International Group Health Insurance

A. PREAMBLE

ICICI Lombard General Insurance Company Limited ("We / Us / the Company"), having received a Proposal and the premium from the Proposer named in Part I of the Policy (hereinafter referred to as the "Policy Schedule") and the said Proposal and Declaration together with any statement, report or other document leading to the issuance of this Policy and referred to therein having been accepted and agreed to by Us and the Proposer as the basis of this contract do, by this Policy agree, in consideration of and subject to the due receipt of the subsequent premiums, as set out in the Policy Schedule, and further, subject to the terms, conditions and exclusions contained in this Policy that on proof to Our satisfaction of the claim having become payable to the title of the said person or persons claiming payment or upon the happening of an event upon which one or more benefits become payable under this Policy , the Annual Sum Insured / appropriate benefit amount will be paid by Us.

PART I OF POLICY: POLICY SCHEDULE

Policyholder Details

Policy Number:
Issued At:

1. Name of the Policyholder:
2. Mailing Address of the Policyholder:
3. Email ID of the Policyholder:

Policy Details

4. Period of Insurance:
    - From: 00:00 Hours of dd/mm/yyyy
    - To: Midnight of dd/mm/yyyy

5. Total Lives:
6. Total Sum Insured:
7. Details of Insured Persons:
8. Geographical Area:
9. Benefit Schedule:
10. Premium Payment Mode: Electronic Mode
11. Manner of Payment of Premium (In full /Instalments): If Instalments-(Monthly/Quarterly/Half Yearly)
12. Premium:

	Premium Break-Up	Premium (USD) or XX*
A	Basic Premium	
B	Taxes (if applicable)	

C= A+B	Total Amount including taxes	

XX* - Any equivalent freely convertible currency

13. Premium Payment Warranty Date:

Instalment No	Premium	Due Date	PPW Date
1			
2			
3			
4			

14. Conditions/Endorsements:

- ……
- ……
- ……

15. Special Conditions:

- ……
- ……
- ……

16. Clauses:

- ……
- ……
- ……

17. Warranties:

- ……
- ……
- ……

18. Intermediary Details :

Agency/Broker Code:
Agency/Broker Name:
Agent's/Broker's Mobile No.:
Agent's/Broker's Email ID:

19. TPA Details:

"*Following Policy Dispute Clauses shall be applicable if agreed between the Insured and the Company as against the Policy Dispute Clause mentioned in the Policy Wordings:*

"Policy Dispute:
Any dispute(s) concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both the Insured and the Company to be adjudicated or interpreted in accordance with the Laws of <Dynamic Field> and only competent Courts of <Dynamic Field> shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court

"*Following Arbitration Clauses shall be applicable if agreed between the insured and the company as against the Arbitration Clause mentioned in the Policy Wordings:*

Arbitration Clause:
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 <Dynamic Field> and the Arbitration shall be conducted in accordance to the provisions of <Dynamic Field>.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy."

Subject Otherwise to terms and conditions of International Group Health Insurance Policy.

Signed for and on behalf of ICICI Lombard General Insurance Company Limited, at IIO Gift City (Gandhi nagar) on this date ……..

Authorized Signatory

PART II OF POLICY

B. Definitions

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this Policy or related Extensions:
Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

Accident

A sudden, unexpected, unforeseen or involuntary external event that results in physical injury to an Insured Person during the period of cover.

Act of terrorism

An act of terrorism means an act, including but not limited to, the threat or use of force or violence of any person or group of persons whether acting alone or on behalf of any organizations or governments or unlawful associations, committed for political, religious, ideological or similar purposes or reasons including the intention to influence governments and/or to put the public or any section of the public, in fear**.**

Acute

The sudden onset of a medical condition which is likely to respond quickly to treatment.

Annual Maximum/Annual Sum Insured

This is the overall maximum benefit limit of your policy and applies per Insured Person, per period of cover. We will pay for the cost of benefits allowable under the policy subject to the overall annual maximum and any specified benefit-limits.

Appliances

Devices and equipment when used as an integral part of a surgical procedure administered by a medical practitioner/specialist except those defined as prosthesis or durable medical equipment.

Benefit(s)

Insurance cover provided under the policy and any extensions, restrictions, special conditions as or endorsements noted in your certificate of insurance.

Benefit limit(s)

A limitation that applies to selected benefits or particular parts of a benefit as noted on your benefit schedule. These can either be limited by cost or frequency. All benefit limits are applied per Insured Person, and either per medical condition or per period of cover.

Benefit schedule

The list of benefits outlining the scope of cover provided including any monetary or frequency limits that may be applicable.

Cancer

A malignant tumor, tissues or cells, characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Certificate of insurance

The certificate outlining details of the policyholder, Insured Person(s), the period of cover, the date of entry of each Insured Person and the start date and expiry date of the cover, a summary of the benefits provided, (which should be read in conjunction with the benefit schedule), annual maximum limit, the geographical area of the cover, as well as any deductibles, co-insurances, waiting periods or any other relevant details that may apply.

Chronic condition

A disease, illness or injury which has one or more of the following characteristics:

- it is recurrent in nature
- it has no known recognized cure
- it requires prolonged monitoring and/or supervision through consultations, examinations, check- ups, tests or medication
- it needs palliative treatment
- it requires your rehabilitation or for you to be specially trained to cope with it
- it may lead to disability.

Co-insurance

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

Alternative treatment

Alternative treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and include Ayurveda, Unani, Siddha and Homeopathy in the Indian context. This will also cover acupuncture, acupressure, osteopathy chiropractic treatment, podiatry, traditional Chinese medicine provided by a practitioner who is qualified and licensed to practice in the country where the treatment is given.

Refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional medicine is taught and specifically refers within the cover to acupuncture, homeopathy, osteopathy, chiropractic treatment, podiatry, traditional Chinese medicine and ayurvedic medicine, provided by a practitioner who is qualified and licensed to practice in the country where the treatment is given.

Congenital disorder

Abnormalities, deformities, diseases, illnesses or injuries present at the time of birth whether diagnosed at the time or not.

- Internal Congenital Anomaly : Congenital anomaly which is not in the visible and accessible parts of the body
- External Congenital Anomaly : Congenital anomaly which is in the visible and accessible parts of the body

Country of residence

The country where you reside for a period of no less than three months per period of cover.

Cover

The level of insurance coverage which applies to you and any dependents and is subject to financial limits which are set out in your certificate of insurance and your benefit schedule.

Day-patient

A person who is admitted to a hospital or day care unit where they need a period of medically supervised recovery but do not stay for more than 24 hours.

Date of entry

The date shown on the certificate of insurance on which you were first included under the policy and where you have been on continuous cover with us.

Deductible

The annual amount that each Insured Person must pay each period of cover before the policy will pay certain benefits. Where applied, deductibles are payable per Insured Person per period of cover, unless indicated otherwise in the benefit schedule. Deductible amounts applicable will be indicated in your certificate of insurance.

Dental practitioner

A person who is legally licensed to carry out this profession by the relevant licensing authority to practice dentistry in the country where the dental treatment is given and recognized by us.

Dependent(s)

One spouse or adult partner or any unmarried children, step-children or legally adopted children provided that they are under the age of 19 (or under age 26 and in full-time education) on the start date of the policy or at any subsequent renewal date. All dependents must be named as Insured Persons in the certificate of insurance.

Diagnostic tests

Investigations such as x-rays, blood tests and pathology to assist in finding the cause of symptoms of a medical condition.

Drugs and dressings

Essential prescription drugs, dressings and medicines needed to treat an eligible medical condition, which are authorized and recognized in the country where they are prescribed and are administered by a medical practitioner/specialist.

Durable medical equipment

Any medical items, supplies, equipment or devices used in the course of medical treatment or home care. These may include but are not limited to orthopedic supports and braces (including arch- supports), crutches, wheelchairs, speaking aids and any medical or surgical supplies.

Emergency

A sudden, serious, and unforeseen acute medical condition or injury requiring immediate medical treatment to avert death or significant bodily impairment. Such treatment being undertaken within 24 hours of the medical condition or injury occurring.

Emergency dental treatment

Dental treatment necessary as a result of an accident caused by an extra-oral impact (i.e. any form of impact/accident or injury occurring from outside the oral cavity) received within 48 hours from the date and time of the accident for the immediate relief of pain caused by natural teeth being lost or damaged.

Examinations

Routine examinations including a review and record of the patient's complete medical history, a check of all body systems and a review and discussion of the exam results with the patient. Well-child examinations include a review and record of the child's complete medical history and a check of all body systems in accordance to normal growth and development.

Geographical area

The geographical scope of the cover provided and where treatment can be undertaken. This will be highlighted in your certificate of insurance.

Grace period

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

Group agreement

The agreement we have with the Policyholder which sets out which persons are eligible to be covered under the policy, when cover begins, how it is renewed and how premiums are paid.

Home birth

Delivery of a child in a non-clinical setting using natural childbirth methods attended by a midwife with expertise in managing home births.

Hospital

Any establishment, which is licensed as a medical or surgical hospital under the laws of the country where it operates or other suitably licensed medical facilities used for the same purpose and which are licensed and supervised by the appropriate medical authorities in the country in which they are based.

Immediate family member

A blood relative limited to mother, father, brother, sister, son or daughter and any step-children or legally adopted children.

Injury

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.

In-patient

A patient who is admitted to hospital for a minimum period of 24 consecutive 'In-patient Care' hours or longer for medical reasons.

