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

28. Arbitration:

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 arbitrators, comprising of 2 arbitrators - 1 to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such 2 arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.

It is hereby agreed and understood that no dispute or difference shall be referred to arbitration, as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss shall be first obtained.

29. Sum Insured Enhancement:

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a duly filled fresh Proposal Form to the Company.

ii. The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured members, claim history and subject to acceptance by the Company post underwriting.

All waiting periods as defined in the Policy shall apply afresh for this enhanced Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy in respect of such increased Sum Insured.

30. 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.

31. 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

32. Notices:

1. Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to

   i. In case of the Insured, at the address given in the Schedule to the Policy.

2. In case of the Company, to the Policy issuing office/nearest office of the Company.

How do I claim my insurance?

Cashless Basis

In case of emergency or planned Hospitalisation, use Your health ID card at our Network Provider and avail of cashless service 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. Cashless approval is subject to Pre-authorisation by Us

Pre-authorization means prior to taking any treatment or incurring Medical Expenses at a Network provider, You must contact Us accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, nature of Illness or Injury, name and address of the doctor/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request pre-authorisation at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation

Reimbursement Basis

In case of reimbursement settlement, You should immediately notify Us about the claim by calling at the toll free number as specified in the Policy. You or someone claiming on Your behalf, should then send us the following documents in original within 30 days after Your discharge from the Hospital:

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

We suggest our prospective customers to kindly have a detailed look at our Policy wording for complete information.

Annexure – A

Benefit Illustration in respect of policies offered on individual and family floater basis (Health AdvantEdge)

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (₹)	Sum insured (₹)	Premium (₹)	Discount (₹)	Premium after discount (₹)	Sum insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount, if any	Premium after discount (₹)	Sum insured (₹)
46	20,777	15,00,000	20,777	5%	19,738	15,00,000	41,554	-	26,432	15,00,000
49	20,777	15,00,000	20,777	5%	19,738	15,00,000				
Total Premium for all members of the family is ₹41554 when each member is covered separately.			Total Premium for all members of the family is ₹39,376 when they are covered under a single policy.				Total Premium when policy is opted on floater basis is ₹26,432			
Sum insured available for each individual is ₹15,00,000.			Sum insured available for each family member is ₹15,00,000.				Sum insured of ₹15,00,000 is available for the entire family.			

Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also the premium rates shall be exclusive of taxes applicable.

Annexure – A

Benefit Illustration in respect of policies offered on individual and family floater basis (Health AdvantEdge)

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (₹)	Sum insured (₹)	Premium (₹)	Discount (₹)	Premium after discount (₹)	Sum insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount, if any	Premium after discount (₹)	Sum insured (₹)
36	15,942	20,00,000	15,942	5%	15,145	20,00,000	31,885	-	21,109	20,00,000
40	15,942	20,00,000	15,942	5%	15,145	20,00,000				
Total Premium for all members of the family is ₹31,885 when each member is covered separately.			Total Premium for all members of the family is ₹30,290 when they are covered under a single policy.				Total Premium when policy is opted on floater basis is ₹21,109			
Sum insured available for each individual is ₹20,00,000.			Sum insured available for each family member is ₹20,00,000.				Sum insured of ₹20,00,000 is available for the entire family.			

Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also the premium rates shall be exclusive of taxes applicable.

Annexure – A

Benefit Illustration in respect of policies offered on individual and family floater basis (Health AdvantEdge)

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (₹)	Sum insured (₹)	Premium (₹)	Discount (₹)	Premium after discount (₹)	Sum insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount, if any	Premium after discount (₹)	Sum insured (₹)
32	10,280	10,00,000	10,280	5%	9,766	10,00,000	20,560	-	14,305	10,00,000
35	10,280	10,00,000	10,280	5%	9,766	10,00,000				
Total Premium for all members of the family is ₹20.560 when each member is covered separately.			Total Premium for all members of the family is ₹19,532 when they are covered under a single policy.				Total Premium when policy is opted on floater basis is ₹21,194			
Sum insured available for each individual is ₹10,00,000.			Sum insured available for each family member is ₹10,00,000.				Sum insured of ₹10,00,000 is available for the entire family.			
Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also the premium rates shall be exclusive of taxes applicable.										

List of Generally excluded in Hospitalization Policy

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

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES

Sl No	Item
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT

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

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

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

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

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

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

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

Section-II: Term insurance cover (ICICI Pru Life iProtect Smart):

How does this plan protect you

You can choose your level of protection by selecting one of the below benefit options:

Benefit Option	Benefits
Life	Death Benefit + Terminal Illness + Waiver of Premium on permanent disability
Life Plus	Death Benefit + Terminal Illness + Waiver of Premium on permanent disability + Accidental Death Benefit
Life & Health	Death Benefit + Terminal Illness + Waiver of Premium on permanent disability + Accelerated Critical Illness Benefit
All in One	Death Benefit + Terminal Illness + Waiver of Premium on permanent disability + Accidental Death Benefit + Accelerated Critical Illness Benefit

Your premium will vary depending on the benefit option chosen.

Key benefits for women

1. Special premium rates for life cover and Accelerated Critical Illness Benefit.
2. Covers female organ cancers such as breast cancer and cervical cancer under Accelerated Critical Illness Benefit.

Benefits in detail

Life Option:

1. We will pay the Death Benefit (DB) to your nominee/legal heir, on the first occurrence of either
   i. Death of the Life Assured, or
   ii. Diagnosis of Terminal Illness

   The policy will terminate on payment of this benefit. Death Benefit is the Sum Assured chosen by you.
2. On diagnosis of Permanent Disability (PD) due to an accident, the future premiums under your policy for all benefits are waived. We understand that paying future premiums to continue your life cover may be a burden in case of a disability. That is why this feature ensures that you do not need to pay your future premiums to continue your protection.

Life Plus Option:

In addition to the benefits under the Life Option, you are also covered for Accidental Death (AD) Benefit. In case of death due to an accident within Accidental Death Benefit term, we will pay your nominee/ legal heir AD Benefit as lump sum. This benefit ensures that you enhance your coverage significantly at very affordable rates. The policy will terminate on payment of these benefits. In case no AD Benefit is triggered within the AD Benefit term, then AD Benefit will terminate and premiums corresponding to it will not be payable. However You would be required to pay premiums for all other Benefits to keep the policy in force.

Life & Health Option:

In this option, along with the benefits under the Life Option, you are also covered for the Accelerated Critical Illness Benefit (ACI Benefit). The ACI Benefit offers you coverage against 34 critical illnesses. When a major illness strikes, it can place a huge burden on your family, not only because of the cost of medical care but also because you may not be able to work. To protect you against this, we will pay you the ACI Benefit, as a lump sum to meet your financial needs. The benefit is payable irrespective of the actual expenses incurred by the policyholder.

This benefit is payable, on first occurrence of any of the covered 34 illnesses. The ACI Benefit, is accelerated and not an additional benefit which means, the policy will continue with the Death Benefit reduced by the extent of the ACI Benefit paid. Premium payment on account of ACI Benefit will cease after payout of ACI Benefit and the future premiums payable under the policy for death benefit will reduce proportionately. If ACI Benefit paid is equal to the Death Benefit, the policy will terminate on payment of the ACI Benefit. In case of incidences covered under accidental Permanent Disability as well as Critical Illness, benefits shall be paid out under both the options.

In case no ACI Benefit is triggered within the ACI Benefit term, then ACI Benefit will terminate and premiums corresponding to it will not be payable. However You would be required to pay premiums for all other Benefits to keep the policy in force.

All in One Option:

In this option, along with the benefits under Life Option, you are covered for both Accidental Death Benefit and Accelerated Critical Illness Benefit.

