Policy wordings - Group Hospital Cash

PREAMBLE:

The insurance cover provided under this Policy to the Insured / Insured Person up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium and (c) Disclosure to Information Norm (including by way of the Proposalor Information Summary Sheet) and (d) Policy Schedule/ Certificate of Insurance

SECTION 1- DEFINITIONS:

Any word or expression, to which a specific meaning has been assigned in any part of this Policy Wording or the Policy Schedule/ Certificate of Insurance, shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meaning as set forth herein below:

Standard Definitions:

"Accident" means a sudden, unforeseen, and involuntary event caused by external, visible and violent means.

"Any one illness" means continuous period of illness and includes relapse within 45 days from the date of last consultation with theHospital where treatment was taken.

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

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

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

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

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

"Pre-existing disease (PED)" means any condition, ailment, injury or disease: that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

"Specific waiting period" means a period up to 24 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of

the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

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

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

"Congenital Anomaly" means a condition which is present since birth, and which is abnormal with reference to form, structure orposition.

i. **Internal Congenital Anomaly -** Congenital anomaly which is not in the visible and accessible parts of the body;
ii. **External Congenital Anomaly-** Congenital anomaly which is in the visible and accessible parts of the body.

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

"Day Care treatment" means medical treatment, and / or surgical procedure which is:undertaken under general or local anesthesia in hospital/day care centre in less than 24 hours because of technological advancement, and which would have otherwise required hospitalization of more than 24 hours.Treatment normally taken on an out-patient basis is not included in the scope of this definition.The list of Day Care Treatment is availablein our website.

"Day care Centre" means any institution established for day care treatment of Illness and / or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualifiedmedical practitioner and must comply with all minimum criteria as under:

a. Has qualified nursing staff under its employment.
b. has qualified medical practitioner/s in charge;
c. has a fully equipped operation theatre of its own where surgical procedures are carried out ;
d. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.
e. 'Day care Centre' Includes AYUSH day care centre.

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre
where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative. (Explanation: Medical Practitioner referred in the definition of "AYUSH Hospital" and "AYUSH Day Care Centre" shall carry the same meaning as defined in the definition of "Medical Practitioner")

" Deductible" means a cost sharing requirement under a health insurance policy

that provides that the company will not be liable for a specified rupee amount in case of indemnity sections and for a specified number of days/hours in case of hospital cash section which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

"Disclosure to information norm" means 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.

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

a. has qualified nursing staff under its employment round the clock;
b. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
c. has qualified medical practitioner(s) in charge round the clock;
d. has a fully equipped operation theatre of its own where surgical procedures are carried out;
e. Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

'**Hospital'** Includes AYUSH Hospital.

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

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
1. Having at least 5 in-patient beds;
2. Having qualified AYUSH Medical Practitioner in charge round the clock;
3. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
4. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

"Hospitalisation" means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for Day care treatments, where such admission could be for a period of less than 24 consecutive hours.

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

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

- **Acute condition -** Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to returnthe person to his or her state of health immediately before

suffering the disease/ illness/ injury which leads to full recovery

- **Chronic condition -** A chronic condition is defined as a disease, illness, or injury that has one or more of the followingcharacteristics:
  - it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
  - it needs ongoing or long-term control or relief of symptoms
  - it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
  - it continues indefinitely
  - it recurs or is likely to recur

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

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

"Intensive Care Unit/ICU" means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

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

Medically Necessary Treatment:
Medically necessary treatment means any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which:
i) is required for the medical management of the illness or injury suffered by the insured;
ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii) must have been prescribed by a *medical practitioner*;
iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

"Notification of claim" means the process of intimating a claim to the insurer through any of the recognized modes of communication.

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

"Post-hospitalization Medical Expenses" means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

"Pre-hospitalization Medical Expenses" means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

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

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

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

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

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

SPECIFIC DEFINITIONS:

"Certificate of Insurance" means the document issued to Individual Insured by the Company detailing the effective date, instalment date, Insured Person(s), Benefits, Sum Insured, Deductible, Franchise, Premium and more generally all special conditions and or endorsements.

