Annexure II
PROSPECTUS FOR RASHTRIYA SWASTHYA BIMA YOJNA

Introduction

Rashtriya Swasthya Bima Yojana is a health insurance scheme targeted at the Below Poverty Line population or as described in the specific government scheme.

Scope of Cover

The Policy covers the Hospitalisation expenses of the Insured (insured Family members) because of any Illness or Injury, upto the sum insured and subject to the sub limits (if any) and other terms and conditions of the Policy.

Eligibility

1. Coverage under the scheme would be provided for BPL people and their families.
2. The scheme covers the Insured, upto ___dependents of the Insured.
3. The Family members should be listed as a part of the Below Poverty Line database.
4. In case the spouse is not present, upto ___ dependents can be covered.
5. Smart Cards are issued to the Insured to determine their eligibility under this scheme.

Add-On Covers

Some of the additional covers that can be opted for are:

1. Maternity Expenses
2. New Born baby Cover
3. Inclusion of Pre-Existing Diseases
4. Cover for transportation allowance
5. Cover for Pre-Hospitalization and Post-Hospitalization Expenses

Terms of Renewal

- The Policy can be renewed under the then prevailing Rashtriya Swasthya Bima Yojana product or its nearest substitute (in case the product Rashtriya Swasthya Bima Yojana is withdrawn by the Company)
- A health insurance policy shall ordinarily be renewable except on grounds of established fraud, or misrepresentation or non-cooperation by the insured. Any person in the age group of 91 days – 100 years of age can be covered under this Policy with no restriction on the renewal age
- The Policy may be renewed as per relevant regulatory prescriptions and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the Policy and in no case later than Grace Period of 30 days from the expiry of the Policy
- Renewal Premium - Premium payable on renewal and on subsequent continuation of cover are subject to change
- Tenure of Policies: The policy tenure could be for a period of 1 year only.

Sum Insured

Every _____(Family / Insured), with Family size of ____ members is covered for a sum insured of Rs____

Premium Details

Premium (and associated loading/discounting if any) is applicable as per the government scheme. Reflects in the work order as below-

Premium Paid by the Policyholder including all taxes Rs._____
Premium Paid by the Insured including all taxes Rs._____
Total Premium including all taxes Rs._____
Any other charges (like registration charges, identity card charges) to be paid by the Insured Rs._____

Smart Card

1. Smart Card is a biometric card which would be given to the Inured. The Smart Card includes all the details of Insured along with the fingerprints.
2. The Smart Card needs to be produced in order to acquire benefits under the Policy
3. In case of the Smart Card is lost or damaged, a new card can be issued to the insured on payment of a fee of Rs. __ to the district kiosk.
4. Insured should intimate any change of details of Insured like name, age to the district kiosk

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 in connection with or in respect of:

1. Such diseases, which were pre-existing at the time of proposing this insurance

2. Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power

3. Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials

4. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident

5. Vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery unless necessary for treatment of an Illness or Injury not excluded by the terms of the policy or as may be necessitated due to treatment of an Accident.

6. Dental treatment or surgery of any kind unless requiring Hospitalisation.

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

8. 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 Illness or Injury whether or not requiring Hospitalisation.

9. Expenses on vitamins and tonics unless forming part of treatment for Injury or Illness as certified by the attending Medical Practitioner.

10. Treatment arising from or traceable to pregnancy, childbirth including caesarean section (including voluntary termination of pregnancy, childbirth, miscarriage, abortion or complications of any of these, including caesarean section) and any fertility, infertility, sub fertility or assisted conception treatment or sterilization or procedure, birth control procedures and hormone replacement therapy. However, this exclusion does not apply to ectopic pregnancy proved by diagnostic means and is certified to be life threatening by the Medical Practitioner

11. All expenses arising out of any condition directly or indirectly caused to or associated with Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV –III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

12. Experimental, unproven or non-standard treatment which is not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury

13. Conditions that do not require Hospitalization and can be treated under Out Patient Diagnostic (OPD) medical & surgical procedures or treatment unless necessary for treatment of a disease covered under day care procedures will not be covered.

