Policy Wording – Smart Health Critical Illness Policy

1) Preamble:

1.1. WHEREAS, the Insured designated in the Schedule to this Policy having by a proposal and declaration together with any statement, report or other document, which shall be the basis of this contract and shall be deemed to be incorporated herein, has applied to ICICI Lombard General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the period as specified in the Schedule.

1.2 Now this Policy witnesseth: That, subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company, undertakes, that if during the period as specified in the Schedule to this Policy, the Insured / Insured Person shall contract any of the specified diseases, illnesses or sustain any injury leading to such specified illness, then depending upon the terms of this contract of insurance, the Insured / Insured Person his /her nominee, or legal representatives, as the case may be, shall be entitled to payment of a fixed amount of compensation to the extent of sum insured as specified in this policy on behalf of such Insured / Insured Person for such treatment if such disease, illness or injury shall upon the advice of a duly qualified Medical Practitioner require such Insured/Insured Person, to incur hospitalisation and / or other related expenses towards treatment of such disease, illness or injury at any Hospital/ Nursing Home in India as an inpatient.

2. Definitions:

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meaning as set forth herein below:

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

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

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

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

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

"Condition Precedent" means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

"Disclosure to information norm" means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

"Day Care treatment" means medical treatment, and / or surgical procedure which is:

undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and

which would have otherwise required a hospitalization of more than 24 hours.

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

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

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

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

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

"Hospital" - 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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

has qualified nursing staff under its employment round the clock;

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;

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

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

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

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

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

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

b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
I) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

ii) it needs ongoing or long-term control or relief of symptoms
iii) it requires your/insured person's rehabilitation or for you/insured member to be specially trained to cope with it
iv) it continues indefinitely
v) it recurs or is likely to recur

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

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

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

The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured/Insured Person's family.

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

"Medically Necessary" treatment is defined as any treatment, tests,medication, or stay in hospital or part of a stay in hospital which is required for the medical management of the illness or injury suffered by the insured; must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope,duration, or intensity; must have been prescribed by a medical practitioner, must conform to the professional standards widely accepted in international medical practice or by the medicalcommunity in India.

"Medical Advise" means any consultation or advice from a Medical Practitioner including the issuand of any prescription or follow-up prescription

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

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

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

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

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

"Post-hospitalization Medical Expenses" means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital provided that:

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

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

"Pre-Existing Disease" Pre-existing Disease means any condition, ailment, injury or disease:
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

"Pre-hospitalization Medical Expenses" means medical expenses incurred immediately before the Insured Person is Hospitalized, provided that:

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

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

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

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

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

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

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

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

"Critical Illnesses" mean diseases / illnesses limited to the following:

Cancer of Specified Severity

First heart attack - of specified severity

Coronary Artery Disease

Open Chest CABG (Coronary Artery By-pass Graft)

Open Heart replacement or Repair of Heart Valves

Surgery to Aorta

Stroke resulting in Permanent Symptoms

Kidney Failure Requiring Regular Dialysis

Aplastic Anaemia

End Stage Lung Disease

End Stage Liver Failure

Coma of Specified Severity

Major Burns

Major Organ/Bone Marrow Transplantation

Multiple Sclerosis with Persisting Symptoms

Fulminant Hepatitis

Motor Neurone Disease with Permanent Symptoms

Primary Pulmonary Hypertension

Terminal Illness

Bacterial Meningitis.

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

"Disease" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certifiedby a Medical Practitioner.

"Dependent Child" refers to a child (natural or legally adopted) below the age of 23 years, who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

"Family" means the Insured, his/her lawful spouse and maximum of two dependant children upto the age of 23 years.

"Insured" means the individual who has a permanent place of residence in India and on whose name the Policy is issued. In case of group policies it means the group, organization, institution, firm, society or body corporate engaged in any trade or business in India on whose name the Policy is issued.

"Insured Person" means the person named in the Schedule of the Policy, who has a permanent place of residence in India and for whose benefit the insurance is proposed and appropriate premium paid.

