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ICICI Lombard
Nibhaye Vaade

Zyaada ka Vaada

Now Super top-up your
Health Insurance cover with

Health Booster

ICICI Lombard
Nibhaye Vaade

INTRODUCTION

Health is the most important asset to an individual. Security of health brings mental and physical relaxation thereby helping us maintain an optimum quality of life. It not only comes with the security of financial coverage for medical requirements but also tax benefits.

Now your insurance cover has just got bigger with Health Booster. A Super top-up Health Insurance cover that takes care of excess payment that may arise due to the amount paid for illness over and above your existing Health Insurance policy. What's more, even if you don't have any existing Health Insurance policy, you can still opt for the Super top-up cover and get the Sum Insured beyond the deductible chosen.

FEATURES OF THE POLICY

- **Wide range of annual Sum Insured (5 lakhs to 50 lakhs) and flexible deductible options (3,4,5 lakhs)** to suit your needs
- Individual and Floater cover for the family
- **Lifetime renewability**
- **Policy Period:** Available in one, two or three year policy period options(10%, 12.5% discount on 2yrs, 3yrs policy)
- **Floater option:** Covering up to 2 Adults and 3 Children in a single policy
- **Eligibility:** This policy can be offered to an individual with minimum age of 6 years under an individual policy. However children aged 3 months to 5 years can be insured under a floater plan only. No restriction on maximum entry age
- **Pre-Exisiting Diseases:** All the declared and accepted Pre-Exisiting diseases will be covered after 2 years of continuous coverage since inception of the policy.
- **Tax Benefit:** Avail tax saving benefit on premium paid under health section of this policy, as per section 80D of Income Tax act,1961 and amendments made thereafter.
- **Cashless Hospitalisation:** Avail cashless hospitalisation at any of our network providers/hospitals. List of these providers/hospitals is available on our website.
- **Pre-policy medical checkup:** No medical tests will be required for insurance cover below the age of 46 years and upto Sum Insured of ₹10 Lakhs
- **Free look period:** Policy can be cancelled by giving a written notice within 15 days of receipt.

BENEFITS ^

- **In-patient treatment:** Medical expenses for hospitalisation as an in-patient for a minimum period of 24 consecutive hours
- **Day Care Treatments:** All Day care medical expenses incurred by you while undergoing Specified Day Care Treatment (as mentioned in the Day Care Surgeries list), which require less than 24 hours hospitalisation.
- **In patient AYUSH treatment:** Expenses for Ayurveda, Unani, Siddha and Homeopathy (AYUSH) treatment only when the treatment has been undergone in a Government Hospital or in any Institute recognised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health upto Sum Insured.
- **Domiciliary Hospitalisation Cover:** Medical expenses incurred by you during your domiciliary hospitalisation upto Sum Insured.
- **Donor Expenses:** Hospitalisation expenses, as incurred by the organ donor for undergoing organ transplant surgery for your use, are covered upto Sum Insured.
- **Pre & Post Hospitalisation:** Medical expenses incurred by you, immediately up to 60 days before and up to 90 days after your hospitalisation covered upto Sum Insured.
- **Domestic Road Emergency Ambulance Cover:** The reasonable and actual expenses up to 1% of your Sum Insured, maximum up to ₹5,000, incurred by you on availing an ambulance services offered by a Hospital/ambulance service provider in an emergency condition.
- **Reset Benefit:** For plans with deductible of ₹3 lakhs and above, we shall reset up to 100% of the Sum Insured once in a policy year in case the Sum Insured including accrued Additional Sum Insured (if any) is insufficient due to previous claims in that policy year.
- **Relationships covered:** Self, spouse, dependent children, brother, sister, dependent parent, grandparents, grandchildren, mother-in-law, father-in-law, son-in-law, daughter-in-law, dependent brother-in-law and dependent sister-in-law.
- **Wellness Program:** Wellness program intends to promote, incentivize and reward you for your healthy behavior through various wellness services. All the wellness activities as mentioned below make you earn wellness points which will be tracked by us.

