PROSPECTUS

Eligibility

1. **Entry age:** Product can be offered to a customer with a minimum age of 6 years without any restriction on maximum entry age (Proposer shall be 18 years and more). Children between the ages of 3 months to 5 years can be covered under a floater plan only. In cases where it is infeasible to cover such children in floater plan, the proposals shall be considered on individual basis. Maximum age up to which dependent children can be covered under a floater policy would be 20 years (which can be extended to 25 or 30 years as per underwriting guidelines).
2. **Number of members:** A maximum of 6 members can be added in a single policy. You can avail a floater cover and get Your immediate family covered for the same sum insured under a single Policy by paying one premium amount. Any individual above 3 months of age can be covered under the Policy provided 1 Adult is also covered under the Policy
3. **Relationships covered:** Relationships allowed will be self, spouse, dependent children, dependent parents, parents in law, son in law, daughter in law, brother(s) and sister(s), Grandparents, Grandchildren, dependent Brother-in-law and dependent Sister-in-law.
4. Applicant should be a member of the group and if self & spouse or self only is enrolled under one plan then they may enrol dependent parents, children, parents in law, son in law, daughter in law, brother(s), sisters(s), grandparents, grandchildren, dependent brother-in law and dependent sister-in-law in a separate plan in your Policy Certificate.
5. Policy can be issued as Individual and Family Floater
   (Same or separate Certificate of insurance can be issued with group member as Proposer in all such certificate.)
   One certificate can include:
   - Members as floater SI
   - Members with separate SI
   - Combination of both

   (Group member must be the proposer for any of the above)
6. **Premium calculation:** In a family floater policy, the age of the eldest member will be considered while computing premium for all the members covered under the family floater. Other factors determining premium are addition/deletion of any optional covers, change in policy conditions such as tenure, increase or decrease in sum insured opted for and change in any tax laws by the government and health status of the individual being insured.

Salient features

- **Tenure of Policies:** The policy tenure could be of up to 5 Years.
- Lifetime renewability

- Claims made in respect of an Insured Person for any eligible cover shall be subject to the terms, conditions and exclusions of this Policy. At any point of time, our liability for any claims admitted in respect of any/all Insured Person/s during the period of insurance shall not exceed the maximum limit of indemnity as stated in the Policy Certificate against the respective cover(s) or a set of covers.
- Group product covers are subject to the group requirements and will be marketed accordingly.

What is covered?

A) Base Cover (Mandatory)

- **Hospitalization Expenses** We will pay You for the in-patient Hospitalisation expenses such as boarding and nursing expenses, intensive care unit charges, surgeon's, doctor's fee, anaesthesia, blood, oxygen, operation theatre charges etc. incurred by You during Hospitalisation for a minimum period of 24 consecutive hours.
- Room rent capping shall be applicable to room rent of a hospital room, ICU/ICCU and will be specified in policy schedule/Customer Information Sheet against the benefit.

- **Day Care Treatment/Surgeries**: We will pay You for the Medical Expenses incurred by You while undergoing Day Care Procedures/Treatment, which require less than 24 hours Hospitalisation.

- **Pre-Hospitalisation and Post-Hospitalisation Expenses** we will compensate You for the relevant medical Expenses incurred for a period before and after Your Hospitalisation.

- **In Patient AYUSH Hospitalisation:** We will cover the expenses for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) treatment only when the treatment has been undergone in a AYUSH hospital or AYUSH day care centre.

- **Unlimited Reset Benefit** Reset will be available unlimited times in a policy year in case the annual Sum insured including accrued Loyalty Bonus and Super Loyalty Bonus (if any), Sum insured protector(if any) is insufficient as a result of previous claims in that policy year.
- **Loyalty Bonus** We will provide Loyalty Bonus of 10% for every year up to a maximum of 100% of sum insured.
- **Donor Expenses** We will cover you up to the annual sum insured for the Medical Expenses incurred in respect of the donor for any of the organ transplant surgery, provided the organ donated is for your use and the organ donor is an eligible donor in accordance with "The transplantation of Human Organ Act", andWe have admitted the In-patient Hospitalization Claim under the base plan.