"Period of Insurance" means the Policy period defined hereunder.

"Policy period" means the period between the inception date and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier.

"Policy" means this document of Policy describing the terms and conditions of this contract of insurance including the Company's covering letter to the Insured, if any, the Schedule attached to and forming part of this Policy, the Insured's Proposal Form and any applicable endorsement thereon. The Policy contains details of the scope and extent of cover available to the Insured/Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.

"Third Party Administrator (TPA)" means any organization or institution that is licensed by the IRDA as a TPA and is engaged by the Company for a fee or remuneration for providing Policy and claims facilitation services to the Insured / Insured Person as well as to the Company for an insurable event.

"Schedule" means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to.

"Sum Insured" means the sum as specified in the Schedule to this Policy against the name of Insured / each Insured Person, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy period for the respective benefit(s) against which the sum is mentioned in the Schedule to this Policy.

"Terrorism/Terrorist Incident" means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or the commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism

3. Scope of Cover

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, to pay the fixed compensation and/ or reimburse the following benefits in manner, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy.

3.1) Section I Hospitalization Expenses Payment / Reimbursement

If, 60 days after the inception of this Policy, the Insured / Insured Person is at any time during the Policy period is diagnosed as contracting any of the Critical Illnesses and upon the advice of a duly qualified Medical Practitioner such Insured/Insured Person is required to incur hospitalisation and / or other related expenses towards treatment of such disease, illness or injury at any Hospital/Nursing Home in India as an inpatient, the Hospitalisation expenses incurred towards such treatment is covered under this benefit upto the specific Sum Insured stated against this benefit in the following manner:

3.1.1) Hospitalization Expenses

Hospitalization Expenses benefit provides cover for reimbursement / payment of hospitalisation 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 as defined in this Policy as Critical Illness, during the Policy period, in a Hospital in India as in patient which among other things, includes, Hospital (Room & Boarding and Operation theatre) charges, admission and registration charges in the Hospital, fees of Surgeon, Anaesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc. The

Insured/ Insured Person should have been hospitalized as an in-patient for a minimum period of 24 hours. The benefit under this Section is limited to the Sum Insured specified for this Section in the Schedule to this Policy. In case of diagnosis of multiple critical illnesses requiring treatment covered under this Policy the maximum liability of the Company under this Section shall not exceed the Sum Insured as mentioned against this particular Section in the Schedule to this Policy.

3.1.2) Pre-hospitalization

This benefit covers relevant medical expenses incurred during a period up to 30 days prior to hospitalisation for treatment of the specified disease, illness contracted or injury sustained for which the Insured / Insured Person was

hospitalized, giving rise to an admissible claim under Section 3.1.1 of this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 3.1.1. However this condition will not be incorporated in case the critical illness cover opted on benefit basis.

3.1.3) Post Hospitalisation

This benefit covers relevant medical expenses incurred during a period up to 60 days after discharge from Hospital for continuous and follow up treatment of the specified disease, illness contracted or injury sustained for which the Insured / Insured Person was hospitalized, giving rise to an admissible claim under Section 1a this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a. However this condition will not be incorporated in case the critical illness cover opted on benefit basis.

3.1.4) Dread Disease recuperation-

If the Insured/Insured Person contracts any of the Critical Illnesses and undertakes treatment for the same in a Hospital as an in-patient for which a valid claim under Section 1 a of this Policy is admissible, a daily allowance for certain number of days as specified in the Schedule to this Policy towards Recuperation Expenses incurred post discharge from the Hospital after the treatment for the specified critical illness, is payable under this benefit subject to medical requirement as certified by the treating Physician.

3.1.5) Transplantation of Organs

Where the Insured/Insured Person contracts any of the critical illnesses requiring major Organ Transplantation surgery and undergoes surgery and treatment in a Hospital as an in-patient for which a valid claim under Section 1 a of this Policy is admissible, the hospitalization expenses incurred by/on the Donor towards donation of the major organ for the Insured /Insured Person for this treatment is covered under this benefit, subject to overall limit of the Sum Insured as specified in the Schedule to this Policy.

