GROUP HEALTH (FLOATER) INSURANCE

b. Preamble

ICICI Lombard General Insurance Company Limited ("the Company"), having received a Proposal and the premium from the Proposer named in the Schedule referred to herein below, and the said Proposal and Declaration together with any statement, report or other document leading to the issuance of this policy and referred to therein having been accepted and agreed to by the Company and the Proposer as the basis of this contract do, by this Policy agree, in consideration of and subject to the due receipt of the subsequent premiums, as set out in the Schedule with all its Parts, and further, subject to the terms and conditions contained in this Policy, as set out in the Schedule with all its Parts, that on proof to the satisfaction of the Company of the compensation having become payable as set out in Part (a) of the Schedule to the title of the said person or persons claiming payment or upon the happening of an event upon which one or more benefits become payable under this Policy, the Sum Insured/appropriate benefit will be paid by the Company.

c. DEFINITIONS

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

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

I. **Standard Definitions whose wordings are specified by IRDAI**

1. Accident: An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. Admission means admission of the insured in a Hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness.

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

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

5. Any One Illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

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

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

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

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

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

9. Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co- payment does not reduce the Sum Insured.

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

11. Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

12. Day Care Treatment means medical treatment, and/or surgical procedure which is:

a) Undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and

b) Which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition

13. Day care canter A day care canter means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under

a) Has qualified nursing staff under its employment

b) Has qualified medical practitioner/s in charge;

c) Has a fully equipped operation theatre of its own where surgical procedures are carried out

d) Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

14. Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured. (Insurers to define whether the deductible is applicable per year, per life or per event and the manner of applicability of the specific deductible).

15. Proportionate deduction-

i) When higher room category is chosen, following expenses are not allowed under 'associate medical expenses' - Cost of pharmacy/consumables, Cost of implants/medical devices, C o s t o f diagnostics.

ii) Proportionate deductions not allowed for ICU expenses

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

a) The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

b) The patient takes treatment at home on account of non-availability of room in a hospital.

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

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

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

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

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

a) Has at least 10 in-patient beds, in those towns having a population of less than 10, 00,000 and 15 inpatient beds in all other places;

b) Has qualified nursing staff under its employment round the clock;

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

d) Has a fully equipped operation theatre of its own where surgical procedures are carried out

e) Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

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

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

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

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

b) Chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:-

1) It needs ongoing or long-term monitoring through consultations, examinations, check- ups, and / or tests

2) It needs ongoing or long-term control or relief of symptoms

3) It requires rehabilitation of the insured or for the insured to be specially trained to cope with it

4) It continues indefinitely

5) It recurs or is likely to recur

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

26. Intensive Care Unit Intensive care unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the

continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

27. ICU Charges

ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

28. Maternity Expenses means

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization)

b) Expenses towards lawful medical termination of pregnancy during the policy period

29. Medical Advise means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

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

31. Medical Practitioner means a person who holds a valid registration from Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude the insured and his/her Immediate Family.

"Immediate Family would comprise of spouse, dependent children, brother(s), sister(s) and dependent parent(s) of the insured.

32. Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

a) is required for the medical management of the illness or injury suffered by the insured;

b) Must not exceed the level of care necessary to provide safe, adequate and

c) Appropriate medical care in scope, duration, or intensity;

d) Must have been prescribed by a medical practitioner;

e) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

33. New born Baby means baby born during the Policy Period and is aged up to 90 days

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

The list of the Network Providers is available with the Company/ TPA and is subject to amendment from time to time.

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

36. Notification of Claim: Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication. .

37. Out-patient means the Insured who is not hospitalized for more than 24 consecutive hours but who visits a Hospital, clinic, or associated facility for diagnosis or treatment. However any Insured undergoing any specified "Day care surgeries/Treatment" will not be considered as an Out-patient.