"Company/We/Our/Ours" means ICICI Lombard General Insurance Company Limited.
"Daily Allowance" means the benefit amount payable to the Insured/Insured Person for each continuous and completed period of 24hours as inpatient care in the hospital upto the limits as specified in the Policy Schedule/ Certificate of Insurance .

"Dependent Child" means a natural or legally adopted child, aged between 91 days to 23 years and financially dependent on thePolicy holder.

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

"Family Floater" means the Sum Insured shown in the Policy Schedule/ Certificate of Insurance which represents the Company's maximum liability for any and all claims made by any one Insured and/or all Insured Person(s) together during the Policy Period.

"Franchise" means the company is not responsible for the loss which does not exceed specified number of days/hours for Hospitalcash section, but is responsible to cover the risk from the first day/hour if it exceeds specified number of days/hours.

"**Insured/You/Your**" means the primary Insured who has the highest age amongst other person named in the Policy Schedule/ Certificate of Insurancein case of family floater Policy. In case of an Individual Policy the only member mentioned in the Policy Schedule/ Certificate of Insuranceshall be referred as **"Insured"**.

" **Medical Practitioner**" means a person who holds a valid registration from the Medical Council of any State or Medical Council of Indiaor Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
a. The registered practitioner should not be the insured or close member of the family.

"Period of Insurance" means the period between the date when the policy had first incepted, its subsequent renewals without anybreak till policy expiry date under the last renewed policy.

"Policy Holder" means the entity named in the Policy Schedule who is responsible for remitting the premium

" Policy period" means the period between the inception date and the expiry date as specified in the Policy Schedule/ Certificate of Insuranceor the cancellation of this insurance, whichever is earlier.

"Policy Schedule" means the document issued to the Policyholder which is attached to and forming part of this Policy mentioning thedetails of the Insured Person(s), the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

"Senior citizen" means any person who has completed sixty or more years of age as on the date of commencement or renewal of ahealth insurance policy.

"Insured Person(s)" means the person(s) named in the Policy Schedule/ Certificate of Insurance .

" **Sum Insured**" means the sum shown in the Policy Schedule/ Certificate of Insurance which represents Our maximum liability for eachInsured Person for any and all benefits claimed for during the Policy Period.

SECTION 2- SCOPE OF COVER

Scope of cover has been specified in detail under the Endorsement wordings (Optional Cover) Section.Admissibility of claims under any specified section of the endorsement wordings of the policy shall be accepted provided the Insured Person suffers an illness/sickness/injury/specific condition during the Policy Period that results in Insured Person's hospitalisation for each continuous and completed period of 24 hours, as an inpatient or if the treatment qualifies as a day care procedure.

Modern Treatment Methods and Advancement in Technologies:

Claims pertaining to the following treatment methods will be also admissible under this policy and claims, if payable, would be paid in accordance with the Endorsement

Wording:

A. Uterine Artery Embolization and HIFU
B. Balloon Sinuplasty
C. Deep Brain Stimulation
D. Oral Chemotherapy
E. Immunotherapy- Monoclonal antibody to be given as injection
F. Intra Vitreal Injections
G. Robotic Surgeries
H. Stereotactic Radio Surgeries
I. Bronchical Thermoplasty
J, Vaporisation of the Prostrate (Green Laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditons to be covered.

SECTION 3- EXCLUSIONS

A Exclusion Name: Pre-Existing Diseases - Code- Excl01

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the relevant regulatory prescriptions, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time ofapplication and accepted by Insurer.

B. **Exclusion Name: Specified disease/procedure waiting period- Code- Excl02**

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 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 specificexclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis
7. Stones in the urinary and biliary systems
8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
9. Cataracts,
10. Hernia of all types and Hydrocele
11. Fistulae in anus
12. Fissure in anus
13. Fibromyoma
14. Hysterectomy
15. Surgery for any skin ailment
16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
17. Dialysis required for Chronic Renal Failure.
18. Joint Replacement Surgeries unless

necessitated by Accident happening after the Policy risk inception date.
19. Dilatation and curettage
20. Varicose Veins and Varicose Ulcers
21. Non Infective Arthritis and other form arthritis
22. Gout and Rheumatism
23. Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

C. **30-day waiting period- Code- Excl03**

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded exceptclaims 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 insuredsubsequently.

