

ICICI Lombard Health Booster- Top Up

Customer Information Sheet/ Know Your Policy

This document provides key information about your policy. You are advised to go through your policy document.

S. No	Description (Please refer to applicable Policy Clause Number in next column)	Policy Clause Number
1.	<u>Name of Insurance Product/Policy</u> Health Booster - Top Up	
2.	<u>Policy Number</u> <Policy Number>	
3.	<u>Type of Insurance Product/Policy</u> Both Indemnity and Benefit	
4.	<u>Sum Insured</u> Basis- Individual Sum Insured ₹ XXXX - where each member has a separate sum insured under the policy Floater Sum Insured- ₹ XXXX – where all members under the policy have a single sum insured limit which may be utilized by any or all members	
5.	<u>Policy Coverage (What the policy covers?)</u> <u>Expenses in respect of:</u> <u>Basic Covers:-</u> In-patient Treatment- Admission in hospital beyond 24 consecutive hours Day Care Treatments – Covered up to annual sum insured. In Patient AYUSH Hospitalization- Up to the annual sum insured. Domiciliary Hospitalisation - Up to the annual sum insured. Donor Expenses- Covers an organ donor's hospitalization for an organ donated up to the annual sum insured. Pre Hospitalization and Post Hospitalisation expenses - Up to 60 days before hospitalization and up to 90 days post discharge from the hospital. Domestic Road Emergency Ambulance Cover- Covers up to 1% of the sum insured, with a maximum limit of ₹5,000 per hospitalization for emergency road ambulance services.	Section d. A d.A.1 d.A.2 d.A.3 d.A.4 d.A.5 d.A.6 d.A.7 d.A.8

	8. Reset Benefit – Resets 100% of the sum Insured once per year if available sum insured gets exhausted; only for plans with Deductible 3 Lakhs and above. 9. Loyalty bonus – Provides 10% of the sum insured for each policy year, maximum up to 50% of the sum insured upon continuous Policy Renewal. 10. Complimentary Health Check-Up- Maximum 2 Health Check-up coupons per year for floater policies. 11. Wellness Program – Designed to encourage and reward healthy behaviour through redemption of wellness points by using services on our IL TakeCare App. Services available under the Wellness Program are: - I. Manage and Track Your Health- a. Online Risk Assessment b. Medical Risk Assessment c. Preventive Risk Assessment II. Disease Management Services III. Medical Concierge Services IV. Affinity to Wellness Optional Covers (Applicable if opted by the customer):- <u>Note- Please refer to section 8 of CIS for coverage limits.</u> Optional Cover 1. 1. Hospital Daily Cash- A daily cash allowance (as per plan opted) will be given per day of hospitalization, maximum up to 30 consecutive days, minimum of 3 consecutive days hospitalization required. 2. Convalescence Benefit - A lump sum amount will be given (as per plan opted) per policy year for minimum hospitalization of 10 consecutive days. Optional cover 2. 3. Personal Accident Cover- A fixed lump sum amount will be given (as per plan opted) on occurrence of the below events- i. Accidental Death ii. Permanent Total Disablement (PTD) 4. Temporary Total Disablement (TTD) Rehabilitation Cover (resulting from Accident Extension) – Provides	d.A.9 d.A.10 d.A.11 Section. d. B d.B.1 d.B.2 d.B.3 d.B.4
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	payment of a fixed lump sum amount per week for rehabilitation. 5. Repatriation of remains – Covers expenses for transporting the insured person's remains to their place of residence or for burial/cremation in the city where the death occurred while traveling within India. Optional cover 3. 6.Critical illness cover - A fixed amount will be paid (as per plan opted) upon first-time diagnosis of a listed critical illness during the policy period.	d.B.5 d.B.6
6.	<u>Exclusions (What does the policy not cover)</u> Standard Exclusions- -Code- Excl04: Investigation & Evaluation -Code- Excl05: Rest Cure, rehabilitation and respite care -Code- Excl06: Obesity/ Weight Control: Expenses related to the surgical treatment of obesity that does not fulfil all the conditions as mentioned in the Policy wordings. -Code- Excl07: Change of Gender treatments Including surgery, to change body characteristics to the opposite sex. -Code- Excl08: Cosmetic or plastic surgery expenses unless for reconstruction due to an accident, burn(s), cancer, or as part of medically necessary treatment. -Code- Excl09: Expenses related to any treatment due to hazardous or adventure sports. -Code- Excl10: Breach of law -Code- Excl11: Excluded Providers. The list of excluded /delisted hospitals is available on our website here: https://www.icicilombard.com/docs/default-source/apps/healthclaims/assets/files/delisted-hospital-list.pdf -Code- Excl12: Excludes treatment for alcoholism, drug or substance abuse or any addictive condition and consequences thereof. -Code- Excl13: Treatment in health hydros, nature cure clinics, spas, or similar places, and in private beds registered as a nursing home for domestic reasons.	Section e.i.