38. Out-Patient (OPD) Treatment means treatment in which the insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient

39.Period of Insurance means the period as specifically appearing in the Policy Schedule and commencing from the Policy Period Start Date of the first Policy taken by the insured from the company and then, running concurrent to the current Policy subject to the Insured's continuous renewal of such Policy with the company.

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

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

42. Policy Period means period of one policy year as mentioned in the schedule for which the Policy is issued

43. Policy Year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule

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

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

a. diagnose by physician within 48 month prior to the effective date of the policy issued by insurer or its reinstatement or

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

46.Post Hospitalization Medical Expenses: Post Hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

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

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

47.Pre Hospitalization Medical Expenses Pre-hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

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

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

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

51. Room Rent: Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

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

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

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

55. Third Party Administrator (TPA) means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

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

57. Standard Nomenclature and Procedures for Critical Illnesses:

"Critical Illness" for the purpose of this Policy (if covered as an extension in Part (a) of the Policy) includes the following:

(i) Cancer of Specified Severity

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

b) The following are excluded -

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

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

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

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix. All tumors in the presence of HIV infection.

(ii) MYOCARDIAL INFARCTION (First Heart Attack-of Specified Severity)

a. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

ii New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

b. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris.

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

(iii) Open Chest CABG

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

b) The following are excluded:

Angioplasty and/or any other intra-arterial procedures

(iv) Kidney Failure Requiring Regular Dialysis

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

(v) Major Organ /Bone Marrow Transplant

a) The actual undergoing of a transplant of:

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

b) The following are excluded:

- Other stem-cell transplants
- Where only islets of Langerhans are transplanted

(vi) Stroke Resulting In Permanent Symptoms

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

b) The following are excluded:

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

(vii) Permanent Paralysis of Limbs

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

(viii) Open Heart Replacement or Repair of Heart Valves

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

(ix) Coma of Specified Severity

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

- No response to external stimuli continuously for at least 96 hours
- Life support measures are necessary to sustain life; and

- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma

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

(x) Motor Neurone Disease with Permanent Symptoms

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

(xi) Multiple Sclerosis with Persisting Symptoms

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

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

a. Others causes of neurological damage such as SLE are excluded.

d. Benefits covered under the policy

Insured may also avail the following additional covers/add-ons under the policy. Risk Premium would be charged as per the cover provided in Part (a) of the Policy:

1. Cover for Pre-Existing Diseases: By way of this add-on, Pre-existing Diseases shall be covered after 1 year (or as stated in Part (a) of the Policy).

For the purpose of avoidance of doubt, it is to clarified that,

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

a. diagnose by physician within 48 month prior to the effective date of the policy issued by insurer or its reinstatement or

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

2. Maternity Expenses: This add-on provides cover for medical expenses incurred for delivery, during hospitalization or lawful medical termination of pregnancy during the Policy Period This coverage may be offered with or without any waiting period. The cover also extends to provide child birth related expenses up to a specified limit and pre-post natal expenses as specifically stated in Part (a) of the Policy. Provided that-

a) The cover under this add-on shall be available after 9 months (or as stated in Part (a) of the Policy) of continuous coverage have elapsed since the inception of the first Policy with the Company

b) Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.

3. Out Patient Department (OPD) Expenses: The Company will reimburse medical expenses incurred by the Insured as an Outpatient.

For the purpose of this add-on, Outpatient means the Insured person who is not hospitalized for more than 24 consecutive hours but who visits a hospital, clinic or associated facility for diagnosis or treatment. However, any Insured person undergoing any named day care procedure/ treatment will not be considered as an Outpatient.

4. Cost of Prescribed External Medical Aid: The Company will reimburse Insured for the charges incurred by Insured during the Policy Period on account of procuring medically necessary prosthetic or artificial devices or any medical equipment including but not limited to hearing aids, spectacles, contact lenses etc.

5. Baby Day One Cover: This add-on will cover medical expenses incurred on the "new born baby" only as an in-patient in hospital for a maximum period up to 91 days.

