Policy Document - Terms and Conditions of your policy

ICICI Pru Health Saver

In this Policy, the investment risk in investment portfolio is borne by the Policyholder
Unique Identification Number (UIN) allotted by Insurance Regulatory and Development Authority (IRDA)
UIN: ICICI Pru Health Saver: 105L087V01

Brief Policy Description: ICICI Pru Health Saver is a unit linked health insurance plan which provides reimbursement against actual medical expenses along with a savings mechanism for other health care expenses subject to the Policy terms and conditions. The Policyholder has an option to avail the Policy either on Individual or on Family Floater basis. "Family Floater" means the Policy will cover Family Members as defined in Clause 1.11 and specified in the Policy Certificate or subsequent endorsement to the Policy. Under the Family Floater, any other person apart from the Family Members shall not be covered. The total benefit payable towards all Insured Person(s) shall not exceed the Annual Limit as specified in the Policy Certificate or subsequent endorsements. This cover has to be specifically opted for by the Proposer and shown in the Policy Certificate. The Family Floater Cover can also be availed by single parents and their first three Dependent children. The Company relies upon the information given by the Proposer or the Insured Person(s) in the proposal form and in any other document(s) and / or during the medical examination, if any. The Policy is declared void in case the information given is incomplete or inaccurate or untrue or in case it is found that the Policy was issued on the basis of fake or tampered documents or proofs or where the claim was found to be fraudulent. The "Incontestability" clause is given under General Conditions. This Policy enables the Policyholder to participate only in the investment performance of the Fund, to the extent of allocated Units and does not in any way confer any right whatsoever on the Proposer or Insured Person(s) to otherwise share in the profits or surplus of the business of the Company in any manner whatsoever or make any claim in relation to the assets of the Company. The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the laws of India.

Freelook Period (15 / 30 days Refund Policy)

If you are not satisfied with the terms and conditions of this policy, please return the policy document to the Company for cancellation within • 15 days from the date you received it, if your policy is not sourced through Distance marketing* • 30 days from the date you received it, if your policy is sourced through Distance Marketing* On cancellation of the policy during the freelook period, we will return the premium paid subject to the deduction of: **a)** Stamp duty under the policy **b)** Expenses borne by the Company on medical examination, if any. The policy will terminate on payment of this amount and all rights, benefits and interests under this policy will stand extinguished. *For details of Distance Marketing, please refer to clause 11

1. **DEFINITIONS:**

In the Policy Document, unless the context otherwise requires:

1. "Accident" means an unexpected and unforeseen incident caused by violent, external and means which causes Injury. **2. "Allocation"** means creating the Units at the prevailing NAV offered by the Company. This is applicable in case of premium payment and Switches. **3. "Annual Limit"** is the maximum benefit payable under the Policy towards all the Medical Expenses incurred during a Policy Year. Any unutilised amount shall not be carried forward to the next Policy Year. **4. "Company"** means ICICI Prudential Life Insurance Company Limited. **5. "Co-pay"** is the percentage of total Medical Expenses which is to be paid by the Policyholder. The balance amount shall be paid by the Company subject to the Annual Limit. **6. "Cover Cessation Date"** as shown in the Policy Certificate is the date on which the Hospitalisation Insurance Benefit shall cease to exist. **7. "Dependant"** means an Insured Person(s) who does not have any independent source of income. Proof of dependency for the child of age above 21 will be required. **8. "Diagnosis"** shall mean the findings of a Medical Practitioner based upon but not limited to radiological, clinical, histological or laboratory tests. **9. "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 disorder and certified by a Medical Practitioner to that effect. **10. "Event"** means Hospitalisation including Day Care Procedures arising as a result of any Disease or Injury. **11. "Family Members"** include the Primary Insured, spouse and/or up to the first three Dependent children. The children under this Policy shall be covered only till age 25 years nearest birthday. **12. "Fund Value"** is the product of the total number of Units under the Policy and the NAV. The Fund Value for all transactions applicable under this policy shall be calculated on the basis of NAV table given in clause 21. **13. "Hospital"** shall mean any institution established for indoor care and day care treatment and treatment of sickness or injuries and which has been registered either as a Hospital or Nursing Home with the local authorities and is under the supervision of a registered and Qualified Medical Practitioner; and must comply with all minimum criteria as under: a. Have at least 10 patient beds, in those towns having a population of less than 10,00,000 and 15 patient beds in all other places. b. Has fully qualified nursing staff and Medical Practitioner(s) under its employment round the clock. c. Has a fully equipped operation theatre of its own where surgical procedures are carried out. For the purpose of this definition, the term "Hospital" shall not include an establishment, a place of rest, a place for the aged, a place for drug-addicts or place of alcoholics, a rehabilitation center, a hotel or any similar place. **14. "Injury"** means bodily damage or harm caused solely and directly by an Accident. **15. "Insured Person(s)"** means the person(s) who has or have been insured by the Company under this Policy. **16. "Medical Practitioner"** shall mean qualified allopathic (i.e. conventional) holding a valid and subsisting licence, granted by the appropriate licensing authority, registered with the Medical Council of India, acting within his scope of licence and who is neither the Insured Person(s) himself nor related to the Insured Person(s) by blood or marriage. The term "Medical Practitioner" would include physician, specialist, anaesthetist, surgeons, consultants, pathologists, radiologists and radiation oncologists. **17. "Minimum Guaranteed NAV"** is the guaranteed NAV per Unit of a tranche of the Health Return Guarantee Fund (HRGF), at the time of termination of a tranche. **18. "Net Asset Value (NAV)"** means the value per Unit calculated in Rupees. **19. "Network Hospitals"** is a group of Hospitals where services can be availed without Co-pay being applicable subject to Policy terms and conditions and are classified as Network Hospitals as per the discretion of the Company. The updated list of Network Hospitals will be made available by the Company on request. **20. "Policy"** This Policy is the evidence of a contract between ICICI Prudential Life Insurance Company Limited ('the Company") and the Policyholder referred below. This Policy is issued on the basis of the proposal made by the Policyholder (as stated in the Policy Certificate) and submitted to the Company along with the required declaration, personal statement, applicable medical reports, the first or single premium deposit and any other document submitted evidencing the insurability of the Insured Person(s) for the issuance of the Policy. The Company hereby agrees to the Policy terms and conditions in consideration of and subject to the due receipt of the subsequent premiums (where applicable) under the Policy. **21. "Policyholder"** means the proposer under the Policy or the owner of the Policy. **22. "Policy Commencement Date"** as shown in the Policy Certificate is the effective date of Policy and is the date on which the age of the Insured Person(s) is calculated. **23. "Policy Year"** means the period of twelve consecutive calendar months between any two consecutive Policy anniversaries. **24. "Primary Insured"** means an Insured Person and in case of Family Floater Cover is the eldest of all Insured Persons. **25. "Redemption"** means encashing the Units at the prevailing NAV offered by the Company where the process involves cancellation of Units. This is applicable in case of exercising Health Savings Benefit, Switches or in the case of payment on death of the Primary Insured. **26. "Switch"** means the facility allowing the Policyholder to change the investment pattern by moving from one fund to other fund (s) amongst the funds offered under this product. **27. "Unit"** means the portion or a part of the underlying segregated Unit linked Fund. **28. "Unit Linked Fund"** means the pool of the premiums paid by the Policyholders and invested in a portfolio of assets to achieve the fund objective. The price of each Unit in a fund depends on how the investments in the fund perform. The fund is managed by the Company. **29. "Valuation"** is the determination of the value of the underlying assets of the Unit Linked Funds.