3.2) Section II Payment of Compensation

If, 60 days after the inception of this Policy, the Insured Person is at any time during the Policy period, is diagnosed as contracting any Critical Illness and surviving for more than 30 days post such diagnosis, the Sum Insured specified in the Schedule to this Policy for this benefit shall be payable to the Insured / Insured Person as compensatory benefit.

This Section operates as a benefit cover and compensation shall be payable if the Insured / Insured Person is surviving for more than 30 days post diagnosis of any critical illness.
However, in case of diagnosis of multiple illnesses qualified as Critical Illness as defined under this Policy, the payment of compensation shall be limited to the Sum Insured as specified above and shall be payable only once.

The Insured / Insured Person can either opt the benefit under Section I or Section II of the Policy.

3.3) Critical Illnesses in respect of which benefits are payable under this Policy are as set out below:

3.3.1. CANCER OF SPECIFIED SEVERITY

I. 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.

II. **The following are excluded:**

I. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3..

II. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

III. Malignant melanoma that has not caused invasion beyond the epidermis;

IV. All 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

V. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
VI. Chronic lymphocytic leukaemia less than RAI stage 3
VII. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
VIII. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

3.3.2) Myocardial Infarction FIRST HEART ATTACK - OF SPECIFIED SEVERITY

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

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g.typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

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 anintra-arterial cardiac procedure.

3.3.3) Coronary Artery Disease:

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery

3.3.4) OPEN CHEST CABG

I. 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.

II. The following are excluded

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

3.3.5) OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES:

I. 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 besupported 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.

3.3.6) SURGERY TO AORTA:

The actual undergoing of major surgery to repair or correct 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. Surgery performed using only minimally invasive or intra arterial techniques are excluded.

Angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures are excluded

3.3.7) STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in

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CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:

i. Transient Ischaemic Attacks(TIA);
ii. Traumatic injury of the brain;
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

3.3.8) KIDNEY FAILURE REQUIRING REGULAR DIALYSIS –

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

3.3.9) APLASTIC ANAEMIA:

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

i. Blood product transfusion;
ii. Marrow stimulating agents;
iii. Immunosuppressive agents; or
iv. Bone marrow transplantation

The diagnosis must be confirmed by a haematologist.

3.3.10) END STAGE LUNG DISEASE:

I. End Stage Lung Disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

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

3.3.11) END STAGE LIVER FAILURE:

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

a) Permanent jaundice;
b) Ascites; and
c) Hepatic Encephalopathy.

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

3.3.12) COMA OF SPECIFIED SEVERITY

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

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

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

3.3.13) MAJOR BURNS:

I. 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.

3.3.14) 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

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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

3.3.15) MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS
I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
· investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
· there must be current clinical impairment of motor or sensory function,which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE are excluded.

3.3.16) FULMINANT HEPATITIS:
A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:
i. Rapid decreasing of liver size;
ii. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
iii. Rapid deterioration of liver function tests;
iv. Deepening jaundice; and
v. Hepatic encephalopathy

3.3.17) MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS:
I. 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 anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

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

II. The NYHA Classification of Cardiac Impairment are as follows:
i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. 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
3.3.19) TERMINAL ILLNESS:
The conclusive diagnosis of an illness that is expected to result in the death of the Insured Person within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed Doctor.

3.3.20) BACTERIAL MENINGITIS:
Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks.

This diagnosis must be confirmed by:

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1) The presence of bacterial infection in cerebrospinal fluid by lumbar punctur; and
2) A consultant neurologist.

4. Additional features

Benefits under this Section are payable as Additional Benefits upto the limits specified in the Schedule to this Policy. A valid claim should have been admitted under the Hospitalisation expenses Section of the Policy (under Section 3.1), for admission of liability under this Section.