6. Critical Illnesses Cover: The Company will pay the sum insured for this add-on, in case Insured is diagnosed as suffering from one or more of the Critical Illnesses for the first time in life, during the Policy Period.

This benefit can be availed only by the Insured only once during his lifetime.

7. Travel Expenses for Medical Treatment: The Company will reimburse the travel expense incurred outside the city of residence at a nearest place as prescribed by treating Medical Practitioner wherein the treatment is not possible in his place.

8. Dental Expenses: The Company will reimburse the medical expenses related to dental treatment incurred by the Insured during the Policy Period.

9. Cover for Alternate Methods of Treatment: By way of this add-on, the Company will reimburse the Insured for medical expenses incurred on homeopathic, Ayurvedic, Siddha, Unani, Acupressure, Acupuncture, Yoga and Naturopathy treatment provided that such treatment is administered by medical practitioner.

10. Donor Expenses: The Company will indemnify the Insured for the medical expenses incurred in respect of donor for any of the organ transplant surgery during the Policy Period, provided the organ donated is for Insured's use and the claim is considered admissible by the Company.

11. Ambulance Charges: Ambulance charges would include transportation cost to the nearest hospital in case of life threatening emergency conditions.

12. Pre and Post Hospitalization: By way of this add-on, the Company will pay medical expenses incurred 30 days prior to hospitalization and 60 days after hospitalization or as stated in Part (a) of the Policy.

13. Health Check-Up: The Company by way of this add-on, will cover the cost of health check-up incurred by the Insured for medical examination undergone being a requirement from employer. Such medical examination is generally conducted to understand health status of the employee.

14. Disease-Wise Sub-Limit: By way of this add- on, the company can introduce sub-limits on certain diseases based on the claim experience and the requirement of the Insured.

15. Domiciliary Hospitalization: The Company will reimburse the Insured for medical expenses incurred by the Insured during domiciliary hospitalization.

16. Treatment Outside India (along with traveling cost & boarding & lodging of the attendant): This add-on covers the cost of medical treatment along with the travelling cost and cost pertaining to boarding and lodging of the cost and cost pertaining to boarding and lodging of the attendant in a country outside India when required and prescribed by treating Medical Practitioner.

17. Convalescence Benefit: The Company will pay the Insured up to a certain amount as stated in Part (a) of the Policy if the Insured is hospitalized for a minimum period of consecutive days as specified in Part (a) of the Policy, due to any injury or illness as covered under the Policy. This benefit is payable only once to an Insured person during the Policy period.

18. Loss of wages/salary due to hospitalization (Hospital Daily Cash Allowance): The Company will pay the Insured a fixed amount for each day of his hospitalization to compensate against the loss of wage/salary incurred by Insured on account of hospitalization.

19. Cover for allied hospital charges: By way of this add-on, Company will reimburse either one or combinations of the expenses incurred on the allied hospital charges such as ambulance charges, administration charges, service charges and miscellaneous charges, boarding/lodging charges, including transportation costs of machine/medical instruments of any special medical team to the city of the insured or any such other charges wherever prescribed by medical practitioner.

20. Limit on room rent, nursing charges, consultation fees, diagnostic charges, OT charges etc.: This add-on restricts the coverage for respective heads up to a specified amount. In cases, where the claim amount exceeds this amount, the entire admissible claim amount which includes various hospital bills etc, will be reduced in the proportion which the eligible room rent limit bears to the actual room rent.

21. Wellness & Preventive Care: By way of this add-on the insured can avail any or all of the below mentioned:

- Health Risk Assessment
- Health Check-up's (add-on of report evaluation service)
- Medical Centre Management Diet & Nutrition Plans
- Online Doctor Chat
- Health Camps - on campus Expert Sessions - on campus
- Second Opinions: Domestic and International markets
- Discounted offerings - on health and wellness services (Eg Gyms, Diagnostic Canters, Medicines, Beauty clinics etc)
- Disease Management Programs: Eg Diabetes, Healthy Heart, Stress Management etc
- Lifestyle/Wellness Management Programs: Eg Maternity, Quit Smoking PHR - Personalized Health Records Health Assistance Services : Opinions - Doctor on call/home - Ambulance- Health tools
- Health & Wellness Reminder Services Health Concierge Desk
- Others

e. EXCLUSION

The Company shall not be liable to make any payment under this policy in connection with or in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

i. Standard exclusions for which standard wordings are specified by IRDAI

1. Pre-Existing Diseases - Code- Excl01

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

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

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

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer

2. 30-day waiting period- Code- Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