2. **Waiting Period:** "Waiting Period" is a period of 30 days from the Policy Commencement Date or 30 days from the date of revival of the Policy, where the Policy is revived after 60 days from the date of first unpaid premium. While the Policy is in force, no Hospitalisation Insurance Benefit as described in clause 3 below shall become payable for any claim which occurs or where the signs or the symptoms of Disease or Injury and / or condition for the Event has occurred during the Waiting Period. The Waiting Period shall not be applicable where the claim occurs due to Injuries caused by an Accident.
3. **Benefits:** "Benefits" are payable subject to the Policy being in force on the date of Event. **A. Hospitalisation Insurance Benefit:** "Hospitalisation Insurance Benefit" shall be available only till the Primary Insured attains the age of 75 years nearest birthday. This benefit reimburses the Medical Expenses incurred for the Insured Person(s) in case of following: **a. Hospitalisation:** "Hospitalisation" means admission and subsequent stay in a Hospital for a continuous period of minimum 24 hours for the purpose of necessary medical treatment of a Disease or Injury upon the written advice of a Medical Practitioner. **b. Day Care Procedure:** "Day Care Procedure" means the course of medical treatment or surgical procedure carried out in a Hospital which is fully equipped with advanced technology and specialised infrastructure for the listed procedure. The procedure must require Hospitalisation for less than 24 hours and must be on written advice of Medical Practitioner. The requirement of minimum beds of the Hospital definition will be waived provided other conditions are met. The list of Day Care Procedures covered under the Policy is given in Annexure I. The Company reserves the right to modify the list of Day Care Procedures from time to time, subject to prior approval from the Insurance Regulatory and Development Authority (IRDA). The Policyholder shall be informed of the same. **c. Pre-Hospitalisation and Post-Hospitalisation: i) "Pre-Hospitalisation Expenses"** means Medical Expenses incurred during the period of 30 days prior to the date of Hospitalisation or Day Care Procedure, on the written advice of Medical Practitioner. Any Medical Expenses not directly related to the Event shall not be included as a part of Pre-Hospitalisation Expenses and shall not form part of any claim under the Policy. **ii) "Post-Hospitalisation Expenses"** means Medical Expenses incurred during the period of 60 days from the date of discharge from the Hospital, on the written advice of Medical Practitioner. Any Medical Expenses not directly related to the Event shall not be included as a part of Post-Hospitalisation Expenses and shall not form a part of any claim under the Policy. These expenses shall be reimbursed only in the Event of acceptance of the related Hospitalisation or Day Care Procedures claim by the Company. **d. Medical Check-up:** After completion of the first Policy year, the Company shall provide for a free medical check-up to all Insured Person(s) once in every two Policy years. The aggregate medical check- up benefit for all the Insured Person(s) is subject to a limit of Rs. 5,000 or 1% of the Annual Limit, whichever is lower and shall be reimbursed subject to the submission of Original bills. Any unutilised benefit cannot be carried forward. **e. "Medical Expenses"** means the necessary reasonable and customary charges incurred for the Insured Person(s) in respect of the medical treatment for the Disease or Injury. For the purpose of these benefits the term "Medical Expenses" includes following expenses: **a.** Room, boarding & nursing expenses as charged by the Hospital (including intensive care unit charges, if applicable), **b.** Fees of Medical Practitioner, **c.** Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, artificial limbs and similar expenses. The maximum benefit payable for artificial limbs shall be subject to a maximum limit of Rs. 25,000 or 10% of Annual Limit, whichever is lower. **d.** The aggregate ambulance expense for all the Insured Person(s) is subject to a limit of Rs. 1,000 per Policy year. These expenses shall be reimbursed only in the event of acceptance of the related Hospitalisation or Day Care Procedure claim by the Company. **e.** All Medical Expenses with date of Hospitalisation or Day Care Procedure falling within a Policy year will be aggregated for the purpose of comparison with the Annual Limit of that Policy year. Any unutilized limit shall not be carried forward to the next policy year. The Policyholder can access following room types for all Network Hospitals: **Single Room:** Actual room rent up to 1% of Annual Limit, **Twin Share Room:** Actual room rent. **"Single Room"** means an air- conditioned room in a Hospital where accommodation of only one patient bed is allowed and should be the lowest level (in per day charge) of such single occupancy available in that Hospital. **"Twin Sharing Room"** means an air-conditioned room in a Hospital where accommodation of two or more patient beds is allowed and should be the lowest level (in per day charge) of such twin occupancy available in that Hospital. A **Co-pay** of 20% of the total Medical Expenses incurred related to an Event shall be applicable in case the Insured Person(s) avails Hospitalisation or undergoes Day Care Procedure at **An Out of Network Hospital or Room rent higher than that specified in the above table.** Hospitalisation for any urgent medical and/or surgical treatment taken at a Hospital for acute cardiac or Accident or trauma to avoid serious impairment of health at an Out of Network Hospital would be treated as within network claims and no Co-pay would be applicable. These claims would be considered only to the extent of Twin Sharing Room in an Out of Network Hospital. In the event where the Insured Person(s) has opted for any higher level of room-type other than Twin Sharing Room, Co-pay of 20% shall be applicable. **f. No Claim Bonus:** A no claim bonus in the form of increase in annual limit by 5% of the base Annual Limit is provided for every claim free year for Hospitalisation insurance Benefit. The maximum increase over the base Annual Limit shall be 25%. In case of a claim for Hospitalisation Insurance Benefit, the accumulated no claim bonus will reduce by 10% of base Annual Limit in the following year. However the base Annual Limit will be maintained and shall not be reduced. **B. Health Savings Benefit:** The Health Savings Benefit (Whole Life benefit) allows the Policyholder to claim from his funds which are invested in Unit linked funds of the Company as described in Clause 13. This benefit can be claimed for the below mentioned health care expenses for Insured Person(s) under the Policy. **i)** medicines and drugs **ii)** diagnostic expenses **iii)** dental expenses **iv)** Co-pays or deductibles as part of the medical insurance cover **v)** Other miscellaneous Medical Expenses not covered under any medical insurance. This benefit can be availed only after completion of three Policy years from the Policy Commencement Date. Health Savings Benefit will be paid by cancellation of Units from the fund and the maximum benefit payable will be subject to the availability of the funds under the Policy. The benefit shall become payable only on the fulfilment of the below mentioned conditions: **a.** Submission of original bills or proof of expenses incurred on the health of the Insured Person(s) within two years of incurring such expenses. **b.** The benefit under the Health Savings Benefit can be claimed once in every Policy year after the completion of three policy years subject to a minimum of Rs. 1,000. The Company may revise this limit from time to time and the Policyholder shall be notified of the same. The maximum amount that may be claimed from the fund in any year is given below. The benefit can only be claimed for the Insured Persons covered under the policy. **Year 1 to 3:** Nil, **Year 4 & 5:** 20% of the fund, **Year 6 to 10:** 50% of the fund, **Thereafter:** 100% of the fund **c.** If the Policyholder claims an amount, post payment of which the Fund Value under the Policy would fall below 110% of one full year's premium, then the Company shall before payment of this benefit provide an option to the Policyholder to reduce the claim amount in such a manner so that the Fund Value does not fall below 110% of one full year's premium. If the Policyholder is not willing to reduce the claim amount, then the benefit will be paid and the Policy will be foreclosed as per the foreclosure condition given in Clause 26.
4. **To whom the Benefits are payable:** To the Proposer, Insured Person(s), or the assign(s) where a valid assignment or endorsement has been recorded, or the nominee(s) where a valid nomination has been registered by the Company (in accordance with Section 39 of the Insurance Act, 1938), or the executors, administrators or other legal representatives who should take out representation to the estate or to such person as directed by a court of competent jurisdiction in India, limited at all times to the monies payable under this Policy. The Company does hereby agree, that on proof to the satisfaction of the Company of the benefits having become payable as set out in the Schedule and of the title of the said person or persons claiming payment and of the correctness of the age of the Insured Person(s) stated in the Proposal (if not previously admitted) or upon the happening of an Event upon which one or more benefits become payable under this Policy, the appropriate benefit will be paid by the Company.
5. **Policy Alterations:** "Policy Alterations" would be allowed after payment of at least one full year's premium, subject to the rules of the Company and IRDA guidelines at that time. The Policyholder can make following alterations to the Policy: **a. Increase in the Annual Limit :** The Policyholder can opt to increase the Annual Limit any time, subject to the following terms and conditions: **i)** Any increase in the Annual Limit shall be effective only on the next Policy anniversary subject to the Policy being in force as on that date. **ii)** Any increase in the Annual Limit would be subject to underwriting and the cost of medical examination, if any, would be borne by the Policyholder. **iii)** All existing Policy terms and conditions would continue to apply to the new increased limit. **iv)** No increase in Annual Limit shall be allowed on or after the Policy anniversary on which the Primary Insured is aged 65 nearest birthday. **v)** The Policyholder shall have to pay the increased Insurance Charges and the premium determined by the Company as a result of increase in Annual Limit. **vi)** The minimum and maximum amount by which the Annual Limit can be increased shall be as decided by the Company from time to time. **b. Decrease in the Annual Limit:** The Policyholder can opt to decrease the Annual Limit any time, subject to the following terms and conditions: **i)** Any decrease in the Annual Limit shall be effective only on the next Policy anniversary subject to the Policy being in force as on that date. **ii)** Notwithstanding anything contained above in relation to the increase in the Annual Limit, once the Policyholder has opted for decrease in the Annual Limit, any future increase shall be subject to underwriting and the cost of the medical examination, if any, shall be borne by the Policyholder. **iii)** All existing Policy terms and conditions would continue to apply to the new decreased limit. **iv)** No decrease in Annual Limit shall be allowed on or after the Policy anniversary on which the Primary Insured is aged 65 nearest birthday. **v)** The Insurance Charge shall be reduced from the effective date of decrease in the Annual Limit. **vi)** The minimum and maximum amount by which the Annual Limit can be decreased shall be as decided by the Company from time to time. **vii)** The decrease in Annual Limit cannot be lower than minimum Annual Limit applicable under the policy as decided by the Company from time to time. **c. Increase or decrease in the premium amount:** The Premium payable under this Policy can be increased or decreased anytime subject to the minimum premium condition as applicable for this Policy. However, any decrease in premiums will be allowed only after the completion of three policy years and subject to the payment of premiums for first three full policy years. Any revision in the premium shall be effective only on the next Policy anniversary and only if all the premiums due till date have been paid. **d. Addition of Family Member:** The Policyholder may opt to convert a Policy to a Family Floater Cover or add a Family Member to an existing Family Floater Cover. This shall be allowed only in the event of marriage or birth or legal adoption of a child. The Policyholder should opt for this within 90 days from the date of event or on the next Policy anniversary date. Such change shall be carried out subject to receipt of the proof of the event by the Company and subject to the fulfilment of the underwriting norms of the Company in this regard. The cover for the new Family Members shall be effective for the purpose of this Policy from the next premium due date. The Company shall deduct additional Insurance Charges for the new Family Member(s) from the date of addition of the member to the Policy. The Policyholder may have to pay additional premium on addition of a Family Member as determined by the Company. **e. Removal of Family Member:** The

removal of a Family Member can occur due to death of the Insured Person(s) other than the Primary Insured or on divorce or on subsequent ineligibility of any child. Such revision shall be carried out subject to receipt by the Company of the proof of the event and subject to the fulfilment of the norms of the Company in this regard. Such change shall be effective from the next premium due date and the Insurance Charge shall be reduced from the date of removal of the member to the Policy.