4.1) Hospital Cash Allowance:

In case the Insured / Insured Person is hospitalized for treatment of any specified critical illness for which a valid claim is admissible under Section 3.1 of this Policy and if the hospitalisation exceeds a specified number of days mentioned in the Schedule to this Policy, this benefit provides for payment to the Insured/Insured Person of a daily hospital allowance up to the specified limits as mentioned in the Schedule to this Policy.

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

4.2) Home Nursing:

This benefit provides for payment to the Insured/Insured Person of an allowance for medical care services of a nurse at the residence of the Insured/Insured Person following discharge from hospital after a treatment for a Critical illness for which a valid claim under Section 1a of this Policy is admissible provided such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to the Critical illness for which the Insured/Insured Person has undertaken treatment during the hospitalisation, subject to the limit prescribed 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.

4.3) Ambulance Charges:

This benefit provides for reimbursement to the Insured/Insured Person of expenses incurred for his /her transportation by ambulance to and from the Hospital for treatment of Critical Illness in a Hospital as an in-patient for which a valid claim under Section 1 a of this Policy is admissible, subject to the limits 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

4.4) In-patient Physiotherapy Charges:

This benefit provides for reimbursement of charges incurred towards physiotherapy in the Hospital that is confirmed as being necessary by the attending Medical Practitioner and the same relates directly to the Critical Illness for which the Insured/Insured Person has undertaken treatment in the Hospital for which a valid claim is admissible under Section 3.1 of this Policy, subject to limits as specified in the Schedule to this Policy.

4.5) Recovery Grant:

In case the Insured / Insured Person is hospitalized for a period of 8 days or more for treatment of critical illness for which a valid claim is admissible under Section 3.1 of this Policy, this benefit provides for payment to the Insured/Insured Person of a fixed allowance as mentioned in the Schedule to this Policy.

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

4.6) Accompanying Person's Expenses:

This benefit provides for payment an allowance to the Insured/Insured Person towards expenses incurred on the accompanying person at the Hospital/Nursing Home during hospitalisation treatment of the Insured/Insured Person for

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the Critical Illness for which a valid claim is admissible under Section 3.1 of this Policy, subject to the limit of Sum Insured as mentioned in the Schedule to this Policy.

4.7) Children Education Fund
This benefit provides for payment of a fixed amount as specified in the Schedule to this Policy, to a maximum of two dependant children upto the age of 23 years pursuing studies, in the event of death of the Insured / Insured Person at Hospital whilst undertaking treatment for Critical Illness, for which a valid claim is admissible under this Policy.

4.8) Mortal Remains
This benefit provides for reimbursement of expenses, as specified in the Schedule to this Policy, incurred for transportation of the mortal remains of the Insured / Insured Person from Hospital to his/her place of residence in the event of death of the Insured / Insured Person at the Hospital while under treatment for Critical Illness for which a valid claim is admissible under this Policy.

4.9. Additional features

4.9.1 Renewal Discount
The Policy shall provide for a discount, equivalent to 5% of renewal premium every year on a progressive scale, as Renewal Discount at the time of renewal, provided that the Policy being renewed is claim free in the expiring year. This renewal discount on a progressive scale will be allowed up to a maximum of 25%. In case of renewal of a Policy where there is a claim, the
Insured will lose the entire Renewal Discount accumulated.

The Company offers life long renewal, subject to the renewal being effected before the expiry of the policy or within grace period allowed.

4.9.2 Income Tax benefit

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income tax Act.

5. EXCLUSIONS

The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

A. Exclusion Name: Pre-Existing Diseases - Code- Excl01
a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted byInsurer.
B. Exclusion Name: Specified disease/procedure waiting period- Code- Excl02
a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

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

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

D. Investigation & Evaluation- Code- Excl04

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

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

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.

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);
a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

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G. Change-of-Gendertreatments: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- Excl11 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. (Explanation: Details of
excluded providers shall be provided with the policy document. Insurers to use various means of communication to notify the policyholders, such as email, SMS about the updated list being uploaded in the website.)
L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl12**
M. 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**
N. 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- Excl16
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Un proven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
Q. Sterility and Infertility: Code- Excl17
Expenses related to sterility and infertility. This includes:
(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization
R. Maternity: Code Excl18
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
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:
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.