3. Investigation & Evaluation- Code- Excl04

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

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

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

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

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

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

5. Obesity/ Weight Control: Code- Excl06

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

1) Surgery to be conducted is upon the advice of the Doctor.

2) The surgery/Procedure conducted should be supported by clinical protocols.

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMI):

a) Greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co- morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

6. Gender treatments: Code- Excl07

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

7. Hazardous or Adventure sports: Code- Excl09 Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

8. Breach of law: Code- Excl10

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

9. Excluded Providers: Code- Excl11

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

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

11. Cosmetic or plastic Surgery: Code- Excl08 Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or

Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner

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

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

14. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

15. Unproven Treatments: Code- Excl16

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

16. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

iv. Reversal of sterilization

17. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

ii. Specific Exclusions other than those mentioned under e (i) above

1.The expenses on treatment of diseases, or illness such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagisa or Fibromyoma, Hernia, Hydrocele, Congenital Internal Diseases, Fistula in anus, piles, Sinusitis and related disorders during the first year of operation of this policy. If these diseases, or illnesses are pre-existing at the time of proposal, they will not be covered during subsequent renewal of the policy.

2.Diseases, illness, accident or injuries directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not).

3.Circumcision whether or not necessitated by vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery unless necessary for treatment of a disease not excluded by the terms of the policy or as may be necessitated due to treatment of an accident.

4. The cost of spectacles and contact lenses, hearing aids.

5. Dental treatment or surgery of any kind unless requiring hospitalisation.

6.Convalescence, general debility, run-down condition or rest cure, congenital external disease or defects or anomalies, intentional self-injury (whether arising from an attempt to suicide or otherwise) and use of intoxicating drugs and/or alcohol.

7.Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-Ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any diseases, illness or injury whether or not requiring Hospitalisation/ Domiciliary Hospitalisation.

8. Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Medical Practitioner.

9.Diseases, illness, accident or injuries directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.

10. Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.

11. Naturopathy treatment.

Note: If any Add-On has been opted as mentioned in Part (a) of Policy, then the respective Exclusion as mentioned above will not be applicable

f. . General Terms and Clauses

Standard General Terms and Clauses (General Terms and clauses whose wordings are specified by IRDAI)

1. Claim Settlement (provision for Penal Interest)

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

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

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

(iv)In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim. Interest provision shall be as per IRDAI (Protection of Policyholders' Interests) Regulations, 2017 or any amendments made thereto from time to time.

2. LIMITATION PERIOD

In no case whatsoever shall the Company be liable for any claim under the Policy, if the requirement of Clause V (1) (b) (iii) (b) above are not complied with, unless the claim is the subject

of pending action or arbitration; it being expressly agreed and declared that if the Company shall disclaim liability for any claim hereunder and such claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

3. Condition Precedent to Admission of Liability

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

4. Complete Discharge

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

5. POLICY RELATED TERMS AND CONDITIONS

a) Claim must be filed within 30 days from the date of completion of treatment. However, the Company may at its discretion consider waiver based on merits of the claim, where there is delay in intimation or in submission of documents due to unavoidable circumstances and it is proved that the delay was for reasons beyond the control of the insured and under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

b) The Insured Person shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim.

c) Any medical practitioner authorised by the Company shall be allowed to examine the Insured Person in case of any alleged diseases, illness, accident or injuries requiring Hospitalisation or Domiciliary Hospitalisation when and so often as the same may reasonably be required on behalf of the Company.

d) All medical/surgical treatment under this policy shall have to be taken in India (unless agreed upon in Part (a) of the Policy) and admissible claims thereof shall be payable in Indian currency.

e)Low Claim Ratio Discount (Bonus): Low Claim Ratio Discount will be allowed on the total premium at renewal depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Insurance Policy as mutually agreed by the insured and the insurer.

f)High Claim Ratio loading (Malus): The Total Premium payable at renewal of the Group Policy will be loaded depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Insurance Policy as mutually agreed by the insured and the insurer.