- **Domiciliary Hospitalization** We will cover the Medical Expenses incurred in respect of Your Domiciliary Hospitalization during the Policy Period

B) Base Cover (Optional)

- **Worldwide cover Including India (Hospitalization cover)** We will cover you for hospitalization expenses including planned hospitalization, incurred within India and anywhere across the world including USA and Canada, up to the amount specified against this benefit in the policy schedule/Customer information Sheet
  - ✓ A co-pay of 10% will be applied to every admissible claim over and above to any other co-pay levied, if the treatment is taken outside India
  - ✓ The benefit is available for 45 consecutive days from the date of travel in a single trip and 90 days in a cumulative basis as a whole in a Policy year
  - ✓ Coverage/benefit associated with **A Base covers_(Mandatory)** i.e. domiciliary hospitalization, Donor expenses, In-patient AYUSH, unlimited reset and Loyalty Bonus will be applicable only within the geographical boundaries of India
  - ✓ The expenses covered under this benefit shall be limited to Inpatient hospitalization expenses, days care treatment/ procedure expenses only

Further, the following optional covers/extensions can be provided under the Policy on payment of additional premium.

Extension 1 to 5 will be available only when the Base cover (optional) "Worldwide Including India (Hospitalization cover)" is opted by the group. Rest of the extensions/optional covers can also be opted along with it, but the utilization will be limited within the geographical boundaries of India.

C) Extension/Optional Covers

1 **Road Emergency Ambulance (worldwide including India)** we will cover you up to the amount as specified against this benefit (per hospitalization) in the policy schedule/Customer Information sheet on availing an ambulance service offered by a Hospital/ambulance service provider in an emergency condition.

2 **International Emergency Medical Assistance (worldwide including India**
   - **Air Ambulance** We will cover the expenses incurred by You on air ambulance services which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer You to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care upto the sum insured as specified against this benefit in the policy schedule/ Customer information sheet

- **Repatriation of Mortal Remains** In the event of the death of the insured person oversea/abroad we will pay/reimburse the policyholder up to the amount specified in the policy schedule/ Customer Information Sheet against this benefit for the cost incurred towards the return of the mortal remains of the insured person to his/her place of residence in India

3 **Dependent Accommodation (Worldwide including India):** We will pay the daily amount for the accommodation of the dependent in the hospital only as specified in the Policy Schedule/ Customer Information Sheet against this benefit in respect of each continuous and completed day of Hospitalization of the Insured Person for a minimum of 3 consecutive days maximum up to 10 days

4 **Convalescence Benefit (Worldwide including India):** We will pay you an amount as specified against this benefit in the policy schedule/ Customer Information Sheet. If you are hospitalized under worldwide cover including India (Hospitalization cover) for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy

5 **Worldwide Loyalty Bonus:** Loyalty Bonus accrued by You under base cover 6- "Loyalty Bonus" can be utilized by you outside the geographical boundaries of India. The Loyalty Bonus accrued can be utilized only for Inpatient hospitalization, day care treatment and surgeries and pre and post hospitalization expenses

6 **Domestic Road Emergency Ambulance Cover** we will cover you up to the amount as specified against this benefit (per hospitalization) in the policy schedule/ Customer Information sheet on availing an ambulance service offered by a Hospital/ambulance service provider in an emergency condition

7 **Air Ambulance** We will cover the expenses incurred by You on air ambulance services which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer You to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care up to the sum insured as specified against this benefit in the policy schedule/ Customer information sheet.

8 **Tele Consultation(s)** We will arrange consultations and recommendations for routine health issues by a qualified Medical Practitioner or health care professional.

For the purpose of this Optional Cover, Tele Consultation shall mean consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile application. Kindly go through our mobile application for more details on the same. There shall be no maximum limit on the count of tele-consultations that can be availed by You in a policy year.

Note: Extension/Optional Cover 28 “360 Wellbeing Program” shall not be applicable if this cover is opted.

9 **Sum Insured Protector** The Sum Insured protector is designed to protect the Sum Insured against rising inflation by linking the Sum Insured under the base plan to the Consumer Price index (CPI).
The Sum Insured will be increased on cumulative basis at each renewal on the basis of inflation rate in previous year. Inflation rate would be computed as the average CPI of the entire calendar year published by the Central Statistical Organization (CSO).
At the time of renewal if the Insured person opts out of this optional cover, then the Sum insured protector accrued up until the expiring policy year will be forfeited

10 **Claim Protector** If a claim has been accepted under the inpatient hospitalization cover, then the items which are not payable under the claim as per the List of Excluded items specified in the policy wordings, that is related to the particular claim will become payable.