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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.
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 OPD treatment unless covered under the policy.
V Treatment taken outside the geographical limits of India
X. Maternity expenses where maternity cover is opted:The benefits will not be available for any condition(s) as defined in the Policy, until 9 months since inception of the first Policy with the Company. In all other cases where maternity benefit cover is not opted, all claims directly or indirectly related to maternity stands excluded always.

5. GENERAL CONDITIONS

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.

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.

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 shal! be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
a) the suggestion, as a fact of that which is not true and which the insured person does not belieVe to be true;
b) the actiVe concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceiVe; and

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

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

Multiple policies and Contribution:

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

Free Look Period:

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

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

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

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

Cancellation/Termination:
i. The policyholder may cancel this policy by giving l5days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Period On Risk	**Rate Of Premium to be retained**
Up to l month	25% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	75% of annual rate
Exceeding six months	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.
ii. 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.

Renewal of Policy:
The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 d ays (Note to insurers: Insurer to specify grace period as per product design) to maintain continuity of benefits withoutbreak in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

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

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 policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently coVered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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

Withdrawal of Policy

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

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

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.

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

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

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.

Redressal of Grievance:

In case of any grie\lance the insured person may contact the company through via:
•Website: www.bharti-axagi.co.in
•Email: customersupportba@icicilombard.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office
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 company branches. For updated details of grievance officer, kindly refer the link www.bharti-axagi.co.in

Escalation Level 1
In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed through one of the above methods (After 5 days of intimating of your complaint), Policyholder/ Insured/ Insured Person may contact the National Grievance Redressal Officer at :
Write to: ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025,
Call: 18001032292
Email: https://www.bharti-axagi.co.in/grievance-redressal/procedure

Escalation Level 2
In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed through any of the above methods (After 5 days of approaching National Grievance Redressal Officer), Policyholder/ Insured/ Insured Person may contact the Chief Grievance Redressal Officer at:
Email : //www.bharti-axagi.co.in/grievance-redressal/procedure

Escalation Level 3
In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, or, If Policyholder/ Insured/Insured Person is not satisfied with Company's redressal of the grievance through one of the above methods, Policyholder/ Insured/ Insured Person may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsman offices are mentioned below. Policy holder may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders' interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:
In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company for faster attention or speedy disposal of grievance, if any.
•Website: www.bharti-axagi.co.in
•Email: customersupportba@icicilombard.com

•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office
Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Grievance Redressal Cell of the Consumer Affairs Department of IRDAI

The insurance company should resolve the complaint within a reasonable time. In case if it is not resolved within 15 days or if the Insured/Insured Person is unhappy with their resolution you can approach the Grievance Redressal Cell of the Consumer Affairs Department of IRDAI.
Grievance may also be lodged at IRDAI Integrated Grievance Management System
- https://iqms. irda.qov. in/
•Website: igms.irda.gov.in
•Email: complaints@irda.gov.in
•Toll Free Number 155255 (or) 1800 4254 732

Claim Settlement (provision for Penal Interest)

1. 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.
2. 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.
3. 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.
4. 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.

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

Checklist of documents for settling Claims:

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.

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 ofunderwriting the risk

Family Floater
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 and any one of the Insured Persons for one or more claims during the Policy period.

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.

No Constructive Notice;
Any knowledge or information of any circumstances or condition in connection with the Insured / Insured Person, in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of the premium.

Notice of Charge
The Company shall not be bound to take notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy; but the payment by the Company to the Insured / Insured Person, his/her nominee or legal representative, as the case may be, of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

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 confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, Electronic data interchange, call centres, teleservice 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 or the Company's other products and services, 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. The Insured / Insured Person agrees that the Company mayexchange, share or part with any information to or with other Group Companies, or other persons in connection with the Policy as may be determined by the Company and shall not hold the Company liable for such use/application.

