

Group Health (Floater) Insurance Policy Wordings

a. 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 I of Policy 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.

Part II of Policy

b. 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

Standard Definitions

1. Accident:

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

2. Any One Illness:

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.

3. Ayush Treatment:

"AYUSH treatment" refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

4. Break in Policy:

"Break in policy" means the period of gap that occurs at the end of the existing policy term / instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

5. Cashless Facility:

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.

6. Condition Precedent:

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

7. Congenital Anomaly:

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

ICICI Lombard General Insurance Company Limited

IRDA Reg. No. 115
Mailing Address:
601 / 602, 6th Floor, Interface Building No. 16,
New Link Road, Malad (West),
Mumbai - 400 064.

UIN: ICILGP26055V072526
CIN: L67200MH2000PLC129408
Registered Office Address:
ICICI Lombard House, 414, P Balu Marg, Off Veer Savarkar Road,
Nr Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400 025.

Product Name: Group Health (Floater) Insurance
Toll free No. : 1800 2666
Alternate No.: 86552 22666 (Chargeable)
Website : www.icicilombard.com
E-mail : customersupport@icicilombard.com

8. Co-Payment:

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.

9. Cumulative Bonus:

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

10. Day Care Center:

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

- i) has qualified nursing staff under its employment
- ii) has qualified medical practitioner/s in charge
- iii) has a fully equipped operation theatre of its own where surgical procedures are carried out
- iv) maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

11. AYUSH Day Care Centre:

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

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

12. Day Care Treatment:

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

- i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
- ii. Which would have otherwise required Hospitalisation of more than 24 hours.

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

13. Deductible:

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.

Deductible is applicable per year, per life or per event as stated in part I of the policy and specific benefit/cover based deductible shall be applied if specified in the part I of the policy.

14. Dental treatment:

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

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15. Disclosure to information norm:

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

16. Domiciliary Hospitalisation:

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

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

17. 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.

18. Grace Period:

"Grace period" means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

19. Hospital:

A hospital means any institution established for in-patient care and day care treatment

of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the

Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:

- i) has qualified nursing staff under its employment round the clock;
- ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
- iii) has qualified medical practitioner(s) in charge round the clock;
- iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
- v) maintains daily records of patients and make these accessible to the Insurance Company's authorized personnel.

20. AYUSH Hospital:

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

- a. Central or State Government AYUSH Hospital; or
- b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
- c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

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- iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

21. Hospitalisation:

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.

22. Illness:

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

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

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

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 for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or it likely to recur

23. Injury

Injury means 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

24. Inpatient care:

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

25. 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.

26. 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.

27. Maternity Expenses:

Maternity expenses means

- a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation)
- b) Expenses towards lawful medical termination of pregnancy during the policy period

28. Medical Advice:

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

29. Medical Expenses:

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

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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.

30. Medical Practitioner:

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

The term medical practitioner would include physician, specialist, anaesthetist and surgeon but should not be the Insured or Insured's Immediate Family. "Immediate Family" would comprise of spouse, children, brother(s), sister(s) and parent(s)e.

31. Medically Necessary Treatment:

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

- i) is required for the medical management of the illness or injury suffered by the insured;
- ii) must not exceed the level of care necessary to provide safe, adequate and
- iii) must have been prescribed by a medical practitioner;
- iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India

32. Migration:

"Migration" means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

33. Network Provider:

Network Provider means hospitals or health care providers enlisted by an insurer, TPA

or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

34. New born Baby:

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

35. Non- Network Provider:

Non-Network provider 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. OPD treatment:

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

38. Portability

"Portability" means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

39. Pre-existing Disease:

"Pre-existing disease (PED)" means any condition, ailment, injury or disease:

- a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
- b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Provided that the definition of the pre-existing disease shall not be applicable for Overseas Travel Policies.

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40. Pre Hospitalisation Medical Expenses:

Pre-Hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days preceding the Hospitalisation of the Insured Person, provided that:

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

41. Post Hospitalisation Medical Expenses:

Post-Hospitalisation 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 Hospitalisation was required, and
- ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

42. 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.

43. Reasonable and Customary Charges:

Reasonable and Customary charges mean 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

44. Renewal

Renewal Means the terms on which the contract of insurance can be renewed as per regulatory prescriptions 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.

45. Room Rent:

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

46. Specific Waiting Period: Specified Disease/ Procedure waiting period:

"Specific waiting period" means a period up to 12 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

47. 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

48. 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 center by a medical practitioner

49. 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.

Specific Definitions

1. Accidental Emergency

Accidental Emergency means a traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a person's health or result in loss of life.

2. Admission

Admission means admission of the

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

3. Alternative treatments

Alternative treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and include acupressure and acupuncture in the Indian context.

4. Annual Sum Insured:

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. Contribution:

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.

6. Claim:

"Claim" means a demand made by Insured/Policyholders or on Insured/Policyholders behalf for payment of Medical Expenses or any other expenses or benefits, as covered under the Policy

7. Out-patient:

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.

8. Period of Insurance:

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.

9. Policy:

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 person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person

10. Policy Holder:

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).

11. Policy Period:

Policy period means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Schedule

12. Policy Year:

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.

13. Proportionate deduction:

Proportionate deduction means

- When higher room category is chosen, following expenses are not allowed under 'associate medical expenses' - Cost of pharmacy/ consumables, cost of implants/ medical devices, Cost of diagnostics.
- Proportionate deductions not allowed for ICU expenses

14. Senior Citizen:

Senior citizen means any person who has completed sixty or more years of

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age as on the date of commencement or renewal of a health insurance policy.

15. Third Party Administrator (TPA):

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.

16. Standard Nomenclature and Procedures for Critical Illnesses

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

1. CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded –

- i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
- ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- iii. Malignant melanoma that has not caused invasion beyond the epidermis;
- iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- vi. Chronic lymphocytic leukemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaNOM0 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;

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

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

- i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
- ii. New characteristic electrocardiogram changes
- iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. II. The following are excluded:
 - i. Other acute Coronary Syndromes
 - ii. Any type of angina pectoris
 - iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

- I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- II. The following are excluded:
 - i. Angioplasty and/or any other intra-arterial procedures

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4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

- I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must 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.

5. COMA OF SPECIFIED SEVERITY

- I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
 - i. no response to external stimuli continuously for at least 96 hours;
 - ii. life support measures are necessary to sustain life; and
 - iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma
- II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS

- I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage 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.

- II. The following are excluded:
 - i. Transient ischemic attacks (TIA)
 - ii. Traumatic injury of the brain
 - iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN / BONE MARROW TRANSPLANT

- I. The actual undergoing of a transplant of:
 - i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
 - ii. Human bone marrow using hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner
- II. The following are excluded:
 - i. Other stem-cell transplants
 - ii. Where only islets of Langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

- I. 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.

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

- I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological

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Mailing Address:

601 / 602, 6th Floor, Interface Building No. 16,
New Link Road, Malad (West),
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UIN: ICILGP26055V072526

CIN: L67200MH2000PLC129408

Registered Office Address:

ICICI Lombard House, 414, P Balu Marg, Off Veer Savarkar Road,
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impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

- I. 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.
- II. Neurological damage due to SLE is excluded.