6. **Death of Insured Person(s): a.** On death of Insured Person(s) during the Hospitalisation or Day Care Procedure, the Company shall pay the Hospitalisation Insurance Benefit towards Pre-Hospitalisation, Hospitalisation or Day Care Procedure, as the case may be. **b.** On death of the Primary Insured, the Company shall also pay the Fund Value under the Policy to the nominee in addition to the amount as stated in Clause 6(a). The Policy will terminate for all the Insured Person(s) under the Policy. The remaining Insured Person(s) can however apply for a new policy. The new Policy will be issued without any underwriting with then prevailing terms and conditions including the no claim bonus as for the previous Policy if the cover is renewed within 60 days of termination of the existing Policy. The outstanding waiting period and the outstanding period for the specific exclusions as given in Clause 8.8 of the existing Policy will be applicable to the new Policy. The Fund Value paid out on death of the Primary Insured may be taxable in the hands of the nominee as per the prevailing tax regulations at that time. **c.** On death of the family member other than the primary insured, the policy will continue after deletion of the family member and reduction in insurance charge shall be applicable from next policy month.
7. **Maximum Benefit Payable:** The maximum benefit payable during a period of 12 months under all the medical reimbursement policies taken on the same Insured Person(s) from the Company is restricted to Rs. 25,00,000 (Rupees Twenty Five lacs only) or the total of Annual Limits under these Policies, whichever is lower.
8. **Exclusions for Hospitalisation Insurance Benefit:** The Company shall not be liable to make any payments under this Policy in respect of any expenses whatsoever incurred by any Insured Person(s) in connection with or in respect of any of the following **1.** Medical Expenses including Pre & Post Hospitalisation expenses not directly related to the specific Disease or Injury for which Hospitalisation or Day Care Procedures took place. **2.** Pre & Post-Hospitalisation claims arising from an Event which was not accepted for Hospitalisation or Day Care Procedure. **3.** Pre-Hospitalisation expenses for more than 30 days prior to the date of Hospitalisation or Day Care Procedure and Post-Hospitalisation expenses beyond a period of 60 days from the date of discharge. **4.** Notwithstanding anything contained herein the benefit under the Policy shall not apply to any Medical Expenses incurred by the Insured Person(s) in any place or geographical area other than India. **5.** Pre-existing condition unless stated in the proposal form and specifically accepted by the Company and endorsed thereon. "Pre-existing Condition" means a condition for which, prior to the Policy Commencement Date or Policy revival date, the Insured Person(s) had signs or symptoms of an Disease or Injury which would have caused any ordinarily prudent person to seek treatment, Diagnosis or care, or medical advice, or treatment was recommended by or received from a Medical Practitioner, or the Insured Person(s) has undergone medical tests or investigations. Any investigation or treatment for any Disease, disorder, complication or ailment arising out of or connected with the Pre-existing Disease shall be considered part of that Pre-existing Condition. **6.** Permanent exclusions as specifically stated in the Policy Certificate **7.** For conditions of diabetes or hypertension or both, if disclosed at inception and accepted for cover, any investigation/treatment for these conditions and any complications arising from these conditions (including but not restricted to Ischemic Heart Disease and Renal Failure) shall be excluded for the first two consecutive Policy Years from the Policy Commencement Date or revival date in case the revival is 60 days after first unpaid premium. **8.** Any expense incurred during the first 2 years from Policy Commencement Date or revival date in case the revival is after 60 days from the date of first unpaid premium shall not be payable for the following Diseases or surgeries & any complications arising out of them. **1.** Functional Endoscopic Sinus Surgery / Septoplasty for Deviated Nasal Septum / Sinusitis **2.** Surgery for Tonsillitis / Adenoiditis **3.** Thyroidectomy for Nodule / Multi Nodular Goitre **4.** Hernia (Inguinal / Ventral / Umbilical / Incisional) **5.** Hydrocoel / Varicocoel / Spermatocoel surgery **6.** Piles / Fissure / Fistula / Rectal prolapse **7.** Trans Urtheral Reclause of Prostrate / Open Prostatectomy for Benign Enlargement of Prostrate. **8.** Dilation & Curettage for menstrual irregularities. **9.** Hysterectomy for Fibroids, menorrhagia, Dysfunctional Uterine Bleeding, Uterine Prolapse **10.** Myomectomy for Fibroids and menorrhagia **11.** Lap / Open Chole cystectomy for Cholecystitis / Gall stones **12.** Lithotripsy / Basketing for Renal Calculus **13.** Traction / Discectomy / Laminectomy for Prolapsed Inter Vertebral Disc. **14.** Vitrectomy and Retinal Detachment surgery for Retinopathy **15.** Amputation due to diabetes **16.** Renal failure due to diabetes **17.** Osteoporosis leading to Fracture Neck of Femur or Hip **18.** Cataract (Claim of up to Rs. 20,000) will be covered in any policy year only two years after the later of Risk Commencement Date or revival date, where the revival occurred more than 60 days after the first unpaid premium. **19.** Osteoarthrosis leading to Total Knee Replacement or Total Hip Replacement (Claim for one knee or hip treatment will be covered in any policy year only two years after the later of Risk Commencement Date or revival date, where the revival occurred more than 60 days after the first unpaid premium.) **9.** Treatment directly or indirectly arising from or consequent upon war, commando or bomb disposal duties or training, terrorism, invasion, acts of foreign enemies, engagement in hostilities, active military and police duties such as maintenance of civil order whether war be declared or not, civil war, rebellion, active participation in strikes, riots or civil commotion, revolution, insurrection or military or usurped power or travel by military aircraft or waterborne vessel, and fulltime service in any of the armed forces. **10.** Circumcision (unless necessary for treatment of a Disease not excluded hereunder or as may be necessitated due to any Accident), Vaccination, Inoculation. **11.** Treatment which results from or is in any way related to sex change or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an Accident or as a part of any Disease. **12.** Routine medical, eye and ear examination, Laser or other surgery for correction of refractive errors of sight, cost of spectacles, contact lenses, hearing aids, cost of Cochlear implant(s), issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose. **13.** Costs of Donor screening or treatment including surgery to remove organs from a donor in case of transplant surgery. **14.** Any dental treatment or surgery which is corrective, cosmetic or of aesthetic in nature, filling of cavity, root canal treatment, and treatment of wear and tear, any orthodontics or orthographic surgery, or temporo-mandibular joint disorder, except as necessitated by an Accidental Injury. **15.** Convalescence, general debility, "run down" condition or rest cure, congenital external Diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, Hormone replacement therapy, intentional self-Injury/suicide, all psychiatric and psychosomatic disorders and Diseases / Accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction. **16.** All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymohadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications and all sexually transmitted Diseases. **17.** Expenses incurred at Hospital primarily for evaluation / diagnostic purposes, wherein such tests are possible to be carried out on out patient basis and which is not followed by active treatment or intervention during the period of Hospitalisation. **18.** Expenses on vitamins and tonics unless medically necessary as a part of treatment for Injury or Disease as certified by the attending physician. **19.** Any treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean clause, abortion or complications of any of these including changes in chronic condition as a result of pregnancy, tests and treatment relating to Infertility and in vitro fertilisation. However, the exclusion do not apply to Ectopic Pregnancy proved by Ultrasonography / diagnostic means and is certified to be life threatening by the Medical Practitioner. **20.** Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies, Ayurvedic, Homeopathy, Unani, reflexology, bone-setting, herbalist treatment, hypnotism, rolfing, massage therapy, aroma therapy, Steam bathing, Shirodhara and alike treatment under Ayurvedic treatment or any other treatments other than Allopathy /western medicines and any treatment taken at home, health hydro, nature care clinic or similar establishments. **21.** Expenses incurred for investigation or treatment irrelevant to the Diseases diagnosed during Hospitalisation or primary reasons for admission, private nursing/attendants charges incurred during Pre-Hospitalisation period or Post-Hospitalisation period, Referral fee to Family doctors, out station consultants / Surgeons fees. **22.** Genetic disorders and stem cell implantation / surgery. **23.** Any treatment related to sleep disorder or sleep Apnoea syndrome. **24.** External and or durable medical / non medical equipment of any kind used for Diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker , Crutches, Belts ,Collars ,Caps, splints, slings, braces ,Stockings of any kind, Diabetic foot wear, Glucometer / Thermometer and similar related items and also any medical equipment which is subsequently used at home. **25.** All non Medical Expenses including Personal comfort and convenience items or services such as telephone, television, special mattresses, personal attendant or barber or beauty services, diet charges, baby food, cosmetics, napkins , toiletry items, guest services and similar incidental expenses or services. **26.** Only one Coronary Angiography is payable in a Policy year except in case where a Coronary Intervention has been undergone after the first angiography. **27.** Medical or surgical treatment of obesity and any other weight control programme, services or supplies. **28.** Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing unless specifically agreed by the Insurance Company. **29.** Any stay in the Hospital or extended period of Hospitalisation beyond the customary length of stay for any domestic reason or where no active regular treatment is given by the specialist. **30.** Out patient diagnostic / medical or surgical procedures and / or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy. **31.** Any kind of service charges, surcharges, admission fees or registration charges etc levied by the Hospital. **32.** Treatment which is continued before Hospitalisation and continued even after discharge for a Disease or Injury different from the one for which Hospitalisation was necessary. **33.** Failure to seek or follow reasonable medical advice. Reasonable Medical Advice refers to tests or treatments as recommended by a Medical Practitioner that a prudent person would normally undergo. **34.** Hospitalisation and treatment of any kind not actually performed, necessary or reasonable, or any kind of elective surgery or treatment which is not medically necessary. **35.** Treatment for Disease or Injury not taken in a Hospital. **36.** Treatments or procedures customarily and usually performed by Medical Practitioners in out patient department or clinic and casualty setting shall not be payable even if performed as Day Care Procedures or hospitalised. **37**. Any treatment for xanthelesema, syringoma, acne and Alopecia.