Duty of the Insured/insured person on occurrence of loss:
On the occurrence of loss within the scope of cover under the Policy, the Insured / Insured Person shall:
Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.
Allow the Medical Practitioner or any agent of the Company to inspect the medical and hospitalisation records and to examine the Insured/Insured Person.
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.

Right to Inspect
If required by the Company, an agent/representative of the Company including a Physician appointed in that behalf shall in case of any loss 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. 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 or such circumstance in his/her possession including presenting himself 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 will in any way assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

Position after a claim
In case of method of benefit is payment of compensation (Section I) on payment of a claim under the Policy, the Policy shall stand cancelled in respect of the Insured Person for whom such claim is payable without any refund of premium.

Forfeiture of claims:
If any claim is made and rejected and no court action or suit commenced within 12 months after such rejection or, in case of arbitration taking place as provided herein, within 12 calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

Grace Period:
All applications for renewal of the policy must be received by us before the end of the policy. A Grace Period of 30 days for renewing the Policy is provided under this Policy.However, there is no coverage for injury sustained or disease contacted during this period.

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.
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. Each party agrees to subject to the executive jurisdiction of the High Court of Karnataka and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

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 two Arbitrators and one to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such two Arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliations Act 1996.
It is hereby agreed and understood that no dispute or difference shall be referable to arbitration, as hereinbefore 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.

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.

Inclusion of Dependent members under the Policy:
New Person can be added to this Policy, either by way of endorsement in case of mid-term inclusion or at the time of renewal. Mid-term inclusion is available only in case of such new person i.e. spouse and or new born child post 90 days of birth subject to acceptance by underwriters.
The pre-existing Disease clause, exclusions and waiting periods will be applicable afresh in respect of such newly added person,

Renewal:

The Company shall allow renewal of the Policy and accept renewal premium in all cases except in case of noncooperation of the Insured/Insured Person in implementing the terms and conditions of this Policy..

Notices:

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to
a) In case of the Insured, at the address given in the Schedule to the Policy.
b) In case of the Company, to the Policy issuing office/nearest office of the Company.

Customer Service:

If at any time the Insured / Insured Person requires any clarification or assistance, the Insured/ Insured Person may contact the Policy issuing office or any other office of the Company or the TPA.

Claim Notification Multi Model Intimation:

It is the endeavor of Company to give multiple options to the Insured/covered person/patient's care taker to intimate the claim to the Third party administrator (TPA)/Company. The intimation can be given in following ways:

Toll Free call Centre of the Insurance Company(24x7) - **1800-103-2292**

Login to the website of the Insurance Company and intimate the claim – http://www.bharti-axagi.co.in/contact-us

Send an email to the TPA/Company- customersupportba@icicilombard.com

Post/courier to TPA/Company - Claims, ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032.

Directly Contacting our Company office but in writing. - ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025

In all the above, the intimations are directed to a central team for prompt and immediate action.

Claim Form

Upon the notification of the claim the TPA/Company will dispatch the claim form to the Insured/Covered person. Claim forms will also be available with the network hospitals and Company offices.

Claim Procedure:

In case OF BENEFIT OPTION, the final submission of claim documents to be done after minimum survival period as mentioned in the policy.

Cashless Hospitalisation:

1. Company will work with one or more TPAs for providing cashless facility to the Insured/Covered person.

2. List of network hospitals will be provided to the Insured/Covered person along with the policy and it will be regularly updated and informed to them. Insured/Covered person can view the updated hospital list from the website of the TPA/Company too.

3. Insured/covered person on admission (emergency) or willing to admit (planned admission) in the network hospitals a pre-authorization request form has to be filled in by the treating doctor/hospital and the same has to be faxed to the TPA by the insured/hospital. The TPA after verifying the same will decide on the issuance of authorization. The action of preauthorization
will be done within 6 hours for emergency admission and 48 hours for planned admission.