11 **Super Loyalty Bonus** We will provide you with a Super Loyalty bonus of 50% of sum insured for each completed year subject to a maximum of 100% of sum insured. At the time of renewal if You opt out of this optional cover, then the Super Loyalty bonus accrued up until the expiring policy year will be forfeited
Super Loyalty bonus will be calculated on the previous policy Sum insured subject to maximum of 100% of renewal policy Sum Insured.

12 **Maternity Cover** We will cover you for medical expenses incurred for delivery, including a caesarian section, during Hospitalization or lawful medical termination of pregnancy and pre and postnatal expenses during the Policy Year up to the amount as specified in the policy schedule/ Customer information sheet. The cover shall be limited to 2 deliveries/ terminations during the Period of Insurance.

13 **New-born baby cover** We will cover Your new born baby up to the limit as specified in the policy schedule under this Policy during the Hospitalisation of such child for a maximum period of up to 90 days from the date of birth of the child. This cover will be provided only if Maternity cover is available to You

14 **Out Patient Treatment Cover** We will cover you for the Medical Expenses incurred by You on outpatient consultation, Diagnostic test and pharmacy up to the sum insured as specified in the policy schedule/ Customer information sheet

15 **Hospital Daily Cash** we will pay the daily amount specified in the Policy Certificate for each continuous and completed day of Hospitalization as specified in the policy schedule/Customer information sheet

16 **Daily Cash Benefit for Leave from Job** We will pay You a daily cash amount for each completed day of hospitalization for a minimum of 3 days and maximum of 10 days as specified in the policy schedule/ Customer Information Sheet if You require leave from work, to attend to your spouse only

17 **Compassionate Visit** We will reimburse the cost of the economy class air ticket incurred by Your Immediate family from and to the place of origin of such immediate family or the place of residence of the immediate family

18 **Convalescence Benefit** We will pay You an amount as specified against this benefit in the policy schedule/Customer Information Sheet, if You are Hospitalized for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy. This benefit is payable only once to an Insured Person during each Policy Year of the Policy Period

19 **Rehabilitation care** We will pay You an amount as specified against this benefit in the policy schedule/Customer Information Sheet for the post-surgical/operative rehabilitation care for a minimum period of 10 consecutive days, due to any Injury or Illness as covered under the Policy

20 **Nursing at Home** We will pay You a daily amount as specified against this benefit in the policy schedule/Customer information sheet for a maximum of 15 days post hospitalization for the medical services of a Qualified nurse at Your residence.

21 **Home Health care** we will cover the medical expenses incurred by you on availing treatment at home for non-emergency conditions advised by the medical Practitioner

22 **Dependent Accommodation** We will pay the daily amount for the accommodation of the dependent in the hospital only as specified in the Policy Schedule/Customer Information Sheet against this benefit in respect of each continuous and completed day of your Hospitalization for a minimum of 3 consecutive days maximum up to 10 days

23 **Voluntary Deductible** In case you have opted, the Deductible will be applicable on aggregate basis for all Hospitalization expenses during the Policy Year. Voluntary deductible shall not be applicable to any optional covers.

24 **Voluntary Co-Payment** In case You have opted for a voluntary co-payment, you will be liable to pay the % of admissible claim amount for each and every claim as specified in the policy schedule. Voluntary Co-payment shall be applicable only after the Voluntary Deductible has been exhausted, provided both has been opted by you. Voluntary Co-payment applicable shall be in addition to zone based co pay opted. Voluntary Co-payment shall not be applicable to any optional covers

25 **Zone wise premium** If opted you will pay the co-pay as per Zone explained below:

a. Zone 1 : NCR*, Mumbai, Thane District, Raigad District(Maharashtra), Navi Mumbai, Gujarat, Kolkata
b. Zone 2: Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Raigad District (Maharashtra), Navi Mumbai)
c. Zone 3: Rest of India

