Group Health (Floater) Insurance

PREAMBLE

ICICI Lombard General Insurance Company Limited ("the Company"), having received a Proposal and the premium from the Proposer named in the Schedule referred to herein below, 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 the Company 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 Schedule with all its Parts, and further, subject to the terms and conditions contained in this Policy, as set out in the Schedule with all its Parts, that on proof to the satisfaction of the Company of the compensation having become payable as set out in Part I of Policy 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 Sum Insured/appropriate benefit will be paid by the Company.

Part I of Policy: Policy Schedule

Insured Details Policy Number:
Issued At:
Name of the Insured:
Nominee details:
Mailing Address of the Insured:
Intermediary Details
Agency/Broker Code:
Agency/Broker Name: Agent's/Broker's Mobile No.: Agent's/Broker's Email ID:

Policy Details Period of Insurance:
From:
To: Product:
Total Lives Insured:
Sum Insured:
Details of Person Insured: As mentioned in Annexure

Premium Computation Basic Premium
Service Tax
Education Cess on Service Tax Higher Education Cess
Total Premium

Coverages

- .....
- .....
- .....

Add-ons

- .....
- .....
- .....

Conditions

- No. of Employees:
- No. of Dependents:
- Third Party Administrator (TPA)/ In house:
- Address of TPA:
- Toll free number of TPA:
- Website of TPA:

Special Conditions

- .....
- .....
- .....

Part II of Policy

I) 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/Endorsements:

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.

Standard Definitions

1. Accident:

An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. Any One Illness:

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

3. Ayush Treatment:

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

4. Break in Policy:

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

5. Cashless Facility:

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

6. Condition Precedent:

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

7. Congenital Anomaly:

Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position

a. Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body

b. External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body

8. Co-Payment:

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

9. Cumulative Bonus:

Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

10. Day Care Center:

A day care center means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under

i) has qualified nursing staff under its employment

ii) has qualified medical practitioner/s in charge

iii) has a fully equipped operation theatre of its own where surgical procedures are carried out

iv) maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

11. AYUSH Day Care Centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with

the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

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

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

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

12. Day Care Treatment:
Day care treatment means medical treatment, and/or *surgical procedure* which is:

i. undertaken under General or Local Anesthesia in a *hospital/day care centre* in less than 24 hours because of technological advancement, and

ii. Which would have otherwise required Hospitalisation of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition

13. Deductible:
Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Deductible is applicable per year, per life or per event as stated in part I of the policy and specific benefit/cover based deductible shall be applied if specified in the part I of the policy.

14. Dental treatment:
Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

15. Disclosure to information norm:
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

16. Domiciliary Hospitalisation:
Domiciliary Hospitalisation means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances

i)The condition of the patient is such that he/she is not in a condition to be removed to the Hospital, or

ii)The patient takes treatment at home on account of non-availability of room in a hospital

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

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

19. Hospital:
A hospital means any institution established for *in-patient care* and *day care treatment* of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the

Schedule of Section 56(1) of the said act **Or**

complies with all minimum criteria as under:

i) has qualified nursing staff under its employment round the clock;

ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;

iii) has qualified medical practitioner(s) in charge round the clock;

iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;

v) maintains daily records of patients and make these accessible to the Insurance Company's authorized personnel.

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

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

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

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

21. Hospitalisation:
Hospitalisation means admission in a Hospital for a minimum period of 24 consecutive *'In-patient Care'* hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

(a)Acute condition- Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.

(b)Chronic condition- A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check- ups, and / or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or it likely to recur

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

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

25. Intensive Care Unit:

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

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

27. Maternity Expenses:
Maternity expenses means

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation)

b) Expenses towards lawful medical termination of pregnancy during the policy period

28. Medical Advice:
Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

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

30. Medical Practitioner:
Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
The term medical practitioner would include physician, specialist, anaesthetist and surgeon but should not be the Insured or Insured's Immediate Family. "Immediate Family" would comprise of spouse, children, brother(s), sister(s) and parent(s).