Insured Person(s)/you/your

The principal member and the dependents (if any) named on the certificate of insurance.

Medical condition

Any disease, injury, or illness, including mental health disorders.

Medical history disregarded (MHD)

Insurance policies with Medical History Disregarded do not require the customer to provide details of their medical history before their policy is accepted. Cover is provided for treatment of pre-existing medical conditions.

Medically necessary

Treatment, which in the opinion of a qualified medical practitioner/specialist is appropriate and consistent with the diagnosis, is proven and demonstrated to have medical value and which is in accordance with the medical standards widely accepted in international medical practice and community and could not have been omitted without adversely affecting the Insured Person's condition, or the quality of medical care rendered. Such treatment must be required for reasons other than the comfort or convenience of the patient or medical practitioner/specialist and provided only for an appropriate duration of time.

Medical practitioner

A physician who has attained primary degrees in medicine or surgery at a recognized medical school and who is licensed to practice medicine under the law in the country in which treatment is given within its scope and jurisdiction of license. The term medical practitioner would include physician, specialist, anesthetist and surgeon but should not be the Insured Person's Immediate Family. "Immediate Family" would comprise of spouse, children, brother(s), sister(s) and parents .

Mental health disorders

Any disorder associated with substantial distress or impairment which impacts the patient's ability to function in a major life activity, such as employment. These disorders must meet international criteria classification against, for example, the Diagnostic and Statistical manual (DSM-IV-TR).

Medical Evacuation

The cost of immediate transportation of the Insured Person suffering an Injury or Illness to the nearest hospital where appropriate medical treatment can be obtained, scenarios which necessitates the Medical Evacuation of the Insured Person are:

i. Current hospital where Insured Person is taking treatment is not equipped enough or lack facilities to carry out further treatment of the Insured Person.
ii. Insured Person suffering an Injury or Illness is stuck or stranded in a remote area which lacks Hospital and the Insured Person has to be transported to the nearest Hospital on an Emergency basis.

Medical Repatriation

Transport costs for a medical repatriation of the Insured Person specified country of nationality as given on your application form, or your specified country of residence, when the required treatment is not available locally.

Network Provider/Network Hospitals

Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured Person.

New born

A baby who is within the first 16 weeks of its life following birth during the policy period.

New born care

Refers to any medical condition arising which requires treatment within the first 30 days of birth.

Out-patient

Out-patient treatment means the one in which the Insured Person 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 Person is not admitted as a day care or in-patient.

Palliative treatment/Hospice Care

Treatment aimed at alleviating the physical/ psychological suffering of progressive, incurable illness.

Period of cover

The period of cover set out in the certificate of insurance. This will usually be a 12-month period starting from the start date or any subsequent renewal date as applicable.

Persistent vegetative state / neurological damage

Chronic state of unconsciousness resulting from overwhelming damage to the cerebral hemispheres whereby you are unable to express any behavioral or cerebral metabolic evidence of possessing cognitive function or being able to respond in a learned manner to external events or stimuli.

Physiotherapist

A practicing physiotherapist who is registered and licensed to practice in the country where treatment is provided.

Physiotherapy

Treatment recommended by a medical practitioner/ specialist as being medically necessary to treat an illness, bodily injury or medical condition where provided by a licensed and qualified physiotherapist.
Physiotherapy does not include ante-natal and maternity exercises, manual therapy or sports massage.

Policy

Our contract of insurance with the Policy holder/Insured Person and the cover which it provides you.

Policyholder

The organization that employs the principal member and is under an agreement to take the policy from the company.

Pre-authorization

The confirmation needed from us before receiving treatment of an injury or medical condition for selected benefits as defined in the benefit schedule.

Pre-existing condition

Any medical condition, mental health disorder or any related condition for which you have received treatment, suffered any symptoms (whether investigated or not) or sought advice for prior to your date of entry.

Pregnancy

Refers to the period of time from conception until delivery.

Pre Hospitalization Medical Expenses

Pre-Hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person, provided that:

o Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

o The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.

Post Hospitalization Medical Expenses

Post-Hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital provided that:

o Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and

o The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.

Premature birth

A baby born prior to the start of the 37th week of pregnancy.

Principle member

An employee of the employer who we have agreed to cover under the policy.

Prosthesis

An artificial substitute or replacement for part of the body including but not limited to artificial heart valves, eyes, joints and limbs.

Qualified nurse

A nurse whose name is currently on any register or roll of nurses, maintained by any statutory nursing registration body within the country where treatment is provided and recognized by us.

Reasonable and customary charges

The standard fee that would typically be made in respect of your treatment costs, in the country where the treatment took place. We may require such fees to be substantiated/authenticated by an independent third party.

Rehabilitation

Medically necessary treatment in the form of a combination of therapies such as physical, occupational or speech therapy aimed at restoring independent activities of daily living and the normal form and/or function of an Insured Person following a medical condition.

Related condition(s)

Any medical condition that we deem to be either an underlying cause of or directly attributable to the medical condition to which you are claiming.

Renewal date

The anniversary of the start date of the policy. This will be the day following the expiry date as shown on your certificate of insurance.

Room rent

Refers to a standard private single room or semi- private room with a private bathroom.

Specialist

A surgeon, anesthetist or physician who has attained primary degrees in medicine or surgery who is licensed to practice medicine by the relevant authority in the country where the treatment is given, and is recognized as having a specialized qualification in the field of, or expertise in, the treatment of the disease, illness or injury being treated.

Start date

The date from which your cover begins under the policy as shown on your certificate of insurance.

Terminal

Where treatment can no longer be expected to cure the medical condition and with death anticipated within 12 months of diagnosis.

Treatment(s)

Any medical, dental or surgical services (including diagnostic tests) that are needed to diagnose, relieve, manage or cure any medical condition, illness or injury under the direction of a recognized medical practitioner/specialist.

Urgent medical care

The provision of immediate out-patient medical service for the treatment of an acute medical condition or injury, such that should immediate care not be provided, it could lead to deterioration or significant impairment of bodily function.

Vaccinations

All basic immunizations and booster injections under the regulation of the country where the treatment is given, any medically necessary travel vaccinations and malaria prophylaxis, vaccinations to aid the prevention of cancer, such as the Human Papilloma Virus (HPV), and vaccinations recommended as part of a national immunization program in your country of residence or home country. Routine vaccinations and immunizations include influenza (seasonal flu) vaccination, Diphtheria, Hepatitis A & B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella, Haemophilus Influenza B, Rotavirus, Meningococcal and Pneumococcal Conjugate.

Waiting period

Is a period of time starting on the date of entry of the Insured Person, during which the Insured Person is not entitled to cover for particular benefits. Your benefit schedule will indicate which benefits are subject to waiting periods.

C. Benefits Covered Under the Policy

This Policy is a contract of insurance between the Policyholder and Us which is subject to the receipt of premium against each Benefit in full (first instalment in case the customer has opted for Premium Payment option in instalment) in respect of the Insured Persons and the terms, conditions and exclusions of this Policy.

Claims made in respect of an Insured Person for any Benefit applicable to the Insured Person shall be subject to the availability of the annual sum insured, applicable benefit-limits (if any) and/or deductible (if any)and /or co-payment(if any) for the Benefit claimed as specified in the Policy Schedule/Certificate and the terms, conditions and exclusions of this Policy.

All claims shall be made in accordance with the procedures set out in this Policy. Admitted claims will be payable to the Insured Person.

Geographical Area-

- **Worldwide Incl US/Canada**
- **Asia**
- **Schengen**
- **Rest of the World**

Section 1- Base Benefits (Inpatient Hospitalization)

This benefit schedule should be read in conjunction with the policy schedule and your certificate of insurance, which will highlight the benefit purchased and any optional benefits provided.

Base benefit includes hospital charges, costs associated with operations, surgeries and other in-patient treatments, rehabilitation and palliative care following discharge from hospital and emergency assistance.

Reimbursement- Unless specifically noted to the contrary, treatment is reimbursed 100% of the limit mentioned in the policy schedule, subject to applicable reasonable and customary charges after the payment of any applicable deductibles. Where WW Incl US/Canada cover has been opted, any treatment undertaken outside of the network will be subject to 20% co-insurance, unless there is no network hospital within 30 miles of your address or the treatment you require is not available in a network hospital, or it is an emergency.

Annual Maximum/Sum Insured- This is the overall maximum benefit limit of your policy and applies per Insured Person, per period of cover. We will pay for the cost of benefits allowable under the policy subject to the overall annual maximum and any specified benefit-limits.

1) Hospital Charges

a) **Room rent-** Charges for in-patient or day-patient room when a stay in hospital is medically necessary, the length of stay is judged medically necessary and treatment is managed by a specialist. If Insured Person is admitted in a higher category, then Insured Person will bear difference of all medical expenses as in final hospital bill in same proportion.

b) **Hospital cash-** For treatment that would have ordinarily been eligible under this policy and was received free of charge, a defined cash benefit will be paid for each night the Insured Person receives in-patient treatment. The benefit is available for a maximum of 30 nights unless specifically mentioned under part I of the policy. .

c) **Parent accommodation-** Room costs of one parent staying in hospital overnight with an Insured Person under 18 years old while the child is admitted and is receiving eligible treatment as an in-patient.

d) **Dependent Accommodation**- Room costs of one dependent staying in hospital overnight with an Insured Person while the Insured Person is admitted and is receiving eligible treatment as an in-patient.
We will pay the daily amount for the accommodation of the one dependent in the hospital only as specified in the Policy Schedule against this benefit in respect of each continuous and completed day of Insured Person's hospitalization.