Covered Critical Illnesses

Sr. No.	Critical Illness	Categories
1	Cancer of specified severity	Cancer
2	Angioplasty*	Heart and Artery Benefit
3	Myocardial Infarction (First Heart Attack - of specified severity)	
4	Heart Valve Surgery (Open Heart Replacement or repair of Heart Valves)	
5	Surgery to aorta	
6	Cardiomyopathy	
7	Primary (Idiopathic) Pulmonary hypertension	
8	Open Chest CABG	
9	Blindness	Major Organ Benefit
10	End stage Lung Failure (Chronic Lung Disease)	
11	End stage Liver Failure (Chronic liver disease)	
12	Kidney Failure requiring regular dialysis	
13	Major Organ/ Bone Marrow Transplant	
14	Apallic Syndrome	Brain and Nervous System Benefit
15	Benign Brain Tumour	
16	Brain Surgery	
17	Coma of specified severity	
18	Major Head Trauma	
19	Permanent Paralysis of Limbs	

Sr. No.	Critical Illness	Categories
20	Stroke resulting in permanent symptoms	
21	Alzheimer's Disease	
22	Motor Neurone Disease with Permanent Symptoms	
23	Multiple Sclerosis with Persisting Symptoms	
24	Muscular Dystrophy	
25	Parkinson's Disease	
26	Poliomyelitis	
27	Loss of Independent Existence	Others
28	Loss of Limbs	
29	Deafness	
30	Loss of Speech	
31	Medullary Cystic Disease	
32	Systematic lupus Eryth. w. Renal Involvement	
33	Third degree Burns (Major Burns)	
34	Aplastic Anaemia	

Please read the definitions and exclusions mentioned in the Terms & Conditions.

*The ACI Benefit for Angioplasty is subject to a maximum of ₹5,00,000. On payment of Angioplasty, if the ACI enefit is more than ₹5,00,000 the policy will continue for other CIs with ACI Benefit reduced by Angioplasty ayout. The future premiums payable for the residual ACI Benefit will reduce proportionately.

Death Benefit payout options

The term insurance cover provides the flexibility to take the Death Benefit in a way that meets your financial requirement. The Death Benefit payout option has to be selected by you at Policy inception. The Death Benefit can be paid to your beneficiary as:

1. **Lump sum** – the entire benefit amount is payable as a lump sum
2. **Income** – 10% of the benefit amount is payable every year for 10 years. This will be paid in equal monthly instalments in advance at the rate of 0.83333% of Death Benefit Amount. The beneficiary can also advance the first year's income as lump sum. The monthly income will start from the subsequent month for 9 years at the rate of 0.80% of the Death Benefit Amount.
3. **Lump sum and Income** – The percentage of the Sum Assured to be paid out as lump sum is chosen at inception. The balance Sum Assured will be paid out in equal monthly instalments in advance at the rate of 0.83333% per month over 10 years.
4. **Increasing Income** – The benefit amount is payable in monthly instalments for 10 years starting with 10% of the benefit amount per annum in the first year. The income amount will increase by 10% per annum simple interest every year thereafter.

At any time, your beneficiary will have the option to convert all or some of his monthly income into a lump sum. The lump sum amount will be the present value calculated at a discount rate of 4% p.a.

The premium for your policy will vary based on the Death Benefit payout option chosen.

Life stage protection

Responsibilities change with time and your protection cover should match those responsibilities. The term insurance cover offers the flexibility to increase the level of protection at key life stages of marriage and child birth, without any medicals as below.

Event	Additional Death Benefit (percentage of original Death Benefit)	Maximum additional Death Benefit allowed
Marriage	50%	₹50,00,000
Birth / Legal adoption of 1st child	25%	₹25,00,000
Birth / Legal adoption of 2nd child	25%	₹25,00,000

Additional premium will be calculated based on the increased Sum Assured and outstanding policy term as per your age at the time of each such increase.

Maturity or paid-up or survival benefit

There is no maturity, paid-up value or survival benefit available under this product.

Surrender

For Single Pay policies, unexpired risk premium value will be payable if the policy holder voluntarily terminates the policy during the policy term.

Unexpired risk premium value = (Single Premium * Unexpired risk premium value factor/100)

For unexpired risk premium value for Limited Pay policies, please refer T&C 14.

Smart Exit Benefit

You have an option to cancel the policy and receive Smart Exit Benefi¬t, equal to Total Premiums Paid** under the policy. No additional premium is payable to avail this option.

The following terms and conditions shall apply:

- The Sum Assured in the policy at inception is ₹ 6,000,000 or above.
- This option can be exercised in any policy year greater than 25 but not during the last 5 policy years, provided the age of the life assured is 60 years or more at the time of exercise.
- The policy is in-force with all due premiums paid at the time of exercising this option.
- No claim for any of the underlying benefits has been registered and is under evaluation/ or accepted/ or paid/ being paid on the policy.

Once this feature is exercised and the benefit is paid, the policy shall terminate and all benefits and interests under this policy will stand extinguished. The policyholder can either opt for Smart Exit Benefit or Unexpired Risk Premium Value as per T&C 14 i.e. he cannot avail both the benefits simultaneously.

**Total Premiums Paid means the total of all premiums received, excluding any extra premium, any rider premium and taxes. Where Life Stage Protection options has been exercised, Total Premiums Paid includes Premium paid for each tranche of additional sum assured purchased. In case the benefit term for additional benefit(s), for which additional premium has been paid, has expired at the time of exercise of Smart Exit Benefit, then Total Premiums Paid shall exclude the premium paid towards such additional benefit(s).

Section-III: Benefits Under The BeFit Rider:

The Benefits listed below are in-built benefits and shall be available to You in accordance with the procedures set out in this BeFit rider.

Any unutilized consultations/e-consultations/ annual sum insured/ sessions cannot be carried forward to the next year.

Choosing the services under this BeFit Rider is purely upon Your own discretion and at own risk. The services provided under the various covers are via third party health service providers/ network providers and we are not responsible for liability arising out of them.

You should seek assistance from a medical practitioner should You still have any concerns about Your health even post availing services from our health service providers/network providers.

All claims under this Section shall be paid in accordance with the procedure set out in Section IV (Claim Procedure).

Table of Benefits	Plan					
	A	B	C	D	E	F
Out patient Consultations	-	-	6	8	12	18
Routine Diagnostic & Minor Procedure Cover	-	1000	1000	2000	3000	5000
Pharmacy Cover	-	1000	1000	2000	3000	5000
Physiotheraphy Sessions	-	-	6	8	10	12
Tele-consultations	12	12	12	12	18	Unlimited
e-councelling	6	6	6	8	12	Unlimited
Diet & Nurtition e-counsultaion	6	6	6	8	12	Unlimited
Preventive Care	-	-	Yes	Yes	Yes	Yes
Wellbeing Program	Applicable					
Health Management Program(HMP)	Not Applicable	If Opted by You voluntarily OR Basis your health Condition				
Ambulance Assistence	Applicable					
Value Added Services	Applicable					

1. Outpatient Consultations:

We will pay You for the medical expenses incurred during the policy period for out-patient consultations from a General Medical Practitioner or Specialist Medical Practitioner or Super Specialist Medical Practitioner or AYUSH medical practitioner in relation to any illness contracted or injury suffered during the Policy Period subject to the overall maximum number of consultations as specified against this benefit in the policy schedule. These services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment.

We will also provide for e-consultations of General Medical Practitioner or Specialist Medical Practitioner or Super Specialist Medical Practitioner or AYUSH medical practitioner registered in our network via chat, e-mail, online portal or mobile application. This benefit of e-consultation shall also be subject to the overall maximum number of times as specified against this benefit in the policy schedule.

Physiotherapy sessions and counselling availed for psychiatric ailments or mental health issues shall be excluded from the scope of this benefit.