9. **Revival (Re-instatement) of Lapsed Policy:** A Policy, which has lapsed for non-payment of premium within the days of grace, may be revived subject to the following conditions. **a.** The application for revival is made within 2 years from the due date of the first unpaid premium and before the Cover Cessation Date. Revival will be based on the then applicable revival norms of the Company. **b.** The revival of the Policy may be on terms different from those applicable to the Policy before it lapsed. **c.** In case of Family Floater Cover, the application for revival should be made for all Insured Person(s). **d.** No Waiting Period will be applicable for any revival within 60 days from the due date of the first unpaid premium. **e.** There shall be a Waiting Period of 30 days from the date of revival applicable for all Insured Person(s) where the Policy was lapsed for a period of more than 60 days from the date of first unpaid premium. Also, all exclusions applicable at the Policy Commencement Date shall once again become applicable. **f.** The Company may subject all the Insured Person(s) to medical examination before taking a decision on the revival of the Policy. The Policyholder shall have to furnish, at his own expense, satisfactory evidence of health as required by the Company. **g.** No benefit is payable for an Event which occurred or symptoms of which first occurred or were first diagnosed during the period when Policy was in lapsed condition. **h.** The revival will take effect only on its being specifically communicated by the Company to the Insured Person(s).
10. **Contribution Clause:** "Rateable proportion of any loss" means the part of the claim amount that will be payable by the Company in cases where the Policyholder is covered under more than one Policy. The proportion of claim payable inclusive of Co-pay will be determined by the ratio of the Annual Limit under this Policy to the total cover on the health of the Insured Person(s). The total cover refers to the sum of Annual Limits or Sum Assured applicable to the claim under all in force medical reimbursement policies. If at the time when a claim arises under this Policy, there is in existence any other insurance whether it be effected by or on behalf of any Insured Person(s) in respect of whom the claim has arisen covering the same loss, liability, compensation, costs or expense, the Company shall not be liable to pay or contribute more than its Rateable Proportion of any loss, liability, compensation, costs or expenses.
11. **Premium: a.** Premiums are payable on the due dates and for the amounts mentioned in the Policy Certificate at time of commencement of the Policy. A grace period of not more than 30 days, where the frequency of payment of premium is other than monthly, and not more than 15 days in the case of monthly frequency is allowed. **b.** Premium Payment: You may pay premium through any of the following modes: **a.** Cash **b.** Cheque **c.** Demand Draft **d.** Pay Order **e.** Banker's cheque **f.** Internet facility as approved by the Company from time to time **g.** Electronic Clearing System / Direct Debit **h.** Credit or Debit cards held in your name. *Amount and modalities will be subject to our rules and relevant legislation or regulation.* **c.** Premiums are payable without any obligation on the Company to issue a notice for the same. Where premiums have been remitted otherwise than in cash, the application of the premiums received is conditional upon the realization by the Company of the proceeds of the instrument of payment including electronic mode. **d.** Premium shall be construed to be received only when the same is received at any of the Company's offices. **e.** If the Policyholder suspends payment of premium for any reason whatsoever, the Company shall not be held liable and the benefits, if any will be available only in accordance to the Policy conditions. **f.** In case of Policy alterations by the Insured Person(s) the premium payable under the Policy may be revised as per the norms of the Company. **g.** If the premiums are paid in advance then Units will be allocated on the respective premium due date.
12. **Continuation of the Policy :** # Before payment of three full years' premium if any premium is not paid within the allowed days of grace, the Policy shall lapse. The Policy may be revived within two years from the date when the first unpaid premium was due. During this period, Hospitalisation Insurance Benefit will cease and no Insurance Charges will be deducted. However, the Policy Administration and Fund Management Charges will continue to be applicable. The Policyholder will continue to have the benefit of investment in the respective Unit funds. If the Policy is not revived within this period, it will be terminated at the end of third Policy year or at the end of the revival period, whichever is later, and no benefits shall be payable. # If premiums have been paid for the first three years and thereafter if any due premium is not paid even after the expiry of the days of grace, the Policy will continue for two years, during which the Policyholder can resume payment of the premium. During this period, the Hospitalisation Insurance Benefit will continue and all applicable charges will be deducted from the fund subject to the foreclosure conditions stated in Clause 26. The Policyholder will continue to have the benefit of investment in the respective Unit funds. If the Policy is not revived within this period, it will be foreclosed at the end of the revival period as per the foreclosure conditions stated in Clause 26. # If premiums have been paid for the first five years and thereafter if any due premium is not paid even after the expiry of the days of grace, the Policy will continue for two years, during which the Policyholder can resume payment of the premium. During this period, the Hospitalisation Insurance Benefit will continue and all applicable charges will be deducted from the fund. The Policyholder will continue to have the benefit of investment in the respective Unit funds. Then, if the premium payment is not resumed within the period of two years from the due date of the first unpaid premium, the Policyholder will have the cover continuance option as stated in Clause 22.3.
13. **Funds:** The Company shall select the investments, including derivatives and units of mutual funds, by each Fund at its sole discretion subject to the investment objectives of the respective Fund and the applicable IRDA regulations. All assets relating to the Fund shall be and shall remain in the absolute beneficial ownership and control of the Company. There is no trust created, whether express or implied, by the Company in respect of the investments in favour of the Policyholder/assignee/nominee of the Policy or any other person. Following are the funds, which the company offers, along with their objective and risk- return profile. **i) Health Flexi Growth(SFIN:ULIF 057 15/01/09 HFlexiGro 105):** To generate superior long-term returns from a diversified portfolio of equity and equity related instruments of large, mid and small cap companies. **Portfolio Allocation:** Equity & related securities- Maximum: 100% and Minimum: 80%. Debt, Money market & Cash- Maximum: 20% and Minimum: 0%. Potential risk- reward profile of the fund: High **ii) Health Flexi Balanced(SFIN: ULIF 060 15/01/09 HFlexiBal 105):** To achieve a balance between capital appreciation and stable returns by investing in a mix of equity and equity related instruments of large, mid and small cap companies and debt and debt related instruments. **Portfolio Allocation:** Equity & related securities- Maximum: 60% and Minimum: 0%. Debt, Money market & Cash- Maximum: 100% and Minimum: 40% **Potential risk- reward profile of the fund:** Low **iii) Health Protector(SFIN: ULIF 061 15/01/09 HProtect 105):** To provide accumulation of income through investment in various fixed income securities. The fund seeks to provide capital appreciation while maintaining a suitable balance between return, safety and liquidity. **Portfolio Allocation:** Debt, Money market & Cash- Maximum: 100% and Minimum: 100% **Potential risk- reward profile of the fund:** Low **iv) Health Multiplier(SFIN: ULIF 058 15/01/09 HMultip 105):** To provide long-term capital appreciation through investments primarily in equity and equity-related instruments. **Portfolio Allocation:** Equity & related securities- Maximum: 100% and Minimum: 80%. Debt, Money market & Cash- Maximum: 20% and Minimum: 0%. **Potential risk- reward profile of the fund:** High **v) Health Balancer: (SFIN: ULIF 059 15/01/09 HBalancer 105):** To provide a balance between long-term capital appreciation and current income through investment in equity as well as fixed income instruments in appropriate proportions depending on market conditions prevalent from time to time. **Portfolio Allocation:** Equity & related securities- Maximum: 40% and Minimum: 0%. Debt, Money market & Cash- Maximum: 100% and Minimum: 60%. **Potential risk- reward profile of the fund:** Moderate **vi) Health Preserver(SFIN: ULIF 056 15/01/09 HPreserv 105):** To provide suitable returns through low risk investments in debt and money market instruments while attempting to protect the capital deployed in the fund. **Portfolio Allocation:** Equity & related securities- Maximum: 50% and Minimum: 0%. Debt, Money market & Cash- Maximum: 100% and Minimum: 50%. **Potential risk- reward profile of the fund:** Low **vii) Health Return Guarantee Fund (HRGF)(SFIN[1]: 5 year tranche: ULIF 109 22/12/10 HRGF9 105, 10 year tranche: ULIF 110 22/12/10 HRGF(S1) 105):** To provide guaranteed returns through investment in a diversified portfolio of high quality fixed income instruments. **Portfolio Allocation:** Debt, Money market & Cash- Maximum: 100% and Minimum: 100% **Potential risk- reward profile of the fund:** Low