For this purpose, Dependent means immediate family members as defined
Provided:
i. We have accepted the claim under Insured Person's hospitalization expenses for the same Accident/Illness.
ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
iii. The medical practitioner certifies that the hospitalised Insured Person required hospitalization of minimum 3 consecutive days, maximum up to 10 days or any pre-defined days mentioned in the policy schedule.
iv. We will pay only for one immediate family member.

e) **Operating theatre, drugs and dressings & internal prosthesis-** The costs of the operating theatre, the recovery room, internal appliances integral to the surgical procedure, drugs and dressings used in the operating or recovery room and drugs and dressings and durable medical equipment used during your hospital stay.

f) **Intensive & high dependency care-** Medically necessary costs for the use of an intensive care unit (ICU) or high dependency unit (HDU).

g) **Surgery costs, surgeons' and anaesthetists' fees-** The costs of medically necessary treatment required immediately before, during, and after the surgery. These include the surgeons' and anaesthetist's fees.

h) **Physician and nurse fees-** The cost of consultation fees associated with a medical practitioner/specialist or qualified nurse for the period of your in-patient or day-patient stay.

i) **Diagnostic test-** The costs of medically necessary diagnostic tests including pathology, radiology and electrocardiograms (ECG), when you are referred by your medical practitioner/specialist in order to diagnose or assess the symptoms of your medical condition during an in-patient or day-patient stay.

j) **CT/MRI/PET scans**- The costs of medically necessary radiology including CT, MRI or PET scan (or combination of these scans) when recommended by your medical practitioner/specialist and undertaken as an in-patient, day-patient. 'CT/MRI/PET scans' are not covered under 'Diagnostic test'.

k) **External prosthesis-** The cost of the initial prosthesis needed as part of your treatment and which is required at the time of your surgical procedure. We do not pay for any replacement prosthesis including any replacement devices required in relation to a PED condition.

2) <u>Operations, Surgeries and Treatment (as part of inpatient hospitalization)</u>

a) **Reconstructive / remedial surgery-** Surgery required as a result of an accident, illness or surgery which occurred during the period of cover and is undertaken within 12 months of the accident/illness/surgery occurring to restore natural function or appearance, subject to the cover being in force. Cover includes one reconstructive/remedial surgery per medical condition unless medically necessary to perform multiple surgeries.

b) **Emergency dental treatment-** Emergency dental treatment arising from an accident.

c) **Cancer-** In-patient, day-patient treatment given for a diagnosed cancer condition. This includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination as well as any prescribed drugs and dressings required to treat the medical condition. Following a cancer diagnosis, the cost of a genomic profiling service provided by an independent diagnostics provider selected by us, used to identify the most appropriate treatment according to the Insured Person's genome where clinically appropriate, as determined by your medical practitioner.

d) **Transplant services-** Treatment for and in relation to life-sustaining human organ, tissue and cell transplants including but not limited to kidney, pancreas, liver, heart, lung, bone marrow and cornea, in respect of the Insured Person as a recipient. The transplant shall be carried out in internationally accredited institutions by accredited surgeons and where the organ, tissue or cell procurement is in accordance with World Health Organization (WHO) guidelines. We will only pay for medical costs associated with the donor as an in-patient or day-patient when services are rendered in the same network facility where the transplant occurs and where the donation does not lead to a loss of the donor's life. Costs associated for the donor search or procurement of the organ, tissue or cell are excluded. Cover includes the cost of anti-rejection medication (immunotherapy). The specific type and length of treatment will be determined by the type of transplant and underlying medical condition.

e) **Renal dialysis-** Treatment of renal failure, including renal dialysis as an in-patient or day-patient. This includes pre and post-operative renal dialysis as part of intensive care and for ongoing maintenance while waiting for a kidney transplant for a limit of up to two years.

f) **Psychiatric treatment and psychotherapy-** Medically necessary in-patient or day-patient treatment of a recognized mental health disorder in a recognized psychiatric unit of a hospital. All treatment must be administered under the direct supervision of a consultant psychiatrist.

g) **Emergency treatment outside geographical area of cover-** Emergency treatment for any accident or medical condition, excluding any pre-existing conditions, which has developed whilst traveling outside your geographical area until you are stable for transfer, or up to the benefit limit specified, whichever is the lesser amount. Cost of a flight back to your country of residence or home country is not included.

h) **Acute phases of chronic conditions-** Acute flare-up of a chronic condition, providing active treatment as an in-patient or day-patient stay in order to stabilise the medical condition for the period of admission only.

i) **Emergency out-patient care-** We will pay for emergency treatment at an accident and emergency unit or emergency room of a hospital.

j) **Congenital conditions-** Treatment of a congenital disorder requiring acute care or surgical intervention to cure the medical condition.

k) **Out-patient surgery-** Treatment costs for a surgical procedure performed in an out-patient surgery, hospital out-patient department or clinic.

l) **Pre Hospitalization Medical Expenses**- We will pay medical expenses incurred prior to Hospitalisation as stated in the policy schedule.

m) **Post Hospitalization Medical Expenses**- We will pay medical expenses incurred after Hospitalisation as stated in the policy schedule.

3) **<u>Rehabilitation and palliative care following discharge from hospital</u>**

a) **Home nursing-** We pay for home nursing following discharge from a hospital as consequence of eligible in-patient treatment. We pay if the home nursing:

- is medically necessary
- is required only to provide medical care
- starts immediately following discharge from hospital
- is provided by a visiting qualified nurse
- is recommended or prescribed by your medical practitioner/specialist.

b) **Palliative care /hospice care-** Treatment following the diagnosis that your medical condition is terminal and you will no longer receive treatment that will result in a recovery. We pay for your palliative treatment, social, psychological and spiritual care and hospital or hospice accommodation, nursing care and prescribed drugs and dressings.

c) **Rehabilitation services-** Rehabilitation undertaken in a hospital as an in-patient or in a recognised rehabilitation unit and under the direction of a specialist, including room rent, physical therapy, occupational therapy, dieticians and speech therapy.
Treatment must begin within 30 days after the end of your treatment in hospital for a medical condition which is covered by your policy and arose as a result of the medical condition which required hospitalisation, or as a result of the treatment for that medical condition. We do not pay room rent for rehabilitation when the treatment given is solely physiotherapy.

4) Complications in pregnancy and other related post-birth benefits

a) **Pregnancy related medical conditions-** In-patient treatment of a medical condition which arises during the antenatal stages of pregnancy or during childbirth. We would consider treatment including, but not limited to: ectopic pregnancy, stillbirth, abnormal cell growth in the womb (hydatid form mole), retained placenta or placenta previa, placenta abruption, pre-eclampsia or eclampsia and/or toxemia, pregnancy related diabetes, post-partum hemorrhage, miscarriage requiring immediate surgical treatment, failure to progress in labor, pregnancy related vitamin and mineral deficiency and cholestasis of pregnancy.

We will cover the cost of emergency caesarean section, where it is medically necessary due to non-progression in labor. This exclude any caesarean section which was not medically necessitated.

b) **Child accommodation-** Room rent costs relating to a new born (up to 16 weeks old) to accompany its mother (being an Insured Person) while she is receiving treatment as an in-patient in a hospital.

c) **New born care-** We will pay for new born care of a medical condition requiring in-patient treatment, including congenital disorders which manifest themselves within 30 days of birth under the mother's policy.

5) Evacuation and repatriation services

a) Medical evacuation- Costs of an Insured Person, in the event of emergency treatment not being readily available in the region or country of incident, to be transported by the most medically appropriate means to the nearest appropriate medical facility or, where cover has been purchased, to the country of your choice within your geographical area (if, in the opinion of your medical practitioner / specialist and us that you are in the appropriate medical position to be able to undertake the journey), for the purpose of admission to hospital as an in-patient or day-patient.
We will pay the reasonable expenses for:

- the most medically appropriate transportation costs for the Insured Person.
- local travel costs to and from medical appointments when treatment is being received as a day-patient.
- standard hotel room in a 4* hotel or equivalent, to be determined by us, for the Insured Person immediately pre- and post-hospital admission periods provided that the Insured Person is under the care of a specialist for a period of up to seven day's post discharge from hospital.
- an economy class airfare ticket to return the Insured Person to the site where the emergency initially arose.

b) Medical repatriation- Costs of an Insured Person, in the event of emergency treatment not being readily available in the region or country of incident, to be transported at the specified country of nationality as given on your application form, or your specified country of residence or,

where cover has been purchased, within your geographical area (if, in the opinion of your medical practitioner / specialist and us that you are in the appropriate medical position to be able to undertake the journey), for the purpose of admission to hospital as an in-patient or day-patient.

We will pay the reasonable expenses for:

- the most medically appropriate transportation costs for the Insured Person.
- local travel costs to and from medical appointments when treatment is being received as a day-patient.
- standard hotel room in a 4* hotel or equivalent, to be determined by us, for the Insured Person immediately pre- and post-hospital admission periods provided that the Insured Person is under the care of a specialist for a period of up to seven day's post discharge from hospital.
- an economy class airfare ticket to return the Insured Person to the site where the emergency initially arose or to the that person's country of residence.