2. Routine Diagnostic Cover and Minor Procedure Cover

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

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

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

List of Minor Procedures#

1. Drainage of abscess
2. Injection including Intramuscular (Per Injection cost)
3. Intravenous injection(IV)
4. Sprain Management (Joint movement/ exercise)
5. Otoscopic examination (Magnifying otoscopy)
6. Nasal packing for control of haemorrhage
7. Nebulizer therapy
8. Removal of foreign body
9. Suturing(Staple under LA)
10. Removal of suture
11. Stabilization of joint
12. Syringing ear to remove wax
13. Application or removal of plaster cast
14. Laryngoscopy
15. Minor wound management

#this includes only the cost of administration. The actual cost of consumables shall be either covered under the pharmacy cover or have to be borne by the insured person in case the annual sum insured under the pharmacy cover has been exhausted or is out of scope of the Pharmacy cover or in case the consumable is a non-payable item as per the Base Product

3. Pharmacy Cover

We will pay You for the medical expenses incurred during the Policy Period on purchase of medicines, drugs, and medical consumables, as prescribed by a Medical Practitioner under our cashless network available in the mobile application for any Illness contracted or Injury suffered by You maximum up to the Annual sum insured limit as specified against this benefit in the policy schedule through our Empaneled Health Service Provider subject to availability on the date of the request.

Health supplements, Nutraceuticals, foods for special dietary use, foods for special medical purpose, foods with added probiotics and/or foods with added prebiotics, vaccinations, vitamins, tonics or other related products shall be excluded from the scope of this cover

4. Physiotherapy Session

We will cover medical expenses incurred by You for physiotherapy sessions with a qualified physiotherapist to treat any Illness, Injury, or deformity suffered as advised by qualified medical practitioners during the Policy Period by physical methods such as but not limited to massage, heat treatment, ultrasound, Laser and exercises maximum up to the number of sessions as specified against this benefit in the policy schedule.

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

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

5. Tele-consultation

We will cover medical expenses incurred on telephonic/ virtual consultations and recommendations for any Injury sustained or Illness contracted by You during the Policy Period by a qualified Medical Practitioner or health care professional subject to the overall maximum number of consultations as specified against this benefit in the policy schedule. For the purpose of this benefit Telephonic/Virtual consultation shall mean

consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile application.

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

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

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

We/Medical Practitioner/Healthcare professional may refer You to a specialist medical practitioner or a general physician, if required

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

6. E-counseling

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

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

7. Diet and Nutrition e-consultation

We will cover expenses incurred by You on diet and nutrition e-consultation during the Policy Period on a virtual platform via our mobile application maximum up to the number of sessions as specified against this benefit in the policy schedule.

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

8. Preventive Care

Adults aged 21 and above can avail a routine and preventive health check-up as per our pre- defined package (provided as annexure A to policy wordings) at our network providers or health service providers anytime during the Policy period

This benefit can be availed on cashless basis and is limited to once a year for each Adult. Your Health records shall be saved with Us in order to award wellbeing points as a part of the Wellbeing Program and may be made available to You in Your medical vault.

9. Wellbeing Program

Wellbeing program intends to promote, incentivize and reward You for Your healthy behavior through various wellbeing services. All the wellbeing activities as mentioned below in Table 1 enable You to earn wellbeing points which shall be monitored by the Health Coach.

The Health Coach shall only be available to Adults aged 21 and above. The Health Coach is a personalized service that shall encourage and promote optimal health and physical and mental wellbeing through a telephonic / digital connect. You shall have access to the health coach on downloading and registering on the mobile application. This activity needs to be done within 30 days of policy start date to ensure adequate utilization of services offered and to redeem the wellbeing points awarded. Post Registration and successful completion of Health Risk Assessment [HRA], You shall be evaluated by the Health Coach to assess and educate You on adapting a healthy lifestyle

Table 1. Journey of earning Wellbeing points (Refer TABLE A in Policy wordings)

Sr No	Category	Activity Details	Maximum Wellbeing Point Earned per Adult*
A	**On boarding (Mandatory to unlock earnings from other points based stabs**	Addition of BeFit Riders Details	500
		E-Card Verification	300
B	**Health Assesment**	Health Risk Assesment	400
		Advisory on Preventive Care Health check up	300
		Medical Vault	300
		First Usage of chat with Health expert/Health Coach service	100
		Tele-consultations	300
C	**Wellbeing activities**	ICICI Lombard initiated Contest/ health quiz (Any One Contest)	200
		ICICI Lombard initiated Webinar (Any One Webinar)	200
D	**Wellbeing Tasks**	Achieving Targeted steps per Month	Maximum of 2400 per year
E	**Fitness Challenge**	Participation and successful completion of fitness challenge	250 per challenge, maximum of 500 points
F	**Health Events**	Participation and successful completion of Health event	250 per challenge, maximum of 500 points
	Grand Total		**6000**

*The Wellbeing Points to be awarded for each activity have been mentioned considering an individual BeFit rider for a single adult aged 21 and above. In case of a floater BeFit rider with 2 adults aged 21 and above, the wellbeing points to be awarded shall be doubled, provided, that both the Insured Persons complete their respective wellbeing activities.

BeFit Benefit

The Befit Benefit has been designed to reward You for Your healthy behavior displayed throughout the year, which in turn resulted into partial utilization of the following covers:

1. Routine Diagnostic and Minor Procedure cover
2. Pharmacy cover.

The benefits are as per the Table 2 below:

Table 2. Befit Benefit (Refer TABLE C in Policy wordings)

Utilization under routine diagnostic and minor procedure cover and Pharmacy cover	Wellbeing Points awarded
Up to 10% of Annual sum insured	100% of basic premium*
11% to 25% of Annual sum insured	60% of basic premium
26% to 40% of Annual sum insured	40% of basic premium
>40% of Annual sum insured	Nil

* Basic premium refers to the premium charged to You (i.e. premium excluding GST) as mentioned on the policy certificate

For example, Your basic premium is INR 5,000. The annual sum insured for routine diagnostic and minor procedure cover is INR 1,000 and the annual sum insured for pharmacy cover is INR 2,000. In case You utilize only INR 300 overall, You shall be awarded 5000 wellbeing points as a part of the BeFit Benefit.

Also, As a Reward for Your loyalty and long association with us, We shall increase the Rupee value of the Wellbeing Points Year on Year as per the Table 3 below:

Table 3. Increase in Rupee Value of Wellbeing Points (Refer TABLE D in Policy wordings)

	Rupee Value of Wellbeing Points	Wellbeing Points	Rupee Value of Wellbeing Points
First Renewal (2nd Year of BeFit Rider)	INR 0.10	1000	INR 100
Second Renewal (3rd Year of BeFit Rider)	INR 0.12	1000	INR 120
Third Renewal (4th Year of BeFit Rider)	INR 0.15	1000	INR 150
Fourth Renewal (5th Year of BeFit Rider)	INR 0.20	1000	INR 200

Redemption of Wellbeing Points

The Wellbeing points earned by You (as detailed in Tables 1 & 2) can be redeemed in any of the below mentioned ways

Discount on Renewal premium- The Wellbeing points earned by You can be redeemed to avail a discount on renewal premium. However, the maximum discount that You can avail shall be as per the Table 4 below:

Terms and Conditions for Redemption of Wellbeing Points

i. The Insured Person has to accumulate minimum 1000 wellbeing points in order to redeem them against discount on renewal premium. There shall be no minimum points limit for redemption against health related deals and offers on mobile application.

ii. Alternately, the Insured Person(s) can even choose to carry forward the wellbeing points for 3 years, in case they do not wish to redeem the same.