1. The preauthorization request form will be available in the benefit guide issued along with the policy, available in the hospitals, can be downloaded from the website of the TPA/Company, can request for the same to theTPA/Company via email or fax or can be collected in person from the branches of the TPA/Company. Insured/Covered person will be suitably informed about the specific conditions of listed illnesses for compliance withthe critical illness policy

2. Denial of the cashless does not mean the claim has been rejected. The insured/covered person can send the requisite claim documents to the TPA/Company seeking reimbursement.

3. The insured/covered person need not pay any amount to the hospital if he has received the authorization letter except

If the bill amount is in excess of the sum insured
Non medical expenses
Unrelated treatments

Excess, if any

4. The hospital will receive the payment from TPA/Company within 21 days from the date of receipt of complete claim documents.

Reimbursement claims All reimbursement claims should be intimated to TPA/Insurance company within 7 days from date of discharge.

Insured/covered person admitted in a non-network Hospital can send the claim documents to the TPA/ Company for the reimbursement within 30 days from the date of discharge. However Pre and post hospitalization bills can be sent within 15 days from the end of post hospitalization period as specified in the Policy.

Insured has to submit all original Documents/verified photo copies of original bills where the benefit option is being claimed. The client needs to submit in writing the reason for the submission of the photocopies. The photocopies shall be verified by the insurance company where the claim for indemnity has been submitted and insured person shall authorize the company for such verification.

Documents:

It is the policy of the Company to seek documents in a single shot.request. Based on documents submitted, If any further documentation is required then it will be sought promptly. In cases where investigation is deemed necessary, the same will be conducted in all promptitudes. Every attempt will be made to keep the process transparent.

SL.NO	CHECKLIST	Tick the boxes
1	Claim form duly signed along with attending physician statement	√
2	Pre auth form-if cashless claim	√
3	Discharge summary	√
4	Hospital final bill	√
5	Attending Surgeon's/Physician's Prescription advising hospitalization	√
6	Surgery/consultation bills and receipts	√
7	Operation theatre and pharmacy bills	√
8	Medicines bill with doctor's prescription	√
9	Pre hospitalization bills with receipts	√
10	Post hospitalization bills with receipts	√
11	Hospital payment receipt in case of reimbursements	√
12	Diagnostic reports with doctor's prescription	√

Repudiations

The power to repudiate claims is vested in the Corporate office to ensure transparency and standardization across the country. This is also with a view to keep the guidelines of regulator in mind. In the unfortunate event of repudiation, the retail customers will be informed of the existence of forums for grievance.

LIST OF INSURANCE OMBUDSMEN

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

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Location	**Office Details**	**Jurisdiction of Office, Union Territory, District**
Ahmedabad	Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
Bengaluru	Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
Bhopal	Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh

Registered and corporate office address: ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025, IRDAI Registration No: 115,CIN:L67200MH2000PLC129408, Telephone: 18001032292, Website: www.bharti-axagi.co.in, Email: customersupportba@icicilombard.com

Bhubaneshwar	Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa
Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
Chennai	Office of the Insurance Ombudsman,Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet,CHENNAI – 600 018.Tel.: 044 - 24333668 / 24335284Fax: 044 - 24333664Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu,Pondicherry Town andKaraikal (which are part of Pondicherry)
Delhi	Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
Guwahati	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura

Hyderabad	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
Jaipur	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
Ernakulam	Ms Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
Kolkata	Shri P.K. RathOffice of the Insurance Ombudsman,Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341Email: bimalokpal.kolkata@cioins.co.in	West Bengal,Sikkim,Andaman & Nicobar Islands

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Lucknow	Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Mumbai	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Noida	Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120- 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur

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Patna	Shri N. K. SinghOffice of the Insurance Ombudsman,1st Floor,Kalpana Arcade Building,, Bazar Samiti Road,Bahadurpur,Patna 800 006.Tel.: 0612-2680952Email: bimalokpal.patna@cioins.co.in	Bihar,Jharkhand
Pune	Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

Registered and corporate office address: ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025, IRDAI Registration No: 115,CIN:L67200MH2000PLC129408, Telephone: 18001032292, Website: www.bharti-axagi.co.in, Email: customersupportba@icicilombard.com