Medical repatriation does not extend to include air/sea rescue or mountain rescue services. Only available within the geographical area of your policy.

c) **Accompanying person expenses-** Reasonable costs for an immediate family member to accompany you during a medical evacuation if there is a reasonable need, which would include physical assistance during transportation, you do not have a medical escort or the reason for evacuation relates to a serious, acute illness and only where the treatment received is on an in-patient or day-patient basis.

Reasonable costs include:

- 1 economy return flight (even if the Insured Person is travelling in another class for medical reasons). Or, where the accompanying person is providing medically necessary assistance to the Insured Person during transportation, we will cover the costs of the accompanying person's travel on the medically necessary transport
- Reasonable living expenses
- Reasonable costs for travel to and from hospital
- Standard hotel room in a 4* hotel or equivalent, to be determined by us

This benefit will only be paid once per medical condition and must be pre-authorized by us.

d) **Repatriation of mortal remains**- Reasonable costs for the transportation of your mortal remains following your death whilst outside of your home country. The costs of a local burial in the country where the death occurred, other than your home country, cremation costs in the country where the death occurred and transportation of the urn to your country of residence or home country. Where a local burial or cremation is chosen, costs will be covered to the same cost of repatriation to home country. We do not pay for the cost of burial caskets, or the transportation costs for someone to collect or accompany your mortal remains.

e) **Compassionate travel-** An economy return flight for you, together with any dependent to travel from your country of residence to visit an immediate family member who is in a High-Dependency Unit, Intensive Care Unit or facing a life-threatening illness or injury in your home country. We will cover one visit per medical condition only. We will not cover any living expenses associated with the visit.

f) **Local road ambulance**- We will pay for in-country ambulatory transportation by road to the nearest suitable hospital or other place of treatment where services are available to provide treatment for your eligible accident or medical condition, as well as a clinical escort where deemed medically necessary to accompany you. We do not pay for mountain/air/sea rescue services.

g) **Local air ambulance**- We will pay for in-country ambulatory transportation if medically necessary, air ambulance to the nearest suitable hospital or other place of treatment where services are available to provide treatment for your eligible accident or medical condition, as well as a clinical escort where deemed medically necessary to accompany you. We do not pay for mountain/air/sea rescue services.

Section 2- Out-patient Benefit

Out-patient benefit is optional benefit as specified below and is subject to payment of additional premium. .

Out-patient (OP) maximum limit/sum insured

We will pay for the cost of **covers** allowable under the **policy** subject to the overall annual maximum/sum insured and any specified benefit-limits.

1) **Consultations and scans**

a) **Out-patient consultations-** Out-patient medical practitioner/specialist or qualified nurse fees including consultations to:
   - assess the symptoms of your medical condition
   - arrange or receive treatment
   - follow-up on treatment already received
   - prescribe drugs and dressings

b) **Out-patient psychiatric treatment and psychotherapy-** Consultations and associated costs for treatment with mental health specialists in an out-patient setting. Mental health treatment must be a consequence of a defined mental health disorder, provided the overall treatment is under the referral of a practicing registered psychiatrist licensed to practice as such in the country where the treatment is taking place

c) **Dietician / Nutritionist-** The cost of a dietician or nutritionist consultation for the purpose of undertaking a dietary control regime related to the control of weight or the management and control of an eligible medical condition when referred by a medical practitioner/specialist.

d) **Routine chronic condition management-** Management of chronic conditions requiring ongoing or long-term monitoring through consultations with a medical practitioner/specialist including examinations, check-ups and the prescribing of drugs and dressings. Prescriptions for drugs and dressings that exceed the period of cover will only be covered for the duration of the remaining period of cover.

e) **Diagnostic tests-** The costs of diagnostic tests used to diagnose or assess the symptoms of your medical condition when ordered by your medical practitioner/specialist.

2) Medicines and medical equipment

a) **Prescribed drugs and dressings-** The cost of drugs and dressings prescribed by your medical practitioner/specialist and will only be used for the treatment of a medical condition or injury.
Prescriptions for drugs and dressings that exceed the period of cover will only be covered for the duration of the remaining period of cover. Drugs and dressings does not include prescriptions which can be purchased over-the-counter.

b) **Durable medical equipment-** The cost to rent, or at our discretion to purchase, any durable medical equipment that is ordered by a medical practitioner/specialist to be used in the course of treatment for an accident or medical condition, or while undertaking nursing at home where medically necessary and where recommended by a medical practitioner/specialist.

c) **Hearing aids-** The costs of one set of hearing aids as a consequence of a diagnosed medical condition significantly impairing the Insured Person's ability to hear.

3) Specialist and alternative treatments

a) **HIV/AIDS -** Costs which arise from, or are in any way related to Human Immuno Deficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any variations thereof. Expenses are limited to pre and post-diagnosis consultations, routine check-ups and drugs and dressings.

b) **Physiotherapy-** We will pay for physiotherapy costs under the direction of a registered physiotherapist, where the treatment is of short duration to relieve pain or restore function. If you are not referred by a medical practitioner/ specialist, you will need to gain pre-authorisation from us.

c) **Hormone replacement therapy (early onset)-** Treatment of the menopause as a consequence of a hysterectomy or due to early onset. For the purposes of this cover, early onset shall mean where initial onset, by whatever cause, takes place in a woman under the age of 40 unless specifically mentioned under part I of the policy.

d) **Alternative treatment-** Alternative treatment provided as an out-patient in respect of an eligible medical condition. The practitioner must be appropriately qualified and registered to practice in the country where the treatment is received.

e) **Speech therapy-** Speech therapy as part of a treatment programme for a medical condition and when referred by a medical practitioner/specialist.

4) Prevention and wellbeing

a) **Vaccinations-** Vaccinations must have completed clinical trials and be approved for use in the country where treatment is taking place. The cost of the vaccine along with the visit and administration cost of the vaccination is included.

Section 3- Optional/Add-Ons Benefits

These add-on packages give you the option to increase your cover in the areas that are important to you. You can add on as many of these additional benefits as you like subject to payment of additional premium. However, you are only eligible for these covers if you have chosen Out-patient benefit.

1) Wellness

a) **Annual health assessment**- We will pay for one health assessment per period of cover to assess your state of health where it is provided in one single medical facility, by a recognized medical practitioner/specialist or qualified nurse, all the tests are undertaken in the same consultation and results are provided as a single medical report. The actual tests you have will depend on the health screening offered by your provider but may include routine tests such as blood sugar and cholesterol tests, a blood pressure test and a kidney function test. It may also include specific screening tests, such as mammogram, pap test, colon cancer screening, or prostate cancer screening.

b) **Well-baby checks-** Well-baby checks, effective from 24 hours after birth and up until the child's second birthday and as recommended by a medical practitioner/specialist, including physical examinations, measurements, screenings, evaluations and blood tests as is recommended in the country where the treatment is undertaken.

2) Fertility treatment-

Diagnostic tests for the diagnosis and treatment of infertility including approved surgeries, other therapeutic procedures and any ovulation induction induced via certain oral or injectable infertility medication, artificial insemination including Advanced Reproductive Technology (ART) procedures and In Vitro Fertilization (IVF) with embryo transfer. You must be an Insured Person for at least 12 months prior to incurring costs, with fertility treatment being undertaken directly to you.

We will not pay for the cost of:

- any treatment for complications of birth (for both mother and child) from In Vitro Fertilisation (IVF) or any other form of assisted reproduction
- any infertility services when the infertility is caused or related to voluntary sterilisation
- any donor charges and services
- any cryopreservation of donor eggs and sperm
- any experimental, investigational or unproven infertility procedures or therapies

3) Vision Outpatient

a) **Annual eye test-** One eye test each period of cover, which includes the cost of your consultation.

b) **Glasses and contact lenses-** The costs of spectacle lenses and non-disposable contact lenses which are prescribed by an ophthalmologist or optician to correct a sight/vision problem, such as short or long sight to a maximum of one pair per Insured Person per period of cover. The cost of frames, only if you have been prescribed new spectacle lenses, and where confirmation of the prescription/ purchase of lenses is provided. New spectacle lenses to a maximum of one pair per Insured Person for every two periods of cover. The cost of disposable contact lenses where submissions are for no more than 90 days' supply at any one time.

c) **Laser eye surgery-** Treatment or surgery to correct eyesight, such as laser treatment, refractive keratotomy (RK) and photorefractive keratotomy (PRK). Limited to once per eye per period of cover. It must be undertaken by a recognised specialist, registered in the country where the treatment is undertaken. Expenses related to treatment for correction of eyesight due to refractive error less than 7.5 dioptres will be covered under this cover.

4) Pregnancy and childbirth-

a) **Natural childbirth-** Medically necessary costs incurred during normal pregnancy and childbirth including scans and delivery costs in a hospital or at home. Complications of pregnancy as a result of fertility treatment and artificial insemination (IVF) will be covered if this option is purchased.

b) **C-section-** Non-emergency caesarean section and medically necessary caesarean section costs due to previous elective caesarean section.

c) **Pre-and post-natal check-ups-** Pre and post-natal check-ups up to six weeks following birth for a mother, being an Insured Person, prior to and following childbirth.

d) **Pediatricians costs-** Well-baby examinations and pediatrician costs for the first examination/check-up of a new born baby, if the examination is made within 24 hours of delivery.

e) **New born care benefit-** The costs incurred for the care of the new born until discharge or number of days specified otherwise in the Policy Schedule of the Insured Person from the Hospital following birth when the new born is accompanying such Insured Person mother whilst she is receiving medically necessary treatment as an In-patient.