* Includes Delhi and the following districts: Faridabad, Gurgaon/Gurugram, Mewat, Rohtak, Sonipat, Panipat, Jhajjhar, Palwal, Karnal, Ghaziabad, Noida/Gautam Budh Nagar, Bulandshahr, Baghpat, Hapur, Shamli, Muzaffarnagar

Zone Opted for	Co-pay for each and every claim in Zone I	Co-pay for each and every claim in Zone 2	Co-pay for each and every claim in Zone 3
Zone 1	Nil	Nil	Nil
Zone 2	10%	Nil	Nil
Zone 3	15%	5%	Nil

26 Sub Limits on Illness/ Surgeries / Procedures

- In case You have opted for sublimit, our maximum liability to make payment for the Medical Expenses incurred during any Hospitalisation (including its related Pre and Post Hospitalization expenses if applicable) due to the below mentioned Surgeries / Medical Procedures or any medical treatment pertaining to an Illness / Injury shall be limited as per the table below

S. No.	Particulars	Sub-limits (Rs.)
1	Cataract per eye	As specified against this benefit in the policy schedule/Customer Information sheet
2	Other Eye Surgeries	
3	ENT	
4	Surgeries for - Tumors/Cysts/Nodule/Polyp	
5	Stone in Urinary System	
6	Hernia Related	
7	Appendectomy	
8	Knee Ligament Reconstruction Surgery	
9	Hysterectomy	
10	Fissures/Piles/Fistulas	
11	Spine & Vertebrae related	
12	Cellulites/Abscess	

27 **Health Check-up Cover** Expense incurred on Health checkup will be availed only at our empanelled service provider on cashless basis as per the available medical test packages

28 **360 Wellbeing Program** 360 Wellbeing program aims to empower individuals to manage their lifestyle and prevent complication arising from adverse health conditions. It intends to promote, incentivize and reward You for your healthy behavior through various health and wellbeing activities. The point structure includes Be-Healthy points and Stay-Healthy points.

For policy tenure 1 year: Points earned can be carry forwarded maximum of 3 years, provided policy is renewed continuously with us and the points shall have to be redeemed at the end of the 3rd Policy Year.

For policy tenure >1 year: Points earned can be carry forwarded maximum to next renewal, provided policy is renewed continuously with us and the points shall have to be redeemed in the first year of such renewed policy.

In case, you do not wish to redeem the wellbeing points earned, the same will be forfeited**.**

In case of expiry of policy, the wellness points may be carried forward for a period not exceeding three months.

29 **Critical illness Cover** We will pay You a lump-sum amount on Your first diagnosis of critical Illnesses listed below as specified in the policy schedule/Customer information sheet. provided that the signs or symptoms of such Critical Illness first commence after 90 days from the Risk Inception Date of this optional cover. On the acceptance of a claim under this Benefit, the cover under this Benefit will terminate in relation to you, and further no subsequent Renewals of this optional cover in the Policy will be allowed.

S. No.	Body system
Heart and vascular conditions	
1	Myocardial Infarction
2	Refractory heart failure
3	Cardiomyopathy
Lung Conditions	
4	End stage lung Failure
5	Primary(Idiopathic) pulmonary Hypertension
Liver conditions	
6	End stage liver Failure
Neuro/ spinal & psychiatric disease	
7	Multiple sclerosis with Persisting symptoms
8	Motor neuron disease with Permanent symptoms

9	Permanent paralysis of limbs
10	Stroke resulting in permanent symptoms
11	Coma of specified severity
12	Alzheimer's Disease
13	Parkinson's disease
14	Apallic syndrome
15	Benign brain tumour
16	Creutzfeldt-jakob disease (CJD)
17	Major head trauma
Renal diseases	
18	Kidney failure requiring regular dialysis
19	Medullary cystic disease
Musculoskeletal diseases	
20	Muscular dystrophy
21	Poliomyelitis
Bleeding disorders	
22	Aplastic Anemia
Auto immune diseases	
23	Systemic Lupus Erythematosus with renal involvement
24	Myasthenia gravis
25	Scleroderma
26	Good pastures syndrome with lung or renal involvement
Others	
27	Blindness
28	Deafness
29	Cancer of specified severity
30	Third Degree Burns
31	Loss of speech
32	Loss of limbs
33	Loss of Independent Existence

30 Personal Accident Cover

a) Death Benefit We will pay You or Your Nominee / legal heir, as the case may be, the Annual Sum Insured as specified against this benefit in the Policy Schedule/Customer Information Sheet if you suffer an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's death within 365 days from the date of the Accident.