[1]The SFIN for subsequent tranches shall be determined at the time of seeking Authority's approval for launch of each new RGF tranche and shall be represented as:

For 5 year tranche: ULIF XXX dd/mm/yy HRGF(TX) 105

For 10 year tranche: ULIF XXX dd/mm/yy HRGF(SX) 105

14. **Portfolio Strategies available under the Policy:** The premiums are allocated in the Fund(s) after deducting the applicable premium allocation charges. The Policyholder has an option to invest in either of the Portfolio Strategies as mentioned below.

14.1. LifeCycle – based Portfolio Strategy: a. Under this strategy, investment will be made in the funds "Health Flexi Growth" and "Health Protector" in the proportion shown below according to the age of Primary Insured. **Age band 18-25:** Health Flexi Growth: 85%, Health Protector: 15%; **Age band 26-35:** Health Flexi Growth: 75%, Health

Protector: 25%; **Age band 36-45:** Health Flexi Growth: 65%, Health Protector: 35%; **Age band 46-55:** Health Flexi Growth: 55%, Health Protector: 45%; **Age band 56-65:** Health Flexi Growth: 45%, Health Protector: 55%; **Age band 66-75:** Health Flexi Growth: 35%, Health Protector: 65%; Age band 76+: Health Flexi Growth: 0%, Health Protector: 100% **b.** Further on a quarterly basis, Units shall be rebalanced as necessary to achieve the stated proportion of the Fund Value in the "Health Flexi Growth" and "Health Protector" funds as stated in the Table given above. The re-balancing of Units shall be done on the last day of each Policy quarter. **c.** The Policyholder does not have the flexibility to alter the above stated proportions of Health Flexi Growth and Health Protector. **d.** If the last day of the quarter is not a Valuation date then the Company shall apply the NAV of the next immediate Valuation date. **e.** The quarter means the quarterly anniversary of the Policy with reference to Policy Commencement Date.

14.2. Fixed Portfolio Strategy: Under this option, the Policyholder has to decide the premium allocation among one or more from the funds as mentioned in Clause 13 above. The Policyholder shall specify the type of fund(s) and the proportion in which the premiums are to be invested in the chosen fund(s) at the inception of the Policy or at the time of change to Fixed Portfolio Strategy from LifeCycle- based Portfolio strategy or at the time of exercising Premium Re-Direction described in Clause 22.2, as the case may be.

14.3. Automatic Transfer Strategy: The Policyholder can choose to automatically transfer, from his investments in the Health Preserver Fund, every month, into any of the equity funds available under the plan (namely Health Multiplier and Health Flexi Growth). The Policyholder can opt for a transfer date of either 1st or 15th of every month. If the 1st or 15th of the month is not a Valuation day then the NAV of next Valuation day will be applicable. At the time of transfer, the required number of Units will be withdrawn from Health Preserver Fund, at the prevailing NAV, and new Units will be created in the chosen destination fund. The minimum transfer amount is Rs. 2,000 and is subject to change as per the Company's rules from time to time with prior approval from IRDA. The automatic transfer strategy will continue till the company is notified, through a written communication, to discontinue the same. The automatic transfer strategy will not be applicable if the source Fund Value is less than the amount nominated for transfer.

14.4. The Policyholder has an option to change the Portfolio Strategy once in every two years and no charge shall be levied for the same.

14.5. At any point of time the entire investment under the Policy must be invested in any one of the Portfolio Strategies mentioned above.

14.6. When the Portfolio Strategy is changed to LifeCycle-based Portfolio Strategy, Policyholder's existing funds as well as all future premiums will be allocated between Health Flexi Growth and Health Protector as per the LifeCycle schedule mentioned earlier. The Switch of Units, as necessary, shall be carried out by using the NAV of respective funds on the date of change. This Switch transaction would be free of charge.

15. Risks of investment in the Funds: The Policyholder agrees that he is making the investment in the Units with full knowledge of the following, amongst other, risks **a.** The investment risk in the investment portfolio is borne by the Policyholder. **b.** ICICI Pru Health Saver is only the name of the Policy and does not in any way indicate the quality of the Policy or its future prospects or returns. **c.** Health Flexi Growth, Health Flexi Balanced, Health Multiplier, Health Balancer, Health Protector, Health Preserver, Health Return Guarantee Fund, LifeCycle - based Portfolio Strategy, Fixed Portfolio Strategy and Automatic Transfer Strategy are the names of the Funds / Asset allocation Strategies respectively and do not in any manner indicate the quality of the Fund / Strategy, their future prospects or returns. **d.** The investments in the Units are subject to market and other risks and there can be no assurance that the objectives of any of the Funds will be achieved. **e.** The Fund Value of each of the Funds can go up or down depending on the factors and forces affecting the financial and debt markets from time to time and may also be affected by changes in the general level of interest rates. **f.** The past performance of other Funds or the Portfolio Strategies of the Company is not necessarily indicative of the future performance of any of these Funds or Strategies. **g.** The Funds or Strategies do not offer a guaranteed or assured return except for the Health Return Guarantee Fund, which offers a Minimum Guaranteed NAV at the time of termination of a tranche. **h.** All benefits payable under the Policy are subject to the tax laws and other financial enactments as they exist from time to time.

16. Valuation Date : The NAV shall be declared by the Company on a daily basis except on Bank holidays, Exchange holidays, Saturdays, Sundays and the days on which the Corporate Office of the Company or Banks or Exchange is closed.

17. Valuation of the Fund: The NAV of each Segregated fund shall be computed as set out below, or by any other method as may be prescribed by regulation. [Market Value of investment held by the fund plus Value of Current Assets less Value of Current Liabilities and provisions] Divided by, Number of units existing under the Fund at valuation date, before any new units are created or redeemed

18. Investment of the Funds: The Company shall select the investments, including derivatives and units of mutual funds, by each Fund at its sole discretion subject to the investment objectives of the respective Fund and the applicable IRDA regulations in that behalf. All assets relating to the Fund shall be and shall remain in the absolute beneficial ownership and control of the Company. There is no trust created, whether express or implied, by the Company in respect of the investments in favour of the Policyholder or assignee or nominee of the Policy or any other person.

19. New Funds: New Funds may be introduced by the Company from time to time subject to prior approval from IRDA. The Policyholder shall be notified of the introduction of such new Funds, provided the same shall be made available to the Policyholders. The Company may offer the Policyholder the option to Switch to those Funds at such NAV and subject to such terms and conditions as may be specified by the Company at that time subject to prior approval from IRDA.

20. Fund Closure: (a) Although the Funds other than the Health Return Guarantee Fund are open ended the Company may, at its sole discretion and subject to prior approval from IRDA, completely close any of the Funds on the happening of any event, which in the sole opinion of the Company requires the said Fund to be closed. The Policyholders shall be given at least three months' prior written notice of the Company's intention to close any of the Funds completely or partially except in 'Force Majeure' situations or conditions like, but not limited to, floods, cyclones, earthquake, war, etc which are beyond human control, where the Company may give a shorter notice. **(b)** In case of complete closure of a Fund, on and from the date of such closure, the Company shall cease to issue and cancel Units of the said Fund and cease to carry on activities in respect of the said Fund, except such acts as are required to complete the closure. In such an event if the Units are not switched to another Fund by the Policyholders, the Company will Switch the said Units to any other Fund at its sole discretion and subject to prior approval from IRDA. However no fee would be charged by the Company for switching to another Fund or exiting from the Policy in the event of complete closure of Funds. In case of complete closure of the any of the Fund(s) of LifeCycle–based Portfolio Strategy, the Company shall continue the LifeCycle–based Portfolio Strategy by switching all the Units lying in the closed fund(s) to other fund(s) with similar asset allocation and risk reward profile. **(c)** In case of partial closure of a Fund, after giving notice as above on and from the date of such closure, the Company shall cease to accept any contributions into the said Fund. The Policyholder would be given an option to Switch the investment under such Fund to any other existing Funds. However no fee would be charged by the Company for switching to another Fund or exiting from the Policy in the event of complete or partial closure of Funds.

21. Units:

21.1. The nominal value of the Units is Rs.10. The Units are allocated in the manner described below and such allocations may be made up to 1/1000th of a Unit or such other fraction as the Company may, in its sole discretion, decide.

21.2. Applicability of NAV: a. The allocation and redemption of Units for various transactions would be at the NAV as described below:• In case of **First Premium Deposit received by way of local cheque or pay order or demand drafts payable at par:** NAV of the Policy Commencement Date is applicable. • In case of **First Premium Deposit received by way of outstation cheque or pay order or demand drafts:** NAV of the Policy Commencement Date or date of realization of the amount by the Company, whichever is later is applicable. • In case of **Health Saving Benefit, Death Claim, Request for Freelook cancellation:** NAV of the date of receipt of the request / intimation of claim is applicable. (Intimation means written intimation for the purpose of claims. Request means written or through electronic mode or any other manner as decided by the Company from time to time). • In case of **Direct debit, ECS, credit card, etc for the purpose of renewal premiums:** NAV of the date of receipt of instruction or the due date, whichever is later is applicable • In case of **Renewal premiums received by way of local cheque or pay order or demand drafts payable at par:** NAV of the date of receipt of instrument or the due date, whichever is later • In case of **Foreclosures or revival:** NAV of the date of effect of foreclosure / revival **b.** In the exceptional case that the date of any of the above transactions coincides with the termination date of a tranche of the HRGF, then the higher of NAV of the HRGF as on that date (subject to the same being a Valuation day) and the Minimum Guarantee NAV of the HRGF tranche would apply while calculating the value of the portion of investments of the HRGF. **c.** The Units allocated shall be reversed in case of non realization of the premium amount. **d.** Cut-off time means the time before which transaction requests (such as premiums, Health Expense Benefit etc.) should be received at the Company's Office for the applicability of the NAV of the same day. Currently the cut-off time is 3.00 p.m. **e.** If the request/instruction is received after the cut-off time, then NAV of the next date or the due date, whichever is later, shall be applicable. **f.** If the same day or the next day or the transaction due date or the re-balancing day is not a Valuation date, then the Company shall apply the NAV of the next immediate Valuation date. **g.** In respect of transactions which are not specifically mentioned herein but involve the allocation and redemption of Units, the Company shall follow the same norms as mentioned in this Clause. **h.** In the event of the new applications or proposals received on the last day of the financial year, the NAV of that day would be applicable. The cut-off time shall not be applicable for such transactions. **i.** The Company may, subject to prior approval from IRDA, change the cut-off time by which requests for transactions have to be received and accepted for the purpose of determining the NAV of the relevant fund to be used for calculating the number of Units.