5) Dental Outpatient

a) **Routine-** Routine dental treatment which includes preventative care exams every six months (oral check, hygienist visit and oral x-ray) and basic restorative treatment including tooth fillings, basic non-surgical extractions (other than wisdom teeth) and root canal treatment. Costs of medically necessary drugs and dressings required as part of the eligible dental treatment.

b) **Routine and restorative-** Routine dental treatment which includes preventative care exams every six months (oral check, hygienist visit and oral x-ray) and basic restorative treatment including tooth fillings, basic non-surgical extractions (other than wisdom teeth) and root canal treatment. Major restorative treatment defined as the removal of impacted, buried or unerrupted teeth, removal of roots, removal of solid odontomes, apicectomy bridges and crowns (new or repair), provision of dentures, removal of wisdom teeth and dental implants where medically necessary rather than for cosmetic purposes compared with other treatment options available.
Costs of medically necessary drugs and dressings required as part of the eligible dental treatment.

c) **Routine, restorative and orthodontic-** Routine dental treatment which includes preventative care examination every six months (oral check, hygienist visit and oral x-ray) and basic restorative treatment including tooth fillings, basic non-surgical extractions (other than wisdom teeth) and root canal treatment.
Major restorative treatment defined as the removal of impacted, buried or unerrupted teeth, removal of roots, removal of solid odontomes, apicectomy bridges and crowns (new or repair), provision of dentures, removal of wisdom teeth and dental implants where medically necessary rather than for cosmetic purposes compared with other treatment options available.

Orthodontic treatment covering the fees and associated costs of a dental practitioner carrying out orthodontic treatment on any Insured Person up to and including 18 years of age.

Costs of medically necessary drugs and dressings required as part of the eligible dental treatment.

6) Bariatric Surgery- We will cover the Reasonable and Customary Expenses while treatment of Insured Person to undergo Bariatric Surgery as advised by a medical practitioner due to below mentioned conditions –

1. For adults aged 18 years or older, presence of severe obesity documented in contemporaneous clinical records defined as any of the following:
2. BMI (body mass index) of 40 or over and in conjunctions with any of the following severe co morbidities:
   - Coronary heart disease; or
   - Medically refractory hypertension (blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes); or
   - Type 2 diabetes mellitus

Special Conditions applicable to Bariatric Surgery Cover

i. Bariatric surgery performed for any other reason not listed above shall not be covered.
ii. The indication for the procedure should be found appropriate by two qualified surgeons and the Insured Person shall obtain prior approval of the company before proceeding with treatment.

7) Second Medical Opinion - In case the Insured Person diagnosed with critical illness, life-threatening and life altering diagnosis during the policy year we will pay the cost of second medical opinion on diagnosis or treatment recommendation to help Insured Person with regards to the current health condition.

Section 4- Online Health Services

Online health services are subject to availability by TPA and can only be availed on sign in basis via TPA application/website. Further, these services are also subject to terms, conditions, waiting periods, exclusions and the availability of the Annual sum insured.

All services shall be provided through the application/website subject to availability at the time of appointment Any unutilized annual sum insured/ sessions cannot be carried forward to the next policy year.

Choosing the Online health services under this policy is purely upon the Insured Person's own discretion and

at own risk. The services provided under the various covers are via third party health service providers/ network providers/ and the Insurer is not responsible for making these services available and/or liability arising out of the services provided by these third parties.

The Insured Person(s) should seek assistance from a medical practitioner should they still have any concerns about their health even post availing services from the TPA applications.

1) **Online wellbeing tools**

In your TPA member portal you will find a range of tools to help you identify your health risks and take steps to prevent ill health and improve your wellbeing.
These include:

- health and fitness calculators
- interactive symptom checker
- interactive health risk assessment
- healthcare advice

2) **Online General Practitioner (GP) service**

We have partnered with Advance Medical, an independent provider of healthcare services to provide you with access to a doctor 24/7, no matter where you are*.
You can use the service to inquire about symptoms or medication in a private setting with full confidentiality, without having to physically go to the doctor. You can share images and test results and a highly trained medical practitioner will provide you with advice and next steps.
To use this service visit your TPA member portal where you will find more information and a link to access the service. You can then arrange a voice or video call with a doctor using the appointment booking system.
(*access to the Internet is required to use this service)

3) **Employee assistance services**

We have registered vendors to give you an independent and confidential support service that can help you and your dependents manage a wide range of challenges including loneliness, adapting to new cultures, personal or emotional impacts of relocation, stress, anxiety, and depression.
The service offers a variety of counselling and consultation support options so you can find one to suit your comfort level, learning style, and lifestyle:

- in-person
- by telephone via email
- through video call
- by instant messaging

This service is available 24/7 by web, phone or mobile.

how does it work?

visit your TPA member portal to access the service.

- a Client Care Representative will assess your situation and find the support that best suits your needs.
- typically, a local counsellor who speaks your preferred language will connect with you within 24 business hours and offer an appointment.
- in case of a crisis or emergency, telephone counselling is available immediately.

To find out more, contact our customer service team.

D. Exclusions

There are certain medical conditions and treatment that we do not cover. If you are unsure about anything in this section, please contact us for confirmation that you are eligible before you go for your treatment.

1. Personal exclusions

Please check **your certificate of insurance** to see if **you** have any personal exclusions or restrictions on **your policy**.

The exclusions in this section apply in addition to and alongside any such personal exclusions and restrictions and apply to any and all **related conditions**, their complications or increases in costs arising from them.

2. Alcohol and substance abuse

Medical treatment and/or care for alcoholism, drug and substance abuse/dependency including any medical condition and/or bodily injury directly or indirectly arising from such abuse or dependency or for any treatment due to the Insured Person being under the influence and/or suffering from the effects of alcohol, intoxicants, drugs, narcotics or other such substances.

3. Artificial life maintenance

Artificial life maintenance including life support machine use where such maintenance is judged by the treating medical practitioner/specialist that it will not result in recovery or restore you to your previous state of health.

4. Birth control

Investigations, treatment, tests or prescribed drugs and dressings related to contraception, sterilization, termination of pregnancy or family planning

5. Chemical contamination and exposure

Termination of any medical condition or for any claim arising directly or indirectly from chemical or biological contamination, exposure to asbestos or from contamination by radioactivity from any nuclear material whatsoever, however caused, including those caused by or contributed to by an act of war or **act of terrorism**.

6. Conflict/acts of terrorism

Claims resulting from war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, riot, civil commotion, military or usurped power or any act of terrorism, except where such injury/illness is sustained as an innocent bystander and where there was no exposure to nuclear, chemical or biological weapons or contamination.

7. Consequential loss

Consequential loss of any kind including without limitation loss of income, loss of opportunity and loss of profit.

8. Cosmetic treatment

Treatment costs relating to cosmetic or aesthetic treatment or any treatment which is carried out to restore your appearance as a result of any medical condition or psychological condition, injury or previous surgery except as is particularly specified in the benefit schedule.

9. Convalescence

Provision of care when it is used solely or primarily for convalescence, supervision, pain management or any other purpose other than for receiving eligible treatment as specified in the benefit schedule or for the purpose of receiving services which would not normally require trained medical professionals to provide such assistance**.**

10. Criminal acts

Intentional, fraudulent, illegal, criminal acts by the Insured Person, including resisting authority.

11. Dental treatment

A medical condition or related condition arising from or as a consequence of gum disease, including but not limited to gingivitis (treatment extending beyond preventative scaling and polishing) or Periodontitis, jaw shrinkage or the treatment of bone disease when related to gum disease, disorders of the temporomandibular joint, Gnathological treatment and scans where the dental treatment is being covered by your policy.
Any other dental treatment except as outlined in your benefit schedule and as specified on your certificate of insurance.

12. Dietary supplements

Dietary supplements and substances including but not limited to vitamins, minerals, protein supplements, infant foods and organic substances regardless as to whether prescribed by a medical practitioner/specialist and/or are acknowledged as having therapeutic effects. However, products classified as vitamins and minerals are covered if needed during pregnancy, to treat diagnosed clinically significant vitamin deficiency syndromes or form part of an accepted clinical treatment plan.

13. Developmental disorders

Testing or medical treatment for learning difficulties, autism, hyperactivity, attention deficit disorder, speech disorders, dyslexia, social or behavioral problems, child development and physical developmental problems or treatments that encourage positive social- emotional relations.

14. Eating disorders

Investigations or treatment (including cosmetic surgery and bariatric surgery) for obesity, eating disorders, weight problems or weight loss whether or not resulting from any medical condition or psychological condition.

15. Epidemics

Healthcare services relating to internationally and locally recognized epidemics, or pandemics.

16. Experimental treatment

Any costs in connection with treatment, services or drug therapy that is deemed by us to be experimental or unproven based on generally accepted medical practice or provided by an unlicensed physician or any immediate family member.

17. Eyesight

Expenses related to treatment for correction of eyesight due to refractive error less than 7.5 dioptres. The provision of any eyewear or contact lenses except where provided within your benefit schedule as indicated on your certificate or insurance.

18. Fertility treatment

Treatment to assist reproduction, including but not limited to ART treatment and IVF, or surrogacy, unless particularly specified within the benefit schedule and you become eligible for that benefit.

19. Foot care

Treatment for corns, calluses, or thickened or misshapen nails.