D. **Investigation & Evaluation- Code- Excl04**

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

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

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

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

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

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

F. Obesity/ Weight Control: Code- Excl06

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

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

G. Change-of-Gender treatments: Code- Excl07

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

H. Cosmetic or plastic Surgery: Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to beconsidered a medical necessity, it must be certified by the attending Medical Practitioner.

I. Hazardous or Adventure sports: Code-

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

J. Breach of law: Code- Excl10
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

K. Excluded Providers: Code- Excl11
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/ notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition andconsequences thereof. Code- Excl 12

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

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

O.. Refractive Error: Code- Excl15
Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

P. Unproven Treatments: Code- Exel 16
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.

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

(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, /CS/
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

Q. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

R. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

S. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel

or the emission,discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

T. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

U. Treatment taken outside the geographical limits of India

V. Annexure A: List I: Optional Items

SECTION 4 - Standard General Terms and Clauses

I. Disclosure of Information :

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

II. Condition Precedent to Admission of Liability :

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

III. 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.

IV. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims made under the policy which are found fraudulent later under this policy 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.

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 party, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

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

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

(c) any other act fitted to deceive; and

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

The company shall not repudiate the policy on the ground of fraud, if the insured person

/ beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer.

V. Cancellation:

i. The policy holder may cancel this Policy, by giving 7 days' notice in writing and in such an event the Company shall refund thepremium for the unexpired policy as detailed below :

Period on Risk	Rate of Premium to be retained by Company
Up to 1 month*	25%
Exceeding 1 month Up to 3 months	50%
Exceeding 3 months Up to 6 months	75%
Exceeding 6 months Up to 12 months	100%

*Not applicable for policies with freelook period; Premium refund for cancellations during the freelook period will be provided as per the Free look clause

Credit linked policies may be issued for a period not exceeding 5 years. The refund on cancellation of Policy/Certificate of Insurance by thePolicyholder/ Insured shall be made as per the Company's short period scales given below provided no claim has/is occured/reported up to the date of cancellation of this Policy/Certificate of Insurance.

Loan Period(Year)	1	2	3	4	5/5+
Policy Period (Year)	1	2	3	4	5
Year Of Cancellations	**Rate of Premium to be retained by Company**				
1*	100%	50%	33%	25%	20%
2		100%	67%	50%	40%
3			100%	75%	60%
4				100%	80%
5					100%
*Not 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 this policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation, non disclosure of material facts, fraud by the insured person by giving 15 days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non disclosure of material facts or fraud.

VI. 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.

VII. 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

VIII. Renewal of Policy

i. The Company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
ii.At the end of the Policy Period, the policy shall terminate and can be renewed with in the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
ii.No loading shall apply on renewals based on individual claims experience

IX. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting periodas per regulatory prescriptions, provided the policy has been maintained without a break.

X. 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 c 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.

1. 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)

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.

i. 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.
ii. No interest will be charged If the instalment premium is not paid on due date.
iii. In case of instalment premium due not received within the grace period, the policy will get cancelled.

iv. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
v. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

XI. 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.

XII. Free look period

Every insured of new 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.

XIII. Redressal of Grievance

In case of any grievance the insured person may contact the Company through
Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com
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

Office of the Insurance Ombudsman	Area of Jurisdiction
AHMEDABAD Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.

BENGALURU Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).
DELHI Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 /	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

2602205 Email: bimalokpal.guwahati@cioins.co.in	
HYDERABAD Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141-2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
KOCHI Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email:	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.

bimalokpal.ernakulam@cioins.co.in	
KOLKATA Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar,

	Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.			Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
MUMBAI Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).		PATNA Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
NOIDA Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli,		PUNE Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

THANE Shri Umesh Sinha Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane - 400604 Email:bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.

XIV. 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. For Claim settlement under reimbursement, the Company will pay the policyholder. 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.

