PROSPECTUS FOR GROUP HEALTH INSURANCE POLICY

A) What is covered?

The policy provides indemnification of medical expenses incurred by the Insured during day care treatment, hospitalization, domiciliary hospitalization, for any illness or injury suffered during the Policy Period.

Basic Hospitalization – We will pay the Insured or Network Provider for the in-patient hospitalization expenses such as boarding and nursing expenses, intensive care unit charges, surgeon's , doctor's fee, anesthesia ,blood, oxygen, operation theatre charges etc. incurred by the Insured during Hospitalization for a minimum period of 24 consecutive hours

Day Care Treatment - We will pay the Insured or Network Provider for the medical expenses incurred by the Insured while undergoing day care treatment

Day care Treatment means medical treatment, and/or Surgical Procedure which is:

a) Undertaken under General or Local anesthesia in a Hospital/Day care centre in less than 24 hours because of technological advancement, and
b) Which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

B) Exclusions and Limitations

The Company shall not be liable to make any payment under this policy in connection with or in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

1. Pre-Existing Diseases - Code- Excl01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. 30-day waiting period- Code- Excl03

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

The expenses on treatment of diseases, or illness such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagisa or Fibromyoma, Hernia, Hydrocele, Congenital Internal Diseases, Fistula in anus, piles, Sinusitis and related disorders during the first year of operation of this policy. If these diseases or illnesses are pre-existing at the time of proposal, they will not be covered during subsequent renewal of the policy

3. Investigation & Evaluation- Code- Excl04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4. Investigation & Evaluation- Code- Excl04

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5. Investigation & Evaluation- Code- Excl04

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

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

6. Rest Cure, rehabilitation and respite care- Code- Excl05

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

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

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

7. Obesity/ Weight Control: Code- Excl06

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

1) Surgery to be conducted is upon the advice of the Doctor

2) The surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co- morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

Diseases, illness, accident or injuries directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not).

8. .Gender treatments: Code- Excl07

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

9. Hazardous or Adventure sports: Code- Excl09

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

10. Breach of law: Code- Excl10

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

11. Excluded Providers: Code- Excl11

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

12. Circumcision whether or not necessitated by vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery unless necessary for treatment of a disease not excluded by the terms of the policy or as may be necessitated due to treatment of an accident.

13. Cosmetic or plastic Surgery: Code- Excl08

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

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

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

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

17. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

18. Unproven Treatments: Code- Excl16

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

19. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

20. The cost of spectacles and contact lenses, hearing aids.

21. Dental treatment or surgery of any kind unless requiring hospitalisation.

22. Convalescence, general debility, run-down condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-injury (whether arising from an attempt to suicide or otherwise) and use of intoxicating drugs and/or alcohol.

23. Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-Ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any diseases, illness or injury whether or not requiring Hospitalisation/DomiciliaryHospitalisation.

24. Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Medical Practitioner.

25. Diseases, illness, accident or injuries directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.

26. Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.

27. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

28. Naturopathy treatment

Note: If any Add-On has been opted as mentioned in Part I of the Policy, then the respective Exclusion as mentioned above will not be applicable

C) Add-Ons/ Extensions

Insured may also avail the following additional covers/add-ons/extensions under the policy on payment of additional premium

Cover for Pre-Existing Diseases: By way of this add-on, Pre-existing Diseases shall be covered after 1 year (or as stated in Part I of the Policy.)

For the purpose of avoidance of doubt, it is to clarified that, the term 'Pre-existing Disease'

means any condition, ailment or injury or disease

a. diagnose by physician within 48 month prior to the effective date of the policy issued by insurer or its reinstatement or

b. .for which medical advice or treatment was recommended by, or received from, a physician within 48 month prior to the effective date of the policy issued by the insurer or its reinstatement

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1. Maternity Expenses: This add-on provides cover for medical expenses incurred for delivery, during hospitalization or lawful medical termination of pregnancy during the Policy Period .This coverage may be offered with or without any waiting period. The cover also extends to provide child birth related expenses up to a specified limit and pre- post natal expenses as specifically stated in the Policy
Provided that-

a) The cover under this add-on shall be available after xx* days / month(s) of continuous coverage have elapsed since the inception of the first Policy with the Company

b) Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.