For detailed Terms and conditions, disclaimers for availing the Wellbeing Program kindly refer to the policy wordings

10. Health Management Program (HMP)

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

You shall be subjected to a mid- term assessment via a Wellbeing Risk Assessment [WRA] which includes the Preventive Care health check-up-outcomes and questionnaire based assessment covering aspects of lifestyle, current medical history & family history. The assessment will be carried out using a telephonic/digital connect with the Health Coach. In case of any adverse health conditions/ lifestyle diseases, You shall be mandatorily shifted to HMP at the time of renewal of the BeFit rider. This mid-term assessment will be carried out every year to monitor Your health condition.

Your lifestyle/health conditions that shall be considered for HMP will include below listed 37 health conditions.

Hypertension (refer levels defined in Table 6 & 7)	Permanent paralysis of limbs	Loss of limbs
Diabetes Mellitus (refer levels defined in Table 6 & 7)	Stroke resulting in permanent symptoms	Poliomyelitis
Obesity (refer levels defined in Table 6 & 7)	Coma of specified severity	Aplastic Anaemia
Hyperlipidemia (refer levels defined in Table 6 & 7)	Alzheimer's Disease before age of 50 years	Loss of Independent Existence
Myocardial Infarction	Parkinson's disease before age of 50 years	Myasthenia gravis
Refractory heart failure	Apallic syndrome	Scleroderma
Cardiomyopathy	Benign brain tumour	Muscular dystrophy
End stage lung Failure	Creutzfeldt-Jakob disease (CJD)	Blindness
Primary(Idiopathic) pulmonary Hypertension	Major head trauma	Deafness
End stage liver Failure	Kidney failure requiring regular dialysis	Cancer of specified severity
Multiple sclerosis with Persisting symptoms	Medullary cystic disease	Third Degree Burns
Motor neuron disease with Permanent symptoms	Good pastures syndrome with lung or renal involvement	Loss of speech
Systemic Lupus Erythematous with renal involvement		

Table 4. Maximum discount that can be availed by Insured Person (Refer TABLE E in Policy wordings)

Year of BeFit Rider	Maximum Discount that can be availed as % of basic premium*
1st Year	20
2nd Year	20
3rd Year	25
4th Year	25
5th Year	25

*Basic premium refers to the premium charged to You (i.e. premium excluding GST) as mentioned on the policy certificate

Wellbeing points accumulated by You (as detailed in Table 1 & 2) can be redeemed against health related deals and offers on health supplements, dietary supplements, food supplements etc., only as available on our platform of mobile application or through our specified network providers or health service providers.

Illustration for redemption of Wellbeing Points

Below mentioned Table 5 is a road map journey of 5 years for an individual BeFit rider

Table 5. Illustration for redemption of Wellbeing Points (Refer TABLE F in Policy wordings)

	Particulars	Fresh Policy	1st Renewal	2nd Renewal	3rd Renewal	4th Renewal
		1st year	2nd year	3rd year	4th year	5th year
A	Basic Premium w/o GST (INR)	5000	5000	5000	5000	5000
B	Renewal Discount (INR)	-	1000	1000	1250	1250
C	Renewal Premium (A-B)(INR)	-	4000	4000	3750	3750
D	Maximum Wellbeing Point that can be accured(through wellbeing program)	6000	6000	6000	6000	6000
E	Maximum Wellbeing Point accured (through BeFit Benefit)	5000	5000	5000	5000	5000
F	Total Points accumulated (D+E)	11000	11000	11000	11000	11000
G	Value of 1 wellbeing point (INR)	0.1	0.12	0.15	0.20	0.20
H	Value in terms of INR (F*G)(INR)	1100	1320	1650	2200	2200
I	Maximum discount that can be availed	20% of the base premium		25% Of the base premium		
J	Maximum rupee dicount can be availed as renewal premium discount (I*A)(INR)	1000	1000	1250	1250	1250
K	Balance can be availed against health related deals & offers on mobile application (H-J)(INR)	100	320	400	950	950

Once You qualify for the HMP, You shall have to pay the HMP premium and follow the customized HMP which has been designed to achieve Your respective health goals. You will have to be part of the HMP for a consecutive period of 2 years.

Post the successful completion of 2 years in the HMP, Your health condition will be reviewed by the health coach. Basis the health condition at the time of review, it will be decided whether You need to continue with the HMP or not.

The health check-up outcomes that will be used for categorization purpose of

Hypertension, Diabetes Mellitus, Obesity, Hyperlipidemia are as Table 6 & 7below:

Table 6 (applicable for first time buyer) (Refer Table G in policy wordings)

Medical Tests	Category 1 (Normal Program)	Category 2 (Health Management Program)
Glycosylated Hemoglobin (HbA1c)	< 6%	>6 and up to7%
Blood Pressure reading	Systolic Up to 120 mm hg Diastolic Up to 80 mm hg	Systolic >120mm and <140 mmhg Diastolic > 80 mm and <90 mm hg
Low – density lipoprotein (LDL)	< 100 mg/dl	>100 and < or = 190 mg/dl
High – density lipoprotein(HDL)	> or = 40 mg/dl	> 20 mg/dl and <40 mg/dl
Serum cholesterol	< or = 200mg/dl	>200 and < or =300 mg/dl
Triglycerides	<or = 150 mg/dl	> 150 and <= 250mg/dl
Body Mass Index(BMI)	< or = 32	>32 and < or = 40

Table 7 (for renewal customers) (Refer Table H in policy wordings)

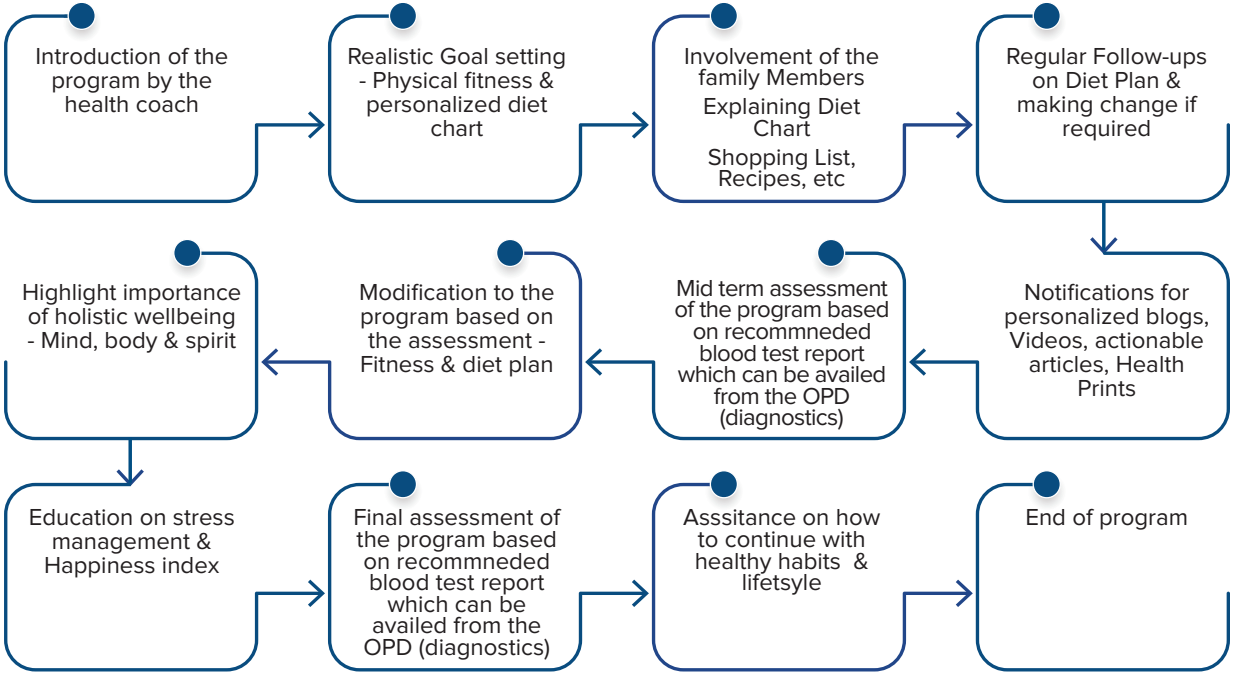
Medical Tests	Category 1 (Normal Program)	Category 2 (Health Management Program)
Glycosylated Hemoglobin (HbA1c)	< 6%	>6%
Blood Pressure reading	Systolic Up to 120 mm hg Diastolic Up to 80 mm hg	Systolic >120mm Diastolic > 80 mm
Low – density lipoprotein (LDL)	< 100 mg/dl	>100 mg/dl
High – density lipoprotein(HDL)	> or = 40 mg/dl	> 20 mg/dl
Serum cholesterol	< or = 200mg/dl	>200 mg/dl
Triglycerides	<or = 150 mg/dl	> 150 mg/dl
Body Mass Index(BMI)	< or = 32	>32

The HMP can also be voluntarily opted by Insured person(s) even if they are found to be fit, basis the wellbeing risk assessment, as a conscious step towards healthier living by paying the requisite premium for it and avail the benefits of the HMP. (refer rate chart below for HMP premium).