XV. Consideration :

The Frequency of Premium payable under the policy and or each Certificate of the Insurance issued under this Policy shall be annuallyor instalment.

- In the case of annually paid premium - premium is payable before the beginning of each 12 Monthly period when the annual premium is due.

a. There is no grace period for the first instalment

XVI. Observance of terms and conditions:

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

XVII. Material Change:

The Policyholder/ Insured / Insured Person shall immediately notify the Company in writing of any material change in the risk on account ofchange in nature of occupation or business, partial disclosure of the medical history at Insured / Insured person's own expense. The Company may, adjust the scope of cover and / or the premium, if necessary, accordingly.

XVIII. No Constructive Notice:

The Company shall not take notice of any information relating to the Insured person unless such information is submitted in writing by the Policyholder/ Insured, even if such information was available with the Company.

XIX. Notice of Charge:

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to thePolicy. However, any payment by the Company to Policyholder/ Insured or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

XX. Special Provisions:

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

XXI. Room Categorization:
There is no restriction on the room category availed during the period of hospitalisation. During hospitalization if the insured person is transferred from Normal room to ICU or vice versa the benefit would be payable only under one heading as per the hospital bill for the respective day.

Further the Daily allowance payable shall be same for Normal Room and ICU unless specified otherwise by an endorsement.

XXII. Electronic Transaction:
The Policyholder/ Insured / Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may

be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or relevant regulatory prescriptions.

XXIII. Duty of the Insured on occurrence of loss/event leading to claim
On the occurrence of loss/event/claim within the scope of cover under the Policy resulting in a claim, the Policyholder/ Insured / Insured Person shall:

- Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.
- Allow the Medical Practitioner or any representative of the Company to inspect the medical and hospitalization records and toexamine the Insured / Insured Person
- Assist and not hinder or prevent the Company or any of its representatives in pursuance of their duties

In case the Policyholder/ Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Policyholder/ Insured / Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

XXIV. Right to Investigate:
If required by the Company, a representative of the Company including a physician appointed in that behalf in case of any loss/event/claim or any circumstances that have given rise to a claim to the Insured / Insured Person, be permitted at all reasonable times to investigate into the circumstances of such loss/event leading to claim. The Insured / Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss/event or such circumstance in his/her possession including presenting himself/herself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or shall assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

The Company shall bear all cost of investigation required under this section.

XXV. Position after a claim:
As from the day of receipt of the claim amount by the Policyholder/ Insured / Insured Person, the days Insured for the remainder of the Policy year of insurance shall stand reduced by a corresponding

amount.

XXVI. Forfeiture of claims:
If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any rights whatsoever.

Termination :
The Policy will terminate at the expiration of the period for which premium has been paid or on Expiration Date shown in the Policy Schedule, whichever is earlier.

Termination of Individual Certificates of Insurance : Each Certificate of Insurance will terminate on the earliest of the following dates

- The date the expiry of the certificate of Insurance.
- The date the Insured person is no more eligible to get covered under the group.
- The instalment premium is not paid.
- The date We or You cancel the Certificate of Insurance.

XXVII. Cause of action/Currency of payment:
Coverage for all Sections on Benefit basis shall be applicable on worldwide basis. Indemnity Sections shall be restricted to terrritorial limits of India.All claims shall be payable in India in Indian Rupees only.

XXVIII. Policy Disputes:
The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Policyholder/ Insured and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

XXIX. Arbitration:
If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 arbitrators, comprising of 2 arbitrators - 1 to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such 2 arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.
It is hereby agreed and understood that no dispute or difference shall be referred to arbitration, as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.
It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss shall be first obtained.

XXX. Inclusion of members under the Policy:
New Person can be added to this Policy, either by way of endorsement in case of mid-term inclusion or at the time of renewal subject to acceptance by underwriters.

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

- In case of the Policyholder/ Insured, at the address given in the Policy Schedule/ Certificate of Insurance.
- In case of the Company, to the Policy

issuing office/nearest office of the Company.