II) 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 I 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 as stated in Part I 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 I of the Policy hereto, to the extent and the manner hereinafter provided.

For the purpose of this Cover, "Hospitalisation" shall include In-Patient Hospitalisation and Day Care Hospitalisation.

In-Patient Hospitalisation Cover:

We will cover the following Medical Expenses incurred in respect of the Hospitalisation of the Insured Person during the Policy Period, up to the Annual Sum Insured specified in the Policy Schedule for In-Patient Care treatment:

- i. Room Rent charges
- ii. Intensive Care Unit (ICU) charges;

- iii. Qualified nurse charges;
- iv. Medical Practitioner's fees;
- v. Anaesthesia, blood, oxygen, operation theatre charges, medicines, drugs and consumables (other than those specified in the list of non-payable expenses in Annexure II);
- vi. Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and used intra-operatively during a Surgical Procedure;
- vii. Cost of investigative tests or prescribed diagnostic procedures directly related to the Injury/Illness for which the Insured Person is hospitalised.

Room Rent and Associated Medical Expenses-Conditions:

We will consider a claim under this cover subject to the following:

- i. If the Insured Person is admitted in a room category higher than the one specified in the Policy Schedule, the Insured Person shall bear a proportional share of the total Associated Medical Expenses (including surcharges or taxes) in proportion to the difference between the entitled room rent and the room rent actually incurred.
 - a. "Associated Medical Expenses" shall include room rent, nursing charges, operation theatre charges, and Medical Practitioner fees (including surgeon/anesthetist/specialist) within the same hospital, and shall exclude pharmacy and consumables, implants, medical devices and diagnostics.
 - b. Proportionate deductions shall not apply to ICU charges.
 - c. Proportionate deductions shall not apply for hospitals that do not follow differential billing or for expenses for which differential billing is not adopted based on room category.

Day Care Treatment Cover

We will cover Medical Expenses incurred in respect of the Day Care Treatment of the Insured Person during the Policy Period, up to the Annual Sum Insured specified in the Policy Schedule, provided that:

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- i. Day Care Treatment requires Hospitalisation as an inpatient for less than 24 hours in a Hospital.
- ii. We will also cover Medical Expenses for procedures including but not limited to intravenous chemotherapy, radiotherapy, hemodialysis or any other therapeutic procedure requiring specialized post-procedure medical observation or care.
- iii. We will not cover any Out-Patient treatment or diagnostic services under this benefit.
- iv. Expenses associated with automation machines for peritoneal dialysis shall not be payable.
- v. If the Insured Person is admitted in a room category higher than the one specified in the Policy Schedule, the Insured Person shall bear a proportional share of the Associated Medical Expenses as described for In-Patient Hospitalisation.
 - a. "Associated Medical Expenses" shall include room rent, nursing charges, operation theatre charges, Medical Practitioner fees (including surgeon/anesthetist/specialist) within the same hospital, and shall exclude pharmacy and consumables, implants, medical devices and diagnostics.
 - b. Proportionate deductions shall not apply to ICU charges.
 - c. Proportionate deductions shall not apply in hospitals without differential billing or for expenses where differential billing is not adopted.
- vi. Kindly refer to the list of Day Care treatments/procedures:

<https://www.icicilombard.com/health-insurance/ListOfDayCareSurgeries.pdf>

Base cover includes treatment under AYUSH, **Modern treatment procedures (Technological Advancements and treatments)**, Bariatric surgery, and treatment for mental illnesses, and subject to policy terms, conditions, and limits.

Technological Advancements and treatments (Modern treatments) refer to:

1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
2	Immunotherapy- Monoclonal Antibody to be given as injection
3	Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
4	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
5	Balloon Sinuplasty
6	Oral Chemotherapy
7	Robotic surgeries
8	Stereotactic radio Surgeries
9	Deep Brain stimulation
10	Intra vitreal injections
11	Bronchical Thermoplasty
12	IONM - (Intra Operative Neuro Monitoring)

The Company shall also cover pre-existing conditions after the waiting period as specified in the Part I of the Policy (Policy Schedule).

The Company would be liable for the add-on coverage's mentioned in Part I of the Policy only if the Insured purchases the same in terms of the policy

II. 2) Exclusions

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:

Standard Exclusions

A. 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 36 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 relevant regulatory prescriptions, then waiting period for the same would be reduced to the extent of prior coverage.

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- d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. Specific Waiting Period: /Specified Disease/ Procedure waiting period- Code-Excl02

- a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of specified number of months as mentioned in the policy schedule of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- f) List of specific diseases/procedures
Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Fistula in anus, piles, Sinusitis and related disorders

C. 30-day waiting period- Code- Excl03

- a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

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

D. Investigation & Evaluation-Code- Excl04

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

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

- a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - I. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
 - II. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

F. Obesity/ Weight Control: Code- Excl06

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

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

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- G. Change of Gender treatments: Code- Excl07**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- H. Cosmetic or plastic Surgery: Code-Excl08**
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
- I. Hazardous or Adventure sports: Code- Excl09**
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
- J. Breach of law: Code- Excl10**
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- K. Excluded Providers: Code- 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.
- L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl12**
- M. Treatments received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code- Excl13**
- N. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of Hospitalisation claim or day care procedure. Code- Excl14**
- O. Refractive Error: Code- Excl15**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
- P. 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.
- Q. Sterility and Infertility: Code- Excl17**
Expenses related to sterility and infertility. This includes:
(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization
- R. Maternity: Code Excl18**
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period
- Specific Exclusions**
1. 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.

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2. The cost of spectacles and contact lenses, hearing aids.
3. Dental treatment or surgery of any kind unless requiring Hospitalisation.
4. 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.
5. 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.
6. Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Medical Practitioner.
7. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
 - a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
 - b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
 - c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.
8. Voluntary medical termination of pregnancy
9. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
10. Any expenses incurred on Out Patient treatment
11. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively
12. Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident
13. Treatment taken outside the geographical limits of India.
14. Personal comfort, cosmetics, convenience and hygiene related items and services
15. Acupressure, acupuncture, magnetic and other therapies
16. Expenses for venereal disease or any sexually transmitted disease except HIV.
17. Screening, counselling or Treatment relating to external birth defects and external congenital illnesses or defects or anomalies
18. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
19. Any ailment/illness/injury/condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.
20. Expenses for non-medical items listed in Annexure II shall not be covered under this Policy.
21. Any expenses incurred on second opinion, oocyte and surrogacy.
22. If any Add-On has been opted for as specified in Part II.3 of the Policy, or if any risk or condition otherwise excluded under the Policy has been specifically covered upon payment of an additional premium and is stated as such under

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the Special Conditions in Part I of the Policy Schedule, then the respective exclusion shall not be applicable to the extent of such cover.

II. 3) Add-Ons/ Extensions

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

In case if there is any expense that is covered under the scope of more than one add ons opted, then the coverage limit for such expense will be equal to the sum of respective limits under such opted add ons.

Claims process & documents as mentioned under Section III "Claims administration" shall be applicable.