Note:

1. Customers who are classified into Category 1 will pay premium for Normal program, if they do not voluntarily opt for HMP (refer rate chart below for Normal Program premium)
2. Customers who are classified into Category 2 as mentioned in Table 6 & 7 and who are diagnosed with any of the listed 37 conditions post policy issuance (as mentioned in point no 10, health management program), will be offered HMP only on payment of HMP premium. (refer rate chart below for HMP premium)
3. Policy issuance is subject to underwriting guidelines of the base product

How does the HMP work?



Additional components of HMP:-

- Reminders on medicines and diagnostic test
- You will also be eligible for an additional 3 Tele-consultations & 3 e-counselling sessions

11. Ambulance Assistance

We will facilitate through Our Health Service provider ground medical transportation to transport You to the nearest Hospital or any clinic or nursing home for medically necessary treatment

This is only an assistance service to arrange for an ambulance, the cost of the ambulance has to be borne by You as per the invoice provided at the time of availing the service. There is no restriction on the number of times the Ambulance Assistance can be availed.

Kindly visit our mobile application for updated list of cities/locations where the services are provided.

12. Value Added Services (VAS)

We at Your request will arrange or will facilitate the following additional services through Our empanelled health service provider

1. Deals and Discounts on services or products provided by our network providers/ Health service providers– We shall only facilitate You in availing deals and discounts on services/ products offered by our network providers/ health service providers. In case of exhaustion of annual sum insured under the BeFit rider benefits mentioned above, You can still avail the discount provided by our network providers / health service providers, in which case the actual cost of the product/service shall have to be borne by You.
2. Health Assistance (HAT) – We will assist You in understanding Your health condition better by providing answers to any queries related to health service provider on Our dedicated helpline or through our app/other digital means from 8am to 8pm from Monday to Saturday except public holidays

Disclaimer:

i. Choosing the option is purely on insured person's discretion and at own risk. We are only acting as facilitators and are not liable for any costs of the services.

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

EXCLUSIONS (WHAT WE WILL NOT PAY)

All exclusions as mentioned in the Base Product will be applicable to the BeFit rider unless otherwise stated and covered in Section II of BeFit Rider policy wordings.

1. **Waiting Period:** There shall be a waiting period of 30 days applicable for all benefits under this BeFit rider.
2. **General Condition:** We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this BeFit rider.

a. Medical Exclusion:

i. Inpatient treatment and day care treatments will not be covered under this product

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.

b. Non- Medical Exclusions:

I. Any item(s) or treatment specified in list of excluded expenses (non-medical) and available on Our web site, unless specifically covered under the BeFit Rider.

CLAIM PROCEDURE:

All claims will be adjudicated only on cashless basis via our mobile application and are subject to the terms, conditions, waiting periods and exclusions of the BeFit rider and the availability of the Annual sum insured.

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

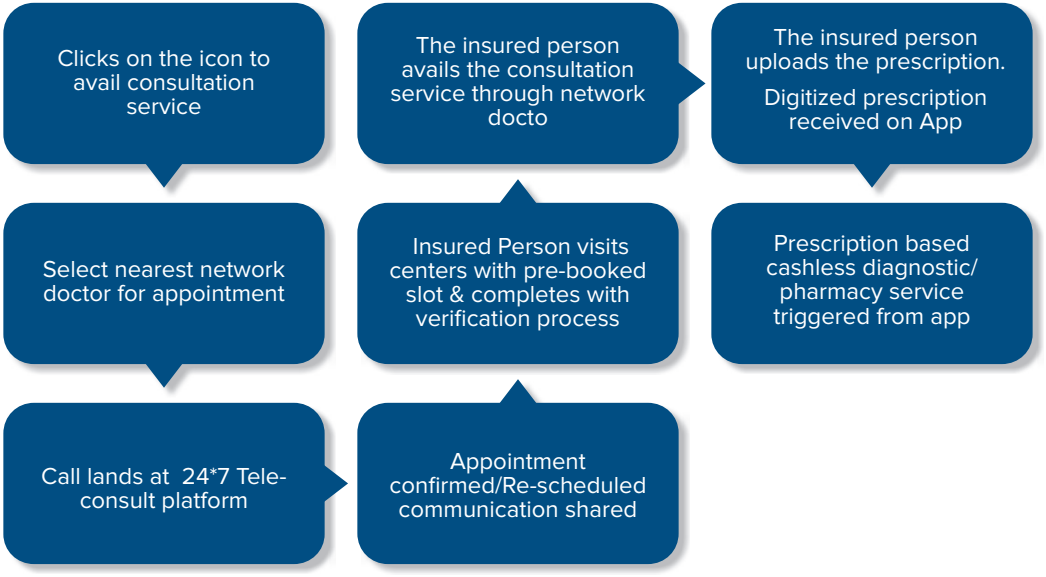
i. To avail of Cashless facility, You are required to produce information on the health card available on the application for verification and validation. The request shall be considered after having obtained accurate and complete information for the Illness or Injury, where applicable, for which Cashless facility is sought and We will confirm the request digitally.

ii. In case the services availed exceed the eligibility, the difference will have to be paid directly to the Hospital/Network Provider/Health Service Provider by You.

iii. To avail the benefits and services under the BeFit Rider, You shall need to raise a request through mobile application

iv. The Routine diagnostic and minor procedure cover /Pharmacy cover services shall only be covered for prescriptions by an empaneled Network Medical Practitioner through the Mobile Application.

How to avail the cashless services on the mobile application



PART III: General Terms & Conditions

All general terms and conditions as mentioned in the Base Product will be applicable to the BeFit rider unless otherwise stated.

1. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In Your case, at Your last known address.

In Our case:

ICICI Lombard General Insurance Company Limited

ICICI Lombard House 414, P Balu Marg, Off Veer Savarkar Road, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

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

2. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified, during normal business hours.

3. Redressal of Grievances

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

Website: www.icicilombard.com

Toll free: 1800 2666

Email: customersupport@icicilombard.com

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at

Manager- Service Quality,

Corporate Manager- Service Quality,

National Manager- Operations & finally

Director-services and Business development at the following address:

ICICI Lombard General Insurance Company Limited,

ICICI Lombard House 414, P Balu Marg, Off Veer Savarkar Road, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

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

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. The contact details of the ombudsman have been provided as an annexure to the policy wordings of the base product.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/ligms.irda.qov.in/

Tax Benefit:

Tax benefit can be availed on premiums paid under Health sections of this BeFit rider, as per Section 80D of Income Tax Act, 1961 and amendments made thereafter.

Note: Policy terms & conditions and Premium rates are subject to change with prior approval from IRDAI. Tax benefits are subject to changes in tax laws. Please consult your financial/tax advisor for more details.