If Insured person is not satisfied with the redressal of grie\lance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
Refer Link for updated list- http://ecoi.co.in/ombudsman.html

Annexure A

List I: Optional Items

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK

61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II- Items that are to be subsumed into room charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX I MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/VARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

List III- Items that are to be subsumed into Costs of Treatment

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

SECTION 6: CLAIM SERVICING:

I. Claim Notification - Multi Model Intimation:

It is the endeavor of Company to give multiple options to the Insured Person/Insured Person's representative to intimate the claim to the Company. The intimation can be given in following ways:

- Toll Free call Centre of the Insurance Company(24x7) - 1800-103-2292
- Login to the website of the Insurance Company and intimate the claim
- Send an email to the Company- customersupportba@icicilombard.com
- Directly contact our Company office but in writing - ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025

In all the above, the intimations are directed to a central team for prompt and immediate action.

II. Information Details

When the Insured Person/Insured Person's representative intimate the claim as mentioned above the following information should begiven for prompt services.

- Policy number
- Name of the Policyholder/ Insured
- Name of Covered person/Insured member making the claim
- Contact details
- Nature of the Disease, Illness or Injury
- Name and address, phone number of the attending medical practitioner/hospital.
- Date of hospitalization
- The Insured / Insured Person must provide notification of claim within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier. The Notification of Claim should be ideally provided by the Insured/Insured Person. In the event Insured / Insured Person is unwell, then the Notification of Claim should be provided by Insured Person's representative.

III. Claim Form

On occurance of any claim under this policy, you are requested to submit completed and duly filled claim form along with other requisite documents. Claim forms will be available with the network hospitals, TPA and Company offices and on its website.

IV. Claim Procedure

V. The Company shall be under no obligation to make any payment under this Policy unless all the premium payments are received infull and all payments have been realized.

- The Company will only make payment as per the Policyholder/ Insured's direction. In case of Insured's unfortunate demise, the Company will only make payment to the Nominee (as named in the Policy Schedule/ Certificate of Insurance).
- This Policy only covers medical treatment taken in India, and payments under this Policy shall only be made in Indian Rupeeswithin India.
- The Company will process the claims and make claim payments.
- If there is any deficiency in the documents/ information submitted by Insured person, the Company will send the deficiency letterwithin 7 days of receipt of the claim documents.
- Benefits payable under this policy will be paid within 15 days of the receipt of claim along with claim form and required documents

VI. Documents

It is the Policy of the Company to seek documents in a single request. Based on documents submitted, if any further

documentation is required then it will be sought promptly, at the earliest.

In cases where investigation is deemed necessary, the same will be conducted in all promptitude. Every attempt will be made to keep theprocess transparent.

VII. Repudiations

The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country.

List of documents required for Claims processing:

Section	Document Checklist	Required
All	Govt. ID Proof, Birth Certificate (For Minors)/ Pan Card(Others)	Photocopy
All	Duly Filled Claim form signed with attending physician statement	Original
All	For Medico Legal Cases - First Information Report from Police Dept/ Medico Legal Certificate	Photocopy
All	Medical Reports, Investigation Reports, case history, treatment papers, discharge summary and final itemised bills from the Hospital, Other Reports (if any)	Verified & attested copy from the hospital
All	Prescription from the Treating Medical Practitioner, Drug and Medicine bills from the Chemist	Photocopy
Pre-Post Hospitalisation	Cash Memos from Pharmacy/Chemist, Receipts & Pathological Reports	Original
Pre-Post Hospitalisation	Prescription from the attending Medical Practitioner /Surgeon demanding Pathological tests/Medicines.	Photocopy
Transportation of Mortal Remains & Funeral Expenses	Bills & Receipts of Ambulance/Hearse, Services availed at the Crematorium/ Burial Ground.	Original
Transportation of Mortal Remains & Funeral Expenses	Death Certificate from treating Medical Practitioner or Hospital Authority	Photocopy