20. Genetic testing

Genetic tests, when such tests are solely performed to determine whether or not you may be genetically likely to develop a medical condition.

21. Harvesting

The policy will not cover the harvesting of stem cells, sperm, eggs, or umbilical cord blood for future use.

22. Hazardous activities

Claims arising as a result of participation in professional sporting activities or any hazardous sports or activity including, but not limited to kite- surfing, mountain biking, rock or cliff climbing, mountaineering, yachting Outside territorial waters, motor sports, aerial activities and sports, bungee jumping, scuba diving (to a depth greater than 30 metres or where a current PADI certificate is not held), any sport involving animals, speed competition, skiing off-piste (unless in a recognized and authorized area) and racing of any form other than on foot.

23. Home visits

Home visits from a **medical practitioner**/**specialist** are not covered unless **you** are medically incapable of going to the medical facility and the visit is pre- authorized by **us**.

24. Maternity

You are not covered for costs relating to normal pregnancy or childbirth, voluntary caesarean section, or home birth unless Pregnancy and Childbirth cover are specifically shown on your benefit schedule and certificate of insurance.

25. Medical equipment/medical error

Claims directly or indirectly arising from medical error or the failure of any medical/surgical equipment or device of any kind.

26. Non-clinical facilities

Treatment or services received in health hydros, nature cure clinics or any establishment that is not a hospital.

27. Not following advice

Treatment rising from or related to your failure to seek or follow medical advice or treatment, your unreasonable delay in seeking or following such medical advice or treatment or for complications arising from ignoring such advice. Any claim arising as a result of air travel when you are more than __28_ weeks pregnant. Costs incurred where you have travelled to a country or specific area which your Government or Embassy (in your country of residence) have advised against travelling to under any circumstances.

28. Organ transplantation

Treatment costs for, or as a result of transplants involving mechanical or animal organs, the removal of a donor organ from a donor (unless the removal of the donor organ is undertaken at the time of the transplant and in the same network facility as the transplant), the removal of an organ from you for purposes of

transplantation into another person or the purchase of a donor organ. We also do not cover any costs associated with the purchase of a donor organ.

29. Persistent vegetative state / neurological damage Hospital treatment

for more than 90 continuous days for permanent neurological damage or if you are in a persistent vegetative state. For the purpose of this policy, coma lasting more than 90 continuous days will be classed as permanent neurological damage.

30. Physical aids and devices

Any physical aid or device which are not appliances, durable medical equipment.

31. Routine examinations/preventative care

Routine medical examinations, health screening examinations or tests to rule out the existence of a medical condition for which you do not have any symptoms, unless these covers are specified in your benefit schedule and on your certificate of insurance.

32. Second opinions

The costs of any second or subsequent medical opinions from a medical practitioner/specialist for the same medical condition unless pre-authorized by us.

33. Sexual/gender issues

Investigations and treatment of any sexual problems or dysfunction or any treatment including counselling and psychotherapy or any surgical procedure which is directly or indirectly associated with gender reassignment.

34. Sexually transmitted diseases

Treatment for sexually transmitted diseases.

35. Sleep disorders

Investigations or treatment for sleep disorders (including sleep apnea and insomnia), snoring or other sleep related breathing problems.

36. Speech therapy

We do not pay for speech therapy, save in relation to the restoration of normal speech post-trauma or an acute medical condition.

37. Suicide/self-inflicted injury/negligent or reckless behaviour

Cost of treatment from any suicide, attempted suicide, deliberate self-inflicted injury, negligent or reckless behavior and/or needless self-exposure to peril, except in an attempt to save human life.

38. Travel and accommodation

Transportation or accommodation costs you incurred during trips made specifically to get medical treatment unless these costs are for an emergency medical evacuation and were pre-authorized by us.

39. Treatment / care provided by relatives

Treatment or care cannot be provided by an immediate family member or dependent of the Insured Person.

40. Unlicensed/unrecognised treatment

Treatment provided or under the direction of a medical practitioner/specialist or medical facility that is not recognized by the relevant authorities in the country where the treatment takes place as having specialized knowledge, or expertise in, the treatment of the medical condition or injury being treated.

E. Claim Handling Process

In the event of the Insured Person sustaining any accidental Injury or suffering from any illness necessitating a medical treatment in Hospital or any other benefit opted, you should report the claim to the TPA via the helpline no / email id specified in the policy schedule.

The Insured Person shall also provide the particulars of insurance cover and also the details of the TPA/The Company to the Hospital.

a) Medical reports and discharge summary issued by the Hospital furnishing the name of the Insured Person, period of treatment and details of treatment rendered.

b) Original Bills and receipts and invoices for:

- Charges paid towards Hospital accommodation, nursing facilities and other medical services rendered;
- Fees paid to the Medical Practitioner, special nursing charges, etc.; Charges incurred towards any and all test and / or examinations rendered in connection with the treatment;
- Charges incurred towards medicines or drugs purchased from a registered pharmacy other than the Hospital duly supported by the prescriptions of the Medical Practitioner attending to the Insured Person.

c) Claim documents to be submitted in support of claims under ‘Hospital cash’, ‘Parent accommodation’, ‘Medical evacuation’, ‘Medical repatriation’, ‘Accompanying person expenses’, ‘Incidental expenses’, ‘Repatriation of mortal remains’, ‘Compassionate travel’ shall be Discharge summary, Claim form and any such document mentioning account details.

d) And any other document as may be appropriately applicable for the claims preferred under these sections of the Policy.

In respect of all claims payable hereunder, the Company may make settlement either in the form of cashless treatment facility or by reimbursement of the amount of claim to the Insured Person, at its sole discretion. The Insured Person as a matter of right cannot demand cashless treatment facility.

e) Common claim documents asked for:

- Claim Form – completed and signed by the Insured person or electronically filled, as per Company's discretion.
- Copy of passport, visa with entry and exit stamp
- Details furnished in the claim form must match with details mentioned in bank statement or any other method of ascertaining payment/account details associated with the customer.
- Claim Documents must be submitted within 30-days from the Date of Claim Intimation else the claim will be treated as withdrawn and closed.

f) On facing a contingency which shall result in a claim under any of the covers under this Policy, immediate notice thereof shall be given by the Insured Person to the Company/TPA appointed by the Company, the details of which are furnished hereunder and after furnishing to them the identity as required by them shall get the claim registered. Failure to send such immediate notice may prejudice the Insured Person's claim under the Policy. The Insured Person without prior approval from the Company however beyond a limit of US$ 1000 shall incur no expenses. This condition shall be applicable even in cases where the Insured Person would like to pursue his claim only on his return to his place of residence in spite of his meeting with the contingency covered herein whilst abroad.

For assistance and registering your claim please contact to the email-id and toll free number as specified in the policy schedule.

OR Login to the e-claim link as provided by the Company/TPA details of which will be mentioned in the policy document

g) Documents of claim appropriate for each contingency and the consequent loss as listed in the respective Covers of this Policy shall be forwarded to the TPA/The Company as soon as practically possible (unless otherwise required by the Company/TPA) and in no case beyond a period of 30 days from the date of such return/report of a claim. Submission of documents shall be a condition precedent to admission of liability under the Policy.
Wherever, details pertaining to claim, are conveyed by the Insured Person to the TPA/the Company after 30 days, Insured Person shall provide the reasons of such delay to the Company and the Company may on analysis of reasons provided by Insured Person, may condone the delay in intimation of claim or delay in providing the required information/documents to the Company/TPA.

h) If at any time during the period of the Policy, or anytime thereafter the Insured Person shall commit any fraud or resort to fraudulent means to recover any claim under this Policy, Insured Person's right for all benefits under this Policy shall be forfeited.

i) All settlements under this Policy shall be made in freely convertible currency of Country of residence of Insured Person as on the date of loss incurred by the Insured Person.

j) Claim Documentation:
Any other document(s) that the Company requires from the Insured Person to process the claim and prove the authenticity of the loss may be asked for. If these additional documents are not submitted, then the Company will be relieved of its liability to pay the claim. If the TPA or the Company request that bills/invoices/receipts in a foreign language be accompanied by an appropriate translation, then the costs of such translation must be borne by the Insured Person.

k) Obligations of the Insured Person:
- Claims for insurance covers must be submitted to the TPA/Company not later than 30 days after the completion of the treatment, or in the event of death, after transportation of the mortal remains/ burial.
- The Insured Person shall provide the TPA/Company on demand any information that is required to determine the occurrence of the insurable event or the Company's liability to pay the claims.
- If requested to do so by the TPA/the Company, the Insured Person shall be obliged to undergo a medical examination by a Medical Practitioner designated by the TPA/the Company. The cost of such medical examinations and/or tests will be borne by the Company
- The TPA/the Company is authorized to take all measures that are suitable for loss prevention and claim minimization, which includes the Insured Person's transportation back to the Country of Residence of the Insured Person.
- The Company shall be released from any obligation to pay insurance claims if any of the aforementioned obligations are breached by the Insured Person.

l) Multiple Policies:

i. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy /policies, even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the Insured Person shall have the right to choose insurers from whom he/she wants to claim the balance amount.
iv. Where an Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

If there is any other insurance covering any of the benefits that are provided under the policy for which a claim is made, then you must disclose this to us at the time of submitting the claim. In these circumstances, we will not be liable to pay or contribute more than our proper ratable proportion.