Terms & Conditions

1. Free look period:

The free look option shall be applied to Combi

product as a whole.

- **Term Insurance:**

If you are not satisfied with the terms & conditions of the policy, you may cancel it by returning the policy document to the Company with reasons for cancellation within:

- 15 days from the date it is received, if the policy is not purchased through Distance mode
- 30 days from the date it is received, in case of electronic policies or policies sourced through Distance mode. Distance mode means every activity of solicitation (including lead generation) and sale of insurance products through the following modes: (i) voice mode, which includes telephone-calling (ii) short messaging service (SMS) (iii) electronic mode which includes e-mail, internet and interactive television (DTH) (iv) physical mode which includes direct postal mail and newspaper and magazine inserts and (v) solicitation through any means of communication other than in person.

- **HEALTH INSURANCE COVER**

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

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

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

a. The policy shall terminate on payment of this amount and all rights, benefits and interests under this policy will stand extinguished.

b. You shall not be allowed to cancel the any coverage individually during the Free-look period. Any application for cancellation during the Free-look Period will cancel this Policy in its entirety.

2. Life stage protection (Term insurance):

The policy has to be in force at the time of availing this feature. This feature needs to be exercised within 6 months from the date of the event and only if no claim for any benefit under the policy has been admitted. This feature is available to the Life Assured underwritten as a standard life at the time of inception of the policy. The insured life has to be less than 50 years of age at the time of opting for this feature. This feature is available for Regular Pay policies only. Such increase in sum assured is only applicable to base death benefit. The ACI Sum Assured and ADB Sum Assured will remain unchanged.

3. Terminal Illness (Term insurance):

A Life Assured shall be regarded as Terminally Ill only if that Life Assured is diagnosed as suffering from a condition which, in the opinion of two independent medical practitioners' specializing in treatment of such illness, is highly likely to lead to death within 6

months. The terminal illness must be diagnosed and confirmed by medical practitioners' registered with the Indian Medical Association and approved by the Company. The Company reserves the right for independent assessment.

A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The Medical Practitioner should neither be the insured person(s) himself nor related to the insured person(s) by blood or marriage.

4. **Permanent Disability (PD) due to accident (Term insurance):** On occurrence of PD due to accident, while the policy is in force, all future premiums for all benefits under the policy are waived. PD will be triggered if the Life Assured is unable to perform 3 out of the 6 following Activities of Daily Work:

   i. Mobility: The ability to walk a distance of 200 meters on flat ground.

   ii. Bending: The ability to bend or kneel to touch the floor and straighten up again and the ability to get into a standard saloon car, and out again.

   iii. Climbing: The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.

   iv. Lifting: The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.

   v. Writing: The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

   vi. Blindness – permanent and irreversible - Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

For the purpose of PD, the following conditions shall apply:

1. The disability should have lasted for at least 180 days without interruption from the date of disability and must be deemed permanent by a Company empanelled medical practitioner. In the event of death of the insured within the above period, the policy shall terminate on payment of applicable benefits and all rights, benefits and interests under the policy shall stand extinguished.
2. PD due to accident should not be caused by the following:
   i. Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Life Assured is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or
   ii. Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or
   iii. The Life Assured with criminal intent, committing any breach of law; or
   iv. Due to war, whether declared or not or civil commotion; or
   v. Engaging in hazardous sports or pastimes, e.g. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off site skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.
3. PD due to accident must be caused by violent, external and visible means.

4. The accident shall result in bodily injury or injuries to the Life Assured independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the PD of the Life Assured. In the event of PD of the Life Assured after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit.
5. The policy must be in-force at the time of accident.
6. The Company shall not be liable to pay this benefit in case PD of the Life Assured occurs after the date of termination of the policy.

5. Accidental Death Benefit (Term insurance):

For the purpose of Accidental Death Benefit payable on accident the following conditions shall apply:

a. Death due to accident should not be caused by the following:
   i. Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Life Assured is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or
   ii. Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or
   iii. The Life Assured with criminal intent, committing any breach of law; or
   iv. Due to war, whether declared or not or civil commotion; or
   v. Engaging in hazardous sports or pastimes, e.g. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off site skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.
b. Death due to accident must be caused by violent, external and visible means.
c. The accident shall result in bodily injury or injuries to the Life Assured independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the death of the Life Assured before the expiry of the Accidental Death Benefit cover. In the event of the death of the Life Assured after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit.
d. The policy must be in-force at the time of accident.
e. The Company shall not be liable to pay this benefit in case the death of the Life Assured occurs after the accidental death benefit term.

6. Critical Illnesses definitions and exclusions (Term insurance):

I. Cancer of Specified Severity:

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

The following are excluded -

1. 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.

2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
3. Malignant melanoma that has not caused invasion beyond the epidermis;
4. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6. Chronic lymphocytic leukemia less than RAI stage 3
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
8. 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;

II. Open Chest CABG:

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

Excluded are: Angioplasty and/or any other intra-arterial procedures

III. Myocardial Infarction (First Heart Attack of Specified Severity):

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

1. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
2. New characteristic electrocardiogram changes
3. 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.

IV. Heart Valve Surgery (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.

V. Surgery to aorta

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

VI. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class III or Class IV, or its equivalent, based on the following classification criteria:

Class III - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure.

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

VII. Primary (Idiopathic) Pulmonary hypertension

An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

b. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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

VIII. Angioplasty

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

IX. Blindness

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

The Blindness is evidenced by:

a. corrected visual acuity being 3/60 or less in both eyes or ;

b. the field of vision being less than 10 degrees in both eyes.

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

X. End stage Lung Failure (Chronic Lung Disease):

End stage lung disease, causing chronic respiratory failure, as confirmed and

evidenced by all of the following:

1. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
2. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
- Dyspnea at rest.

XI. End stage Liver Failure (Chronic Liver Disease):

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

1. Permanent jaundice; and
2. Ascites; and
3. Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

XII. 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.

XIII. Major Organ / Bone Marrow Transplant

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

XIV. Apallic Syndrome:

Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

The definition of approved hospital will be in line with Guidelines on Standardization in Health Insurance. and as defined below:

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

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

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

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

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

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

XV. Benign Brain Tumour:

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor

must be confirmed by imaging studies such as CT scan or MRI.

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

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

The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

XVI. Brain Surgery

The actual undergoing of surgery to the brain, under general anaesthesia, during which a Craniotomy is performed. Burr hole and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

XVII. Coma of Specified Severity:

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

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- permanent neurological deficit which must be assessed at least 30 days after the onset of the coma

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

XVIII. Major Head Trauma

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

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

The Activities of Daily Living are:

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

   The following are excluded: Spinal cord injury;

XIX. 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.

XX. 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:

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

XXI. Alzheimer's Disease

Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by our appointed Medical Practitioner.

The disease must result in a permanent inability to perform three or more Activities of daily living with Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

The following conditions are however not covered:

a. neurosis or neuropsychiatric symptoms without imaging evidence of Alzheimer's Disease

b. alcohol related brain damage; and

c. any other type of irreversible organic disorder/ dementia not associated with Alzheimer's Disease

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility: the ability to move indoors from room to room on level surfaces;

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding: the ability to feed oneself once food has been prepared and made available

XXII. Motor Neurone Disease with permanent symptoms

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

XXIII. Multiple Sclerosis with persisting symptoms

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

1. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
2. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as SLE are excluded.

XXIV. Muscular Dystrophy

Diagnosis of muscular dystrophy by a Registered Medical Practitioner who is a neurologist based on three (3) out of four (4) of the following conditions:

a. Family history of other affected individuals;

b. Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;

c. Characteristic electromyogram; or

d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Life Assured to perform (whether aided or unaided) at least three (3) of the six (6) 'Activities of Daily Living' as defined, for a continuous period of at least six (6) months.