22. Policyholder's Options: The below mentioned options are available to the Policyholder.

22.1. Switching of Units (Applicable only for Fixed Portfolio Strategy): The Policyholder shall have an option to Switch Units or amount from a particular Fund to another Fund. This will be done by way of cancellation of the Units in the Funds to be switched from and creation of new Units in the Fund being switched to base on the NAV of the relevant Fund. The NAV as stated in Clause 21 shall be applicable. **a.** Four free Switches shall be allowed in each Policy year starting from the Policy Commencement Date. Any unutilised free Switch cannot be carried forward. **b.** Currently, for any non-free Switch, a flat charge levied at the time of exercising the Switch of Rs.100 shall be applicable except in case of complete or partial closure of the funds. This charge is subject to change as per the rules of the Company from time to time subject to prior approval from IRDA. **c.** Currently, the minimum amount per Switch is Rs.2,000 and shall be subject to change as per the rules of the Company from time to time subject to prior approval from IRDA. **d.** During the first three Policy years, Switches shall not be allowed unless all due premiums till date have been paid. **e.** The Policyholder can switch from the HRGF to another Fund at any point of time. The option to switch into the HRGF will be available only if a tranche of HRGF is open for subscription at the time of Switch request.

22.2. Premium Re-Direction (Applicable only for Fixed Portfolio Strategy): "Premium Re- Direction" is the facility allowing the Policyholder to modify the allocation of amount of renewal premiums into a different investment pattern from what was specified at the inception of the Policy. The Policyholder shall specify the type of Fund(s) and the proportion in which the premiums are to be invested at the inception of the Policy. The Policyholder shall have an option to change the proportion in which the premiums are to be invested at the time of payment of subsequent premiums. This will not be treated as a Switch. The Policyholder cannot opt for the HRGF for Premium Re-Direction. Premiums can be invested in the HRGF by means of a Switch at a time when a tranche is open for subscription. Please refer to Clause 22.1(e) for details.

22.3. Cover Continuance Option: After payment of five full years' premiums, if any subsequent premium payment is not made, the Policy will continue for all benefits including insurance cover with charges being deducted by cancellation of Units, subject to the foreclosure conditions stated in Clause 26.

23. Surrenders: "Surrenders", either total or partial, are not allowed under this Policy.

24. Charges:

24.1. Premium Allocation Charge: "Premium Allocation Charge" means a percentage of the premium appropriated towards charges from the premium received. The balance known as allocation rate constitutes that part of the premium which is utilized to purchase Units for the Policy. This charge is levied at the time of receipt of premium. Premiums are allocated to the chosen Fund(s) after deducting the Premium Allocation Charges as given below : **Year 1:** 20% of the premium, **Year 2-3:** 9% of the premium, **Year 4-10:** 2% of the premium, **Year 11 & thereafter:** 0% The Policyholder has the option to allocate the premium for purchase of Units amongst one or more of the Fund(s). The number of Units purchased would be computed based on the NAV as provided in Clause 21.2.

24.2. Insurance Charge : "Insurance Charge" means a charge levied for Hospitalisation Insurance Benefit. This charge shall be based on the age of the Primary Insured on the date of deduction of this charge and shall be levied for each Insured Person. This charge shall be deducted on a monthly basis by cancellation of Units. This charge shall be deducted till the death of the Insured Person(s) or till the Primary Insured attains the age of 75 years whichever is earlier. This charge shall be valid for a period of one year from the Policy Commencement Date. The Company reserves the right to revise this charge on every Policy anniversary subject to prior approval from IRDA.

24.3. Policy Administration Charge: "Policy Administration Charge" means a flat charge levied at the beginning of each Policy month from the Fund by cancelling Units for the charge amount as given below. **Annual and Half Yearly:** Rs. 60 per month, **Monthly:** Rs. 90 per month

24.4. Fund Management Charge: "Fund Management Charge" means a charge levied as a percentage of the value of assets and shall be appropriated by adjusting the NAV. This is a charge levied at the time of computation of NAV. The Fund Management Charge shall be as stated below: **Health Flexi Growth, Health Multiplier and Health Return Guarantee:** 1.50% per annum of the net assets. **Health Flexi Balanced, and Health Balancer:** 1.00% per annum of the net assets. **Health Protector and Health Preserver:** 0.75% per annum of the net assets

24.5. Miscellaneous Charge: If there are any Policy alterations during the Policy term, they shall be subject to a one time Miscellaneous Charge of Rs. 250. This charge will be deducted from the Fund by cancellation of Units.

24.6. In the event that the Units are held in more than one Fund, the cancellation of Units for recovery of above mentioned charges will be effected in the same proportion as the Fund Value held in each Fund.

24.7. Revision of Charges: The Company reserves the right to revise the following charges at any time during the term of the Policy. Any revision will apply with prospective effect subject to prior approval from IRDA and after giving a notice to the Policyholders. The following limits are applicable. # The Fund Management Charges may be increased to a maximum of 2.50% per annum of the net assets for each of the funds. # The Policy Administration Charge may be increased to a maximum of Rs. 240 per month. # The Switching Charge may be increased to a maximum of Rs. 200 per switch # The Miscellaneous Charge may be increased to a maximum of Rs. 500 per Policy alteration. # Insurance Charges are reviewable annually. # The Premium Allocation Charges are guaranteed for the term of the Policy.

25. Legislative Changes: This Policy including the premiums and the benefits under the Policy will be subject to the taxes and other statutory levies as may be applicable from time to time. The Policyholder shall be required to pay service tax, education cess or any other form of taxes or charges or levies as per prevailing laws and regulations, wherever applicable as per Company's Policy. All provisions stated in this Policy are subject to the current guidelines issued by the Regulator as on date. All future guidelines that may be issued by the Regulator from time to time will also be applicable to this Policy.

26. Foreclosure of the Policy: If premiums have been paid for three full policy years and after three policy years have elapsed since inception, notice will be given to the policyholder well before the total Fund Value reaches 110% of one full year's premium. Thereafter if the Fund Value reaches or falls below 110% of one full year's premium the Policy will be foreclosed. The foreclosure Fund Value (Fund Value as on the foreclosure date based on that day's NAV) can be claimed within the next five years as Health Savings Benefit subject to a maximum limit of 50% of the foreclosed Fund Value. The maximum aggregate benefit that can be claimed over the five years is limited to the foreclosed Fund Value. On death of the Primary Insured during this period, foreclosed Fund Value minus any Health Savings Benefit paid during this period will be payable to the nominee. The amount paid out on death of the Primary Insured may be taxable in the hands of the nominee as per the prevailing tax regulations at that time. No other benefits shall be payable.

27. Loans: No Loans are allowed under this plan.

General Terms and Conditions

1. Age: a. The Insurance Charge payable under the Policy has been calculated on the basis of the age of the Primary Insured as declared in the Proposal. In case the age of the Insured(s) has not been admitted by the Company, the Policyholder shall furnish such proof of age of the Insured(s) as is acceptable to the Company and have the age admitted. **b.** In the event the age so admitted (the "correct age") is found to be different from the age declared in the Proposal, without prejudice to the Company's other rights and remedies including those under the Insurance Act, 1938, one of the following actions shall be taken: **i)** If the correct age is such as would have made the Insured Person(s) uninsurable under the current plan, the plan shall stand altered to such plan as is generally granted by the Company for the correct age of the Insured Person(s). This will be subject to the terms and conditions as are applicable to that Plan of insurance. If the Policyholder does not wish to opt for altered Plan or if it is not possible for the Company to grant any other Plan of insurance, the Policy shall stand cancelled from the Policy Commencement Date. In such an event, the Fund Value shall be returned subject to deduction of the taxes and expenses incurred by the Company on the Policy. **ii)** If the correct age of the Insured Person(s) is found to be higher than the age declared in the Proposal, then the Policy shall be reviewed subject to the underwriting evaluation of the Company at point of such knowledge. Where the Insured Person(s) is found insurable, the Policyholder shall be required to pay the "Insurance Charge" corresponding to his correct age from the Policy Commencement Date up to the date of such payment with interest at such rate and in such manner as is charged by the Company for late payment of Insurance Charge. Subsequently the Insured person(s) shall be required to pay the correct **"Insurance Charge"** till the end of the Policy term. If the Policyholder fails to pay such accumulated difference, together with interest, the same shall be recovered by cancellation of Units. **iii)** If the correct age of the Insured Person(s) is found to be lower than the age declared in the Proposal, the Policyholder shall be required to pay the "Insurance Charge" corresponding to his correct age from the Policy Commencement Date. In such an event, the Company shall refund the accumulated difference between the original Insurance charge paid and the corrected Insurance charge without interest. **iv)** Where the Insured Person(s) other then the Primary Insured is found uninsurable, then that Insured Person(s) will be removed from the policy and the Insurance Charge will be adjusted from the next premium due date. Also no Benefits as specified in Clause (3) above shall become payable in respect of that Insured Person(s). Where the Primary Insured is found uninsurable, the Company would return the Fund Value subject to deduction of the taxes and expenses incurred by the Company on the Policy and terminate the Policy. c. For the purpose of Clause 1(b) of General Terms and Conditions, the Fund Value shall be calculated by using the NAV of the date of cancellation / termination of the policy by the Company.