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 I 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
- diagnose by physician within 36 months prior to the effective date of the policy issued by insurer or its reinstatement or
- For which medical advice or treatment was recommended by, or received from, a physician within 36 months 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 Hospitalisation or lawful medical termination of pregnancy during the Policy 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 I of the Policy. Provided that-

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

- 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 up to the limit as specified in Policy schedule (Part I of the Policy).

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.

Additional claims documents required are:

- OPD Bills
- OPD prescriptions, bills
- Copy of diagnostic reports

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.

Additional claims documents required are:

- Doctor advise note for external medical aid
- Supporting diagnostic report
- Bills of expenses

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 from date of birth of such new born baby. The coverage shall be up to the limit as specified in Policy schedule (Part I of the Policy).

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

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

Additional claims documents required are:

- Relevant investigation report
- Discharge summary related to the treatment taken for critical illness.
- Legal heir or nominee details if Insured has expired due to the illness

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.

The coverage shall be up to the limit as specified in Policy schedule (Part I of the Policy).

Additional claims documents required are:

- Treating doctor's referral note stating unavailability of treatment in that location
- Travel tickets

8. Dental Expenses: The Company will reimburse the medical expenses related to non-aesthetic dental treatment incurred by the Insured during the Policy Period. Aesthetic or cosmetic dental procedures are not covered under this Add-On. Such excluded procedures include, but are not limited to, teeth whitening/bleaching, veneers, laminates, cosmetic contouring, smile design procedures, cosmetic crown lengthening, dental jewellery, orthodontic treatments undertaken primarily for aesthetic correction, and scaling or cleaning when performed solely for prophylactic or cosmetic purposes, as well as any other procedure carried out primarily for cosmetic enhancement and not medically necessary.

The coverage shall be up to the limit as specified in Policy schedule (Part I of the Policy).

9. Cover for Alternate Methods of Treatment: By way of this add-on, the Company will reimburse the Insured for medical expenses incurred on acupressure and acupuncture treatment provided that such treatment is administered by medical practitioner.

The coverage shall be up to the limit as specified in Policy schedule (Part I of the Policy).

10. Donor Expenses: The Company will indemnify the Insured for the Medical Expenses incurred in respect of an organ donor's Hospitalization for harvesting of the organ donated during the Policy Period, provided:

- a) the organ donated is for Insured's use and the claim is considered admissible by the Company.
- b) We have accepted a claim under Base Cover Section "Hospitalization" in respect of the Insured Person
- c) The organ donation confirms to the Transplantation of Human Organs Act 1994 (and its amendments from time to time) and the organ is used for the Insured Person

We shall not be liable to pay for any claim under this Cover which arises for or in connection with any of the following:

- i. Pre-hospitalization Medical Expenses or Post Hospitalization Medical Expenses of the organ donor.
- ii. Screening expenses of the organ donor.
- iii. Any other Medical Expenses as a result of harvesting from the organ donor.
- iv. Costs directly or indirectly associated with the acquisition of the donor's organ.
- v. Transplant of any organ/tissue where the transplant is experimental or investigational.
- vi. Expenses related to organ transportation or preservation.
- vii. Expenses incurred by an Insured Person as a donor.
- viii. Any other medical treatment or complication in respect of the donor, consequent to harvesting

The coverage shall be up to the limit as specified in Policy schedule (Part I of the Policy).

11. Ambulance Charges:

We will cover the expenses incurred on road ambulance services which are offered by a healthcare or ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital from the place of Accident/Illness with

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adequate emergency facilities for the provision of Emergency Care up to the limit as specified in Policy Schedule, provided that:

- i. We have accepted a claim under "Inpatient Treatment" or "Daycare Procedures/Treatment" in respect of the Insured Person for the same Accident/Illness for which road ambulance services were availed.
- ii. This Benefit includes and is limited to the cost of the transportation of the Insured Person:
 - a. To the nearest Hospital with higher medical facilities which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, and only if that transportation has been prescribed in writing by a Medical Practitioner and is for Medically Necessary Treatment.
 - b. From a Hospital to the nearest diagnostic center during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
- iii. The ambulance / service provider providing the services should be a registered provider with road traffic authority.
- iv. Any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence while transferring an Insured Person after he/she has been discharged from the Hospital are not payable under this cover.

12. Pre and Post Hospitalisation:

We will cover the Pre-Hospitalization Medical Expenses incurred in respect of the Insured Person within the specified number of days (as mentioned in Policy Schedule) immediately before the Insured Person's Admission to Hospital provided that:

- i. We have accepted the claim under "Inpatient Treatment"/Daycare Procedures/Treatment/In Patient AYUSH hospitalization" in respect of the Insured Person.

- ii. We shall not be liable to make any payment in respect of any Pre-Hospitalization Medical Expenses incurred prior to the Policy start date
- iii. Expenses incurred on nursing care at home are excluded from the scope of pre hospitalization expenses.

We will cover the Post-Hospitalization Medical Expenses incurred in respect of the Insured Person within the specified number of days (as mentioned in Policy Schedule) immediately following the Insured Person's discharge from Hospital provided that:

- i. We have accepted the claim under "Inpatient Treatment" or "Daycare Procedures/ Treatment" or "In-patient AYUSH Hospitalisation" in respect of the Insured Person.
- ii. We will also consider Post-Hospitalization Medical Expenses incurred on Physiotherapy if the treating Medical Practitioner advises such Physiotherapy in writing and the same is Medically Necessary Treatment.

These Covers will be provided on a reimbursement basis and/or cashless basis wherever applicable.

13. Health Check-Up: The company by way of this add-on, will cover the cost of health checkup 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.

The coverage shall be up to the limit as specified in Policy schedule (Part I of the Policy).

14. Disease-Wise Sub-Limit: By way of this add-on, the company can introduce sub-limits on certain diseases and procedures based on the claim experience and the requirement of the Insured. Such disease wise sublimit will be as defined in the Policy Schedule.

15. Domiciliary Hospitalisation:

We will cover the Medical Expenses incurred in respect of the Domiciliary Hospitalization of the Insured Person during the Policy Period up to the limit as specified in Policy Schedule, provided that:

The Domiciliary Hospitalization has commenced on the written advice of a medical practitioner and continues for at least 3 consecutive days in which case we will make payment under this Cover in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization. We shall not be liable to pay for any claim under this Cover which arises from or in connection with any of the following:

- a) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
- b) Arthritis, gout and rheumatism;
- c) Ailments of spine/disc
- d) Chronic nephritis and nephritic syndrome;
- e) Any liver disease;
- f) Peptic ulcer
- g) Diarrhea and all type of dysenteries, including gastroenteritis;
- h) Diabetes mellitus and insipidus;
- i) Epilepsy;
- j) Hypertension;
- k) Pyrexia of any origin

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

The coverage shall be up to the limit as specified in Policy schedule (Part I of the Policy).

This cover will be available on cashless and reimbursement basis. The availability of cashless services will be subject to network availability.

Additional claims documents required are:

- Boarding pass in case of air travel, travel tickets
- Boarding & Lodging bills
- Treating doctor's referral note

17. Convalescence Benefit: The Company will pay the Insured up to a certain amount as stated in the Policy Schedule if the Insured is hospitalized for a minimum period of consecutive days

as specified in Part I 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 year.