If it transpires that you have been paid for all or some of the claim costs by another source of insurance we have the right to a refund from you. We reserve the right to deduct such refund from you from any impending or future claim settlements or to cancel your policy from the start date of the policy, or your date of entry (whichever is the later) without a refund of premium.

m) No sum payable under this Policy shall carry any interest/penalty.

n) This Policy covers all countries that come under the Geographical Scope stated in the Policy Schedule.

o) In the event of the Insured Person's death, the Company or the Company's representatives shall have the right to carry out a post mortem/autopsy, at the Company's expense.

Settlement/Rejection of Claim – The settlement of claims would be done by Us within 30 days after the receipt of last necessary documents, any rejections if done, would be provided with proper reasons by Us. The role of the TPA or Assistant Service Provider (if any) would be limited to facilitate the flow of information between You and Us.

CLAIMS PROCEDURE APPLICABLE TO COVER Outpatient Treatment cover

Refer to 'Claims Procedure – General' section. Documents to be submitted in support of the claim:

- Dully filled claims form
- Documents like payment receipts, bills, invoices and other supporting documents as applicable, needed for reimbursement
- Account Details

CLAIMS PROCEDURE APPLICABLE TO COVER - REPATRIATION OF MORTAL REMAINS

Refer to 'Claims Procedure – General' section Documents to be submitted in support of the claim:

- Photocopy of the death certificate providing the details of the place, date and time, and the circumstances and cause of the death (photocopy of the post-mortem certificate wherever required by the TPA / The Company claim settlement team, for cases where post-mortem is conducted), issued by the appropriate authority where the contingency has arisen.
- Proof for expenses incurred towards disposal of the mortal remains.
- In case of transportation of the body of the deceased to the City of Residence or Place of Origin of the Insured Person, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased to the City of Residence or Place of Origin of the Insured person.

CLAIMS PROCEDURE APPLICABLE TO COVER – MEDICAL EVACUATION and MEDICAL REPATRIATION:

In event of circumstances leading to Medical Evacuation and Medical Repatriation of the Insured Person, his / her representatives shall immediately report the same to the TPA and furnish the complete details along with the supporting documentation. Documents to be submitted in support of the claim:

- Medical reports and transportation details issued by the evacuation agency, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirming the necessity of evacuation along with the proof of expenses towards the same.
- Any other document as required by the Company / Assistant Service Provider /TPA on a case to case basis.

CLAIMS PROCEDURE APPLICABLE TO COVER – DENTAL and VISION TREATMENT

Refer to 'Claims Procedure – General' section
Documents to be submitted in support of the claim:

1. Dental/Vision reports, prescriptions and discharge/treatment summary issued by the Hospital/Dental Clinic/Eye Clinic furnishing the name of the Insured Person, period of treatment, details of treatment

rendered.

2. Bills and receipts for:
i. Charges paid towards Hospital accommodation, nursing facilities and other medical/dental services rendered, if any;
ii. Fees paid to the Dentist/ Dental Practitioner/ Ophthalmologist/ Optician, special nursing charges, etc;
iii. Charges incurred towards any and all test and / or examinations rendered in connection with the dental/ eye treatment;
iv. Charges incurred towards medicines / drugs supplied by the Hospital/Clinic or purchased from a registered pharmacy other than the Hospital/Clinic, duly supported by the prescriptions of the Dentist/ Dental Practitioner/ Ophthalmologist/ Optician attending to the Insured Person.

3. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy.

Part III of Policy

F. GENERAL TERMS AND CONDITIONS

1. Eligibility

The policy is designed as Policyholder fully paying the premium or Insured Person is paying the entire premium or partial paid arrangement between the Policyholder and the Insured Person. The policy is available to employees and their eligible dependents (spouse/partner and/or children).

Employees must:

- be employed full time by their employer by which we mean 21 hours per week or more.
- be aged under 65. If the employee is aged 65 or over, this must be declared to us in writing and will be subject to agreement by us. The maximum age of coverage in any event is 80.
- live or work within the geographical area of cover selected by your employer

Your cover will continue under the policy until you cease employment, , you cancel your cover of your own accord, or retire from employment.

Dependents applying to the policy must be living with the principal member (employee).

We will pay for Complications in pregnancy and other related post-birth medical condition of a new born requiring in-patient treatment, including congenital disorders which manifest themselves within 30 days of birth under the mother's policy.

For full cover and benefits to apply to a new born, he/she is required to be enrolled into the policy as a dependent. Where the new born is enrolled after 30 days from his/her date of birth, he/she may be subject to eligibility restrictions. Where the policy does not include pregnancy and childbirth cover, a new born would only receive cover and benefits once enrolled as a dependent under the policy subject to the policy terms and conditions.

Dependents will remain covered by the policy whilst the principal member remains employed by the policyholder.

2. Additions, modifications and cancellations

To add or cancel any dependents under this policy or to modify any details, please consult with the policyholder (your employer).

For any addition or cancellation of members to the group agreement, we require notification from the policyholder (your employer) within 30 days following the date on which the addition or cancellation is to be effective. Beyond that time, we reserve the right to make the required change on the date of notification or invalidate the cover.

For enrolment to the group agreement, date of entry cannot be backdated to account for claims that have already occurred. Additionally, for any cancellation to the policy, we will not be able to backdate the cancellation if claims have been processed or if pre-authorization has been granted.

We are entitled to refuse, accept or impose terms for an application submitted by you or by any dependents and also reserve the right to ask for evidence of age, state of health (including medical records), employment status and proof of full-time education, adoption or any other change of circumstances at any time during the period of cover.

3. Death of the principal member

Should the principal member die, their partner or spouse (provided they are already covered by the policy as a dependent) will automatically become the principal member for the remainder of the period of cover or, if earlier, the date on which their cover under the policy comes to an end.

4. Start date and renewal date of cover

Your cover under the policy is effective from either your date of entry, or the start date of the policy (whichever is the later) as shown on your certificate of insurance and is renewed annually the day following the expiry date thereafter. This is normally in 12 month periods unless otherwise agreed between us and the policyholder. You will receive a certificate of insurance at the beginning of each new period of cover. Your cover is renewed (by way of premium payments) by the policyholder under the group agreement. Both your cover renewal date and the group renewal date are shown on your certificate of insurance.

5. Premiums

The policyholder has taken out the policy with us and is responsible for paying the premiums due under the policy. If the policyholder (your employer) fails to pay those premiums or comply with the terms and conditions of the policy we may terminate the policy and refuse to pay claims.

6. Premium Instalments

If the option for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or any other periodic payment specifically mentioned in the Policy Schedule has been opted, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

- Grace Period of 15 days would be given to pay the instalment premium due for the Policy.
- During such grace period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.
- The Benefits provided under – "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
- No interest will be charged If the instalment premium is not paid on due date.
- In case of instalment premium due not received within the grace Period, the Policy will get cancelled.

7. Alterations to the policy

We may change the premium rates, benefits and terms and conditions of the policy from time to time, but any such changes will not apply until the next renewal date following the introduction of such changes, unless we are legally obligated to do so beforehand.

8. Termination

Your cover under this policy will end in each of the following situations:

- If we have not received the premium on the date due. At our discretion, we may reinstate cover if the outstanding premium is paid to us although we reserve the right to make any variation in the cover provided.
- We may cancel the insurance policy mid-term only on the grounds of fraud, misrepresentation or moral hazards.
- 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 as detailed below.

  We propose following terms of cancellation / termination of contract:

Cancellation period	Refund %
Within 1 month	72.50%
From 1 month to 3 months	60.00%
From 3 months to 6 months	40.00%
From 6 months to 9 months	20.00%
From 9 months to 12 months	0.00%

We will have no liability to pay for treatment received after the date the policy is terminated even if treatment has already been pre-authorized but not received as at the date of termination.

9. Free Look Period

You would be given a period of 15 days (Free Look Period) from the date of receipt of the Policy and prior to the start date of the policy, whichever is earlier, to review its terms and conditions, except for those policies with a tenure of less than a year. Where the Policy Holder disagrees to any of the terms or conditions of the Policy, he has the option to return the Policy stating the reasons for his objection- If the Insured Person has not made any claim during free look period, Insured Person will be entitled to : Where the risk has already

commenced and the option of return of policy is exercised by You, a deduction towards the proportionate risk premium for period on cover or; Where only a part of risk has commenced, such proportionate risk premium commensurate with the risk covered during such period. In case the request for cancellation comes 15 days after the receipt of Policy by You, we would refund to You the premium paid by You, on a short term basis as provided in the termination clause.

10. Help and intervention

Our provision of help and intervention under the policy is subject to applicable national and international laws and the availability of qualified medical facilities. Whilst we will do our best to overcome any local restrictions there may be times when these either prevent us from providing help and intervention or limit our ability to do so.

11. Third party rights

The policy is a contract between us and the policyholder. The policyholder is the only entity with the right to enforce the terms of the policy or, with our consent, to vary its terms. We have agreed with the policyholder that third parties will not have any right to enforce the policy. This does not affect your right to bring a complaint against us.

12. Data protection

In order to provide services under the policy we will collect and hold certain personal information about you and your dependents. This may include your address, bank details, evidence of age, state of health (including medical records) and employment status. The personal information you supply to us and to any third party acting on our behalf may be used for a variety of reasons. For example: to administer
your claim; to arrange for medical treatment; to calculate the premium payable by the policyholder; to deal with any complaints and to enable us to obtain payment from our reinsurers.