External Aids & Appliances	Invoice of the device/equipment	Original
External Aids & Appliances	Prescription from the attending Medical Practitioner /Surgeon demanding the use of device/equipment	Photocopy
Home & Vehicle Modification	Jobcard & Computerised invoice of the modification made to the vehicle from a registered workshop, colour photographs of the vehicle pre & post modification.	Original
Home & Vehicle Modification	Invoice of the raw materials used & labour charges for the modification made to the home, colour photographs of the home pre & post modification.	Original
Home & Vehicle Modification	Prescription from the attending Medical Practitioner /Surgeon demanding	Photocopy
	modification of the Vehicle/Home	
Home & Vehicle Modification	If Cost of Modification exceeds INR. 2 Lacs, Bank Statement clearly mentioning the payment made to the workshop or Contractor	Verified & attested copy from Bank

For Reimbursement Claims :

- If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming amount from other organization/provider (which is otherwise not payable under our policy), then on request from the Insured Person, We will provide attested copies of the bills and other documents submitted by the Insured Person along with settlement letter.

- In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, The Company shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider along with settlement letter.

Endorsement Wordings (Optional coverage)

Endorsement 1. Hospital Daily Cash:

The Company will pay daily cash allowance for each day, in case the Insured Person is hospitalised for treatment of illness/sickness/injury/specific conditions as listed in the terms and conditions below, beyond a specified number of days specified in the Policy Schedule/ Certificate of Insurance, provided that the Insured Person suffers an illness/sickness/injury/specific condition during the Policy Period that results in Insured Person's hospitalisation for each continuous and completed period of 24 hours, as an inpatient.

Our maximum liability shall be restricted to the limits and period mentioned in the Policy Schedule/ Certificate of Insurance

If the treatment is taken for listed day care procedures, the liability of the Company shall be restricted to 50% of the daily allowance payable on In-patient basis, for a single day.

Allowance (INR.)/Day	Benefit Period (Days)	Deductible (Days)	Franchise (Days)

Endorsement 2. Enhanced Hospital Daily Cash (Accident):

If an Insured Person suffers Accidental bodily Injury that requires treatment as Inpatient care, the Company agrees to pay enhanced daily allowance for each day provided that the event of accident and treatment falls within the Period of Insurance.

Our maximum liability shall be beyond specified Deductible/Franchise period and restricted to the allowance limits and benefit period mentioned below.

Allowance (INR.)/Day	Benefit Period (Days)	Deductible (Days)	Franchise (Days)

- Day Care Procedures are specifically excluded from the scope of coverage under this endorsement.
- If there are accidental injury claims under multiple sections/endorsement for a specified date, the Insured Person shall be eligible forthe highest allowance payable in any one section/endorsement. The allowance payable shall not be cumulative unless specified in the respective section(s)

Endorsement 3. Enhanced ICU Benefit:

If an Insured Person suffers illness/sickness/Injury that requires treatment as Inpatient treatment in ICU, the Company agrees to pay enhanced daily allowance for each day provided that the first diagnosis of the disease/illness/injury and treatment falls within the Period of Insurance.

Our maximum liability shall be beyond specified Deductible/Franchise period and restricted to the allowance limits and benefit period mentioned below.

Allowance (INR.)/Day	Benefit Period (Days)	Deductible (Days)	Franchise (Days)

- Day Care Procedures are specifically excluded from the scope of coverage under this endorsement.
- If there are claims under multiple sections/endorsement for treatment in ICU for a specified date, the Insured Person shall be eligiblefor the highest allowance payable in any one section/endorsement. The allowance payable shall not be cumulative unless specified in the respective section(s).
- The Company will pay enhanced ICU Benefit in the event of hospitalization of the insured person who has been transferred from Normal room to ICU or vice versa in any single day and the hospital bill generated for the respective day includes ICU room charges.

Endorsement 4. Enhanced Benefit (Day Care Treatment):

If an Insured Person suffers illness/sickness/Injury that requires treatment as Day care procedure, the Company agrees to pay enhancedfixed benefit provided that, the first diagnosis of the disease/illness/injury and treatment falls within the Period of Insurance.

Our maximum liability shall be restricted to the limits mentioned below.