18. Hospital Daily Cash Allowance: The Company will pay the Insured Person a fixed Hospital Cash Benefit for each completed and admissible day of Hospitalization, subject to the minimum number of consecutive days of Hospitalization required as specified in the Policy Schedule. This benefit shall be payable for a maximum number of days as defined in the Policy Schedule, and is independent of the actual expenses incurred during Hospitalization. The benefit shall be payable only in accordance with the terms, conditions, limits and eligibility criteria stated in the Policy schedule.

Such hospitalization must be admissible under base cover "in-patient hospitalization" cover of this policy.

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 like but not limited Non-medical charges as mentioned in annexure ii, 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.

The coverage shall be up to the limit as specified in Policy schedule (Part I of the Policy).

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.

The coverage shall be up to the limit as specified in Policy schedule (Part I of the Policy).

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

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CIN: L67200MH2000PLC129408
Registered Office Address:
ICICI Lombard House, 414, P Balu Marg, Off Veer Savarkar Road,
Nr Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400 025.

Product Name: Group Health (Floater) Insurance
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Schedule (Part I of the Policy). For these services, the cover limit, if any, shall be as specified in Policy Schedule.

- a. Health Risk Assessment
- b. Health Check-up's (add-on of report evaluation service)
- c. Medical Centre Management
- d. Diet & Nutrition Plans
- e. Online Doctor Chat
- f. Health Camps - on campus
- g. Expert Sessions - on campus
- h. Second Opinions: Domestic and International markets
- i. Discounted offerings - on health and wellness services (Eg Gyms, Diagnostic Centers, Medicines, Beauty clinics etc.)
- j. Disease Management Programs: Eg Diabetes, Healthy Heart, Stress Management etc.
- k. Lifestyle/Wellness Management Programs: Eg Maternity, Quit Smoking
- l. PHR - Personalized Health Records
- m. Health Assistance Services: Opinions - Doctor on call/home - Ambulance- Health tools
- n. Health & Wellness Reminder Services
- o. Health Concierge Desk

22. Proportionate deduction waiver

If this optional cover is in force, as specified in Policy Schedule, the charges applicable on account of ratable proportion on associated medical expenses shall get covered under the Policy.

Proportionate deduction as per base policy applies when:

- room rent actually incurred is higher than the eligible room rent limit (in case of room rent limit applicability in this Policy)
- Room type for availing in patient treatment is higher than the eligible room category (in case of room category limit applicability in this policy).

With this Optional cover in force, the Insured/ Insured Person shall only be required to bear the difference between the actual room rent incurred and the eligible room rent limit and all other expenses as mentioned under proportionate deduction clause are covered by the insurance company.

All other terms and conditions of Base Policy shall remain unchanged.

This is subject to the claim admissibility in this Policy under Base cover 1- In patient hospitalization cover.

23. Change of Gender treatment expenses:

If this optional cover is in force, as specified in Policy Schedule, the expenses for surgery for gender reassignment to change characteristics of the body to those of the opposite sex will be covered.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

Female to male gender reassignment surgery includes:

- Mastectomy
- Vaginectomy
- Hysterectomy
- Oophorectomy
- Scrotoplasty
- Metoidioplasty or Phalloplasty

Male to female gender reassignment surgery includes:

- Facial feminizing surgery
- Breast augmentation
- Voice surgery
- Vaginoplasty
- Orchiectomy
- Labioplasty
- Vaginoplasty

Following expenses will be excluded:

- a) Any outpatient charges
- b) Expenses for Medical therapy like masculinizing/feminizing hormone therapy

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- c) Expenses for any psychological therapy for gender dysphoria, social transition related emotional therapy
- d) Reversal surgery post gender reassignment
- e) Any screening expenses related to gender reassignment
- f) Expenses for egg/sperm preservation

The exclusion **Change of Gender treatments: Code- Excl07** will not be applicable to the extent as defined above in respect of this cover.

24. Infertility treatment expenses:

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses incurred on assisted reproduction procedures as listed below and as specified in Policy Schedule (Part I of Policy):

- IVF (In Vitro Fertilization)
- IUI (Intrauterine Insemination)
- ICSI (Sperm Injection)
- GIFT/ZIFT

Following will be excluded:

- Expenses related to cryopreservation of eggs, sperms or embryos will not be covered
- Any expenses related to diagnosis of infertility/sub-fertility conditions
- Any expenses for screening/ any other expenses with respect to sperm donor/ oocyte donor
- Any expenses with respect to surrogacy

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

The exclusion Sterility and Infertility: Code- Excl17 will not be applicable to the extent as defined above in respect of this cover.

25. External congenital anomaly cover:

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses under Base cover section as well as under Pre and Post hospitalization optional Cover (if opted) of this Policy for treatment of the Insured member for any external congenital anomaly and associated complications.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

The exclusion- specific exclusion point 17 will not be applicable to the extent as defined above in respect of this cover.

26. Vaccination expenses:

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses for vaccination of the Insured member required medically or for preventive care. Expenses for any vaccination required for travel purposes shall also be covered.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

27. Treatment for correction of eyesight due to refractive error

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses incurred by Insured Person for medically necessary lasik eye surgery for refractive error correction, provided the refractive error is upto +/- 7.5 dioptre (or as specified in Policy schedule).

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

The exclusion **Refractive Error: Code- Excl15** will not be applicable in respect of this cover.

28. Age Related Macular Degeneration cover:

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses incurred by Insured Person for medically necessary out-patient treatment undertaken on account of age related macular degenerative disorder.

Only the procedure cost will be covered. Any expenses for diagnostic tests and/or consultations will not be covered.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

29. Bereavement cover:

If this optional cover is in force, as specified in Policy Schedule, no deduction shall be made

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on the claim (as deductible, co-pay, deduction on account of sublimit, room rent deduction or other non-payable expenses as specified in Policy Schedule) pertaining to expenses incurred for the Insured person, if the Insured person dies during hospitalization subject to admissibility of claim as per terms, conditions and exclusions herein contained in the Policy or endorsed thereon.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover. All other terms, conditions and exclusions in the Policy or endorsed thereon remains unchanged.

30. Investigation & Evaluation Expenses:

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses incurred by the insured person for any medical investigations or medical and fitness evaluation.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

The exclusion **Investigation & Evaluation-Code- Excl04** will not be applicable in respect of this cover.

31. Oocyte Donor:

If this optional cover is in force, as specified in Policy Schedule, We will cover the Medical Expenses incurred in respect of Hospitalization of the Oocyte donor appointed by the "Intending Couple"/"Intending woman" for complications arising due to oocyte retrieval during the Policy Period, up to the limit as specified in Policy Schedule against this cover.

Following conditions will apply:

- i. This cover shall be available only for a period of twelve months (12 months) after the oocyte retrieval procedure has been successful
- ii. This benefit is applicable to all or any female insured person
- iii. Any expenses incurred on delivery of the new born (either via normal delivery or caesarean section) are excluded from the scope of coverage of this optional cover
- iv. This coverage shall only be available if all the provisions as specified in The Assisted

Reproductive Technology (Regulation) Act, 2021 and Surrogacy (Regulation) Act, 2021, and all the rules and regulations made thereunder are fulfilled.