DISCLAIMER

^ For detailed information and terms & conditions, kindly read Product brochure and Policy Wordings

WHAT IS DEDUCTIBLE?

SUPER TOP-UP PLAN:

- Deductible will apply on aggregate basis for all hospitalisation expenses during the policy year.
- The deductible will apply on individual basis in case of individual policy and on floater basis in case of a floater policy.
- Claim amount under optional covers will not be considered under deductible.

CLAIM SERVICE GUARANTEE

- **For Reimbursement Claims:** We shall make the payment of admissible claim (as per terms & conditions of Policy) OR communicate non admissibility of the claim within 14 days after you submit the complete set of documents & information in respect of the claims. In case we fail to make the payment of admissible claims or to communicate non admissibility of claim within the specified time period, we shall pay 1% interest over and above the rate defined as per IRDA (Protection of Policy holder's interest) Regulation 2002.
- **For Cashless Claims:** If you notify pre-authorization request for cashless facility through any of our empanelled network hospitals along with complete set of documents & information, we shall respond within 4 hours of the actual receipt of such pre-authorization request with

APPROVAL or **REJECTION** or **QUERY SEEKING FURTHER INFORMATION**

In case the request is for enhancement, i.e. request for increase in the amount already authorized, we shall respond to it within 3 hours.

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

WHAT IS RESET BENEFIT?

- For plans with deductible ₹3 lakhs and above, we shall reset up to 100% of the Sum Insured once in a policy year in case the Sum Insured including accrued Additional Sum Insured (if any) is insufficient due to previous claims insured in that policy year, provided that:
  - The reset amount can only be used for all future claims within the same policy year, not related to the illness/disease/injury for which a claim has been paid in that policy year for the same person
  - Reset will not trigger for the first claim
  - For individual policies, reset Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis
  - Any unutilized reset Sum Insured will not be carried forward to subsequent policy year

RESET BENEFIT FEATURE EXAMPLE:

Reset benefit of Sum Insured (Available once in a Policy Year)

Illustration: Let's understand how reset benefit will be applicable for different scenarios.

		SCENARIO 1	SCENARIO 2
Sum Insured	Basic Sum Insured	₹ 8,00,000	₹ 8,00,000
	Additional Sum Insured (if any)	-	₹1,60,000 (For 2 claim free years)
	Total Sum Insured	₹ 8,00,000	₹ 9,60,000
1st Claim	Reason	Cancer	Accident
	First claim amount	₹ 3,00,000	₹ 5,00,000
	Balance Sum Insured	₹ 5,00,000	₹ 4,60,000
2nd Claim	Reason	Heart Attack	Organ Transplant
	Second claim amount	₹ 3,00,000	₹ 9,60,000
	Available Sum Insured	₹ 5,00,000	₹ 4,60,000

		SCENARIO 1	SCENARIO 2
	Will the Reset trigger?	No Why - Since the available Sum Insured is enough to pay for the claim, reset will not trigger	Why - The available Sum Insured is not enough to pay the claim and the claim is for unrelated disease.The payable claimed amount is ₹ 9,60,000 (Including Additional Sum Insured which is ₹ 1,60,000)
	Balance Sum Insured	₹ 2,00,000	₹ 3,00,000 (From Reset)
3rd Claim	Reason	Accident	NA
	Third claim amount	₹ 10,00,000	
	Available Sum Insured	₹ 2,00,000	
	Will the Reset trigger?	Yes Reset to ₹ 800,000 Why - The available Sum Insured is not enough to pay the claim	
	Balance Sum Insured	₹ 2,00,000 (From Reset)	
		Available from Reset Benefit for all future claims with different illness)	
4thClaim	Reason	Cancer	
	Fourth claim amount	₹ 4,00,000	
	Will the Reset trigger?	No, Why – Reset will not trigger for same illness	

ADDED ADVANTAGES

- **Additional Sum Insured -** You will be entitled for an Additional Sum Insured as under, for every claim-free policy year under the policy on its renewal.