2. Assignment and Nomination: a. An assignment of this Policy may be made by an endorsement upon the Policy itself or by a separate instrument signed in either case by the assignor specifically stating the fact of assignment and duly attested. The first assignment may be only made by the Proposer. Such assignment shall be effective, as against the Company, from and upon the service of a written notice upon the Company and the Company recording the assignment in its books. Assignment will not be permitted where Policy is under the Married Women's Property Act, 1874. Section 38 of the Insurance Act may be referred for the complete provision. **b.** The Primary Insured, where he is the holder of the Policy, may, at any time during the tenure of the Policy, make a nomination for the purpose of payment of the monies of the pending claim in the event of his death. Nomination shall be applicable only in the event where the Proposer and the Primary Insured is the same person. Where the nominee is a minor, the Primary Insured may also appoint a person to receive the monies during the minority of the nominee. In case of death of the Insured Person(s) (other than the Primary Insured) money in respect of any pending claim shall become payable to the Policyholder.

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

4. Incontestability: a. Section 45 of the Insurance Act,1938: "No Policy of life insurance effected before the commencement of this Act shall after the expiry of two years from the Policy Commencement Date of this Act and no Policy of life insurance shall after the expiry of two years from th e date on which it was effected after the coming into force of this Act shall after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal of insurance or any report of a medical officer, or a referee , or friend of the insured , or in any other document leading to the issue of the Policy , was inaccurate or false, unless the insurer shows that such statements was on material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the Policyholder and that the Policyholder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose. Provided that nothing in the clause 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." **b.** The Company would declare the Policy void in case of suppression or mis-statement or mis-representation of facts and all monies paid under the Policy would belong to the Company.

5. Notices: Any notice, direction or instruction given under the Policy shall be in writing and delivered by hand, post, facsimile or e-mail. **In case of the Policyholder or Nominee:** As per the details specified by the Policyholder or Nominee in the Proposal Form or Change of Address intimation submitted by him. Notice and instructions sent by the Company to the Policyholders will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail. It is very important that the Policyholder immediately informs the Company about the change in the address or the nominee particulars to enable the Company to service him effectively.

6. Payment of Claim: Before payment of any claim under the Policy, the Company shall require documents as mentioned below establishing the right of the claimant or claimants to receive payment. Claim payments are made only in Indian currency. **a.** All documents must be duly attested by the Policyholder or Insured Person(s). **b.** In addition to the documents stated in (A) and (B) below, the Insured Person(s) shall also provide the Company such additional information and assistance as the Company may require during processing of the claim. **c.** In the event of any doubt regarding the appropriateness or correctness of the Diagnosis, the Company shall have the right to call for an examination of the Insured Person(s) by a Medical Specialist appointed by the Company. The expenses incurred for the medical examination of the Insured Person(s) for the purpose of this clause shall be solely borne by the Company. The evidence used from such examination, and the opinion of such Medical Practitioner as to such Diagnosis shall be considered binding on both the Policyholder and the Company.

A) Hospitalisation Insurance Benefit: The below mentioned documents should be submitted to the Company within 10 days of discharge from the Hospital. **i)** Photocopy of Policy certificate. **ii)** Claimant statement form or Attending physician certificate. **iii)** Photo Identification proof. **iv)** Original discharge summary or card, original Hospital bill, payment receipts from the Hospital(s). **v)** Admission notes, original receipts, Pathological and other test reports from Medical Practitioner including films etc supported by the note from the attending Medical Practitioner demanding such test. **vi)** Original cash memo from the chemist(s) supported by proper prescription. **vii)** Attending Medical Practitioner's certificates regarding Diagnosis and bill, receipts etc. In case of post Hospitalisation treatment, all supporting claim papers or documents as listed above should also be submitted to the Company within 7 days after completion of such treatment to the Company. **B) Health Savings Benefit:** The below mentioned documents should be submitted to the Company within 1 year of incurring such expenses. **i)** Hospitalisation expenses which exceed the limit covered under medical insurance - Photocopies of Hospital bill + declaration from the customer (ICICI Pru format) + declaration from medical insurance company stating the amount not approved by the Insurer **ii)** Hospitalisation expenses not covered by medical insurance - Original bills + declaration from the customer (ICICI Pru format) **iii)** Co-pays as part of the medical cover - Photocopies of Hospital bill + declaration from the customer (ICICI Pru format)+ declaration from medical insurance company clearly stating the deduction of Co-pay amount. **iv)** Medicines and drugs + Medical Equipments, Diagnostic expenses, Dental expenses, Doctor visits - Original bills + declaration from the customer (ICICI Pru format). ICICI Pru format is the Company's standard format for declarations from Policyholder.

7. Fraudulent Claims: In the event that it is found that any claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person(s) or anyone acting on his or her behalf to obtain any benefit under this Policy , the Company reserves the right to discontinue the Policy and the Policy shall be terminated.

8. Electronic Transactions: The Customer shall adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and 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.

9. Force majeure: If the performance by the Company of any of its obligations herein shall be in any way prevented or hindered in consequence of any act of God or State, Strike, Lock out, Legislation or restriction of any Government or other authority or any other circumstances beyond the anticipation or control of the parties, the performance of this contract shall be wholly or partially suspended during the continuance of the contract.

10. Policy Alterations Policy alterations would be allowed after payment of atleast one full years premium, subject to the rules of the Company and IRDA guidelines at that point in time

11. Distance Marketing: Distance marketing includes 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 & magazine inserts and **(v)** Solicitation through any means of communication other than in person

12. Customer Service: a. For any clarification or assistance, the Policyholder may contact our advisor or call our Customer Service Representative (between 9.00 a.m. to 9.00 p.m, Monday to Saturday; excluding national holidays) on the numbers mentioned on the reverse of the Policy Folder or on our website: www.iciciprulife.com. Alternatively the Policyholder may communicate with us at the Customer Service Desk details mentioned earlier. The Company's website must be checked for the updated contact details. **b. Grievance Redressal Officer:** If the Policyholder does not receive any resolution or the resolution provided does is not satisfactory, the Policyholder may get in touch with our designated Grievance Redressal Officer (GRO). For GRO contact details please refer to the "Grievance Redressal" section on www.iciciprulife.com. **c. Senior Grievance Redressal Officer:** If the Policyholder does not receive any resolution or the resolution provided by the GRO is not satisfactory, the Policyholder may write to our Senior Grievance Redressal Officer (SGRO). For SGRO contact details please refer to the "Grievance Redressal" section on www.iciciprulife.com. **d. Grievance Redressal Committee:** In the event that any complaint / grievance addressed to the SGRO is not resolved, the Policyholder may escalate the same to the Grievance Redressal Committee at the following address: ICICI Prudential Life Insurance Company Limited, Vinod Silk Mills Compound, Chakravarthy Ashok Road, Ashok Nagar, Kandivali (East), Mumbai - 400 101. **e. Insurance Ombudsman: i.** The Central Government has established an office of the Insurance Ombudsman for redressal of grievances with respect to life insurance policies. **ii.** As per provision 13(3) of the Redressal of Public Grievances Rules 1998, the complaint to the Ombudsman can be made only if: **1.** The grievance has been rejected by the Grievance Redressal Machinery of the Insurance Company **2.** Within a period of one year from the date of rejection by the Insurance Company **3.** If any other Judicial authority has not been approached iii. In case if the Policyholder is not satisfied with the decision / resolution of the Company, the Policyholder may approach the Insurance Ombudsman at the address given below if the grievance pertains to • any partial or total repudiation of claims or • the premium paid or payable in terms of the policy • any claim related dispute on the legal construction of the policies in so far as such dispute relate to claims or • delay in settlement of claims • non-issue of policy document to customers after receipt of premiums iv. The complaint to the office of the Insurance Ombudsman should be made in writing duly signed by the complainant (Policyholder) or by his legal heirs with full details of the complaint and the contact information of complainant. Given below are details of the ombudsman office considering address of the Policyholder mentioned in the application form: The Insurance Regulatory and Development Authority's or the Company's website must be checked for the updated contact details.