Claims Procedure

The Claims Settlement is done on a cashless basis through the Empanelled Provider or as per process defined in the relevant government scheme/tender document/relevant regulatory prescriptions.The fulfillment of the terms and conditions of this Policy insofar as they relate to anything to be done or complied with by the Policyholder shall be conditions precedent to admission of 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 liability, the Insured shall undertake the following:

Cashless access in case Package Charges are fixed

1. The Insured contacts the Empanelled Provider. Cashless settlement is only available through an Empanelled Provider.
2. The Insured provides the Empanelled Provider with the Smart Card.
3. The Empanelled Provider checks the identity of the Insured by using the finger prints and Smart Card details of the Insured. The Empanelled Provider also check the available sum insured of the Insured.
4. After these preliminary checks, Empanelled Provider passes a provisional entry to block the claim amount in the Smart Card of the Insured.
5. After the provisional entry is made on the Insured's Smart Card, the Insured avails the treatment.
6. At the time of discharge from the Hospital, the Empanelled Provider passes the final entry on the Insured's Smart Card after verification of the Insured's finger prints (any other enrolled Family member in case of death) to complete the transaction.
7. Thereafter the Empanelled Provider electronically transmits this data to the Company
8. The Company settles the claim electronically with the Empanelled Provider.

Pre-authorisation for cashless access in case no Package Charges are fixed

1. The Insured contacts the Empanelled Provider. Cashless settlement is only available through an Empanelled Provider.
2. The Insured provides the Empanelled Provider with the Smart Card.
3. The Empanelled Provider checks the identity of the Insured by using the finger prints and smart card details of the Insured. The Empanelled Provider also check the available sum insured of the Insured.
4. The Empanelled Provider forwards the Hospitalisation request of the Insured to the Company after taking the disease / ailment details from the treating Medical Practitioner
5. Such request has to be forwarded to the Company within 6 hours of admission in case of an emergency and within 7 days prior to the expected date of admission in case of a planned Hospitalisation.
6. On receipt of such request as per process defined in the relevant government scheme/tender document/relevant regulatory prescriptions., the Company forwards the authorisation letter to guarantee payment in case the claim is considered to be admissible by the Company. In case of denial of such request, the Company will provide clarification to the Policyholder.
7. The Empanelled Provider passes a entry in the Smart Card of the Insured for the authorised amount by the Company.
8. The Company will not be liable for any claim payment in case the information as provided in authorization letter or any other document during the course of authorization is found incorrect or not disclosed

   In case the balance Sum Insured available is less than the Package Charge, the settlement shall be made by the Company upon receipt of original medical bills and documents for the balance amount

Conditions

1. The Smart Card is for the Insured and Family members of the Insured. This card belongs to Policyholder and should be kept with due care.
2. This card makes the Insured eligible for cashless hospitalization facility. The Smart Card is swiped for the treatment taken at network hospital in the Insured's presence.
3. The Insured should not entrust the card to any mediator, broker, or any other person who tries to prove himself/herself as the Company's or Policyholder's representative. The Insured might get deceived and lose benefits under the policy
4. Smart Card is not transferable. Insured would be responsible for any kind of misuse of the card.
5. Please contact District Kiosk for any other clarification.

Cancellation/ termination- Cancellation of the Policy may be-

a. By the Government, at any time, in the event of material breach of the terms of the agreement, committed by the Company, by giving due notice to the Company.
b. By either of the parties that are the Government or the Company, provided they give the other party at least 60 days prior written notice.
c. In case of automatic renewal of the contract, it will be done only if both parties that are the Government and the Company agree for it.

In case of cancellation by either party, the unutilized amount of premium shall be refunded by the Company.

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 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. For branch details, please visit https://www.icicilombard.com/docs/default-source/policy-wordings-product-brochure/final-gro-mapping.pdf

If Insured person is not satisfied with the redressal of grievance ,insured person may contact the grievance redressal 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 of India (IRDAI) 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 IRDAI website: www.irdai.gov.in, or on the Company's website at www.icicilombard.com or on https://www.cioins.co.in/Ombudsman

Note :The foregoing is only an indication of the cover offered. For complete details on coverage, terms, conditions and exclusions, please read the policy document carefully before concluding sale.

PROHIBITION OF REBATES:

(Under Section 41 of Insurance Act, 1938)

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

[Provided that acceptance by an insurance agent of commission in connection with a policy of any class of insurance business taken out by himself in relation to risks associated with his own life, health or property shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.]

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