Tenure	Additional Sum Insured as a percentage of sum insured
For each completed and continuous policy year subject to a maximum of 50%	10%

However, in the event of a claim during any subsequent policy period, the accrued Additional Sum Insured will be reduced by 10% of the Sum Insured at the time of renewal.

- **Complimentary Health Check-up:** We shall provide complimentary health check-up coupons to the insured for every policy year, on issuance or upon renewal of the policy, subject to a maximum of 2 coupons per year for floater policies

OPTIONAL COVERS

Benefit under all the optional covers will be provided even if the hospitalisation claim is below deductible. However other terms and conditions like waiting period and exclusions will be applicable.

Benefits under all these optional covers are applicable on per member basis. These covers are optional and are available only on payment of additional premium.

OPTIONAL COVER 1

OPTIONAL COVER 1	SILVER	GOLD
	SUM INSURED (₹)	
Hospital Daily Cash (maximum 30 days) min 3 days	30,000 (1,000 per day)	90,000 (3,000 per day)
Convalescence Benefit	10,000	20,000

- **Hospital Daily Cash –** We shall pay a fixed amount of ₹1,000/ 3,000 (as per Silver or Gold option) for each and every completed day of hospitalisation, if such hospitalisation is at least for a minimum of 3 consecutive days and subject to a maximum of 30 consecutive days per policy year.
- **Convalescence Benefit –** In the event that the insured hospitalised is for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the policy, we shall pay a benefit amount equal to the sum insured specified against this optional benefit.

OPTIONAL COVER 2

OPTIONAL COVER 2	SILVER	GOLD
	SUM INSURED (₹)	
Personal Accident cover	10,00,000	15,00,000
Temporary Total Disablement (TTD) Rehabilitation cover (max 10 weeks)	50,000 (5,000 per week)	100,000 (10,000 per week)
Repatriation of Remains	Up to 50,000	Up to 1,00,000

- **Personal Accident Cover –** We will pay you/nominee a benefit amount equal to the Sum Insured specified against this optional benefit, upon the unfortunate event of Accidental Death or Permanent Total Disablement resulting from an accident.
- **Temporary Total Disablement (TTD) Rehabilitation Cover** – We shall pay you a benefit amount as stated in policy schedule on a weekly basis up to a maximum of 10 weeks for rehabilitation upon the unfortunate event of Temporary Total Disablement resulting from an Accident.
  - **Rehabilitation** is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible. Only the rehabilitation services provided by a certified practitioner will be considered.
- **Repatriation of Remains** – We shall reimburse to the nominee/legal heir of the insured, upto the Sum Insured as specified against this optional cover, the costs of transporting the remains of the insured back to the place of residence or, up to an equivalent amount, for burial or cremation in the city where death has occurred.

OPTIONAL COVER 3

OPTIONAL COVER 3	SILVER	GOLD
	SUM INSURED (₹)	
Critical Illness cover	5,00,000	10,00,000

- **Critical Illness Cover** – We shall pay a lump-sum amount upto the extent of cover opted on your first diagnosis of such Critical Illnesses.

  No claim will be payable under this cover if you are first diagnosed as suffering from any of these Critical Illnesses within 90 days of the start date of the first policy with us. This cover can be availed only once during your lifetime.

  Once a claim becomes payable under any of the Critical Illness covered, the cover would terminate and this cover will not be offered on any subsequent renewal of policy.

ADDED ADVANTAGES

Wellness program intends to promote, incentivize and reward the customer for their healthy behaviour through various wellness services. The customers can earn wellness points through various wellness activities which they can later redeem as per redemption terms & conditions. The customers will also be entitled for various services like medical practitioners' advice, dietician & nutrition counselling, medical concierge services, etc

HOW TO EARN WELLNESS POINTS?