On the acceptance of a claim under this Benefit and any other applicable Benefit pertaining to the same event, all cover under this Policy shall immediately and automatically cease in respect of that Insured Person

b) **Permanent Total Disablement (PTD) Benefit** We will pay You or Your Nominee / legal heir, as the case may be, the Annual Sum Insured as specified against this benefit in the Policy Schedule/Customer Information Sheet if you suffer from an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Total Disablement of the Insured Person within 365 days from the date of the Accident

c) **Permanent Partial Disablement Benefit (PPD)** We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Schedule/Customer Information Sheet in the manner which is specified in the table below if you suffer an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Partial Disablement of the Insured Person (which is of the nature specified in the table below) within 365 days from the date of the Accident

SR No.	LOSSES COVERED	% OF SUM INSURED payable
1	Loss of one entire hand	70
2	Loss of one entire foot	70
3	Loss of use of one eye	50
4	Loss of all toes	20
5	Loss of great toe - both phalanges	5
6	Loss of great toe - one phalanx	2
7	Other than great toe if more than one toe lost each	5
8	Loss of use of both ears	75
9	Loss of use of one ear	30
10	Loss of four fingers and thumb of one hand	40
11	Loss of four fingers	35
12	Loss of thumb - both phalanges	25
13	Loss of thumb - one phalanx	10
14	Loss of index finger - three phalanges	10
15	Loss of index finger - two phalanges	8
16	Loss of index finger - one phalanx	4
17	Loss of middle finger - three phalanges	6
18	Loss of middle finger - two phalanges	4
19	Loss of middle finger - one phalanx	2
20	Loss of ring finger - three phalanges	5
21	Loss of ring finger - two phalanges	4
22	Loss of ring finger - one phalanx	2

23	Loss of little finger - three phalanges	4
24	Loss of little finger - two phalanges	3
25	Loss of little finger - one phalanx	2
26	Loss of metacarpus - first or second (additional)	3
27	Loss of metacarpus - third, fourth or fifth (additional)	2

31 **Recovery Benefit** We will pay you 1% of Sum insured maximum up to Rs 50,000 as specified against this Benefit in the Policy Schedule/Customer Information Sheet, if you suffer an Injury due to an Accident that occurs during the Period of Cover and that solely and directly results in your hospitalization for at least 7 continuous days

32 **Mobility Benefit** We will pay you 1% of sum insured maximum up to Rs.50,000 under this Benefit to you towards modification of home, office and / or vehicle or towards purchase of an Artificial Limb or any prosthesis or any other expenses because of Permanent Total Disablement or Permanent Partial Disablement (which is only of the nature specified in the table below) covering the disabilities mentioned in the table below suffered by the Insured Person

Permanent Partial Disablement: LOSSES COVERED
One entire hand
One entire foot
Loss of Use of one eye
Loss of Use of both ears
Loss of four fingers and thumb of one hand

33 **Voluntary Co-payment or Per claim Deductible (Whichever is lower)**

In case You have opted for this Extension/Optional Cover, you will be liable to pay the % of admissible claim amount for each and every claim or per claim Deductible amount (whichever is lower) as specified in the Policy Schedule/Customer Information Sheet.

- In case this cover has been opted “Voluntary Co-payment” and “Voluntary Deductible” covers shall not be available.
- Applicability of this cover shall be in addition to zone based co pay (if applicable).
- This cover shall not be applicable to any optional covers.

Illustration-

Scenario	Admissible claim amount	Voluntary Co-payment or Per claim Deductible (Whichever is lower)	Co-payment 10%	Per Claim Deductible Amount	Amount considered to be paid by Insured on admissible claim amount
1st Scenario	1L	Yes	10,000/-	10,000/-	10,000/-
2nd Scenario	1.5L	Yes	15,000/-	10,000/-	10,000/-

34 Sub-limit on specified Disease Categories:

In case You have opted for this Extension/Optional Sublimit, our maximum liability to make payment for the Medical Expenses incurred during any Hospitalization for all the disease category shall be limited to 1/3rd of the annual sum insured per policy year.