Note: Incurred claim would mean claims paid, claims outstanding and claims incurred but not reported (IBNR) in respect of the entire group insured under the policy during the relevant period.

6. TERMS OF RENEWAL

a)The Policy can be renewed as a separate contract under the then prevailing ICICI Lombard Group Health Insurance product or its nearest substitute (in case the product ICICI Lombard Group Health Insurance is withdrawn by the Company) approved by IRDA.

b) The policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured.

c) The policy could be subject to certain changes in terms and conditions including change in premium rate.

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

7. Possibility of Revision of Terms of the Policy including the Premium Rates- the Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

8. Incontestability and Duty of Disclosure

The policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, misdescription or on non-disclosure in any material particular in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or devices being used by the Insured or any one acting on his behalf to obtain any benefit under this policy.

9. Observance of terms and conditions

The due observance and fulfilment of the terms, conditions and endorsement of this policy in so far as they relate to anything to be done or complied with by the Insured, shall be a condition precedent to any liability of the Company to make any payment under this policy.

10. No constructive Notice

Any of the circumstances in relation to these conditions coming to the knowledge of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

11. Notice of Charge etc.

The Company shall not be bound to notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this policy but the receipt of the

Insured or his legal personal representative shall in all cases be an effectual discharge to the company.

12. Special Provisions

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

13. Overriding effect of Part (c to g) of the Policy

The terms and conditions contained herein and in Part (c to g) of the Policy shall be deemed to form part of the policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part (c to g) of the Policy, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in Part (c to g) of the Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable. In case of any inconsistency in terms and conditions mentioned in Part (c to g) of the Policy with Part (a) of the Policy then terms and conditions contained in Part (a) of the Policy will prevail over Part (c to g) of the Policy.

14. Electronic Transactions

The Insured agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call canters, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. The Insured agrees that the Company may exchange, share or part with any information to or with other ICICI Group Companies or any other person in connection with the Policy, as may be determined by the Company and shall not hold the Company liable for such use/application.

15. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited. Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy:-

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

b. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c. any other act fitted to deceive; and

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

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis- statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

16. Cancellation

a. The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Short Period Scales- Policy Cancellation*	
Covered Upto Days	**% of Refund**
7	Up to 90%
30	Up to 75%
60	Up to 65%
90	Up to 50%
120	Up to 40%
180	Up to 25%
240	Up to 15%
Exceeding 240	Up to 0%

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

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

17. Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

18. Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

19. Multiple Policies-

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

ii. insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

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

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

20. Premium Payment in Instalments:

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

i. Grace Period of 15 days would be given to pay the instalment premium due for the Policy.

ii. During such grace period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.

iii. The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace Period, the Policy will get cancelled.

21. Free Look Period-

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

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

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

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

Policies would however be subject to all limits, sub limits, co-payments as per the policy.

22. Arbitration Clause

If any dispute or difference shall arise as to the quantum to be paid under this policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference or if they cannot agree upon a single arbitrator within 30 days of any

party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

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

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

23. Renewal Notice

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

b) The policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the previous year policy and in no case later than Grace Period of 30 days from the expiry of the Policy However, risk coverage shall not be available for such a period.

24. Moratorium Period

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

25. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law. Each party agrees to submit to the jurisdiction of the Courts in India and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

26. Cause of Action/ Currency for Payments

No Claims shall be payable under this policy unless the cause of action arises in India, unless otherwise specifically provided in Part (c to g) of the Schedule to this policy. All claims shall be payable in India in Indian Rupees only.