- v. The coverage shall be for in-patient hospitalization expenses only. All other terms and conditions as specified in the Base policy cover "In-patient Hospitalization" shall apply.

For the purpose of this cover:

"Oocyte" means a developing egg in the ovary

"Oocyte donor" means a person who provides oocyte with the objective of enabling an infertile intending couple or intending woman to have a child

"Oocyte retrieval" means a procedure of removing oocytes from the ovaries of a woman

"Intending couple" means a couple who have a medical indication necessitating gestational surrogacy and who intend to become parents through surrogacy;

"Intending woman" means an Indian woman who is a widow or divorcee between the age of 35 to 45 years and who intends to avail the surrogacy.

Additional claims documents required are:

- Oocyte donor eligibility certificate
- medical fitness certificate of oocyte donor
- Clinic registration proof
- Other relevant regulatory document per ART/Surrogacy Acts

32. Autism Cover:

If this Optional Cover is opted and applicable premium is paid, the following benefits shall be available on an OPD basis to Insured Persons diagnosed with Autism Spectrum Disorder (ASD), as certified by a registered medical practitioner:

a) Therapy & Support Services:

Expenses towards therapy sessions that are evidence-based and recommended by a registered medical practitioner shall be payable up to the limits specified below:

- Speech and Language Therapy
- Occupational Therapy
- Behavioural Therapy (e.g., ABA)
- Psychiatric/Psychological Consultations

b) Expenses for Autism related OPD consultations and diagnostics will also be covered up to the defined limit

Following shall not be covered under this Optional Cover

- Educational and academic interventions, special schooling, vocational training, residential/long-term custodial care, and social/rehabilitation programs.
- Non-allopathic treatment for ASD.
- Assistive devices, communication aids, sensory aids, or any equipment of external use, even if prescribed by a medical practitioner.
- Any treatment not prescribed by a registered medical practitioner.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

Additional claims documents required are:

- OPD Bills
- OPD prescriptions, bills
- Copy of diagnostic reports
- Bills & receipts for therapy sessions

33. Non-medical Expenses Cover:

If this optional cover is in force, as specified in Policy Schedule, and if a claim has been accepted under the "Inpatient Treatment" or "Daycare Procedures/Treatment" Cover, the items which are included in the List I- Items for which coverage is not available in the Policy of Annexure II, which are non – payable, to the particular claim, will become payable.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

34. Air Ambulance:

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses incurred on Air Ambulance services up to the limit as specified in Policy Schedule, subject to following:

- a) We have accepted a claim under Inpatient Treatment in respect of the Insured Person for the same Accident/Illness for which air ambulance services were availed
- b) Such ambulance services offered by a healthcare or an air ambulance service provider having license to operate as such by a competent government Authority
- c) Services are availed to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:
 - It is for a life threatening emergency health conditions of the Insured Person which requires immediate and rapid ambulance transportation from the place where the Insured Person is situated at the time of requiring Emergency Care to a hospital
 - Medically Necessary Treatment cannot be provided at the Hospital where the Insured Person is situated at the time of requiring Emergency Care.
 - The transportation is for Medically Necessary Treatment,
 - It is certified in writing by a Medical Practitioner
 - Domestic Road Ambulance services cannot be provided.

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

Following shall be excluded from the scope of this cover:

- a) Any transportation from one Hospital to another;
- b) Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital
- c) Any transportation or Air Ambulance expenses incurred outside the geographical scope of India.

35. Compassionate Visit:

If this optional cover is in force, as specified in Policy Schedule, in event of Your Hospitalization, which extends beyond a period

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of hospitalization as mentioned in the policy schedule, We will indemnify the cost of the economy class air ticket/railway ticket incurred by Your Immediate Family Member from the place of residence of the Family Member to the place of hospitalization of the Insured member and return journey.

Maximum coverage under this optional cover, in respect of any one event or all events of Hospitalization during the Policy Year will be as specified in Policy Schedule.

For the purpose of this extension, the term "Immediate Family member" would mean the Insured's Spouse, Children, Brother, Sister, Parents, and Parents-in-law.

Additional claims documents required are:

- Travel tickets
- Boarding pass in case of Air travel
- Proof of relationship of insured with travelling family member

36. Home Health care:

If this optional cover is in force, as specified in Policy Schedule, We will cover the Medical Expenses incurred by the Insured Person on Home Care Treatment up to the limit as specified against this cover in Policy Schedule provided that:

- a) The Medical Practitioner advises the Insured Person in writing to undergo treatment at home, for a health condition which otherwise would have required treatment as an in-patient
- b) 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.
- c) Daily monitoring chart including records of the treatment duly signed by the treating Medical Practitioner is maintained.
- d) The condition of the Insured Person is expected to improve in a reasonable and foreseeable period of time.
- e) Prior approval from Us has been taken.
- f) The Home Care Treatment is to be availed only on a cashless basis, subject to availability of our empaneled

Service Provider(s). However, in case of unavailability of our empaneled Service Provider in the Insured Person's location, or in case the Insured Person intends to avail the services of Non-Network Provider and claims for reimbursement, a prior approval from Us needs to be taken before availing such services.

In case the Insured Person breaches the conditions of approval or fails to take the prior written approval from Company, we are not liable to settle any claim under this section.

For the purpose of this cover, Home Care Treatment shall include:

- a) Diagnostic tests underwent at home as advised by Medical Practitioner
- b) Medicine prescribed in writing by a Medical Practitioner
- c) Consultation charges of the Medical Practitioner
- d) Nursing charges if advised by the Medical Practitioner

37. Nursing at home:

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses incurred by You, up to the limit as specified in Policy Schedule against this cover, for the medical services of a Qualified Nurse at Your residence, provided that such Qualified Nurse is certified as necessary by a Medical Practitioner and relate directly to any Illness or Injury, covered under the Policy.

The Claim under this Optional Cover will be payable only if We have admitted Our liability under "In-patient Treatment" section of the Policy.

38. Hazardous or adventure sports Cover:

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses under Base cover sections well as under Pre and Post hospitalization optional Cover (if opted) of this Policy for hospitalization of the insured person required due to injury sustained while engaging in an adventure sports activity. Such activity must have been carried out in accordance of the guidelines, recommendations

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and codes for safety as defined by respective authority/governing body.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

The exclusion **Hazardous or Adventure sports: Code- Excl 09** - will not be applicable in respect of this cover.

39. Modification of initial waiting period:

If this optional cover is in force, as specified in Policy Schedule, the initial waiting period **30-day waiting period- Code- Excl03**

- will stand modified to number of days as specified in Policy Schedule (Part I of Policy).

40. Modification of first year exclusion:

If this optional cover is in force, as specified in Policy Schedule, the specific disease waiting period as defined in this Policy as per section II- **(Specific disease/procedure waiting period- Code-Excl02)** will stand modified to the time as specified in Policy Schedule (Part I of the Policy).