For the purpose of this Extension/Optional Cover the sub limit shall only be applicable on below mentioned Base Covers (Mandatory):

a. Hospitalization Expenses
b. Day care Treatments
c. Pre-Hospitalization and Post-Hospitalization Expenses
d. In-Patient AYUSH Hospitalization
e. Unlimited Reset Benefit
f. Loyalty Bonus
g. Donor Expenses
h. Domiciliary Hospitalization.

For the purpose of this Extension/Optional Cover, Disease categories means any disease other than critical illnesses as mentioned below:

“Liver Disorder, Brain, Heart, Lung, Cancer, Gastro Intestinal System, Kidney, Multi Organ Failure requiring life support system for more than 48 hours for survival.”

For the purpose of this this Extension/Optional Cover, Critical illnesses means any life-threatening illnesses that pose a significant risk to a person’s health or survival. These conditions have the potential to cause severe harm or death if not promptly treated or managed appropriately.

Illustration-

Annual Sum Insured	Treatment taken for	Applicable Annual Sum Insured	Applicable Loyalty Bonus (if accrued)	Applicable Unlimited Reset Benefit
18L	Dengue	6L	6L	100% of Applicable Annual Sum Insured
18L	Cancer	18L	18L	100% of Applicable Annual Sum Insured

Note –
1. Accumulation and applicability shall be as per terms and condition of each cover.
2. Extension/Optional Cover 26 “Sub Limits on Illness/ Surgeries / Procedures” shall not be applicable if this cover is opted.

WHAT WE WILL NOT PAY (EXCLUSIONS UNDER THE POLICY)

We will not be liable for any Deductible amount, if applicable and as specifically defined in the Policy Schedule under the Policy

We shall not be liable to make any payment under this Policy in connection with or in respect of any expenses whatsoever incurred by You in connection with or in respect of:

i. Standard Exclusions

3.1 Code- Excl01: Pre-Existing Diseases

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of specified 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 migration portability norms of the relevant regulatory prescriptions, then waiting period for the same would be reduced to the extent of prior coverage

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

3.2 Code- Excl02: Specified disease/procedure waiting period/ Specific Waiting Period

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of specified months 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 then waiting period for the same would be reduced to the extent of prior coverage.

List of specific diseases/procedure:

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy unless because of malignancy
- All types of Hernia, Hydrocele
- Fissures &/or Fistula in anus, haemorrhoids/piles
- Arthritis, gout, rheumatism and spinal disorders
- Joint replacements unless due to accident
- Sinusitis and related disorders
- Stones in the urinary and biliary systems
- Dilatation and curettage , Endometriosis
- All types of Skin and internal tumours/ cysts/nodules/ polyps of any kind including breast lumps unless malignant
- Dialysis required for chronic renal failure
- Surgery on tonsils, adenoids and sinuses
- Gastric and Duodenal erosions & ulcers
- Deviated Nasal Septum

- Varicose Veins/ Varicose Ulcers

3.3

a) Expenses related to the treatment of the below mentioned illness within specified days from the first policy commencement date shall be excluded unless they are pre-existing and disclosed at the time of underwriting

   i. Hypertension

   ii. Diabetes

   iii. Cardiac Conditions

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

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

3.4 Code- Excl03: Initial waiting period

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

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

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

3.5 Permanent Exclusions

i. Code- Excl04: Investigation & Evaluation

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.

ii. Code- Excl05: Exclusion Name: Rest Cure, rehabilitation and respite care

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.

iii. Code- Excl06: Obesity/ Weight Control 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);
5) greater than or equal to 40 or
6) 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:
   - Obesity-related cardiomyopathy
   - Coronary heart disease
   - Severe Sleep Apnea
   - Uncontrolled Type2 Diabetes

iv. Code- Excl07: Change of Gender treatments

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

v. Code- Excl08: Cosmetic or plastic Surgery

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.

vi. **Code- Excl09:** Hazardous or Adventure sports

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.

vii. **Code- Excl10:** Breach of law

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

viii. **Code- Excl11:** Excluded Providers

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/proposers 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. The list of excluded providers/delisted hospitals is available on our website www.icicilombard.com