Benefit Sum Insured (INR.)	Benefit Period (Days)	Deductible (Days)	Franchise (Days)

- If there are claims under multiple sections/endorsement for treatment as Day Care Procedure on a specified date, the Insured Person shall be eligible for the highest benefit in any one section/endorsement. The allowance payable shall not be cumulative unless specified in the respective section(s).
- Hospital daily cash needs to be opted by the Insured. The endorsement cannot be opted on standalone basis.

Endorsement 5. Parental Accommodation

If Insured Person is aged below 12 years and suffers from any illness/sickness/Injury that requires treatment as Inpatient treatment, the Company agrees to pay daily allowance towards parental accommodation for each day provided that the first diagnosis of the disease/illness/injury and treatment falls within the Period of Insurance.

Our maximum liability shall be beyond specified Deductible/Franchise period and restricted to the allowance limits and benefit period mentioned below.

Allowance (INR.)/Day	Benefit Period (Days)	Deductible (Days)	Franchise (Days)

- Day Care Procedures are specifically excluded from the scope of coverage under this endorsement.
- Allowance payable under this endorsement shall be in addition to any other allowances/benefits payable under the policy for the sameinsured event.

Endorsement 6. Reduction of waiting period (Pre Existing Disease)

On payment of additional premium, the Company agrees to reduce the waiting period of Pre Existing Disease under the policy.

The waiting period of 48 Months for Pre Existing Diseases under definitions and exclusions to the policy stands modified and / or deleted (as applicable) under this endorsement to the extent as mentioned below.

Disease Category	Waiting Period
Pre Existing	

- Deductible specified in the policy document or any endorsement stands unaltered.

Endorsement 7. Reduction of waiting period (30 Days)

On payment of additional premium, the Company agrees to reduce the waiting period of 30 Days for Disease/Illness under the policy.

The waiting period of 30 Days for Disease/ Illness under exclusions to the policy stands deleted under this endorsement to the extent asmentioned below.

Disease Category	Waiting Period
30 Days	

- Deductible specified in the policy document or any endorsement stands unaltered.

Endorsement 8. Reduction of waiting period (2 Years)

On payment of additional premium, the Company agrees to reduce the waiting period of 2 Years for Specific Disease/Illness/Procedure/Surgery under the policy.

The waiting period of 2 Years for Specific Disease/Illness/Procedure/Surgery under exclusions to the policy stands modified/deleted (as applicable) under this endorsement to the extent as mentioned below.

Disease Category	Waiting Period
2 Years	

- Deductible mentioned specified in the Policy Schedule/ Certificate of Insurance or any endorsement stands unaltered

Endorsement 9. Convalescence Benefit

On payment of additional premium, the Company agrees to pay additional lump sum benefit in the event an insured person stays continuously in hospital beyond specified no. of days as mentioned below.

Benefit Sum Insured (INR)	Deductible (Days)

- This benefit can be claimed maximum no. of times as specified in the Policy Schedule/ Certificate of Insurance.
- Exclusion related to Convalescence stands deleted in this context.

Endorsement 10. Pre-Post Hospitalization Expenses

On payment of additional premium, the Company agrees to reimburse the actual expenses incurred by the Insured Person towards Pre- Post Hospitalization Expenses. The liability of the Company shall be restricted upto Sum Insured and period as mentioned below.

Sum Insured	Pre-Hospitalization (Days)	Post-Hospitalization (Days)

Endorsement 11. Transportation of Mortal Remains & Funeral Expenses

In the unfortunate event of Accidental death of Insured Person, the Company agrees to reimburse the cost of transportation of the dead body from the Hospital to the place of residence.

Further the Company shall also reimburse all cost incurred to conduct his/her last rites upto the limits specified.

Transportation of Mortal Remains & Funeral Expenses	Sum Insured (INR)

Endorsement 12. Home and Vehicle modification:

The company agrees to reimburse cost of modification done on home and vehicle following an accidental bodily injury. Such modificationshould be medically necessary for easy movement of the insured to exhibit the routine daily activities.

Home and Vehicle modification	Sum Insured (INR)

- This benefit is payable only if the modifications are compliant with the applicable laws.
- If cost of modification under any of Home/Vehicle exceeds INR. 2 Lacs, the payment to the workshop/contractor should be madethrough payment modes other than cash.
- Cost of Modification of Home including raw material and labour work shall not exceed INR. 200 per square feet for Metro and INR. 150 per square feet for Non Metros.
- Purchase of new vehicle or home is not covered.