To earn wellness points, please follow the steps below:-

- **Collect relevant reports/receipts & bills** for the specific category of activity/activities under which you want to earn your wellness points.
- **Send the required documents** along with dully filled submission form to ICICI Lombard Health Care, ICICI Bank tower, Plot No. 12, Financial District, Nanakramguda, Gachibowli, Hyderabad-5000032.
- We shall acknowledge the receipt of the documents and keep you updated regarding the status of your points accumulation request.
- To track your earned points, Call our toll free no. 1800 2666 or write to us at ihealthcare@icicilombard.com. You can also access your earned points by simply logging on to www.icicilombard.com-> claims & wellness management.
- Your total wellness points earned will be sent to your registered email-id once in every 3 months.
- **Each wellness point is equivalent to 0.25 INR.**

You can redeem your earned wellness points against reimbursement of medical expenses like consultation charges, medicine & drugs, diagnostic expenses, dental expenses, wellness & preventive care and other miscellaneous charges not covered under any medical insurance.

To redeem your wellness points under OPD, follow the below steps:-

- Collect all original bills of medicines/consultations, expenses of which you would like to claim against the points accumulated.
- Send the original bills/invoices, test reports, if any & also the duly completed redemption form to ICICI Lombard Health Care, ICICI Bank tower, Plot No. 12, Financial District, Nanakramguda, Gachibowli, Hyderabad-5000032.
- We shall acknowledge the receipt of the documents and keep you updated regarding the status of your points accumulation request.
- To track the status yourself, Call our toll free no. 1800 2666 or simply loging on to www.icicilombard.com -> Claims & Wellness management->Track your claims. Enter your Claim no. or AL no. & Press Search button to know the status of your claim.
- You can also write to us at ihealthcare@icicilombard.com to put up an enquiry against status of your redemption request.

Maximum points that can be earned under each category are as mentioned in the Table1. The customer can earn maximum 5,000 wellness points per insured, and maximum 10,000 wellness points per floater policy for categories 9, 10 & 11 combined altogether.

ACTIVITY	POINTS ACCUMULATED PER INSURED	POINTS ACCUMULATED PER FLOATER POLICY
1. HRA Health Risk Assessment	250	500
2. Medical Risk Assessment*	1000	2000
3. Heart related screening tests (under PRA**) Above 45 years	500	500
4. HbA1c / Complete lipid profile (under PRA) Any age	500	500
5. PAP Smear (under PRA) Females above age 45	500	500
6. Mammogram (under PRA) Females above age 45	500	500
7. Prostate Specific Antigen (PSA) (under PRA)Males above age 45	500	500
8. Any other test as suggested by our empanelled Medical expert (under PRA)	500	500
9. Gym/ Yoga membership for 1 year	2500	2500
10. Participation in professional sporting events like Marathon/ Cyclothon/Swimathon, etc.	2500	2500
11. Participation in any other health & fitness activity/ event organized by us	2500	2500
12. Quit smoking- based on Self declaration	100	100
13. Share your fitness success story	100	100
14. On winning any health quiz organized by us	100	100

***Under MRA from 2nd year onwards, if tests are within normal limits, additional 1000/2000 points will be awarded**

****PRA stands for Preventive Risk Assessment**

Note:- For HRA & MRA, the customer doesn't need to submit any form or documents as the points earned under those categories will automatically be updated against the policy.

EXCLUSION

DEDUCTIBLE

We shall not be liable for the deductible amount as specifically defined in Part I of Policy Schedule. We are not liable for any payment unless the hospitalisation medical expenses exceed the deductible. No deductible shall be applicable for optional covers.

CO-PAYMENT

We are not liable to pay twenty percent (20%) of admissible claim amount above the deductible applicable under the policy, for insured above 60 years of age. This does not apply if insured is 60 years of age or below. However, this condition will not be applicable if you were aged 45 years or below at the time of buying this policy first time and have renewed it continuously after that.
No co- pay will be applicable for optional covers, if any.