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

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

xi. **Code- Excl14:** 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.

xii. **Code- Excl15:** Refractive Error: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

xiii. **Code- Excl16:** Unproven Treatments: 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.

xiv. **Code- Excl17:** Sterility and Infertility: Expenses related to, sterility and infertility. This includes:

a) Any type of contraception, sterilization

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

c) Gestational Surrogacy

d) Reversal of sterilization

xv. **Code- Excl18:** Maternity: Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

ii. Specific Exclusions

a) Any ailment / illness, injury, condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.

b) 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.

c) Expenses incurred on all dental treatment unless necessitated due to an Accident

d) Personal comfort, cosmetics, convenience and hygiene related items and services

e) Acupressure, acupuncture, magnetic and other therapies

f) Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident. Expenses for venereal disease or any sexually transmitted disease except HIV.

g) Treatment relating to external birth defects and external congenital Illnesses or defects or anomalies such as but not limited to Cleft lip, Combination of cleft lip and cleft palate, Tongue Tie, CTEV (Club foot), Congenital Torticollis, Morphological abnormalities like congenital kyphosis, congenital scoliosis etc., and Phimosis

h) Treatment taken outside the country

i) Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)

j) Any injury or illness caused by or arising from or attributed to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority

k) Any Illness or Injury caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel

**some of the exclusion will be waived off if the extensions/optional cover is opted for the same.*

How do I claim my insurance?

Cashless Basis

In case of emergency or planned Hospitalisation, use Your health ID card at our Network Provider and avail of cashless service OR You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. Cashless approval is subject to Pre-authorisation by Us

Pre-authorization means prior to taking any treatment or incurring Medical Expenses at a Network provider, You must contact Us accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, nature of Illness or Injury, name and address of the doctor/ Hospital and any other information that may be relevant to the Illness/ Injury/ 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

Reimbursement Basis

In case of reimbursement settlement, You should immediately notify Us about the claim by calling at the toll free number as specified in the Policy. You or someone claiming on Your behalf, should then send us the following documents in original within 30 days after Your discharge from the Hospital:

a. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from Our website www.icicilombard.com
b. Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner
c. Original bills from chemists supported by proper prescription.
d. Original investigation test reports and payment receipts.
e. Indoor case papers
f. Medical Practitioner's referral letter advising Hospitalisation in non-Accident cases.
g. Any other document as required by Us or Our In house claim processing team to investigate the Claim or Our obligation to make payment for it

Claims settlement will follow the below mentioned order in case you have opted for super no claim bonus and sum insured protector

1) Sum Insured
2) Loyalty Bonus
3) Super Loyalty Bonus (if opted and accrued)
4) Sum Insured Protector (if opted and accrued)

GENERAL TERMS AND CONDITIONS

1. **Disclosure of Information**

   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 by the policyholder.

   (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected

documents to enable it to take informed decision in the context of underwriting the risk)

2. **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.

3. **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.

4. **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.

5. **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 and the premium paid shall be forfeited.

   Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

   For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on behalf of the insured person, 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 claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

6. Cancellation

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

i. 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.

ii. 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.

Note: Above mentioned refund clause shall not be applicable for policies with freelook period; Premium refund for cancellations during the freelook period will be provided as per the Free look clause.

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

a. The Company may cancel the Policy at any time on grounds of established fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of established fraud.

7. 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.

8. 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.

9. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured person provided the policy is not withdrawn and also subject to moratorium conditions.

a. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
b. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
c. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
d. No loading shall apply on renewals based on individual claims experience.

10. Withdrawal of Policy

a. 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.
b. 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 Loyalty bonus, waiver of waiting period. as per regulatory prescriptions, provided the policy has been maintained without a break.

11. Moratorium Period

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.

12. Premium Payment in installments

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

a. 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 company shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
b. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
c. No interest will be charged If the instalment premium is not paid on due date.
d. In case of instalment premium due not received within the grace period, the policy will get cancelled.
e. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
f. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

13. 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.

14. Free look period

Every insured of new individual health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the insured and stamp duty charges.