2. Out Patient Department (OPD) Expenses: The Company will reimburse medical expenses incurred by the Insured as an Outpatient.
For the purpose of this add-on, Outpatient means the Insured person who is not hospitalized for more than 24 consecutive hours but who visits a hospital, clinic or associated facility for diagnosis or treatment. However, any Insured person undergoing any named day care procedure/ treatment will not be considered as an Outpatient.

3. Cost of Prescribed External Medical Aid: The Company will reimburse Insured for the charges incurred by Insured during the Policy Period on account of procuring medically necessary prosthetic or artificial devices or any medical equipment including but not limited to hearing aids, spectacles, contact lenses etc.

4. Baby Day One Cover: This add-on will cover medical expenses incurred on the “new born baby” only as an in-patient in hospital for a maximum period up to 91 days.

5. Critical Illnesses Cover: The Company will pay the sum insured for this add-on, in case Insured is diagnosed as suffering from one or more of the Critical Illnesses for the first time in life, during the Policy Period.
This benefit can be availed only by the Insured only once during his lifetime.

6. Travel Expenses for Medical Treatment: The Company will reimburse the travel expense incurred outside the city of residence at a nearest place as prescribed by the treating Medical Practitioner wherein the treatment is not possible in his place.

7. Dental Expenses: The Company will reimburse the medical expenses related to dental treatment incurred by the Insured during the Policy Period.

8. Cover for Alternate Methods of Treatment: By way of this add-on, the Company will reimburse the Insured for medical expenses incurred on homeopathic, Ayurvedic, Siddha, Unani, acupressure, acupuncture, yoga and naturopathy treatment provided that such treatment is administered by medical practitioner.

9. Donor Expenses: The Company will indemnify the Insured for the medical expenses incurred in respect of donor for any of the organ transplant surgery during the Policy Period, provided the organ donated is for Insured’s use and the claim is

considered admissible by the Company.

10. Ambulance Charges: Ambulance charges would include transportation cost to the nearest hospital in case of life threatening emergency conditions.

11. Pre and Post Hospitalisation: By way of this add-on, the Company will pay medical expenses incurred xx* days prior to hospitalization and xx* days after hospitalisation

C) Salient Features

- Floater Benefit: The Insured can avail a Floater cover and get immediate family covered for the same Sum Insured under a single policy by paying one premium amount.

- Cashless hospitalisation: The Insured can avail of cashless hospitalization at a Network provider. (List of Network Provider is available at our website)

- Cover Period : The policy tenure would be for a period of 1 year only

- Eligibility:

    - Entry age – The policy can be offered to an individual whose age is Minimum 3 months to > 95 yrs. Children above 3 months can be covered provided one or both the parents are covered concurrently

    - Maximum Renewal age - For lifetime

Premium: The premium charged under the policy depends upon the sum insured opted, add-ons ,if opted by the Insured along with other factors like claims experience.

D) Policy Related Terms and Conditions

a. Claim must be filed within 30 days from the date of completion of treatment. However, the Company may at its discretion consider waiver based on merits of the claim, where there is delay in intimation or in submission of documents due to unavoidable circumstances and it is proved that the delay was for reasons beyond the control of the insured and under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

b. The Insured Person shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim.

c. Any medical practitioner authorised by the Company shall be allowed to examine the Insured Person in case of any alleged diseases, illness, accident or injuries requiring Hospitalisation or Domiciliary Hospitalisation when and so often as the same may reasonably be required on behalf of the Company.

d. All medical/surgical treatment under this policy shall have to be taken in India (unless agreed upon in Part I of the Policy) and admissible claims thereof shall be payable in Indian currency.

e. Low Claim Ratio Discount (Bonus): Low Claim Ratio Discount will be allowed on the

total premium at renewal depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Insurance Policy as mutually agreed by the insured and the insurer.-

f. High Claim Ratio loading (Malus): The Total Premium payable at renewal of the Group Policy will be loaded depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Insurance Policy as mutually agreed by the insured and the insurer-

Note:

- Incurred claim would mean claims paid, claims outstanding and claims incurred but not reported (IBNR) in respect of the entire group insured under the policy during the relevant period.