1. Ahmedabad: Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road,AHMEDABAD-380 014. **Jurisdiction:** State of Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu. Tel: 079-27546840, Fax: 079-27546142, E-mail: ins.omb@rediffmail.com **2. Bhopal:** Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL (M.P)-462 023. **Jurisdiction:** States of Madhya Pradesh & Chhattisgarh. Tel: 0755-2569201, Fax: 0755-2769203, E-mail: bimalokpalbhopal@airtelmail.in. **3. Bhubneshwar:** Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. **Jurisdiction:** State of Orrisa. Tel: 0674-2596455, Fax: 0674-2596429, E-mail: ioobbsr@dataone.in. **4. Chandigarh:** Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building, Sector 17-D, CHANDIGARH-160 017. **Jurisdiction:** State of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh. Tel: 0172-2706468, Fax: 0172-2708274, E-mail: ombchd@yahoo.co.in. **5. Chennai:** Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600 018. **Jurisdiction:** State of Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry) Tel: 044-24333668 /5284, Fax: 044-24333664, E-mail: insombud@md4.vsnl.net.in. **6. New Delhi:** Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. **Jurisdiction:** States of Delhi & Rajasthan. Tel: 011-23239633, Fax: 011-23230858, E-mail: iobdelraj@rediffmail.com **7. Guwahati:** Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). **Jurisdiction:** States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura. Tel: 0361-2132204/5, Fax: 0361-2732937, E-mail: ombudsmanghy@rediffmail.com. **8. Hyderabad:** Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. **Jurisdiction:** States of Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry. Tel: 040-65504123, Fax: 040-23376599, E-mail: insombudhyd@gmail.com. **9. Kochi:** Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. **Jurisdiction:** State of Kerala, UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry. Tel: 0484-2358759, Fax: 0484-2359336, E-mail: iokochi@asianetindia.com. **10. Kolkata:** Insurance Ombudsman, Office of the Insurance Ombudsman, North British Bldg., 29, N.S. Road, 4th Floor, KOLKATA-700 001. **Jurisdiction:** States of West Bengal, Bihar, Jharkhand and UT of Andaman & Nicobar Islands, Sikkim. Tel: 033-22134866, Fax: 033-22134868, E-mail: iombkol@vsnl.net. **11. Lucknow:** Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. **Jurisdiction:** State of Uttar Pradesh and Uttaranchal. Tel: 0522 -2231331, Fax: 0522-2231310, E-mail: insombudsman@rediffmail.com. **12. Mumbai:** Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI-400 054. **Jurisdiction:** States of Maharashtra, Goa. Tel: 022-26106928, Fax: 022-26106052, E-mail: ombudsmanmumbai@gmail.com.

Policy Certificate, terms and conditions of the policy and all the endorsements by the Company, if any, shall form integral part of this contract and shall be binding on the parties (Ver 2.0:U56)

Annexure I

DAY CARE PROCEDURES: EAR: Atticoantrotomy, Closure of mastoid fistula, Mastoidectomy, Mastoidotomy, Myringoplasty, Myringotomy with Grommet insertion, Petrous Apicectomy, Removal of multiple bony outgrowths, Revision of stapedectomy, Stapedectomy, Stapedotomy, Tumour removal, Tympanoplasty, Tympanoplasty with Ossicular Reconstruction. **NOSE:** Antrostomy, Caldwell Luc approach, Fistulectomy, Fistulization of sinus, Functional Endoscopic Sinus Surgery/ Frontal Sinusotomy/Maxillary, Sinusotomy/ Ethmoidectomy/ Sphenoidotomy, Lysis of adhesions of nose, Rhinoplasty (only due to trauma), Septoplasty (medically necessitated), Tumour removals, Turbinectomy/Turbinoplasty. **TONSILS & ADENOIDS:** Adenoidectomy, Excision and destruction of a lingual tonsil, Excision or Biopsy of lesion of tonsil and adenoid, Removal of foreign body from tonsil and adenoid by incision, Tonsillectomy, Tonsilloadenoidectomy, Transoral incision and drainage of a pharyngeal abscess. **MOUTH & FACE:** External incision and drainage in the region of the mouth, jaw and face, Incision of the hard and soft palate, Excision and destruction of Diseased hard and soft palate, Palatoplasty for pure palatal defects* **SALIVARY GLANDS & DUCTS:** Includes operations on lesser salivary gland and duct, parotid gland and duct, sublingual gland and duct, submandibular gland and duct, Closure of salivary fistula, Excision of Diseased tissue of a salivary gland and a salivary duct >2.5 cm in size, Fistulization of salivary gland, Partial resection of a salivary gland, Suture of laceration of salivary gland, Transplantation of salivary duct opening **TONGUE:** Lingual frenectomy*, Lingual frenotomy/frenoplasty *, Partial glossectomy **EYE:** Cataract Surgery (Extra Capsular Cataract Excision or Phacoemulsification + Intra Ocular Lens), Corrective surgery for blepharoptosis when not congenital/cosmetic, Corrective Surgery for entropion/ ectropion, Dacryocystorhinostomy [DCR], Excision and destruction of Diseased tissue of the eyelid, Excision involving one-fourth or more of lid margin, full-thickness, Excision of lacrimal sac and passage, Excision of major lesion of eyelid, full-thickness, Manipulation of lacrimal passage, Operations for pterygium, Operations of canthus and epicanthus when done for adhesions due to chronic infections, Removal of a deeply embedded foreign body from the conjunctiva with incision, Removal of a deeply embedded foreign body from the cornea with incision, Removal of a foreign body from the lens of the eye, Removal of a foreign body from the posterior chamber of the eye, Repair of canaliculus and punctum, Repair of corneal laceration or wound with conjunctival flap, Repair of postoperative wound dehiscence of cornea, Wedge resection of eyelid, Penetrating or Non-Penetrating Surgery for treatment of Glaucoma **SKIN & SUBCUTANEOUS TISSUE:** Free skin transplantation, donor site (Non cosmetic), Free skin transplantation, recipient site (Non Cosmetic), Incision of a pilonidal sinus, **BREAST,** Lumpectomy, Incision of breast abscess, Operations on the nipple except congenital inverted nipples T**RAUMATOLOGICAL SURGERY & ORTHOPAEDICS:** Incision on bone, septic and aseptic, Closed reduction on fracture, sub- luxation or epiphyseolysis, Osteosynthesis/ Internal fixation, Suture and other operations on tendons and tendon sheath, Reduction of dislocation under General Anaesthesia, Arthroscopic knee evaluation/aspiration /joint toilet, Surgery For Carple Tunnel Syndrome **DIGESTIVE TRACT:** Hernia Repair, Incision and excision of tissue in the perianal region, Incision of the anal sphincter (sphincterotomy), Planned Cholecystectomy, Surgical treatment of haemorrhoid **HAEMIC SYSTEM:** Sclerotherapy for - AV Malformations (Non cosmetic only), Bleeding varices (due to non alcohol related causes), Haemorrhoids, Varicose Veins (Non Cosmetic only) **FEMALE GENITAL ORGANS:** Conization of cervical canal, Culdotomy, Diagnostic/therapeutic Dilation and curettage of uterus (other than those related to medical termination of pregnancy), Dilatation of cervical canal, Excision or other destruction of Bartholin's gland (cyst), Hymenectomy, Hysterotomy (Not done as part of Medical Termination of Pregnancy), Incision of Bartholin's gland (cyst), Laparoscopic Salpingectomy (Non sterilisatisation related), Laparoscopic procedures of the ovary-Oophorectomy/Resection, Local excision or destruction of lesions in vagina and cul-de-sac, Marsupialization of Bartholin's gland (cyst), Window operation for treatment of Bartholin's cyst **MALE GENITAL ORGANS:** Drainage of prostatic abscess, Excision / Eversion of hydrocele, Excision of cyst of epididymis, Excision of seminal vesicle, Excision of varicocele and hydrocele of spermatic cord, Excision or destruction of testicular lesion, Incision and drainage of scrotum and tunica vaginalis, Incision and excision of periprostatic tissue, Incision of seminal vesicle, Incision of testis, Local excision or destruction of lesion of penis, Medically necessary Circumcision*, Orchidectomy (with epididymectomy), Orchidopexy * (non congenital) Partial Amputation of penis, Repair of scrotum and tunica vaginalis, Transurethral and percutaneous destruction of prostate tissue **URINARY/RENAL:** Cystoscopic fulguration of tumour, Cystoscopic removal of urinary stones / J stents, Follow up Check cystoscopy after Carcinoma bladder treatment, Haemodialysis, Insertion / Replacement of nephrostomy tube, Insertion / Replacement of pyelostomy tube, Lithotripsy, Marsupialization of kidney lesion, Nephrotomy, Ureteral meatotomy, **CARDIAC:** Coronary Angiography, Electro Physiology Study +Radio Frequency Ablation **GENERAL:** Parenteral Chemotherapy, Radiotheraphy, Intervention Cardiology, Intervention Radiology, Radiofrequency Ablation treatment, Lithotripsy, Dialysis

Annexure II

Insurance Charges: The insurance charges where Primary life is 18 years old will be as following –Annual Limit 2 lacs - Individual: 1,818 and Individual + Spouse: 2,708, Annual Limit 3 lacs - Individual: 2,093 and Individual + Spouse: 3,218, Annual Limit 5 lacs - Individual: 2,240 and Individual + Spouse: 3,444, Annual Limit 7 lacs - Individual: 2,386 and Individual + Spouse: 3,722, Annual Limit 10 lacs - Individual: 2,553 and Individual + Spouse: 4,040. Insurance charges for Child upto 25 years of age – Annual Limit 2 lacs – 1,818, Annual Limit 3 lacs – 2,093, Annual Limit 5 lacs – 2,240, Annual Limit 7 lacs – 2,386, Annual Limit 10 lacs –2,553

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