15. Redressal of Grievances

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/OmbudsmanIn

LIST OF INSURANCE OMBUDSMEN

The contact details of the Insurance Ombudsman offices are mentioned as an Annexure I to this policy. These details can also be found at https:// www.cioins.co.in/ombudsman .

16. Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the

nominee as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

17. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Proposer or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

18. Notice & Communication

a. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
b. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
c. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

19. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only unless worldwide cover has been opted for.

20. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

21. Arbitration

a. If any dispute or difference shall arise as to the quantum to be paid by 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 here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising 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, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

b. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy, iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

22. Policy alignment

Policy Alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy.

Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.

23. Endorsements (Changes in Policy)

a. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
b. The proposer may be changed only at the time of renewal. The new proposer must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.
c. The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.
d. Mid- term endorsement of addition of member in the policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation

24. Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

25. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In Your case, at Your last known address.

In Our case:

ICICI Lombard General Insurance Company Limited

ICICI Lombard House

414, P Balu Marg, Off Veer Savarkar Road,

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, facsimile or e-mail.

26. Non Payables

Below are the non-payable items applicable in the policy. The list may be updated as per the direction of Authority, For updated list please visit Our website: www.icicilombard.com

List of Non Payable Items	
Sr. No	**Items**
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
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
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	RECOVERY KIT, ETC]ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT,
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

Other Terms and Conditions

CLAIM ADMINISTRATION

The fulfillment 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 You shall be conditions precedent to admission of Our liability. You are requested to go through our list of de-listed/excluded providers which is available on our website – www.icicilombard.com. As the list is dynamic, please refer to the latest list.

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 Our liability, You shall undertake the following

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 You:

Pre-authorization

i. Prior to taking treatment and/or incurring Medical Expenses at a Network Provider, You must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Proposer, 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. 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. To avail of Cashless Hospitalisation facility, you are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card Or You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. We will consider your request after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalisation facility is sought by You and We will confirm Your request in writing.

ii. If You notify pre authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will respond within 1 hour of the actual receipt of such pre authorization request.

iii. Further, we shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital."

(B)For Reimbursement Settlement

i. You shall give notice to Us or Our In house claim processing team by calling the toll free number 1800 2666 or emailing us at customersupport@icicilombard.com as specified in the Policy provided to You and also in writing at Our address with particulars as below:

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

The above information needs to be provided to Us or Our In house claim processing team immediately and in any event within 10 days of Hospitalisation, failing which

We will have the right to treat the Claim as inadmissible, as We may deem fit at Our sole discretion.

ii. You must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.

iii. You or someone claiming on Your behalf must promptly and in any event within 30 days of Your discharge from a Hospital (for post-hospitalisation expenses, within 30 days from the completion of post-hospitalisation period) deliver to Us the documentation (written details of the quantum of any Claim along with all original supporting documentation) as more particularly listed in CLAIM DOCUMENTS section collected from the hospital at the time of discharge along with the claim form. In case there is a delay beyond 30 days in submission of claim documents, we may condone the delay provided the insured person submits a valid reason justifying the delay to us in writing. The claim will be processed within 15 days of receipt of claim along with claim form.
However, in both the above cases i.e. g 4.1 (A) & (B), You must take reasonable steps or measure to minimise the quantum of any Claim that may be covered under the Policy

If so requested by Us, You will have to undergo a medical examination from Our nominated Medical Practitioner, as and when We or Our In house claim processing team considers reasonable and necessary. The cost of such examination will be borne by Us.

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 for each Policy Period. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the Renewal/due date of premium of health insurance Policy, if not received earlier.

Claims settlement will follow the below mentioned order in case you have opted for super loyalty bonus and sum insured protector

5) Sum Insured
6) Loyalty Bonus
7) Super Loyalty Bonus (if opted and accrued)
8) Sum Insured Protector (if opted and accrued)

CLAIM DOCUMENTS

You shall be required to furnish the following documents for or in support of a reimbursement Claim:

a) Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from Our website www.icicilombard.com
b) Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner
c) Original bills from chemists supported by proper prescription.
d) Original investigation test reports and payment receipts.
e) Indoor case papers
f) Medical Practitioner's referral letter advising Hospitalisation in non-Accident cases.
g) Any other document as required by Us or Our In house claim processing team to investigate the Claim or Our obligation to make payment for it

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