We are also required to review the information that we hold for the purposes of crime prevention and compliance with international sanctions. We may share your information with, and obtain information about you from, other parties who are involved in provision of services relating to the insurance policy. For example: companies providing administration, claims and medical services on our behalf.

13. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products offered by the company as per applicable guidelines on Migration, if any.

14. Withdrawal of Policy

In the likelihood of this product being withdrawn in future, the Company will intimate the Policyholder about the same 90 days prior to expiry of the policy. 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 waiver of waiting period, provided the policy has been maintained without a break.

15. Terms of Renewal

- The Policy can be renewed as a separate contract under the then prevailing ICICI Lombard International Group Health Insurance product or its nearest substitute (in case the product ICICI Lombard Group Health Insurance is withdrawn by the Company) approved under the authority of IFSCA.

- The policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non- cooperation by the Policyholder.

- The policy could be subject to certain changes in terms and conditions including change in premium rate.

16. Renewal notice

The policy shall ordinarily be renewable except on misrepresentation by the Policyholder and/or Insured Person on grounds of fraud, The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period. 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. No loading shall apply on renewals based on individual claims experience.

The policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the previous year policy and in no case later than Grace Period of 30 days from the expiry of the Policy However, risk coverage shall not be available for such a period.

17. Incontestability and Duty of Disclosure

The Policy shall be null and void and no amount/claim shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or on non-disclosure in any material particular in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or devices being used by the Policyholder/Insured Person or any one acting on his behalf to obtain any coverages under this Policy.

18. Reasonable Care

The Policyholder and/or insured person shall take all reasonable steps to safeguard the interests of the Insured Person against loss or damage that may give rise to a claim.

19. Observance of terms and conditions

The due observance and fulfillment of the terms, conditions and endorsement of this Policy in so far as

they relate to anything to be done or complied with by the Policyholder, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

20. Material change

The Policyholder shall immediately notify the Company in writing of any material change in the risk in relation to the declarations made in the proposal form during the policy period or at the time of renewal and the Company may adjust the scope of cover and / or premium if necessary, accordingly.

21. No constructive Notice

Any knowledge or information of any circumstances or condition in connection with the Policyholder in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

22. Notice of charge etc.

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured Person or his legal representative of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

23. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Policyholder's rights or recovery thereof against any person or organization, and the Policyholder shall execute and deliver instruments and papers necessary to secure such rights.

The Policyholder and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Policyholder's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated. However, this condition shall not be applicable to “Benefit” based covers of the Policy, if any but only applicable to indemnity based covers of the Policy

24. Contribution

Contribution is essentially the right of an insurer to call upon other insurers liable to the same Policyholder to share the cost of an indemnity claim on a ratable proportion of Sum Insured. However, this condition shall not be applicable for all the benefit based covers under the Policy, as applicable

25. Fraudulent claims

If any claim 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 Policyholder and/or Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, or if a claim is made and rejected and no court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or

Arbitrators have made their award, all benefits under this Policy shall be forfeited.

26. Policy Disputes

Unless as otherwise agreed by and between the Policyholder and the Company as per the Policy Schedule, any dispute(s) concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both the Policyholder and the Company to be adjudicated or interpreted in accordance with the Laws of India and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

27. Arbitration clause

Unless as otherwise agreed by and between the Policyholder and the Company as per the Policy Schedule, 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 three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

28. Customer Service

If at any time the Policyholder/Insured Person requires any clarification or assistance, the Policyholder/Insured Person may contact the offices of the Company at the address specified, during normal business hours.

29. 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 at the time of renewal.

30. Notices

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

In case of the Policyholder/Insured Person, at the last-known address, In case of the Company:
ICICI Lombard GIC LTD
(IFSC Insurance Office). Unit No 630,
Hiranandani Signature Building, Block 13B,
Zone, Gift City
Gandhinagar 382355
email : customersupport@icicilombard.com

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

31. Grievances

In case the Policyholder/Insured Person is aggrieved in any way, the Policyholder/Insured Person should do

the following:

For resolution of any query, service request, claim related intimation, support or grievance related to the policy, the Policyholder/Insured Person may contact the IIO Branch of The Company or may call us at toll free no. 1800 2666 or email us at customersupport@icicilombard.com write to us at ICICI Lombard GIC LTD (IFSC Insurance Office). Unit No 630, Hiranandani Signature Building, Block 13B, Zone, Gift City, Gandhinagar 382355.

If you are not satisfied with the resolution provided, you may approach us at "iiogrievance@icicilombard.com"

Benefit Schedule

Section 1- Base Benefit

Section 1- Base Benefit	
Annual maximum/Annual sum insured	$5,000 - $4,500,000 (Or any other freely convertible currency of equivalent amount)
Hospital Charges	
Room rent Hospital cash	in full (standard private room) $50 - $300 for maximum 30 nights (unless specifically mentioned under part I of the policy)
Parent accommodation	In full
Dependent accommodation	In full
Operating theatre, drugs and dressings & internal prosthesis	In full
Intensive & high dependency care	In full
Surgery costs, surgeons' and anesthetists' fees	In full
Physician and nurse fees	In full
Diagnostic tests	In full
CT/MRI/PET scans	In full
External prosthesis	In full
Operations, Surgeries and Treatment Covers	
Reconstructive / remedial surgery	In full
	In full

Emergency dental treatment	
Cancer	In full
Transplant services	In full
Renal dialysis	In full
Psychiatric treatment and psychotherapy	In full (up to 30 to 90 Days) unless specifically mentioned under part I of the policy
Emergency treatment outside geographical area of cover	Covered up to $60,000 unless specifically mentioned under part I of the policy)
Acute phases of chronic conditions	In full
Emergency out-patient care	In full
Congenital conditions	In full
Out-patient surgery	In full
Pre Hospitalization Medical Expenses	30 days - 90 days unless specifically mentioned under part I of the policy)
Post Hospitalisation Medical Expenses	60 days – 180 days unless specifically mentioned under part I of the policy)
Rehabilitation and palliative care following discharge from hospital	
Home nursing	In full (up to 30 to 180 Days) unless specifically mentioned under part I of the policy)
Palliative care /hospice care	Covered
Rehabilitation services	In full (up to 30 to 180 Days) unless specifically mentioned under part I of the policy)
Complications in pregnancy and other post-birth covers	
Pregnancy related medical conditions	In full
Child accommodation	In full
New born care	Covered

Evacuation and repatriation services	
Medical evacuation	In full (nearest country)
Medical repatriation	In full
Accompanying person expenses	In full
Incidental expenses	In full
Repatriation of mortal remains	Covered Upto $13,000 (unless specifically mentioned under part I of the policy)
Compassionate travel	Covered
Local road ambulance	In full
Local air ambulance	In full

Section 2- Out-patient Benefit

Out-patient benefit is an optional benefit and is subject to payment of additional premium, but you must choose it to be eligible for any further optional benefits.

Section 2- Out-patient benefit	
Out-patient (OP) maximum	Maximum upto base benefit annual maximum/SI
Consultations and scans	
Out-patient consultations	in full within out- patient limit
Out-patient psychiatric treatment and psychotherapy	Covered Upto $5000 unless specifically mentioned under part I of the policy

Dietician / Nutritionist	Covered Upto $500 unless specifically mentioned under part I of the policy
Routine chronic condition management	Covered within out- patient limit
Diagnostic tests	Covered within out- patient limit
Medicines and medical equipment	
Prescribed drugs and dressings	Covered within out- patient limit
Durable medical equipment	Covered up to $5,000 unless specifically mentioned under part I of the policy
Hearing aids	1 set per policy year unless specifically mentioned under part I of the policy
Specialist and alternative treatments	
HIV/AIDS	Covered Upto $20,000 unless specifically mentioned under part I of the policy
Physiotherapy	Covered
Hormone replacement therapy (early onset)	Covered
Alternative treatment	Covered Upto $5,000 unless specifically mentioned under part I of the policy
Speech therapy	Covered
Prevention and wellbeing	
Vaccinations	Covered

Section 3- Optional/Add on Benefit

These add-on packages give you the option to increase your benefit in the areas that are important to you. You can add on as many of these additional benefits as you like subject to payment of additional premium.

Section 3- Optional Benefit

Wellness	**Waiting period**	**Coverage Limit**
Annual health assessment	no waiting period	

Well-baby checks		Covered Upto $50,000 unless specifically mentioned under part I of the policy

Fertility	**Waiting period**	**Coverage Limit**
Fertility treatment	0/3/6/9/12 months	$50,000 per policy year unless specifically mentioned under part I of the policy

Vision Outpatient	**Waiting period**	**Coverage Limit**
Annual eye test	no waiting period	in full
Glasses and contact lenses	0/3/6/9 months	Covered Upto $1,000 unless specifically mentioned under part I of the policy
Laser eye surgery	0/6/9/18 months	

Pregnancy and childbirth	**Waiting period**	**Coverage Limit**
Natural childbirth	0/6/9/12 months	Covered in full
C-section		
Pre-and post-natal check ups		
Pediatricians costs		

Dental Outpatient	**Waiting period**	**Coverage Limit**
Routine	0/3/6 months	Covered upto $1,000 unless specifically mentioned under part I of the policy
Routine and restorative		Covered upto $5,000 unless specifically mentioned under part I of the policy
Routine, restorative and orthodontic		Covered upto $5,000 unless specifically mentioned under part I of the policy

Other	Waiting period	Coverage Limit
Bariatric Surgery	no waiting period	in full
Second Medical Opinion		in full