31. Medically Necessary Treatment:
Medically necessary treatment means any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which:

i) is required for the medical management of the illness or injury suffered by the insured;

ii) must not exceed the level of care necessary to provide safe, adequate and

iii) must have been prescribed by a *medical practitioner*;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India

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

33. Network Provider:
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 by a cashless facility.

34. New born Baby:
New born baby means baby born during the Policy Period and is aged upto90 days.

35. Non- Network Provider:
Non-Network provider means any hospital, day care Centre or other provider that is not part of the network.

36. Notification of Claim:
Notification of claim means the process of intimating a claim to the insurer or TPA through any of the

recognized modes of communication.

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

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

39. Pre-existing Disease:
"Pre-existing disease (PED)" means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Provided that the definition of the pre-existing disease shall not be applicable for Overseas Travel Policies.

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

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

41. Post Hospitalisation Medical Expenses:
Post-Hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

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

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

44. Renewal
Renewal Means the terms on which the contract of insurance can be renewed as per regulatory prescriptions with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

45. Room Rent:
Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

46. Specific Waiting Period: /Specified Disease/Procedure waiting period:
"Specific waiting period" means a period up to 12 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

47. Subrogation
Subrogation means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that

may be recovered from any other source

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

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

Specific Definitions

1. Admission
Admission means admission of the insured in a Hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness.

2. Alternative treatments
Alternative treatments are forms of treatments other than treatment "Allopathy" or "modem medicine" and include acupressure and acupuncture in the Indian context.

3. Annual Sum Insured:
Annual sum insured means and denotes the maximum amount of cover available to the insured during each Policy Year of the Policy Period, as stated in the Policy Schedule or any revisions thereof based on Claim settled under the Policy

4. Contribution:
Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a rate able proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

5. Out-patient:
Out-patient means the Insured 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 undergoing any specified "Day care surgeries/Treatment" will not be considered as an Out-patient.

6. Period of Insurance:
Period of insurance means the period as specifically appearing in the Policy Schedule and commencing from the Policy Period Start Date of the first Policy taken by the insured from the company and then, running concurrent to the current Policy subject to the Insured's continuous renewal of such Policy with the company.

7. Policy:
Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person

8. Policy Holder:
Policy holder means the person(s) or the entity named in the Policy Schedule who executed the Policy Schedule and is (are) responsible for payment of premium(s).

9. Policy Period:
Policy period means period of one policy year as mentioned in the schedule for which the Policy is issued

10. Policy Year:
Policy year **mea**ns a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

11. Proportionate deduction:
Proportionate deduction means

a. When higher room category is chosen, following expenses are not allowed under 'associate medical expenses' - Cost of pharmacy/consumables, cost of implants/medical devices, Cost of diagnostics.

b. Proportionate deductions not allowed for ICU expenses

12. Senior Citizen:
Senior citizen means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

13. Third Party Administrator (TPA):
Third Party Administrator (TPA) means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

14. Standard Nomenclature and Procedures for Critical Illnesses
"Critical Illness" for the purpose of this Policy (if covered as an extension in Part I of the Policy) includes the following:

1. CANCER OF SPECIFIED SEVERITY

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. MYOCARDIAL INFARCTION
(First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolization from an extra cranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN / BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of Langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by as specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.II) Scope of Cover

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed herein, that, if during the policy period stated in Part I of the Policy, any Insured Person shall contract any disease or suffer from Any One Illness or sustain any bodily injury through accident, and if such disease, illness, accident or injury shall require any

such Insured Person, upon the advice of a Medical Practitioner to incur Hospitalisation or Domiciliary Hospitalisation expenses or Outpatient department expenses as stated in Part I of the Policy, the Company will pay to the Insured Person, the amount of such expenses as are reasonably and necessarily incurred thereof, by or on behalf of such Insured Person but not exceeding the sum insured for the person as mentioned in the Part I of the Policy hereto, to the extent and the manner hereinafter provided. The Company would be liable for the add-on coverage's mentioned in Part I of the Policy only if the Insured purchases the same in terms of the policy

I) Exclusions

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:

Standard Exclusions

A. Pre-Existing Diseases - Code- Excl01

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the relevant regulatory prescriptions, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. Specific Waiting Period: /Specified Disease/Procedure waiting period- Code- Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

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

f) List of specific diseases/procedures

Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, , Fistula in anus, piles, Sinusitis and related disorders

C.30-day waiting period- Code- Excl03

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

D. Investigation & Evaluation-Code- Excl04

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

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

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

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

I. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing,

dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

F. Obesity/ Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co- morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

G. 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.

H. 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.

I. 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.

J. 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.

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

L. 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

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

N. Refractive Error: Code- Excl15

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

O. 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.

P. 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

Q. Maternity: Code Excl18

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

pregnancy during the policy period

Specific Exclusions

1. 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.