41. Voluntary Co-payment:

If this optional cover is in force, as specified in Policy Schedule, the Insured Person will be liable to bear the specified Co-payment percentage of admissible claim amount for claims arising out of the diseases/conditions and/or applicable to the relationships as mentioned in the Policy Schedule

Such Co-payment will be as defined in the Policy Schedule.

42. Loss of Pay:

If this optional cover is in force, as specified in Policy Schedule, we will pay a fixed amount for defined frequency, to compensate for loss of pay arising due to inability to work on account of any covered illness or injury that renders Insured Person unable to perform duties of his/her occupation.

Following conditions will apply:

- a. Hospitalization claim for such illness/ injury should be admissible under this Policy
- b. Coverage will be for maximum amount and maximum period as specified in the policy

- c. Only the leave days without pay will be covered.

Additional claims documents required are:

- Proof of exhaustion of sick leave/ privilege leave/ any other payable leave days.

43. Top Up Cover:

If this optional cover is in force, as specified in Policy Schedule, the Insured Person will be liable to bear the specified deductible amount, for each and every hospitalization claim arising under this Policy.

This deductible will apply on the admissible claim amount.

44. Enhanced Sum Insured:

If this optional cover is in force, as specified in Policy Schedule, in case of a hospitalization claim arising due to Accident or listed Critical Illnesses wherein balance sum insured is insufficient due to any previous claims in the policy year, We will restore the sum insured upto the limit as specified in Policy schedule.

Such restored sum insured will not be available for any claims other than the Accident or listed Critical illness hospitalization claim.

All other terms and condition of the base policy shall remain unchanged unless mentioned in the policy schedule.

List of Critical illness:

1. Cancer of specified severity
2. Myocardial Infarction
3. Open chest CABG
4. Oper Heart replacement or repair of heart valves
5. Coma of specified severity
6. Stroke resulting in permanent symptoms
7. Kidney failure requiring regular dialysis
8. Major Organ/Bone marrow transplant
9. Permanent paralysis of limbs
10. Permanent paralysis of limbs
11. Permanent paralysis of limbs

45. Animal/Snake Bite Cover:

If this optional cover is in force, as specified in Policy Schedule, we will cover the expenses incurred for treatment required on account of

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Insured Person suffering any animal or snake's bite, limited to treatment taken on an OPD basis..

Such treatment must commence within 7 days from date of animal/snake biting incident.

The coverage under this section will be up to the limit as specified in Policy Schedule against this cover.

46. Voluntary Deductible(Super Top Up):

If this Optional Cover is in force, as specified in the Policy Schedule, the Insured Person shall be liable to bear the specified Deductible amount before a claim becomes payable under this Policy, for claims arising out of the diseases/conditions and/or applicable to the relationships as mentioned in the Policy Schedule.

Following conditions will apply:

- a) The Voluntary Deductible will apply on an aggregate basis for all hospitalisation expenses during the Policy Year which fall under the Basic Cover, subject to the diseases/conditions and/or relationships specified in the Policy Schedule.
- b) The Deductible will apply on an individual basis in case of an Individual Policy and on a floater basis in case of a Floater Policy.
- c) Voluntary Deductible shall apply only to the Basic Cover under the Policy, and only to the extent specified in the Policy Schedule..

47. Corporate Floater:

If this optional cover is in force, as specified in Policy Schedule, an additional sum insured as Corporate Floater amount as mentioned will be available to the Insured. This Sum insured is in addition to the basic sum insured reflected in the policy schedule per person/family.

Following conditions will apply:

- a) This sum insured will be available for those insured person, who have already exhausted their sum insured limit
- b) The Corporate Buffer will not be available for any lump sum benefit based covers and for Maternity claims.
- c) All other terms and conditions under the policy will apply.

48. Reinstatement of Corporate Floater Cover

If this Optional Cover is opted and premium paid, the Corporate Floater Sum Insured shall be automatically reinstated once in a Policy Year upon its exhaustion due to admissible claims, up to the limit and eligibility (relationship, illness type etc.) criteria as specified in the Policy Schedule.

One of the following two conditions along with other eligibility criteria shall be applicable as specified in Part 1 of Policy:

- a) The reinstated Sum Insured shall be available for all future claims, including for the same Insured Person, except for claims arising from the same illness or condition for which a claim has already been paid in that Policy Year.

OR

- b) The reinstated Sum Insured shall be available for all future claims, including for the same Insured Person, for all illness or conditions

All other terms and conditions of the base Policy remain unaltered.

49. Reinstatement of Sum Insured:

If this Optional Cover is opted and premium paid, the Sum Insured under the Policy shall be automatically reinstated to the extent of the claim amount exhausted, immediately upon partial or complete utilization of the Sum Insured during a Policy Year, subject to the maximum limit and eligibility (relationship, illness type etc.) criteria as specified in the Policy Schedule.

One of the following two conditions along with other eligibility criteria shall be applicable as specified in Part 1 of Policy:

- c) The reinstated Sum Insured shall be available for all future claims, including for the same Insured Person, except for claims arising from the same illness or condition for which a claim has already been paid in that Policy Year.

OR

- d) The reinstated Sum Insured shall be available for all future claims, including for the same Insured Person, for all illness or conditions

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Such reinstatement shall not carry forward to subsequent Policy Years and shall not apply to any claim falling under exclusions of the Policy. All other terms, conditions, sub-limits, and exclusions of the base Policy shall apply.

50. Sleep Apnoea Cover

If this Optional Cover is opted and premium paid, the Company shall indemnify expenses incurred for the Out patient medical management of sleep apnea in respect of an Insured Person, up to the limit specified in the Policy Schedule. Coverage shall include:

- Diagnostic sleep study (polysomnography or equivalent) as medically prescribed,
- Specialist consultations with a pulmonologist, ENT, or sleep medicine expert, and
- Medically prescribed CPAP/BiPAP device, subject to a one-time benefit during the Policy Period.

This optional cover shall not cover expenses towards consumables, accessories, maintenance, or replacement of devices, or any non-prescribed diagnostic or wellness screening. All other terms, conditions, and exclusions of the base Policy remain unaltered.

Additional claims documents required are:

- OPD & device prescriptions, bills
- Copy of diagnostic reports

51. Attendant Charges Cover

If this Optional Cover is opted and premium paid, the Company shall indemnify expenses incurred towards accommodation of one attendant staying with the Insured Person during the period of hospitalization, up to the limit specified in the Policy Schedule. Such expenses shall be payable only when the hospitalization is admissible under the Policy and the attendant is an immediate family member. This optional cover shall not cover food, personal expenses, or any other incidental charges of the attendant. All other terms, conditions, and exclusions of the base Policy remain unaltered.

For the purpose of this extension, the term "Immediate Family member" would mean the Insured's Spouse, Children, Brother, Sister, Parents, and Parents-in-law.

Additional claims documents required are:

- Accommodation bill, receipts
- Proof of relationship of Insured with attendant person

52. Advance Cancer Treatment Cover

If this optional cover is opted and premium paid, and the Insured Person is diagnosed and hospitalized due to Cancer on the advice of a Medical Practitioner or Specialist Consultant during the Cover Period, the Company shall indemnify the expenses incurred towards medically necessary treatment of Cancer, up to the Sum Insured specified in the Policy Schedule against this cover. The Sum Insured under this optional cover shall be in addition to and over and above the Sum Insured available under the Base Cover. All other terms, conditions, and exclusions of the Policy remain unaltered.