FIRST 30 DAYS WAITING PERIOD

Any diseases contracted and declared during first 30 days of period of Insurance start date except those arising out of accidents. This exclusion shall cease to apply from first renewal of the policy with us. This will not be applicable if the Insured person(s) was insured continuously and without interruption for at least 1 year under any other Health Insurance plan with an Indian non-life insurer as per guidelines on portability issued by the Insurance regulator.

PRE -EXISTING DISEASE WAITING PERIOD

Any pre-existing condition(s) declared by you and accepted by us, shall not be covered until 24 months of your continuous coverage, since inception of this policy.

FIRST 2 YEAR EXCLUSIONS (SPECIFIC WAITING PERIOD)

For medical diseases/ conditions and treatment/procedure mentioned in specific waiting period table*, a waiting period of 2 years will be applicable unless required due to occurrence of cancer.

PERMANENT EXCLUSION

Injury or diseases directly or indirectly attributable to war, invasion, act of foreign enemy, war like operations, cosmetics, aesthetics treatment unless arising out of accident. Cost of spectacles, contact lenses, and hearing aids (LASIK), dental treatment or surgery of any kind unless requiring hospitalisation etc.

* For detailed list of specific and permanent exclusions refer to policy wordings .

HOW TO MAKE A CLAIM

FOR REIMBURSEMENT

TREATMENT/ PROCEDURE	YOU SHOULD INFORM US
Any planned hospitalisation for which claim can be made	At least 48 hours prior to admission in hospital
Any emergency hospitalisation for which claim can be made	Within 24 hours of hospitalisation
For all other cases/benefits	Within 7 days of completion of such treatment or procedure

For Reimbursement Settlement : Individuals are requested to inform by calling us on our toll free no. or sending an email to us at ihealthcare@icicilombard.com by mentioning the below particulars

- Policy number
- Your Name
- Your relationship with the Policyholder
- Nature of Illness
- Name and address of the attending Medical Practitioner and the Hospital
- Any other information that may be relevant to the Illness/ Hospitalisation

FOR CASHLESS SERVICES

TREATMENT/ PROCEDURE	TAKEN AT	WE MUST BE NOTIFIED ALONG WITH FULL PARTICULARS
Any planned treatment/ hospitalisation	Network hospital	At least 48 hours before the treatment/ hospitalisation
Any emergency treatment/ hospitalisation	Network hospital	Within 24 hours of the treatment/ hospitalisation

For Cashless Settlement: Cashless treatment is only available at a network provider (List of network provider is available at our website. Prior to taking treatment and/ or incurring medical expenses at a network provider, you must contact our in-house claim processing team accompanied with

- Policy number
- Your Name
- Your relationship with the Policyholder
- Nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Hospitalisation.
- You must request pre-authorisation at least 48 hours before a planned hospitalisation and in case of an emergency situation, within 24 hours of hospitalisation.

CLAIM DOCUMENTS

- Duly completed claim form signed by you and the Medical Practitioner
- Original bills, receipts and discharge certificate/ card from the hospital/ Medical Practitioner
- Original bills from chemists supported by proper prescription.
- Original investigation test reports and payment receipts.
- Medical Practitioner's referral letter advising hospitalisation in Non-Accident cases.
- Any other document as required by ICICI Lombard Health Care to investigate the claim or our obligation to make payment for it the same.

WHY ICICI LOMBARD?

We, at ICICI Lombard, ensure that your health security is our priority. With our bouquet of unique Health Insurance products and choice of add on covers, we empower the customers with the flexibility to choose a health plan as per their needs.

ICICI LOMBARD: THE CLAIM EDGE

- Cashless servicing facility at 5000+ Network Hospitals ^ ^, with approval in less than 4 hours
- In-house customer service team for claim settlement
- Claims Leader - General Insurance - Indian Insurance Award - June 2014
- Most Preferred Company for Health Insurance-Consumer Voice Award 2013

DISCLAIMER

^ ^ As on March 31, 2016