27. Withdrawal of Policy-

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

g. Other terms & conditions:

1. SCOPE OF COVER

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed herein, that, if during the policy period stated in Part (a) of the Policy, any Insured Person shall contract any disease or suffer from Any One Illness or sustain any bodily injury through accident, and if such disease, illness, accident or injury shall require any such Insured Person, upon the advice of a Medical Practitioner to incur Hospitalisation or Domiciliary Hospitalisation expenses or Outpatient department expenses as stated in Part (a) of the Policy, the Company will pay to the Insured Person, the amount of such expenses as are reasonably and necessarily incurred thereof, by or on behalf of such Insured Person but not exceeding the sum insured for the person as mentioned in the Part (a) of the Policy hereto, to the extent and the manner hereinafter provided. The Company would be liable for the add-on coverage's mentioned in Part (a) of the Policy only if the Insured purchases the same in terms of the policy.

2. CLAIM ADMINISTRATION

The fulfilment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by each of the insured shall be conditions precedent to admission of the Company's liability. Further, upon the discovery or happening of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admission of the Company's liability, the insured shall undertake the following:

1. Claims Procedure

a. For Cashless Settlement

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

Pre-authorization

Prior to taking treatment and/or incurring Medical Expenses at a Network Provider, the insured must contact the company or the TPA accompanied with full particulars namely,

i. Policy Number,

ii. Name of the insured,

iii. Your relationship with Policy Holder,

iv. Nature of Illness or Injury, name and

v. address of the Medical Practitioner/Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalization.

Request for pre- authorisation should be received at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization. To avail of Cashless Hospitalization facility, the insured is required to produce the health card, as provided to him/her with this Policy, subject to the terms and conditions for the usage of the said health card. The request of insured shall be considered after having obtained accurate and complete information for the Illness or Injury for which cashless hospitalization facility is sought by the insured and the Company will confirm the request in writing.

b. For Reimbursement Settlement

(i) All claims have to be intimated 48 hours prior to hospitalization or within 24 hours post admission in case of emergency for prompt settlement of claims.

(ii) The insured shall give notice to the TPA by calling the toll free number as specified in the Policy provided to the insured and also in writing at the Company's address with particulars as below:

- Policy number;
- Name of the insured;
- Relationship of the proposer with the Policyholder;
- Nature of Illness or Injury;
- Name and address of the attending Medical Practitioner and the Hospital;
- Any other information that may be relevant to the Illness / Injury/Hospitalisation

(iii) The procedure for lodging the claim shall be as under:

Upon the happening of any event giving rise or likely to give rise to a claim under this policy:

a) The Insured shall give immediate notice thereof in writing to the Company.

b) The Insured shall deliver to the Company, within 30 days from the date of completion of treatment, a detailed statement in writing as per the claim form together with bills, vouchers and any other material particular, relevant to the making of such claim.

c) The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

2. Basis of assessment of claims

a) Basis of assessment of the claim shall be as under

:

The benefit payable shall be such expenses reasonably and necessarily incurred by or on behalf of the Insured Person under the following categories but not exceeding the Sum Insured in respect of such Insured person as specified in Part (a) of the Policy.

Heads of compensation payable:

(i) Room and Boarding Expenses as incurred at the Hospital/ Nursing Home;

(ii) Nursing Expenses;

(iii) Fee paid to Medical Practitioner, Surgeon, Anaesthetics, Consultants and Specialist

(iv) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & drugs, Diagnostic Materials and X - Ray, Dialysis, chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and similar expenses; and /or

(v) Pre Hospitalisation and Post Hospitalisation expenses, wherever applicable.

b. Claim documents:

The Insured shall be required to furnish the following for or in support of a claim:

(i) Duly completed claim form signed by the insured

(ii) Original bills, receipts and discharge certificate/card from the Hospital

(iii) Original bills from Chemists supported by proper prescription

(iv) Original investigation test reports and payment receipts

(iv) Indoor case papers

(v) Medical Practitioner's referral letter advising Hospitalization in non-Accident cases

(vi) Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque)

(viii) Any other document as required by the Company or the TPA to investigate the Claim or the Company's obligation to make payment for it.