XXV. Parkinson's Disease

Unequivocal Diagnosis of Parkinson's Disease by a Registered Medical Practitioner who is a neurologist where the condition:

a. cannot be controlled with medication;

b. shows signs of progressive impairment; and

c. Activities of Daily Living assessment confirms the inability of the Insured to perform at least three (3) of the Activities of Daily Living as defined in the Policy, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons.

Drug-induced or toxic causes of Parkinson's disease are excluded.

XXVI. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:

1. Poliovirus is identified as the cause and is proved by Stool Analysis,
2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

XXVII. Loss of Independent Existence

The insured person is physically incapable of performing at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months, signifying a permanent and irreversible inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with

current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor Who is a specialist.

Only Life Insured with Insurance Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this illness.

Activities of Daily Living:

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

XXVIII. Loss of Limbs

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

XXIX. Deafness

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

XXX. Loss of Speech

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

XXXI. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

a. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;

b. clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and

c. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this benefit.

XXXII. Systematic lupus Eryth. with Renal Involvement

Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of

Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

Abbreviated ISN/RPS classification of lupus nephritis (2003):

Class I - Minimal mesangial lupus nephritis

Class II - Mesangial proliferative lupus nephritis

Class III - Focal lupus nephritis

Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis

Class V - Membranous lupus nephritis

ClassVI - Advanced sclerosing lupus nephritis the final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

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

XXXIV. Aplastic Anaemia

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

a. Blood product transfusion;

b. Marrow stimulating agents;

c. Immunosuppressive agents; or

d. Bone marrow transplantation.

The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:

i. Absolute Neutrophil count of 500 per cubic millimetre or less;

ii. Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and

iii. Platelet count of 20,000 per cubic millimetre or less.

Waiting period for Critical Illness Benefit:

1. The benefit shall not apply or be payable in respect of any Critical Illness for which care, treatment, or advice was recommended by or received from a Physician, or which first manifested itself or was contracted during the first six months from the date of commencement of risk or 3 months from the policy revival date where the policy has lapsed for more than 3 months.
2. In the event of occurrence of any of the scenarios mentioned above, or In case of a death claim, where it is established that the Life Assured was diagnosed to have any one of the covered critical illness during the waiting period for which a critical illness claim could have been made, the Company will refund the premiums corresponding to the ACI Benefit from date of commencement of risk or from the date of revival as applicable and the ACI Benefit will terminate with immediate effect.
3. No waiting period applies where Critical Illness is due to accident.

Exclusions for Accelerated Critical Illness Benefit: No ACI benefit will be payable in respect of any listed condition arising directly or indirectly from, though, in consequence of or aggravated by any of the following:

- Pre-Existing Conditions or conditions connected to a Pre-Existing Condition will be excluded. Pre-existing Disease means any condition, ailment, injury or disease:
  i. that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Company or its revival or
  ii. 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 or its revival.

- Existence of any Sexually Transmitted Disease (STD) and its related complications
- Self-inflicted injury, suicide, insanity and deliberate participation of the life insured in an illegal or criminal act with criminal intent.
- Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a qualified medical practitioner.
- War – whether declared or not, civil commotion, breach of law with criminal intent, invasion, hostilities (whether war is declared or not), rebellion, revolution, military or usurped power or wilful participation in acts of violence.
- Aviation other than as a fare paying passenger or crew in a commercial licensed aircraft.
- Taking part in any act of a criminal nature with criminal intent.
- Treatment for injury or illness caused by avocations / activities such as hunting, mountaineering, steeple-chasing, professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, deliberate exposure to exceptional danger.
- Radioactive contamination due to nuclear accident.
- Failure to seek or follow medical advice, the Life assured has delayed medical treatment in order to circumvent the waiting period or other conditions and restriction applying to this policy.
- Any treatment of a donor for the replacement of an organ.
- Any illness due to a congenital defect or disease which has manifested or was diagnosed before the Insured attains aged 17.

7. Death Benefit Payout Options (Term insurance): The monthly income will only be payable electronically.

8. Tax benefits: Tax benefits may be available as per prevailing tax laws. Tax benefits under the policy are subject to prevailing conditions and provisions of the Income Tax Act, 1961. Goods and Services Tax and Cesses, if any, will be charged extra as per applicable rates. The tax laws are subject to amendments made thereto from time to time. Please consult your tax advisor for details, before acting on above.

9. Suicide clause (Term insurance):

If the Life Assured, whether sane or insane, commits suicide within 12 months from the date of commencement of risk of this Policy, the Company will refund higher of 80% of the total premiums paid if any till the date of death or unexpired risk premium value as available on date of death, provided the policy is in force.

In the case of a revived Policy, if the Life Assured, whether sane or insane, commits suicide within 12 months of the date of revival of the Policy, higher of 80% of the total premiums paid if any till date of death or unexpired risk premium value as available on date of death will be payable by the Company.

The Policy will terminate on making such a payment and all rights, benefits and interests under the Policy will stand extinguished.

10. Grace period:

Health insurance:

The Policy may be renewed by mutual consent and in such event the renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable for any Claim which occurs during the Grace Period.

Term insurance:

A grace period for payment of premium of 15 days applies for monthly premium payment

mode and 30 days for other modes of premium payment, commencing from the premium due date, without any penalty or late fee, during which time the policy is considered to be in-force with the risk cover without any interruption, as per the terms and conditions of the policy. In case of Death of Life Assured during the grace period, the Company will pay the applicable Death Benefit. If the premium is not paid within the grace period, the policy shall lapse and cover will cease.

11. **Limited pay option (Term insurance):** Premiums need to be paid only for the chosen premium payment term. Once premiums have been paid for the premium payment term, the policy benefits will continue for the term of the policy.

12. **Premium discontinuance (Term insurance):** If the premium is not paid either on the premium due date or within the grace period, all benefits under this policy will cease.

13. **Cancellation (Health insurance):** 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.

1 year policy		2 year policy		3 year policy	
Months Expired	**Premium Retained**	**Months Expired**	**Premium Retained**	**Months Expired**	**Premium Retained**
0-3	25%	0-3	15%	0-3	15%
03-Jun	50.00%	03-Jun	25%	03-Jun	25%
06-Sep	75.00%	06-Sep	50%	06-Sep	35%
09-Dec	100.00%	09-Dec	65%	09-Dec	40%
		Dec-15	75%	Dec-15	50%
		15-18	85%	15-18	60%
		18-24	100%	18-21	70%
				21-24	80%
				24-27	85%
				27-30	90%
				31-36	100%

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

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

14. Unexpired risk premium value (Term insurance): For Limited Pay policies, unexpired risk premium value, if any, will be payable if the policy holder voluntarily terminates the policy during the policy term

Or for lapsed policies on earlier of:

i. Death of the Life Assured within the revival period, or

ii. At the end of the revival period

Unexpired risk premium value = (Unexpired risk premium value factor/100) X Annual Premium

15. Term insurance:

The bases for computing unexpired risk premium value factors will be reviewed from time to time and the factors applicable to existing business may be revised subject to the prior approval of the IRDAI.

16. Accidental Death Benefit (Term insurance):

For Accidental Death Benefit being added during the policy term, following conditions shall apply:

- The policy must be in-force at the time of adding a Benefit
- There should not be any claim registered under the policy
- Life Assured should not be older than the 55 years (age last birthday)
- The availability of the AD benefit will be subject to underwriting, as per the prevailing board approved underwriting policy.
- The Benefit will commence from subsequent policy anniversary for the remaining policy term or till age 80, whichever is lower. Provided the outstanding policy term is at least 5 years. The policyholder will have to pay an additional premium for the additional Benefit Sum Assured chosen for the outstanding policy term based on his/her then age.