-Code- Excl14: Dietary supplements and non-prescription substances, like vitamins and minerals, unless prescribed by a medical practitioner. -Code- Excl15: Refractive Error: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters. -Code- Excl16: Expenses for unproven treatments, services, or supplies lacking significant medical documentation to support their effectiveness. -Code- Excl17: Expenses related to sterility and infertility. -Code- Excl18: Maternity: Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy; Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period. Specific Exclusions: 1. Deductible: We shall not be liable for the deductible amount as defined in Part I of the Schedule. We are not liable for any payment unless the medical expenses exceed the deductible. Deductible shall not be applicable for optional covers, if any. 2. Co-Payment: For insured individuals above 60 years of age, we don't cover twenty percent (20%) of the admissible claim amount above the deductible under the policy. This doesn't apply if the insured is 60 years of age or below. However, this condition does not apply if you were 45 years old or younger when you first bought this policy with us and have renewed it continuously since then. 3. Co-payment will not be applicable for optional covers, if any. 4. Permanent Exclusions Unless covered by way of an appropriate Extension/optional covers, We shall not be liable to make any payment under this policy in connection with or in respect of -Any physical, medical, or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.	Section e.ii.
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	-Cost of routine medical, eye and ear examinations, preventive health check-up, cost of spectacles, contact lenses or hearing aids, dentures and artificial teeth. - Costs for prosthesis, corrective devices, durable medical equipment (e.g., wheelchairs, crutches), instruments for sleep apnoea or continuous ambulatory peritoneal dialysis (C.A.P.D.), oxygen concentrators for bronchial asthma, and cochlear implants unless due to an Accident or required intra-operatively. -Expenses for dental treatment are not covered unless necessitated by an Accident. -Personal comfort, cosmetic, convenience, and hygiene-related items and services. -Circumcision unless necessary for treatment of a disease or necessitated due to an Accident. -Vaccination and inoculation of any kind unless it is post animal bite. -Intentional self-injury (whether arising from an attempt to commit suicide or otherwise) -Treatment relating to external birth defects and external congenital illnesses or defects or anomalies. -Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose -Treatment received outside the country. -Excludes treatment by a family member, self-medication, or any treatment not scientifically recognized. -Excludes any travel or transportation expenses, except ambulance charges, unless specifically covered. -No coverage for Injuries or Illnesses caused by war, invasion, act of foreign enemies, hostilities, civil war, commotion, confiscation, nationalization, or requisition by any government or public local authority. -No coverage for Injuries or Illnesses caused or contributed to by nuclear weapons/materials or arising from ionizing radiation or contamination by radioactivity from any nuclear fuel or nuclear waste combustion. -Any Injury or Illness sustained or contracted due to flying other than as a passenger on a scheduled regular carrier.	
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	-Any losses directly or indirectly due to contamination caused by any act of terrorism, regardless of any contributory causes -Any consequential or indirect loss or expenses arising out of or related to the Hospitalization. -If the policy is issued with a condition-based exclusion clause, that specific condition and its related complications will be permanently excluded for the insured.					
7.	<u>Waiting period</u> <u>-Time period during which specified diseases/treatments are not cover</u> <u>-It is counted from the beginning of the policy coverage</u> • Initial waiting period: 30 days for all illnesses (except hospitalization due to injury) • Waiting period for treatment of hypertension, diabetes and cardiac conditions: 90 days • Specific waiting periods: 24 months for listed diseases/procedures in the Policy Wordings. • Pre-Existing Diseases: 24 months. • Critical Illness(if opted): 90 days	Section e.i.3 Section e.i.4. Section e.i.2 Section e.i.1 Section.d.B.6				
8.	<u>Financial limits of coverage</u> <u>The policy will pay only up to the limits specified hereunder for the following diseases/procedures:</u> <u>Sub-limits (It is a pre- defined limit and the insurance company will not pay any amount in excess of this limit)</u> Domestic Road Emergency Ambulance Cover- Up to 1% of sum insured subject to a maximum limit of ₹ 5,000 per Hospitalization. <u>Optional Covers (If opted by the customer):-</u> Optional Cover 1. <table><tr><td>Hospital Daily Cash (maximum 30 days) min 3 days</td><td>Silver- ₹30,000 (1,000/day); Gold- ₹90,000 (3,000/day)</td></tr><tr><td>Convalescence Benefit</td><td>Silver- ₹10,000 Gold- ₹20,000</td></tr></table> Optional cover 2.	Hospital Daily Cash (maximum 30 days) min 3 days	Silver- ₹30,000 (1,000/day); Gold- ₹90,000 (3,000/day)	Convalescence Benefit	Silver- ₹10,000 Gold- ₹20,000	d.A.7 Section d. B d.B.1 d.B.2
Hospital Daily Cash (maximum 30 days) min 3 days	Silver- ₹30,000 (1,000/day); Gold- ₹90,000 (3,000/day)					
Convalescence Benefit	Silver- ₹10,000 Gold- ₹20,000					