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

3. Dental treatment or surgery of any kind unless requiring Hospitalisation.

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

5. 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/Domiciliary Hospitalisation.

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

7. 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.

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

9. 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).

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

II) Add-Ons/ Extensions

Insured may also avail the following additional covers/add-ons (extensions) under the policy. Risk Premium would be charged as per the cover provided in Part I of the Policy:

1. 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.)

a. 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

b. diagnose by physician within 36 month prior to the effective date of the policy issued by insurer or its reinstatement or

c. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement

2. Maternity Expenses: This add-on provides cover for medical expenses incurred for delivery, during Hospitalisation 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 Part I of the Policy. Provided that-

a. The cover under this add-on shall be available after 9 months (or as stated in Part I of the Policy) 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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 treating Medical Practitioner wherein the treatment is not possible in his place.

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

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

10. 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.

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

12. Pre and Post Hospitalisation: By way of this add-on, the Company will pay medical expenses incurred 30 days prior to Hospitalisation and 60 days after Hospitalisation or as stated in Part I of the Policy.

13. Health Check-Up: The company by way of this add-on, will cover the cost of health checkup incurred by the Insured for medical examination undergone being a requirement from employer. Such medical examination is generally conducted to understand health status of the employee.

14. Disease-Wise Sub-Limit: By way of this add-on, the company can introduce sub-limits on certain diseases based on the claim experience and the requirement of the Insured.

15. Domiciliary Hospitalisation: The

Company will reimburse the Insured for medical expenses incurred by the Insured during domiciliary Hospitalisation.

16. Treatment Outside India (along with traveling cost & boarding & lodging of the attendant): This add-on covers the cost of medical treatment along with the travelling cost and cost pertaining to boarding and lodging attendant in a country outside India when required and prescribed by treating Medical Practitioner.

17. Convalescence Benefit: The Company will pay the Insured upto a certain amount as stated in Part I of the Policy if the Insured is hospitalized for a minimum period of consecutive days as specified in Part I of the Policy, due to any injury or illness as covered under the Policy. This benefit is payable only once to an Insured person during the Policy period.

18. Loss of wages/salary due to Hospitalisation (Hospital Daily Cash Allowance): The Company will pay the Insured a fixed amount for each day of his Hospitalisation to compensate against the loss of wage/salary incurred by Insured on account of Hospitalisation.

19. Cover for allied hospital charges: By way of this add-on, Company will reimburse either one or combinations of the expenses incurred on the allied hospital charges such as ambulance charges, administration charges, service charges and miscellaneous charges, boarding/lodging charges, including transportation costs of machine/medical instruments of any special medical team to the city of the insured or any such other charges wherever prescribed by medical practitioner.

20. Limit on room rent, nursing charges, consultation fees, diagnostic charges, OT charges etc: This add-on restricts the coverage for respective heads upto a specified amount. In cases, where the claim amount exceeds this amount, the entire admissible claim amount which includes various hospital bills etc, will be reduced in the proportion which the eligible room rent limit bears to the actual room rent.

21. Wellness & Preventive Care: By way of this add-on the insured can avail any or all of the below mentioned:

a. Health Risk Assessment
b. Health Check-up's (add-on of report evaluation service)
c. Medical Centre Management
d. Diet & Nutrition Plans
e. Online Doctor Chat
f. Health Camps - on campus
g. Expert Sessions - on campus
h. Second Opinions: Domestic and International markets
i. Discounted offerings - on health and wellness services (Eg Gyms, Diagnostic Centers, Medicines, Beauty clinics etc)
j. Disease Management Programs: Eg Diabetes, Healthy Heart, Stress Management etc
k. Lifestyle/Wellness Management Programs: Eg Maternity, Quit Smoking
l. PHR - Personalized Health Records
m. Health Assistance Services: Opinions - Doctor on call/home - Ambulance- Health tools
n. Health & Wellness Reminder Services
o. Health Concierge Desk
p. Others

III) CLAIM ADMINISTRATION

The fulfilment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by each of the insured shall be conditions precedent to admission of the Company's liability.