(F) Terms of Renewal

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

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

c) The policy could be subject to certain changes in terms and conditions including change in premium rate.
Possibility of Revision of Terms of the Policy including the Premium Rates- The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

G) Standard terms and conditions applicable are as under:

1.	Incontestability and Duty of Disclosure	2.	Observance of terms and conditions	3.	No Constructive Notice
4.	Notice of charge etc.	5.	Special Provisions	6.	Overriding effect of Part II of the Policy
7.	Electronic Transactions	8.	Fraud	9.	Cancellation
10.	Portability Benefits	11.	Cause of Action/Currency of Payment		
12.	Policy Disputes	13.	Arbitration clause		
14.	Renewal notice	15.	Notices	16.	Customer Service
17.	Redressal of Grievance				

The above terms and conditions are elaborated in the Policy.

H) Claims Procedure

a. For Cashless Settlement

Cashless treatment is only available at a Network Provider (List of Network Providers is available at our website). In order to avail of cashless treatment, the following procedure must be followed by the insured:

Prior to taking treatment and/or incurring Medical Expenses at a Network Provider, the insured must contact the company or the TPA accompanied with full particulars namely,

i. Policy Number,
ii. Name of the insured,
iii. your relationship with Policy Holder,
iv. nature of Illness or Injury, name and
v. address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ -.

Request for pre- authorisation should be received at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization. To avail of Cashless Hospitalization facility, the insured is required to produce the health card, as provided to him/her with this Policy, subject to the terms and conditions for the usage of the said health card. The request of insured shall be considered after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalization facility is sought by the insured and the Company will confirm the request in writing.

b. For Reimbursement Settlement

(i) All claims have to be intimated 48 hours prior to hospitalization or within 24 hours post admission in case of emergency for prompt settlement of claims.

(ii) The insured shall give notice to the TPA by calling the toll free number as specified in the Policy provided to the insured and also in writing at the Company's address with particulars as below:

a) Policy number;
b) Name of the insured;
c) Relationship of the proposer with the Policyholder;
d) Nature of Illness or Injury;
e) Name and address of the attending Medical Practitioner and the Hospital;
f) Any other information that may be relevant to the Illness/ Injury/ - Hospitalisation

(iii) The procedure for lodging the claim shall be as under:

Upon the happening of any event giving rise or likely to give rise to a claim under this policy:

a) The Insured shall give immediate notice thereof in writing to the Company.
b) The Insured shall deliver to the Company, within 30 days from the date of completion of treatment, a detailed statement in writing as per the claim form together with bills, vouchers and any other material particular, relevant to the making of such claim.
c) The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

2. Basis of assessment of claims

Basis of assessment of the claim shall be as under:

The benefit payable shall be such expenses reasonably and necessarily incurred by or on behalf of the Insured Person under the following categories but not exceeding the Sum Insured in respect of such Insured person as specified in Part I of the Policy.

Heads of compensation payable:

(i) Room and Boarding Expenses as incurred at the Hospital/ Nursing Home;
(ii) Nursing Expenses;
(iii) Fee paid to Medical Practitioner, Surgeon, Anaesthetics, Consultants and Specialist
(iv) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & drugs, Diagnostic Materials and X - Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and similar expenses; and /or
(v) Pre -Hospitalisation and Post -Hospitalisation expenses, wherever

applicable.

Claim documents:

I. The Insured shall be required to furnish the following for or in support of a claim:
II. Duly completed claim form signed by the insured
III. Original bills, receipts and discharge certificate/card from the Hospital
IV. Original bills from Chemists supported by proper prescription
V. Original investigation test reports and payment receipts
VI. Indoor case papers
VII. Medical Practitioner's referral letter advising Hospitalization in non-
VIII. Accident cases
IX. Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque)
X. Any other document as required by the Company or the TPA to investigate the Claim or the Company's obligation to make payment for it.

Claim Settlement (provision for Penal Interest)

I. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
III. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
IV. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Interest provision shall be as per IRDAI (Protection of Policyholders' Interests) Regulations, 2017 or any amendments made thereto from time to time.

1. Condition Precedent to Admission of Liability- The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy

2. Complete Discharge- Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

Note: The foregoing is only an indication of the cover offered. For complete details on coverage, terms, conditions and exclusions, please read the policy document carefully before concluding sale

Statutory Warning: Prohibition of Rebates (Under Section 41 OF Insurance Act, 1938) as amended by the Insurance Laws (Amendment) Act, 2015.

1) No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.
2) Any person making default in complying with the provisions of this section shall be liable for a penalty, which may extended to ten lakh rupees.