	Personal accident cover	Silver-₹ 10,00,000 Gold-₹ 15,00,000	d.B.3
	Temporary total disablement(TTD) Rehabilitation cover	Silver-₹50,000 (5,000 per week) Gold-₹1,00,000 (10,000 per week)	d.B.4
	Repatriation of Remains	Silver-₹50,000 (5,000 per week) Gold-₹1,00,000 (10,000 per week)	d.B.5
	Optional cover 3.		
	Critical illness	Silver-₹5,00,000; Gold-₹10,00,000	d.B.6
	Co-payment (It is a specified amount /percentage of the admissible claim amount to be paid by policyholder/insured) Co-payment of 20% will be applicable after 60 years of age.		Section e.ii.2
	Deductible (It is a specified amount: -Up to which an insurance company will not pay any claim, and -Which will be deducted from total claim amount (if claim amount is more than the specified amount) For Top Up plan: Deductible will apply for each and every hospitalisation except for claims made for any one illness.		Section d. How Deductible Works
	Sum Insured options	Basis the Sum Insured opted applicable Deductible options are	
	2L/3L/4L/5L/6L/7L/8L/10L/15L/20L/25L/30L/50L	50k/1L/2L/3L/4L/5L	
	Please refer the Policy Schedule for applicable Deductible		
	Any other limit (as applicable) Not Applicable		
9.	Claims/Claims Procedure Cashless (Pre-Authorization) Procedure:		Section g.2.i.

Step 1 – Get your treatment at our network hospital and during admission submit copy of health card and photo ID proof at Hospital Insurance desk Step 2 – The hospital sends approval request for your cashless admission along with relevant documents (cashless pre-authorization form, investigation reports, past consultation papers (as applicable), copy of health card and photo ID proof, etc.) Step 3 – Request would be processed from insurance as per policy terms and conditions Step 4 – You may avail treatment and claim payment is settled directly to the Provider/Hospital Step 5 – You can check and track your claim status live on IL TakeCare app or WhatsApp 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. Further, we shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital. Reimbursement Procedure: Step 1 – Get treatment at a non-network hospital by paying all the treatment costs. Collect all the documents of treatment and expenses incurred Step 2 – Send the claim documents along with the claim form to insurance. You can emboss the original documents and submit an e-claim on the IL Takecare app. If an e-claim is submitted, please retain all the original documents and produce if asked by Insurance to submit in original hard copy. Step 3 – The claim would be processed as per policy terms and conditions. Step 4 – The approved amount in the claim would be reimbursed to you Step 5 – You can check and track your claim status live on IL TakeCare app or WhatsApp	Section g.2.ii.
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	Insurer needs to be notified of any planned Hospitalization at least 48 hours before admission and 24 hours after admission in the case of emergency hospitalisation. We are to be provided with a duly completed 'Claim Form' and the requisite claim documents, as soon as practicable, latest within 30 days from the date of discharge from the Hospital, failing which we will have the right to treat the claim as inadmissible. The claim will be processed within 15 days of receipt of claim along with claim form. Note: To claim or check your claim status, use the IL TakeCare App or contact us on WhatsApp at +91 7738282666. - The relevant documents to 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 For cashless hospitalization in a non-network hospital, contact health assistance at least 48 hours before admission. Use "Anywhere Cashless" through IL TakeCare App's > Services We Offer > Health Assistance. Available from 8am to 8pm, Mon to Sat (except public holidays). You can also reach them via email at healthassistance@icicilombard.com or through this web link: https://ilhc.icicilombard.com/Home/healthassistance. For customer support during claims, call our toll-free number 18002666 or email us at customersupport@icicilombard.com. Find our extensive list of hospitals providing cashless services on our website	Section d.12.a
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https://www.icicilombard.com/health-insurance/health-claim/partner-hospital or the IL TakeCare App. List of excluded providers/delisted hospitals is available on our website https://www.icicilombard.com/docs/default-source/apps/healthclaims/assets/files/delisted-hospital-list.pdf Notify us 48 hours before planned admission or within 24 hours for emergencies when using cashless services. Non-medical and non-payable expenses are your responsibility. You shall be required to furnish the following documents for or in support of a Claim: 1. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from our website www.icicilombard.com 2. Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner 3. Original bills from chemists supported by proper prescription. 4. Original investigation test reports and payment receipts. 5. Indoor case papers 6. Medical Practitioner's referral letter advising Hospitalization in non-Accident cases. 7. Any other document as required by Us or to investigate the Claim or Our obligation to make payment for it If sending hard copies of claim documents, mail them to: ICICI Lombard GIC LTD, 1st, 4th, 5th & 6th Floor Varun Towers-II, Opp Hyderabad Public School, Begumpet Hyderabad-500016 Telangana. In the event of a payable claim, We shall make such payment through Cashless facility or provide Reimbursement of benefits, up to an amount as specified for said cover.	Section d.12.b
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	Download Claim Form- https://echannel-wf.icicilombard.com/docs/default-source/apps/healthclaims/assets/files/claim-form-greater-then-1-lac.pdf	
10.	Policy Servicing -You may contact us on our Toll Free no: 1800 2666, or email to customersupport@icicilombard.com or use our IL TakeCare App or send a Hi to RIA, our Responsive Intelligent Assistant on WhatsApp (7738282666) for policy services. -For details of Company officials kindly visit our website https://www.icicilombard.com/customer-support .	
11.	Grievances/Complaints - In case of any grievance the insured person may contact the Company through: - Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com Address: ICICI Lombard General Insurance Co. Ltd. Ground floor- Interface 11, Sixth floor- Interface 16 , Office no 601 & 602, New linking Road, Malad (West), Mumbai – 400064 - There is an interactive voice response (IVR) facility for senior citizens' grievance redressal for easy and faster resolution - Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. 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 officer at the details provided in the below link: https://www.icicilombard.com/grievanceredressal.com	Section f.16

	• If Insured person is not satisfied with the redressal of grievance, the insured person may also approach Insurance Regulatory and Development Authority (IRDA) through the Bima Bharosa Portal - https://bimabharosa.irdai.gov.in/ or IRDA Grievance Call Centre(IGCC) at their toll free no. 1800 4254 732 / 155255. • Insured may also approach Insurance Ombudsman, subject to vested jurisdiction, for the redressal of grievance. Details of Insurance Ombudsman offices are available at IRDA website: www.irdaindia.org, or on the Company's website at www.icicilombard.com. •	
12	Things to remember Free Look cancellation: 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 -If you wish to cancel the policy, contact us through our website www.icicilombard.com (Customer Support section), call us toll-free at 1800 2666, or email customersupport@icicilombard.com. Policy renewal: Except on grounds of established fraud or non-disclosure or misrepresentation by the insured, renewal of your policy shall not be denied, provided the policy is not withdrawn and also subject to moratorium conditions. Migration and Portability: 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.	Section f.i.15 Section f.i.10 Section f.i.8. & i.9.

	a. 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 b. The company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines. c. This benefit is not applicable for enhanced sum insured. d. The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company. The Company may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months Change in Sum Insured: The sum insured can be modified (increase/decrease) only at renewal or anytime, subject to company underwriting. Waiting period restarts for increased sum insured. 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.	Section f.ii.6 Section f.i.12
13.	<u>Your Obligations</u> -Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may affect the claim settlement. -If there is misrepresentation, non-disclosure of material facts, fraud, or non-cooperation in the proposal form, personal statement, medical history, or claim documents, the policy becomes void. In such cases, any benefits obtained	Section f.i.1

	through fraudulent means result in the forfeiture of all paid premiums.	
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Declaration by the Policy Holder:

I have read the above and confirm having noted the details.

Place:

Date: _____

Signature of the Policy Holder

NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict, the terms and conditions mentioned in the policy document shall prevail.