3. Notices

Any notice, direction or instruction given under this policy shall be in writing to:

- In case of the Insured, at the address specified in Part (a) of the Policy.
- In case of the Company:

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

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

4.. Customer Service

If at any time the Insured requires any clarification or assistance, the Insured may contact the offices of the Company at the address specified, during normal business hours.

5. Redressal of Grievance-

In case of any grievance, the insured person may contact the company through Website: www.icicilombard.com

Toll Free: 1800 2666

E-Mail: "customersupport@icicilombard.com"

Courier: ICICI Lombard General Insurance Company Limited.

ICICI Lombard House, 414, Veer Savarkar Marg,

Near Siddhi Vinayak Temple, Prabhadevi,Mumbai- 400025.

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

Corporate Manager- Service Quality, National Manager-Operations & finally Director-services and Business development at the following address:

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

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

If insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of insurance Ombudsman of the respective area/region for redressal of grievance as per insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI integrated Grievance Management System

- https:/ligms. irda.qov. in/

If the issue still remains unresolved, the insured may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.

The details of Insurance Ombudsman are available below:-

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

	.in	
4	BHUBANESHWAR - **Shri Suresh Chandra Panda** Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
5	CHANDIGARH - **Dr. Dinesh Kumar Verma** Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
6	CHENNAI - **Shri M. Vasantha Krishna** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
7	DELHI - **Shri Sudhir Krishna** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi
8	GUWAHATI - **Shri Kiriti .B. Saha** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
9	HYDERABAD - **Shri I. Suresh Babu** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 – 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
10	JAIPUR - **Smt. Sandhya Baliga** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	Rajasthan.
11	ERNAKULAM - **Ms. Poonam Bodra** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.	Kerala, Lakshadweep, Mahe-a part of Pondicherry.

	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	
12	KOLKATA - **Shri P. K. Rath** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
13	LUCKNOW -**Shri Justice Anil Kumar Srivastava** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
14	MUMBAI - **Shri Milind A. Kharat** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
15	NOIDA - **Shri Chandra Shekhar Prasad** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar,

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

The updated details of Insurance Ombudsman are available on IRDA website: www.irdaindia.org, on the website of General Insurance Council: www.gbic.co.in, website of the Company www.icicilombard.com or can be obtained from any of the offices of the Company.

Statutory Warning: Prohibition of Rebates (Under Section 41 of Insurance Act, 1938) as amended by the Insurance Laws (Amendment) Act, 2015.

1) No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.

2) Any person making default in complying with the provisions of this section shall be liable for a penalty, which may extended to ten lakh rupees.

ANNEXURE

The IRDAI has taken several proactive measures & granted relaxation for the benefit of policyholders to respond to the outbreak of Covid-19 situation within the Country. The company is offering the below mentioned benefit without any additional cost as an aiding gesture to all the policyholders of the company for this financial year. This benefit shall be available for all the customers until Mar 31st, 2022.

1. Home Healthcare

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

a) The insured person has been advised non-emergency hospitalization by a Medical practitioner and the Insured person out of his own will, opts to undergo treatment at home.

b) The condition of the Insured Person is expected to improve in a reasonable and foreseeable period of time.

c) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.

d) Treatment that can be availed on Outpatient basis will not be qualified to be covered under this clause.

e) Insured can avail the services as prescribed by the medical practitioner on cashless basis which would be arranged by the Insurer through designated network provider.

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

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

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

a. Diagnostic tests undergone at home or at diagnostics centre

b. Medicines prescribed in writing

c. Consultation charges of the medical practitioner

d. Nursing charges related to medical staff

e. Medical procedures limited to parenteral administration of medicines

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