Endorsement 13. Ambulance Cost:

The Company agrees to reimburse expenses upto the limit specified and incurred on a surface transport ambulance offered by registered healthcare or ambulance service provider used to transfer the Insured Person to the nearest hospital requiring emergency care or if advised by medical practitioner.

Ambulance Cost	Sum Insured (INR)

Endorsement 14. External Aids & Appliances

The company agrees to cover medically necessary expenses prescribed by the treating medical practitioner related to any external aids like artificial limbs, crutches or any other external appliance and/or device following a surgery resulting in hospitalization due to accidental bodily injury.

- Exclusion related to external appliances stands deleted in this context.

External Aids & Appliances	Sum Insured (INR)

Endorsement 15. Reduced Allowance (Minor & Senior Citizens):

This endorsement restricts allowances payable under the policy for Insured Person Aged below

18 or Above 60 Years.
The Claim amount payable towards the allowance sections shall be reduced to [XX]% of daily allowance applicable to the specified Section.

- Hospital daily cash needs to be opted by the Insured. The endorsement cannot be opted on standalone basis.

The Reduction in allowances shall apply on the following Sections (as applicable) if opted for by the Insured: Hospital Daily Cash, Enhanced Hospital Daily Cash (Accident), Enhanced ICU Benefit, Enhanced Benefit (Day Care Procedure).

Reduced % of Daily allowance	Benefit Period (Days)	Deductible (Days)	Franchise (Days)

Endorsement 16. Waiver /Revision of Age Restriction:

The Minimum and Maximum entry age under the policy stands revised as mentioned in the table below.

Entry Age	Days/Years
Minimum	[XX] Days/ Day One
Maximum	[YY] Years/ No Restriction

Endorsement 17. Joint Accidental Hospitalization:

The company agrees to pay Daily Cash Benefit individually in case of floater policy to each insured of a same family hospitalized in asingle accident.

Allowance (INR.)/Day/Person	Benefit Period (Days)	Deductible (Days)	Franchise (Days)

	s)		

- This benefit can be claimed maximum no. of times as specified in the Policy Schedule/ Certificate of Insurance.
- This benefit shall be effected only if **Family Floater Sum Insured endorsement is opted.**
- This benefit can be opted only if the Policyholder has not opted for Enhanced Hospital Daily Cash (Accident) endorsement.

Endorsement 18. Family Floater Sum Insured :

The policy covers the Primary Insured and his Dependents under a family floater Sum Insured. The definition of **"Sum Insured"** shall stand replaced with **"Family Floater Sum Insured"** as mentioned below

"Family Floater Sum Insured" represents the Company's maximum liability for any and all claims made by any one Insured and/or all Insured Person(s) together during the Policy Period.

The Limits of allowances payable on per day basis shall remain unaltered. However this limit will be applicable on per Family basis and shall not apply individually to each member in an event of joint hospitalization, unless specified and endorsed under the policy upon payment of additional premium.

Endorsement 19. Named Illness/Sickness/Accident

The endorsement restricts the coverage under the policy to only named Illness/Sickness/Accident as specified in the Policy Schedule/Certificate of Insurance.

Deductible/Franchisee and all other terms and conditions under the policy shall remain unaltered.

Named Ailments
Typhoid/Malaria/Dengue Fever/Tuberculosis/ Kidney Stones/Meningitis/Accident

Endorsement 20. Maternity Extension

The coverage under the policy is extended to include maternity under the Policy.The exclusions mentioned below stands deleted
R. Maternity: Code Excl18
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

Deductible/Franchisee and all other terms and conditions under the policy shall remain unaltered.

However, there shall be a initial waiting period of 9 Months for covering Maternity unless otherwise specified to cover from first day of thepolicy. The 9 Months waiting period is not applicable at the time of renewal without any break.

Maternity Extension
9 Months waiting Period – Applicable / Waived off