53. Miscellaneous Buffer:

If this Optional Cover is in force, as specified in the Policy Schedule, a Miscellaneous Buffer amount shall be made available to the Policyholder, over and above the Basic Sum Insured and any Corporate Buffer, as applicable. The Policyholder may, at its discretion and subject to the available buffer limit, apply this amount towards:

- a) Covering Co-payment or Deductible amounts applicable under the Policy for any Insured Person(s), and/or
- b) Settling expenses towards Non-payable items as defined under the Policy, and/or

This Miscellaneous Buffer shall not be utilized towards any lump sum benefit-based covers or for Maternity claims. All other terms and conditions of the Policy shall remain unaltered.

54. Second Opinion

If this optional Cover is opted and premium paid, the Company shall reimburse the cost of obtaining a second medical opinion from a duly qualified medical practitioner or empaneled specialist in India, in respect of a diagnosed illness or planned surgical procedure of the

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Insured Person, up to the limit specified in the Policy Schedule. The Insured Person may avail this benefit on a cashless basis through the Company's network where available, or on a reimbursement basis upon submission of valid consultation documents. This benefit is limited to advisory consultation only and does not include diagnostic tests, treatment, hospitalization, or any subsequent medical expenses. The decision to act upon the second opinion rests solely with the Insured Person. All other terms, conditions, and exclusions of the base Policy remain unaltered.

55. Two hour Hospitalization:

- a) If this optional Cover is opted, We shall cover the Medical Expenses incurred in respect of Hospitalization of the Insured Person for 2 hours or more (minimum 24 hours for AYUSH treatment in a AYUSH Hospital) during the Policy Period, up to the Base Sum Insured specified in the Policy Schedule, provided: Expenses associated with automation machine for peritoneal dialysis shall not be payable
- b) This benefit does not include expenses associated with the Hospitalization of the Insured Person in case there was no active line of treatment and only diagnostic or investigative procedures were performed (e.g., MRI, CT Scan, Endoscopy, Colonoscopy, etc.)
- c) Treatments or procedures covered under this add on and "Day care procedures/ Treatment" are separate.
- d) If this add on is opted by you, treatments like IV Fluid Therapy for Severe Dehydration, Platelet Transfusions, Iron Infusions, Ligament Sprain & Immobilization etc. will be covered in addition to the treatments covered under In-patient Hospitalization. Please note the above mentioned treatments are indicative only
- e) All other terms, conditions, sub-limits, exclusions shall remain unchanged.

56. In-patient Hospitalization for Surrogacy:

If this optional cover is opted, and if one or both intending parents are Insured under this Policy, We shall cover the Medical Expenses incurred

in respect of In patient Hospitalization of the Surrogate mother appointed by the "Intending Couple"/"Intending woman" for complications arising out of pregnancy and post-partum delivery complications during the Policy Period, up to a maximum limit as defined in Part 1 of this Policy and subject to the following conditions:

- a) Any expenses incurred on delivery of the new born (either via normal delivery or caesarean section) are excluded from the scope of this optional cover
- b) This coverage shall only be available if all the provisions as specified in The Surrogacy Regulation Act (2021), and all the rules and regulations made thereunder are fulfilled
- c) The terms and conditions of Base in-patient Hospitalization cover shall apply

For the purpose of this cover:

"Intending couple" means a couple who have a medical indication necessitating gestational surrogacy and who intend to become parents through surrogacy;

"Intending woman" means an Indian woman who is a widow or divorcee between the age of 35 to 45 years and who intends to avail the surrogacy;

"Surrogacy" means a practice whereby one woman bears and gives birth to a child for an intending couple with the intention of handing over such child to the intending couple after the birth.

"Surrogacy clinic" means surrogacy clinic, centre or laboratory, conducting assisted reproductive technology services, invitro fertilisation services, genetic counselling centre, genetic laboratory, Assisted Reproductive Technology Banks conducting surrogacy procedure or any clinical establishment, by whatsoever name called, conducting surrogacy procedures in any form.

"Surrogate mother" means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the conditions as specified in the surrogacy (regulation) act, 2021

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“Surrogacy procedures” means all gynaecological, obstetrical or medical procedures, techniques, tests, practices or services involving handling of human gametes and human embryo in surrogacy

Additional claims documents required are:

- Surrogacy medical indication certificate
- Surrogate eligibility certificate
- Intending couple eligibility certificate
- Surrogacy agreement

57. PPN Network Advantage:

If this optional cover is opted, the treatment as applicable under Base coverage if taken in a hospital/ clinic/ AYUSH centre which is not a part of Our “Preferred Provider Network” List, then an additional Co-payment as specified in Part 1 of this Policy shall be applicable.

This list of Preferred Provider Network (PPN) is available on Our website www.icicilombard.com and on Our Mobile Application.

No Additional co-payment shall be applied if the treatment is taken in a hospital/clinic/centre that is part of this PPN list.

Discount will be applied if this add on is opted.

58. Accident care:

If this optional cover is opted, then we shall provide additional sum insured for expenses under Base cover for claims arising out of accidents. Such accident event should have happened within the Policy period. This sum insured limit is over and above the Sum insured as defined for Base cover. All the terms and conditions of Base cover shall remain unchanged.

III) 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, Policy Number, Name of the insured, your relationship with Policy Holder, nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. Request for pre- authorisation should be received at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation. To avail of Cashless Hospitalisation facility, 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 Hospitalisation 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 Hospitalisation or within 24 hours post admission in case of emergency for prompt settlement of claims.
- (ii) The insured shall give
- (iii) 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:

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Product Name: Group Health (Floater) Insurance

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- a) Policy number;
 - b) Name of the insured;
 - c) Relationship of the proposer with the Policyholder;
 - d) Nature of Illness or Injury;
 - e) Name and address of the attending Medical Practitioner and the Hospital;
 - f) Any other information that may be relevant to the Illness/ Injury/ Hospitalisation
- (iv) 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, collected from hospital at the time of discharge along with the claim form. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.
- c) The claim will be processed within 15 days of receipt of claim along with claim form and document

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 I 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, Anesthetics, Consultants and Specialist
- IV. Anesthesia, 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
- III. Original bills from Chemists supported by proper prescription
- IV. Original investigation test reports and payment receipts
- V. Indoor case papers
- VI. Medical Practitioner's referral letter advising Hospitalisation in non-Accident cases
- VII. 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.

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- IX. The relevant documents to can be sent to: ICICI Lombard Health Care, 1st, 4th (Half), 5th and 6th floors, Varun Towers- II, Opp. Hyderabad Publicschool, Begumpet, Hyderabad, District Hyderabad, Telangana Pin code -500016

Turn Around Time(TAT) for claim settlements-

TAT for Pre-Authorization of Cashless Facility is within 1 hours from the receipt of last necessary document from Hospital.

TAT for final cashless final bill authorization is within 3 Hours from the receipt of last necessary document from hospital.