17. Policy revival (Term insurance): A policy which has discontinued payment of premium may be revived subject to underwriting and the following conditions:

- The application for revival is made within 5 years from the due date of the first unpaid premium and before the termination date of the policy. Revival will be based on the prevailing Board approved underwriting policy.
- The Policyholder furnishes, at his own expense, satisfactory evidence of health of the Life Assured as required by the prevailing Board approved underwriting policy.
- The arrears of premiums together with interest at such rate as the Company may charge for late payment of premiums are paid. The interest rate applicable in April 2020 is 7.87% p.a. compounded half yearly. The revival of the policy may be on terms different from those applicable to the policy before

premiums were discontinued; for example, extra mortality premiums or charges may be applicable.

- The Company reserves the right to not revive the policy. The revival will take effect only if it is specifically communicated by the Company to the Policyholder.

For ACI Benefit, a waiting period of 3 months will be applicable for any revivals after 3 months from the due date of the first unpaid premium. No waiting period will be applicable for any revival within 3 months of the due date of the first unpaid premium.

Any change in revival conditions will be subject to prior approval from IRDAI and will be disclosed to policyholders.

18. No loans are allowed under this policy.

19. Modal loadings (Term insurance): Loadings for various modes of premium payment are given below

Mode of Premium Payment	Loading (as a % of Premium)
Monthly	2.5%
Semi-Annual	1.25%
Annual	NA

20. **Applicable for Term insurance:** If the policy has been taken on the life of a major and the Policyholder is different from the Life Assured, then upon death of the Policyholder and subsequent intimation of the death with the Company, the policy shall vest on the Life Assured. Thereafter, the Life Assured shall become the Policyholder and will be entitled to all benefits and subject to all liabilities as per the terms and conditions of the policy. The Life Assured cum Policyholder can register due nomination as per Section 39 of the Insurance Act, 1938 as amended from time to time.

21. Nomination: Nomination shall be as per Section 39 of the Insurance Act, 1938 as amended from time to time. For more details on this section, please refer to our website.

22. Assignment: Assignment shall be as per Section 38 of the Insurance Act, 1938 as amended from time to time. For more details on this section, please refer to our website.

23. Section 41: In accordance with Section 41 of the Insurance Act, 1938 as amended from time to time, no person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

24. Section 45: 1) No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later. 2) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date

of the rider to the policy, whichever is later, on the ground of fraud: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based. 3) Notwithstanding anything contained in sub-section (2), no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer: Provided that in case of fraud, the onus of disproving lies upon the beneficiaries, in case the policyholder is not alive. 4) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision to repudiate the policy of life insurance is based: Provided further that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation. 5) Nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the Life Insured was incorrectly stated in the proposal.

25. Combi product discount: If You buy this Combi product, discount of 5% on annual premiums paid towards Health (Health AdvantEdge) will be offered as compared to the individual policies purchased under Health & Life. At any time during the validity of the policy, if You decide to opt out of the insurance coverage of one of the Insurer, the discount, if any, being offered to You under the Combi-Product shall not be available to You going forward.

26. The risks of this Combi Product are distinct and are assumed / accepted by respective insurance companies. ICICI Prudential Life Insurance Company Limited shall assume/accept the risk only in relation to the life insurance component of the Combi Product and ICICI Lombard General Insurance Company Limited shall assume/accept the risk only in relation to the health insurance component of the Combi Product.

27. Where the risk is not accepted by one of the Parties, the Combi-Product shall not be issued and the other Insurer shall be free to issue their respective policy individually to You, if You so desire, as if the business was done by that respective Insurer individually without any obligation of confirmation being taken from the other Insurer. Provided that if the Customer desires to take a policy individually from either of the Parties; the Customer shall not be entitled to the discount, if any, being offered under the Combi-Product and would be governed by the terms and conditions of the individual policy being offered by either of the Parties.

28. The legal/ quasi legal disputes, if any, are dealt by the respective insurers for respective benefits. For protection benefits all the legal disputes if any,

will be handled by ICICI Prudential Life Insurance Co. Ltd and for health benefits all the legal disputes if any, will be handled by ICICI Lombard General Insurance Co. Ltd.

29. All policy servicing requests pertaining to this Combi Product shall be received by either of the insurer. Other than the requests impacting premium or terms and conditions of the policy towards the policy of the respective Insurer all other requests shall be serviced by the receiving insurer. All requests impacting premium or policy terms towards the policy of a respective Insurer shall be serviced by the respective Insurer and the receiving Insurer shall only facilitate in receiving such requests. Both Insurers will fulfill servicing request received by them as per Protection of Policyholders' Interests Regulations, 2017. Both the Parties are responsible for the pro-active and speedy settlement of claims and other obligations in accordance with the terms and conditions of their respective line of business – health or life coverage/ plan of iShield.

30. The liability to settle the claim vests with respective insurers, i.e., for health insurance benefits "ICICI Lombard General Insurance Co. Ltd." and for life insurance benefits "ICICI Prudential Life Insurance Co. Ltd."

31. Customer can lodge a grievance for either or both products at branches of both Insurers. Complaint belonging to any product shall be routed to the respective insurer who shall then respond / address to the Customer directly. Complaints shall be forwarded by the receiving Insurer to the respective Insurer within T+ 2 days, T being the complaint receivable date. In case the Customer is not satisfied with the resolution offered, Customer can also approach the Insurance Ombudsman in his region. Please refer relevant grievance redressal mechanism section mentioned under each policy document.

32. The policyholders of the Combi Product under reference are eligible to continue with either part of the policy, discontinuing the other during the policy term.

33. Where guaranteed renewability of health insurance plan is allowed, the health insurance portion of this Combi Product is entitled to that facility.

34. It is advised to familiarize with the policy benefits and policy service structure of the Combi Product before deciding to purchase the policy.

35. Premium Component of both the products is separate and at the time of renewal customer can discontinue either part of the policy during the policy term and migrate into a similar individual policy with the respective insurer. The terms and conditions of the portion will be similar to the terms and conditions of the product, if it would have been sold in isolation.

36. The product is also available for sale through online mode.

ICICI LOMBARD General Insurance Co. Ltd. CIN: L67200MH2000PLC129408 Reg. No.115

Website: www.icicilombard.com; Toll free: 1800 2666; Email: customersupport@icicilombard.com

Corporate office: ICICI Lombard General Insurance Company Limited, ICICI Lombard House, 414, P Balu Marg, Off Veer Savarkar Road, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai- 400025

ICICI Prudential Life Insurance Company Limited. IRDAI Regn. No. 105. CIN: L66010MH2000PLC127837.

Customers calling from anywhere in India, please dial 1860 266 7766; Do not prefix this number with "+" or "91" or "00" (local charges apply); Customers calling us from outside India, please dial +91 22 6193 0777

Call Centre Timings: 10.00 am to 7.00 pm; Monday to Saturday, except National Holidays.

To know more, please visit www.iciciprulife.com

ICICI Prudential Life Insurance Company Limited. Registered Address: ICICI PruLife Towers, 1089, Appasaheb Marathe Marg, Prabhadevi, Mumbai - 400025. The product brochure is indicative of the terms & conditions, warranties & exceptions contained in the insurance policy. For further details, please refer to the policy document. In the event of conflict, if any between the terms and conditions contained in this brochure and those contained in the policy documents, the terms & conditions contained in the policy document shall prevail. Trade Logo displayed above belongs to ICICI Bank Limited & Prudential IP Services Limited and used by ICICI Prudential Life Insurance Company Limited under license. iShield UIN: ICIHLIP24028V012324 (ICICI Lombard General Insurance Health AdvantEDGE UIN: ICIHLIP23075V032223, BeFit Rider UIN: ICIHLIP21569V012021 & ICICI Prudential Life ICICI Pru iProtect Smart UIN: 105N151V07), ADV/17717.

BEWARE OF SPURIOUS / FRAUD PHONE CALLS!

IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint.