ICICI Lombard
Nibhaye Vaade

PROSPECTUS AND SALES LITERATURE - HEALTH SHIELD 360 RETAIL

Eligibility

1. **Entry age:** This Policy can be offered to an individual with minimum age of 6 years without any restriction on maximum entry age. Children between age of 3 months to 5 years can be insured under a floater plan only. Maximum age for dependent children under Floater Policy is 20years.
2. **Lifetime renewability:** There is no maximum age limit for Renewal.
3. **Number of members:** A maximum of 5 members can be added in a single policy. You can avail a floater cover and get Your immediate family covered for the same sum insured under a single Policy by paying one premium amount. Any individual above 3 months of age can be covered under the Policy provided 1 Adult is also covered under the Policy
4. **Relationships covered:** You and your immediate family (Immediate family would mean spouse, dependent children, brother(s), sister(s) and dependent parent(s), Grandparents, Grandchildren, Mother-in-law, Father-in-law, Son-in-law and Daughter-in-law, dependent Brother-in-law and dependent Sister-in-law. Also individuals/entities with insurable interest can purchase the policy for individuals e.g- employer acting as a proposer for a policy covering employees and their family members.
5. **Premium calculation:** In a family floater policy, the age of the eldest member will be considered while computing premium for all the members covered under the family floater. Other factors determining premium are addition/deletion of any optional covers, change in policy conditions such as tenure, increase or decrease in sum insured opted or Change of Plan for and change in any tax laws by the government and health status of the individual being insured.
6. Policy can only be issued to residents of India. Residents of India shall include all Citizens of India and permanent residents of India as well as expatriates or foreigners who are holding an employment pass, dependant pass or work permit and residing in India. Expatriates or foreigners must provide a copy of either a valid employment pass or work permit, and a bona-fide residential address in India.

   Worldwide cover can only be opted by individuals who are up to the age of 65 years, are permanent residents of India and were within geographical boundaries of India during policy issuance.

Salient features

- Policy tenure: You can opt for a Policy with Policy period of one year or two years or three years
- Tax benefit: You can avail of tax benefit on premiums paid under Health sections of this Policy, as per Section 80D of Income Tax Act, 1961 and amendments made thereafter.
- Annual sum insured: This denotes the maximum amount of cover available to You for a Policy Period of one year.

Minimum Sum Insured: ₹ 3,00,000

Maximum Sum Insured: ₹ 3,00,00,000

- Cashless hospitalization: You can avail of cashless Hospitalization at any of our network providers/ hospitals. A list of these hospitals/ providers will be sent to You along with Your Policy.
- Pre-Policy Medical Check-up: No medical tests will be required, if You approach us for insurance cover below the age of 45 years up to the Annual Sum Insured of Rs.10 Lacs. However if You approach us for insurance when You are 45 years of age* or above, You will have to then compulsorily undergo medical tests at our designated diagnostic centres. If we accept Your proposal, we will reimburse at least 50% of the costs incurred by You in undertaking such pre-insurance medical tests.

  *This age limit may be relaxed for specific channels or plans upon approval from product head.
- **Claim Service Guarantee:** We provide You Claim Service Guarantee as follows

  a) **For Reimbursement Claims:** We shall make the payment of admissible claim (as per terms & conditions of Policy) OR communicate non admissibility of claim within 14 days after You submit complete set of documents & information in respect of the claim. In case We fail to make the payment of admissible claim or to communicate non admissibility of claim within this time period, We shall pay 2% interest over and above the rate defined as per IRDA (Protection of Policyholder's Interest) Regulations 2017.

  b) **For Cashless Claims:** If You notify pre authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will respond within 4 hours (within 2 hours for Covid-19 in-patient claims) of the actual receipt of such pre authorization request with:

  1. Approval, or
  2. Rejection, or
  3. Query seeking further information

  In case the request is for enhancement, i.e. request for increase in the amount already authorized, We will respond to it within 3 hours. (within 2 hours for Covid-19 in-patient claims)

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

  If You are not eligible for 'Claim Service Guarantee' for the reasons stated in the policy conditions, We should inform the same to You, within the 14 days for a) and within 4 hours (within 2 hours for Covid-19 claims) for b) as specified above.

What is covered?

The Policy provides indemnification of Medical Expenses incurred by You during Your Hospitalisation, for any Illness or Injury suffered during the Policy Year.

A. Basic Cover

The payment under this Basic Cover shall be limited to Maximum Limit of Indemnity.

1. **In-patient Treatment:** We will pay You for the in-patient Hospitalisation expenses such as room rent charges, intensive care unit charges, qualified nurse charges, medical practitioner's fee, anaesthesia, blood, oxygen, operation theatre charges, charges incurred on medicines drugs, consumables, surgical appliances and prosthetic devices (recommended in writing), costs of investigations or prescribed diagnostic tests etc. incurred by You during Hospitalisation for a minimum period of 24 consecutive hours, up to the Annual Sum Insured.

   We will consider a claim under this Cover, subject to the following:

   i. Expenses associated with automation machine for peritoneal dialysis shall not be payable

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

3. **Coverage for Modern Treatments** – We will Pay You for the medical expenses incurred on below specified modern treatments during the policy period up to the Annual Sum Insured

Sr. No	Treatment/Procedure
1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
2	Immunotherapy- Monoclonal Antibody to be given as injection
3	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
4	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
5	Balloon Sinuplasty
6	Oral Chemotherapy
7	Robotic surgeries
8	Stereotactic radio Surgeries
9	Deep Brain stimulation
10	Intra vitreal injections
11	Bronchical Thermoplasty
12	IONM - (Intra Operative Neuro Monitoring)

4. **Pre Hospitalization Medical expenses:** We will cover You for the relevant medical Expenses incurred, immediately before hospitalisation up to the limits as specified in the Policy Schedule

5. **Post Hospitalization Medical expenses:** We will cover You for the relevant medical Expenses incurred, immediately after Your Hospitalisation up to the limits as specified in the Policy Schedule.

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

7. **Reset Benefit:** We will reset up to 100% of the Annual Sum insured once for same illness/disease/injury and unlimited times for different illness/disease/injury for the same Insured Person in a policy year, in case the Annual Sum Insured including accrued Guaranteed Cumulative Bonus (if any)/ Sum Insured Protector (if any)/ Super No Claim Bonus (if any) is insufficient as a result of previous claims in that policy year, provided that:

   - The claim will be admissible under the reset benefit only if the Claim is admissible under "Inpatient Treatment" or "Daycare procedure" as per "Scope of cover"
   - Reset will not trigger for the first claim
   - For individual policies, reset sum insured will be available on individual basis whereas for floater policies, it will be available on floater basis
   - The Reset Benefit will not be available for an Illness /Injury or related complications including but not limited to any relapse within 45 days in respect of which a claim has been paid in that Policy Year for the same Insured Person
   - Any unutilized reset sum insured will not be carried forward to subsequent policy year

8. **Domestic Road Ambulance Cover:** We will cover the expenses incurred on road ambulance services which are offered by a healthcare or ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital from place of Accident/ Illness with adequate emergency facilities for the provision of Emergency Care.

   - Our maximum liability under this Benefit for every claim arising during the Policy Year will be restricted to 1% of the Annual Sum Insured maximum up to Rs. 10,000 in case the charges of road ambulance are being reimbursed. In case the services of a health care or ambulance service provider are being availed on cashless basis, the charges of road ambulance will be covered as per actuals. This cover includes and is limited to the cost of the transportation of the Insured Person:

   1. To the nearest Hospital with higher medical facilities which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, and only if that transportation has been prescribed in writing by a Medical Practitioner and is for Medically Necessary Treatment.
   2. From a Hospital to the nearest diagnostic centre during the course of Hospitalization for advanced

diagnostic treatment in circumstances where such facility is not available in the existing Hospital.

9. **Air Ambulance Cover:** We will cover the expenses incurred by You on Air Ambulance services which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer You to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, up to the Annual Sum Insured.
10. **Donor Expenses:** We will cover You for the medical expenses incurred in respect of the organ donor for any of the organ transplant surgery provided the organ donated is for the Insured Person's use up to the Annual Sum Insured.
11. **Domiciliary Hospitalization:** We will cover the medical expenses incurred in respect of Your Domiciliary Hospitalization up to the Annual Sum Insured provided that the Domiciliary Hospitalisation continues for at least 3 consecutive days.

    We shall not be liable to pay for any claim under this Cover which arises directly or indirectly from or in connection with any of the following:

    a) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
    b) Arthritis, gout and rheumatism;
    c) Ailments of spine/disc
    d) Chronic nephritis and nephritic syndrome;
    e) Any liver disease;
    f) Peptic ulcer
    g) Diarrhea and all type of dysenteries, including gastroenteritis;
    h) Diabetes mellitus and insipidus;
    I) Epilepsy;
    j) Hypertension;
    k) Pyrexia of any origin
12. **Home Care Treatment:** We will cover the medical expenses incurred by You on Home Care Treatment up to 5% of Annual Sum Insured subject to a maximum of Rs. 25,000 provided the medical practitioner has advised You in writing to undergo treatment at home. Treatments that can be availed on outpatient basis are outside the scope of this cover.

    Home Care Treatment can only be availed on a cashless basis through our empanelled service providers.
13. **Wellness Program:** The wellness program provides You with the below mentioned benefits

    I. Wellness program
    II. Health Assistance [HAT]
    III. Ambulance Assistance
    IV. Discounts on services and products

I. Wellness program

Wellness program intends to promote, incentivize and reward You for You healthy behavior through various wellness services. All the wellness activities as mentioned below in Table A enable You to earn wellness points which shall be monitored by the Health Coach.

The Health Coach shall only be available to Insured persons aged 21 and above. The Health Coach is a personalized service that shall encourage and promote optimal health and physical and mental wellness through a digital platform. You shall have access to the health coach on downloading and registering on our mobile application. This activity needs to be done within 30 days of policy start date to ensure adequate utilization of services offered and to redeem the wellness points awarded.

Post Registration and successful completion of Health Risk Assessment [HRA], You shall be evaluated by the Health Coach to assess and educate You on adapting a healthy lifestyle

Table A- Journey of earning Wellness points

Category	Activity Details	Maximum Wellness Points Earned per Insured Person*
On boarding (mandatory to unlock earnings from other points based slabs)	Addition of Policy Details	500
	E-card Verification	300
Health Assessment	Health Risk Assessment	400
	Advisory on Preventive health check-up	300
	Medical Vault	300
	First usage of Chat with Health expert/ Health Coach Service	100
	Tele- consultations	300
Wellness activities	ICICI Lombard initiated Contest/ health quiz (Any one contest)	200
	ICICI Lombard initiated Webinar (Any one webinar)	200
Wellness Tasks	Achieving targeted steps per month	Maximum of 2400 per year
Fitness challenge	Participation and successful completion of fitness challenge In App	250 per challenge, maximum of 500 points
Health Events	Participation in Professional sporting events like Marathon/Cyclothon /Swimathon etc.	250 per event, maximum of 500 points
Grand Total		6000

The Wellness Points to be awarded for each activity have been mentioned considering an individual policy for a single adult aged 21 and above. In case of a floater policy with 2 adults aged 21 and above, the wellness points to be awarded shall be doubled, provided, that both the Insured Persons complete their respective wellness activities.

Redemption of wellness points

Each wellness point is valued at INR 0.25.

The Wellness points earned by You (as detailed in Table A) can be redeemed by availing services such as out-patient consultations, purchase of pharmaceutical drugs/ medicines, undergoing diagnostic tests, purchase of health supplements etc. through our mobile application

Terms and Conditions for Redemption of Wellness Points

- You have to accumulate minimum 400 wellness points in order to redeem them on our mobile application.
- Alternately, You can even choose to carry forward the wellness points for 3 years, in case You do not wish to redeem the same provided the policy is continuously renewed without any break.

For detailed Terms and conditions, disclaimers for availing the Wellness Program kindly refer to the policy wordings

II. Health Assistance:

Our Health Assistance Team (HAT) will assist You in understanding Your health condition better by providing responses to any queries related to health and health care providers

The services provided under this shall include:

- Identifying a Physician/ Specialist
- Availability of hospital beds
- Providing guidance on engaging attendants/ nurses
- Facilitation with respect to arrangement of mobility aids, daily living aids, medical equipment etc.
- Scheduling an appointment with any Medical Practitioner empanelled with Us
- Scheduling appointments for a second opinion
- Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
- Scheduling appointments from diagnostic labs empanelled with us
- Providing information, assistance and facilitation on door step delivery of medicines
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.

Please note that services provided under this Cover are solely for assistance, and should not be construed to be a substitute for a visit/ consultation to an independent Medical Practitioner. This service is available on our mobile application or by calling on 040-66274205 (please note that this number is subject to change) from 8am to 8pm from Monday to Saturday except public holidays.

For detailed Terms and conditions, disclaimers for availing Health Assistance kindly refer to the policy wordings

III. Ambulance Assistance:

We will facilitate ground medical transportation by a Service Provider to transport the Insured Person from the site of Accident/ Illness/ Injury to the nearest Hospital or any clinic or nursing home for medically necessary treatment on cashless basis subject to availability of services in that particular city/location. Kindly visit our website for updated list of cities/locations where the services are provided.

Process to avail Ambulance Assistance:

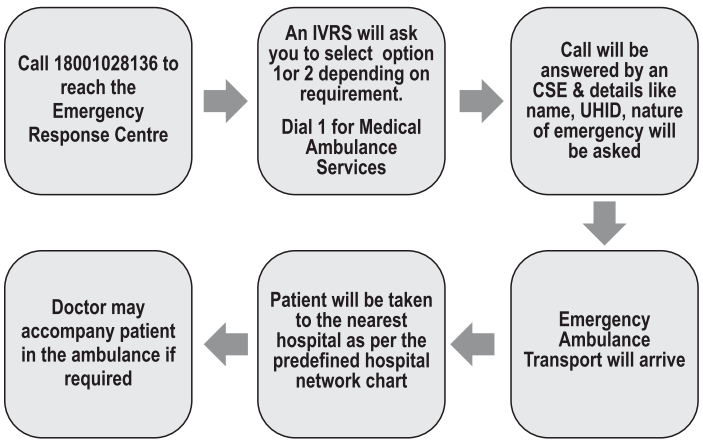
i. On calling Our helpline number provided below, Our trained customer service executive (CSE) will ask You relevant questions to assess the situation.

ii. The call may be redirected to a qualified Medical Practitioner in order to evaluate the requirement for an ambulance with Advanced Life Support based on Your condition.

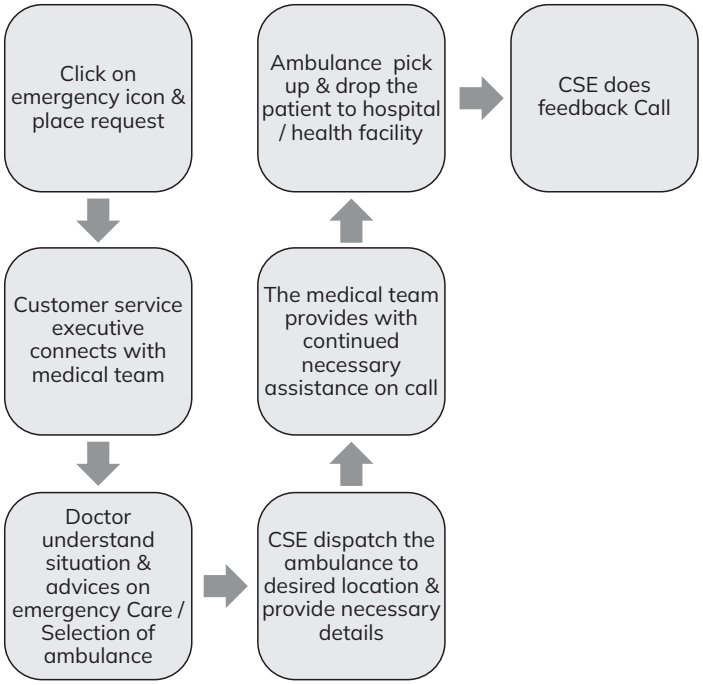
iii. The below mentioned details are to be made available for availing the services:

- Your UHID as provided on the Health Card.
- Your Contact number
- Your Location

How to Call an Ambulance?



How to Call an Ambulance? (Via Mobile Application)



IV. Discounts on services/products

We shall only facilitate You in availing discounts on services/products including but not limited to investigations/diagnostic tests/ laboratory tests /health supplements/ /medical equipment/homecare services/virtual health & wellness sessions/AYUSH products/Fitness & wellness related activities & products etc. at our empanelled diagnostic centres, drugs/medicines ordered from pharmacies etc. offered by our network providers/ health service providers. These discounts can be viewed on our mobile application and one can avail these discounts depending on terms and conditions and subject to availability.

14. **Guaranteed Cumulative Bonus [GCB]:** We will provide a cumulative bonus of 20% for every claim free year(s) up to a maximum of 100% of Annual Sum Insured. Even In the event of Claim, under the Policy, the credited cumulative bonus will not be reduced.

15. **Tele Consultation(s)**

We will arrange consultations and recommendations for routine health issues by a qualified Medical Practitioner or health care professional. For the purpose of this Cover Tele consultation shall mean consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile application. There shall be no maximum limit on the count of tele-consultations that can be availed by You in a Policy Year

16. **Incentives associated with Vaccination against pneumococcal disease:**

We will provide an additional 2.5% discount on premium (fresh or renewal) in case You have taken the conjugate Pneumococcal vaccine or its equivalent vaccine which helps prevent pneumococcal disease. All the adult members covered under the policy should have been vaccinated in the past one year (1 year) from policy start date to avail this discount. i.e. if policy start date is 1st January 2022, all adult members under the policy should have been vaccinated with the conjugate Pneumococcal vaccine in the period from 1st January 2021 to 31st December 2021. This discount shall be provided lifetime as long as You continue to renew this policy

B. Optional Cover

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

The Sum Insured for each of the Optional Covers (except Claim Protector and Worldwide Cover) shall be over and above the Annual Sum Insured of the Policy.

1. **Preventive Health Check-up:** Adults aged 21 and above can avail preventive health check-up as per eligibility under the Plan opted only at our Network Providers or Health Service Providers anytime during the Policy period

This Cover can be availed on cashless basis through our mobile application or via utilization of Health Check-up coupons provided with the Policy kit by calling at our Toll free number: 1800 2666. Maximum of 2 preventive health check-up coupons shall be provided per Policy Year for a floater policy, and is limited to once per Policy Year per Insured Person. Your Health records shall be saved with Us in order to award wellness points as a part of the Wellness Program and may be made available to You in Your medical vault.

2. **Convalescence Benefit:** We will pay You an amount as specified against this Cover in the Policy Schedule/Key Information Sheet, if You get hospitalised for any Injury or Illness as covered under the Policy, for a period of consecutive 10 days or more. This Cover is payable only once to an Insured Person during each Policy Year of the Policy Period.

3. **BeFit:** All benefits under BeFit cover will be provided on cashless basis via our mobile application. All services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment. BeFit cover can only be opted by Insured Person(s) up to the age of 65 years. A waiting period of 30 days will be applicable for this cover. Any unutilized consultations/e-consultations/ annual sum insured/ sessions cannot be carried forward to the next policy year.

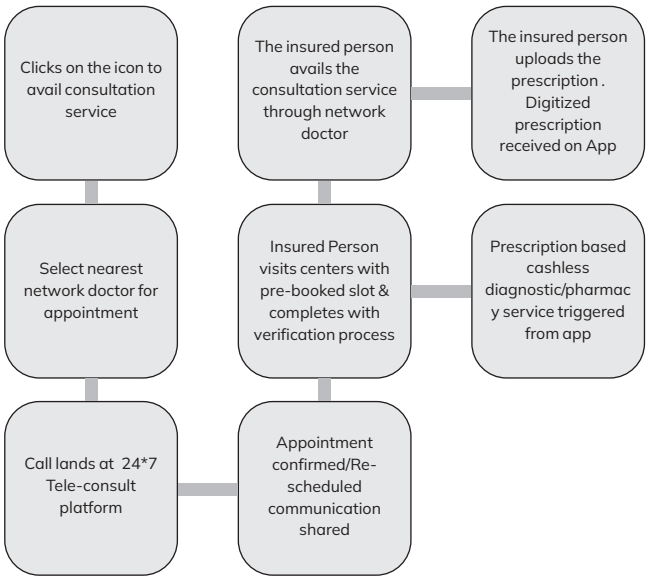
The following benefits will be available subject to the limits as specified in the Policy Schedule

i. Physical consultations
ii. Routine diagnostic and minor procedure cover
iii. Pharmacy cover
iv. Physiotherapy sessions
v. e-counselling
vi. Diet and nutrition e-consultation

Available plans under BeFit

			Covers							
Sr. No.	**Table of Benefit**	**Mode of Utilisation**	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**
1	Outpatient Consultation	Cashless Only	1	2	6	8	12	18	18	20
2	Routine Diagnostics Cover and Minor Procedures Cover	Cashless Only	500	1,000	1,000	2,000	3,000	5,000	7,500	10,000
3	Pharmacy Cover	Cashless Only	500	1,000	1,000	2,000	3,000	5,000	7,500	10,000
4	Physiotherapy Session	Cashless Only	0	0	6	8	10	12	12	12
4	e-Counselling	APP (Online Only)	6	6	6	8	12	Unlimited	Unlimited	Unlimited
4	Diet and Nutrition	e-Consultation APP (Online Only)	6	6	6	8	12	Unlimited	Unlimited	Unlimited

Claim procedure for BeFit



4. **Hospital Daily Cash:** We will pay You an amount of Rs. x for each and every completed day of Hospitalisation, if such Hospitalisation is at least for a minimum of 3 consecutive days and subject to a maximum of 10 consecutive days. This Cover is payable only once to an Insured Person during each Policy Year of the Policy Period.

5. **Nursing at Home Post Hospitalization:** We will pay You a daily amount as specified against this Cover in the Policy Schedule/Key Information Sheet for a maximum of up to 15 days post hospitalisation for the medical services of a Qualified nurse at Your residence. The Claim under this Cover will be payable only if We have admitted Our liability under "In-patient Treatment" section of the Policy.

6. **Compassionate Visit:** We will reimburse You the cost of economy class air ticket incurred by Your "immediate family member" while travelling to Your place of hospitalisation from the place of origin/ residence and back in the event of Your Hospitalisation exceeding 5 days. This cover is subject to a maximum limit of Rs 20,000 per Policy Year

7. **Maternity Cover and New Born Baby Cover:**

   I. Maternity Cover:

   We will cover the Medical Expenses up to the limit as specified in the policy schedule, incurred for delivery, including a caesarean section, during Hospitalisation and Pre-natal and post- natal expenses or lawful medical termination of pregnancy during the Policy Year. The cover shall be limited to 2 deliveries/ terminations during the Period of Insurance. A waiting period of 24/36 months (as per the plan opted)from first issuance of this Policy will be applicable. This cover will be applicable only if both spouse(s) are covered under same floater policy.

   II. New Born Baby Cover:

   We will cover hospitalisation expenses incurred on Your New born baby up to the limits as specified in the policy schedule under this cover. This cover will be provided only if Maternity cover is available to You and for a maximum period of 90 days from the date of birth of Your baby.

8. **Super No Claim Bonus:** We will provide you with a Super No Claim Bonus of 50% of Annual Sum Insured for every claim free completed year subject to a maximum of 100% of Annual Sum Insured. In the event of a claim in the Policy Year, the Super No Claim Bonus will be reduced by 50%. At the time of renewal if You opt out of this cover, then the Super No Claim Bonus accrued up until the expiring Policy Year will be forfeited

9. **Sum Insured Protector**

   The Sum Insured protector is designed to protect the Sum

Insured against rising inflation by linking the Annual Sum Insured under the base plan to the Consumer Price index (CPI).

The Annual Sum Insured will be increased on cumulative basis at each renewal on the basis of inflation rate in previous year. Inflation rate would be computed as the average CPI of the entire calendar year published by the Central Statistical Organization (CSO).

The % increase will be applicable only on Annual Sum Insured under the Policy and not on guaranteed cumulative bonus or any other benefit/cover which leads to increase in Sum Insured.

In case, You opt out of Sum Insured Protector cover at renewal, all the accrued amount under the Sum Insured Protector cover in the policy till date will be reduced to zero

Illustration – Considering Consumer Price Index to be 6%

Year	Annual Sum Insured	Opted for Sum Insured Protector	Sum Insured Protector at renewal	Overall Sum Insured Protector
0	Rs. 10,00,000	Yes	Not applicable	Not applicable
1	Rs. 10,00,000	Yes	6%x 10,00,000 = 60,000	Rs. 60,000
2	Rs. 15,00,000	Yes	6%x 10,00,000 = 60,000	Rs. 60,000 + Rs. 60,000 = Rs. 1,20,000
3	Rs 15,00,000	Yes	6%x15,00,000 = 90,000	Rs. 1,20,000 + Rs. 90,000 = Rs. 2,10,000
4	Rs 15,00,000	No	Nil as customer opted out of the Optional Cover	Nil

* Insured Person has enhanced his/her Annual Sum Insured from Rs. 10 Lacs to Rs. 15 Lacs

10. **Claim Protector:** If a claim has been accepted under the inpatient hospitalization cover , then the items which are not payable under the claim as per the specified List of Excluded items that is related to the particular claim will become payable. The maximum claim payout under this benefit shall be limited to Annual Sum Insured under your policy. Any Sum Insured as available under Guaranteed Cumulative Bonus (if any)/ Super no Claim Bonus (if any)/ Sum Insured Protector (if any) will not be available for Claim Protector Cover.

11. **Worldwide Cover (Outside India):**

I. Hospitalization cover

We will cover You for hospitalization expenses including planned hospitalisation incurred outside India and anywhere across the world including USA and Canada, up to Annual Sum Insured subject to the terms & conditions specified hereunder:

i. This cover can only be availed by You if you are up to the age of 65 years, a resident of India and are within the geographical boundaries of India during policy issuance. Non- disclosure or mis- representation with respect to the above will impact claims admissibility under this cover and lead to policy cancellation.

ii. A co-pay of 10% will be applied to every admissible claim

iii. The coverage is available for 45 consecutive days from the date of travel in a single trip and 90 days in a cumulative bases as a whole in a Policy year

iv. The expenses covered under this benefit will be limited to inpatient hospitalization expenses and days care treatment/ procedure expenses. Expenses incurred for pre and post hospitalization, out-patient treatment or any other basic /optional covers under this policy will not be covered

v. The payment of any claim under this benefit will be based on the rate of exchange as on Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian rupees for payment of claims. If on the insured person's date of loss, if the RBI rates are not published, the exchange rates published next shall be considered for conversion

vi. In case of planned hospitalization, prior intimation at least 7 days in advance of the travel and due approval from Us will be necessary.

vii. Any Sum Insured as available under Guaranteed Cumulative Bonus/ Super No Claim Bonus (if any)/ Sum Insured Protector (if any) will not be available for worldwide cover and Hospitalisation expenses incurred will be covered only up to the Annual Sum Insured under the Policy.

viii. Reset benefit will not trigger for this cover

II. Road Emergency Ambulance

We will cover you up to the amount as specified against this Cover (per hospitalization) in the policy schedule/Key Information sheet on availing an ambulance service offered by a Hospital/ambulance service provider in an emergency condition.

III. Air Ambulance

We will cover the expenses incurred by You on air ambulance services which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer You to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care upto the Annual Sum Insured.

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

WHAT WE WILL NOT PAY (EXCLUSIONS UNDER THE POLICY)

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

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

i. Standard Exclusion (Exclusions for which standard wordings are specified by IRDAI)

1. Code- Excl01: Pre-Existing Diseases

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 12/24 months (as per the plan opted) 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 extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage

d. Coverage under the policy after the expiry of 12/24 months (as per the plan opted) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Code- Excl02: Specified Disease/Procedure waiting period

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 specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

List of specific diseases/procedure:

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

3. Expenses related to the treatment of the below mentioned illness within 90 days from the first policy commencement date shall be excluded unless they are pre-existing and disclosed at the time of underwriting

I. Hypertension

ii. Diabetes

iii. Cardiac Conditions

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

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

4. Code- Excl03: 30-day waiting period

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

5. Permanent Exclusions

i. Code- Excl04: Investigation & Evaluation

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

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

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

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

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

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

iii. **Code- Excl06:** Obesity/ Weight Control

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

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

iv. **Code- Excl07:** Change of Gender treatments

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

v. **Code- Excl08:** Cosmetic or plastic Surgery

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

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

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

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

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

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

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders 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.

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

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

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

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

xiii. **Code- Excl16:** Unproven Treatments: Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

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

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

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

Note: This exclusion shall not be applicable in case Optional Maternity cover has been opted for

ii. Specific Exclusion (Exclusions other than those mentioned under e.i above)

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

b. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively.

c. Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

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

e. Acupressure, acupuncture, magnetic and other therapies

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

g. Expenses for venereal disease or any sexually transmitted disease except HIV

h. Screening, counselling or Treatment relating to external birth defects and external congenital Illnesses or defects or anomalies

i. Treatment taken outside the country unless worldwide cover has been opted for

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

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

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

Discounts/Loading Factors:

1. Tenure discount

Tenure of policy	Discount percentage
2 years	10% discount on 2nd year premium
3 years	15% discount on 3rd year premium

2. Incentives associated with Vaccination against pneumococcal disease:

We will provide an additional 2.5% discount on premium (fresh or renewal) in case You have taken the conjugate Pneumococcal vaccine or its equivalent vaccine which helps prevent pneumococcal disease.

3. Loading: We may apply a risk based loading on premium payable (based upon the declarations made and the health status of the person proposed for insurance). The maximum risk loading applicable shall not exceed 200% of base premium.

This risk based loading will be applicable, to the extent as applied at the time of first policy, at renewals as well.

We will not apply any additional loading at renewal based on claim experience.

We will inform you about the applicable risk loading through a counter offer letter at the time of Your risk assessment before first policy. You need to revert to us with consent and additional premium, if any within 15 days of issuance of such counter offer letter. If You neither accept the counter offer letter nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid. Please note that We will issue policy only after getting Your consent.

How do I claim my insurance?

Cashless Basis

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

Pre-authorization means prior to taking any treatment or incurring Medical Expenses at a Network provider, You must contact Us accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, nature of Illness or Injury, name and address of the doctor/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request pre-authorisation at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation

Reimbursement Basis

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

a. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from Our website www.icicilombard.com

b. Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner

c. Original bills from chemists supported by proper prescription.

d. Original investigation test reports and payment receipts.

e. Indoor case papers

f. Medical Practitioner's referral letter advising Hospitalisation in non-Accident cases.

g. Any other document as required by Us or Our In house claim processing team to investigate the Claim or Our obligation to make payment for it

The relevant documents can be sent to

ICICI Lombard Health Care,

ICICI Bank Tower, Plot no 12,

Financial district,

Nanakramguda, Gachibowli,

Hyderabad- 5000032

Terms of Renewal

- The Policy can be renewed under the then prevailing Health Shield 360 Retail product or its nearest substitute (in case the product Health Shield 360 Retail is withdrawn by the Company) approved by IRDAI.
- A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured
- Auto Renewal option is available. You can opt for ECS payment for Policy renewal at the time of buying this Policy.
- In case of any change in risk material to the queries raised in proposal form, medical examination report to be provided on renewal.
- Renewal Premium - Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDAI. Renewal premium may change basis the age of the Insured Person, Addition or deletion of any extensions/optional covers, Change in any policy conditions such as – floater/ individual, policy tenure, etc, Increase/ decrease in the Sum insured opted for, Change in the plans, Change in any tax laws by the Government. Risk based loading (if any) on premium will be applicable from Policy Period Start Date including subsequent Renewal(s) with Us
- Lifetime renewability
- In the likelihood that this policy is revised/modified/withdrawn in future, we will intimate the insured person regarding the same at least 3 months prior to expiry of the policy. In case of withdrawal, the Insured Person have the option to migrate to the nearest substitute policy as available with Us at the time of renewal with all the continuity benefits, provided the policy has been maintained without a break as per the IRDAI portability guidelines.
- Grace Period - The Policy may be renewed by mutual consent and in such event the renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable for any Claim which occurs during the Grace Period.
- Cancellation: The Policyholder may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium for the unexpired Policy Period detailed below.

Cancellation Period	Refund % for 1 year tenure policy	Refund % for 2 years tenure policy	Refund % for 3 years tenure policy
From 16 days to 1 month	77.50%	80.00%	82.50%
From 1 month to 3 months	62.50%	72.50%	77.50%
From 3 months to 6 months	42.50%	62.50%	70.00%
From 6 months to 9 months	20.00%	52.50%	62.50%
From 9 months to 12 months	0.00%	42.50%	55.00%
From 12 months to 15 months	-	30.00%	47.50%
From 15 months to 18 months	-	20.00%	42.50%
From 18 months to 21 months	-	10.00%	35.00%
From 21 months to 24 months	-	0.00%	27.50%
From 24 months to 27 months	-	-	20.00%
From 27 months to 30 months	-	-	12.50%
From 30 months to 33 months	-	-	5.00%
From 33 months to 36 months	-	-	0.00%

- Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.
- The Company may cancel the Policy at any time on grounds of mis-representation, 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 mis-representation, non-disclosure of material facts or fraud.
- After completion of eight continuous years under this policy no look back to be applied. This period of 8 years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract

- The coverage for the Insured Person shall automatically terminate in case of His/Her demise and upon exhaustion Sum Insured and any other additional Sum Insured (if any), for the policy year
- **Migration:**

  The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast3O days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration

  For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987
- **Portability:**

  The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

  For Detailed Guidelines on portability, kindly refer the link

  https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987
- **Premium Payment in instalments**

  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)

  i. Grace Period of 15 days would be given to pay the instalment premium due for the policy

  ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

  iii. 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.

  iv. No interest will be charged If the instalment premium is not paid on due date.

  v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

  vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

  vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
- **Renewal of policy:**

  The policy shall ordinarily be renewable except on misrepresentation by the insured person

  I. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

  II. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

  III. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

  IV. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period

  V. No loading shall apply on renewals based on individual claims experience
- **Policy Alignment Option:** Policy alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy. Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.
- **Free look period:;**

  The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy

  The insured person shall be allowed free look period of fifteen days from date of receipt of the Policy documents to review the terms and conditions of the Policy, and to return the same if not acceptable.

  If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

  a. a refund of the premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges; or

  b. where the risk has already commenced and the option of return of the Policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

  c. where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;
- **Endorsements:** Any change in plan, optional covers opted may happen only during renewal subject to underwriting. The proposer may be changed only at the time of renewal.

The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India. Mid-term endorsement of addition of member in the policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation

- **Change of Sum insured:** Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.
- **Nomination:**
  The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

Benefit Illustration (Classic Plus)

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount	Premium after discount (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount	Premium after discount (Rs.)	Sum insured (Rs.)
42	11,487	5,00,000	11,487	0.00%	11,487	5,00,000	22,974	31%	15,706	5,00,000
45	11,487	5,00,000	11,487		11,487	5,00,000				
Total Premium for all members of the family is Rs. 22,974 (excluding GST), when each member is covered separately.			Total Premium for all members of the family is Rs. 22,974 (excluding GST), when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 15,706 (excluding GST).			
Sum insured available for each individual is Rs 5,00,000 for 1 yr			Sum insured available for each family member is Rs 5,00,000 for 1 yr				Sum insured of Rs 5,00,000 for 1 yr is available for the entire family.			

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount	Premium after discount (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount	Premium after discount (Rs.)	Sum insured (Rs.)
56	32,969	10,00,000	32,969	0.00%	32,969	10,00,000	65,938	18.9%	53,452	10,00,000
60	32,969	10,00,000	32,969		32,969	10,00,000				
Total Premium for all members of the family is Rs. 65,938 (excluding GST), when each member is covered separately.			Total Premium for all members of the family is Rs. 65,938 (excluding GST), when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 53,452 (excluding GST).			
Sum insured available for each individual is Rs 10,00,000 for 1 yr			Sum insured available for each family member is Rs 10,00,000 for 1 yr				Sum insured of Rs 10,00,000 for 1 yr is available for the entire family.			

Enclosed: Rate chart