Claim falling in two Policy periods-

If the claim event falls within two Policy periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy periods, including the Deductibles (if applicable) for each Policy Period. This is subject to renewal of this Group policy with Us. However, in case such claim is related to any disease/procedure for which sublimit is applicable, maximum claim payable shall remain up to the sublimit defined in the Policy.

- 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.

I. Limitation Period

In no case whatsoever shall the Company be liable for any claim under

the Policy, if the requirement of Clause V (i) (b) (3) (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.

II. 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 authorized 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.

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- d) All medical/surgical treatment under this policy shall have to be taken in India (unless agreed upon in Part I 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.

III. 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)
- b) The policy shall ordinarily be renewable except on grounds of established 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, , may revise or modify the terms of the policy including the premium rates.

Part III of Policy

Standard terms and conditions applicable to group benefits

1. 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, mis-description 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.

2. 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.

3. 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.

4. 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.

5. 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.

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6. Overriding effect of Part II of the Policy

The terms and conditions contained herein and in Part II 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 II 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 II 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 II of the Policy with Part I of the Policy then terms and conditions contained in Part I of the Policy will prevail over Part II of the Policy.

7. 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 centers, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, 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.

8. 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 an insurance Policy: —

- (a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- (b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- (c) any other act fitted to deceive; and
- (d) any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of established 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.

9. Cancellation

The insured may cancel the policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall

- a. refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.
- b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall

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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, established fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or established fraud.

10. Multiple Policies

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 treated as the primary Insurer and 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.

11. Premium Payment in installments:

If the insured person has opted for Payment of Premium on an installment basis as per regulatory prescription and mentioned in Your Policy Schedule/certificate of insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy):

- I. The grace period for payment of premium for all types of insurance policies shall be fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during grace period, if the premium is paid in installments during the policy period.
- II. The insured person will get the accrued continuity benefit in respect of the 'Waiting Periods', 'Specified Disease/ Procedure Waiting Period/ Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period
- III. No interest will be charged If the installment premium is not paid on due date.

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

V. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

VI. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

12. Portability:

- a. The insured has the choice to port his / her policies from one Insurer to another. An Insured desirous of porting his/her policy to another insurer shall apply to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal.
- b. The insured is entitled to transfer the credits gained to the extent of the sum insured and the benefits available in the previous policy, subject to the underwriting policy of the Company
- c. The Company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines.
- d. This benefit is not applicable for enhanced sum insured.

13. Migration:

In case of migration of indemnity based health insurance policy (except Personal Accident and Travel Policies) with the same Insurer, the insured can transfer the credits gained to the extent of the Sum Insured and benefits available in the previous policy to the migrated policy. The Company may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

Turn Around Time(TAT) for claim settlements- TAT for Pre-Authorization of Cashless Facility is within 1 hours from the receipt of last necessary document from Hospital.

TAT for final cashless final bill authorization is within 3 Hours from the receipt of last necessary document from hospital.

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14. 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

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

16. Cause of Action/ Currency for payment

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

17. 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 exclusive jurisdiction of the High Court of Mumbai 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.

18. Withdrawal of Policy

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

19. Moratorium

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim

shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

20. Arbitration clause

If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to 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 and 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 arbitrations 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 award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained

21. Renewal notice

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

ICICI Lombard General Insurance Company Limited

IRDA Reg. No. 115
Mailing Address:
601 / 602, 6th Floor, Interface Building No. 16,
New Link Road, Malad (West),
Mumbai - 400 064.

UIN: ICILGP26055V072526
CIN: L67200MH2000PLC129408
Registered Office Address:
ICICI Lombard House, 414, P Balu Marg, Off Veer Savarkar Road,
Nr Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400 025.

Product Name: Group Health (Floater) Insurance
Toll free No. : 1800 2666
Alternate No.: 86552 22666 (Chargeable)
Website : www.icicilombard.com
E-mail : customersupport@icicilombard.com

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

The policy may be renewed as per regulatory prescriptions 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.

22. 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 I 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.

23. 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.

24. Redressal of Grievance:

In case of any grievance the insured person may contact the Company through

Website: www.icicilombard.com

Toll free: 1800 2666

Email: customersupport@icicilombard.com

Address: ICICI Lombard General Insurance Co. Ltd. Ground floor- Interface 11, Sixth floor- Interface 16, Office no 601 & 602, New Linking Road, Malad (West), Mumbai – 400064.

There is an interactive voice response (IVR) facility for senior citizens' grievance redressal for easy and faster resolution

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, insured person may contact the grievance officer at the details provided in the below link:

<https://www.icicilombard.com/grievanceredressal.com>

If Insured person is not satisfied with the redressal of grievance, the insured person may also approach Insurance Regulatory and Development Authority (IRDA) through the Bima Bharosa Portal - <https://bimabharosa.irdai.gov.in/> or IRDA Grievance Call Centre (IGCC) at their toll free no. 1800 4254 732 / 155255

Insured may also approach Insurance Ombudsman, subject to vested jurisdiction, for the redressal of grievance. Details of Insurance Ombudsman offices are available at IRDA website: www.irdai.gov.in, or on the Company's website at www.icicilombard.com.

You can also approach the Insurance Ombudsman, depending on the nature of grievance and the financial implication, if any. Information about Insurance Ombudsmen, their jurisdiction and powers is available on the website of the Insurance Regulatory and Development Authority of India (IRDAI) at www.irdai.gov.in, or of the General Insurance Council at www.generalinsurancecouncil.org.in, the Consumer Education Website of the IRDAI at <http://www.policyholder.gov.in>, or from any of Our Offices.

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Website : www.icicilombard.com

E-mail : customersupport@icicilombard.com

The details of Insurance Ombudsman are available below:

Name of office of Insurance Ombudsman	Territorial Area of Jurisdiction	Name of office of Insurance Ombudsman	Territorial Area of Jurisdiction
AHMEDABAD 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.	CHANDIGARH Mr. Atul Jerath Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	CHANDIGARH Mr. Atul Jerath Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.	CHENNAI 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, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).
BHOPAL Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh.	DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.		

Name of office of Insurance Ombudsman	Territorial Area of Jurisdiction
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, “Moin Court”, Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja’s College Ground, M.G. Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe- a part of Union Territory of Puducherry.

Name of office of Insurance Ombudsman	Territorial Area of Jurisdiction
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th 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.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareilly, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Mahara-jgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Bal-lia, Sidharathnagar.

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E-mail : customersupport@icicilombard.com

Name of office of Insurance Ombudsman	Territorial Area of Jurisdiction	Name of office of Insurance Ombudsman	Territorial Area of Jurisdiction
MUMBAI 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.	PATNA Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Ut-tarakhand and the following Districts of Ut-tar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Bulandshahr, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kan-shiramnagar, Saharanpur.	PUNE 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.

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Annexure II

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

Sr. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES

Sr. No.	Item
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLEY COVER
66	UROMETER, URINE JUG
67	AMBULANCE

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Sr. No.	Item
68	VASOFIX SAFETY

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

Sr. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/ INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESH- NERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX I MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/VARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMIN- ISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES

Sr. No.	Item
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

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

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

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