Further, upon the discovery or happening of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admission of the Company's liability, the insured shall undertake the following:

1. 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:

Pre-authorization

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, Policy Number, Name of the insured, your relationship with Policy Holder, nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. Request for pre- authorisation should be received at least 48 hours before a planned Hospitalisation and in case of an emergency situation, within 24 hours of Hospitalisation. To avail of Cashless Hospitalisation 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 Hospitalisation 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 Hospitalisation or within 24 hours post admission in case of emergency for prompt settlement of claims.

(ii) The insured shall give

(iii)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

(iv) 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, collected from hospital at the time of discharge along with the claim form. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

c) The claim will be processed within 15 days of receipt of claim along with claim form and document

2. Basis of assessment of claims

a) 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, Anesthetics, Consultants and Specialist

IV. Anesthesia, 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.

b) Claim documents:

The Insured shall be required to furnish the following for or in support of a claim:

I. Duly completed claim form signed by the insured

II. Original bills, receipts and discharge certificate/card from the Hospital

III. Original bills from Chemists supported by proper prescription

IV. Original investigation test reports and payment receipts

V. Indoor case papers

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

VII. Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque)

VIII. 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.

IX. The relevant documents tocan be sent to: ICICI Lombard Health Care, 1st, 4th (Half), 5th and 6th floors, Varun Towers- II, Opp. Hyderabad Public school, Begumpet, Hyderabad, District Hyderabad, Telangana Pin code -500016

Turn Around Time(TAT) for claim settlements-

TAT for Pre-Authorization of Cashless Facility is within 1 hours from the receipt of last necessary document from Hospital.

TAT for final cashless final bill authorization is within 3 Hours from the receipt of last necessary document from hospital.

3. 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

4. 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.

I. Limitation Period

In no case whatsoever shall the Company be liable for any claim under the Policy, if the requirement of Clause V (i) (b) (3) (b) above are not complied with, unless the claim is the subject of pending action or arbitration; it being expressly agreed and declared that if the Company shall disclaim liability for any claim hereunder and such claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

II. 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 authorized 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.

III. 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)

b) The policy shall ordinarily be renewable except on grounds of established 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, , may revise or modify the terms of the policy including the premium rates.

Part III of Policy

Standard terms and conditions applicable to group benefits

1. Incontestability and Duty of Disclosure
The policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, misdescription 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 Insured or any one acting on his behalf to obtain any benefit under this policy.

2. Observance of terms and conditions
The due observance and fulfilment 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 Insured, shall be a condition precedent to any liability of the Company to make any payment under this policy.

3. No constructive Notice
Any of the circumstances in relation to these conditions coming to the knowledge 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.

4. Notice of charge etc.
The Company shall not be bound to notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this policy but the receipt of the Insured or his legal personal representative shall in all cases be an effectual discharge to the company.

5. Special Provisions

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

6. Overriding effect of Part II of the Policy

The terms and conditions contained herein and in Part II of the Policy shall be deemed to form part of the policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Policy, then the term(s) and condition(s) contained herein shall be read *mutatis mutandis* with the scope of cover/terms and conditions contained in Part II of the Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable. In case of any inconsistency in terms and conditions mentioned in Part II of the Policy with Part I of the Policy then terms and conditions contained in Part I of the Policy will prevail over Part II of the Policy.

Electronic Transactions

The Insured agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer,automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. The Insured agrees that the Company may exchange, share or part with any information to or with other ICICI Group Companies or any other person in connection with the Policy, as may be determined by the Company and shall not hold the Company liable for such use/application.

7. Fraud

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

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy: —

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

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

(c) any other act fitted to deceive; and

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

The company shall not repudiate the policy on the ground of established fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

8. Cancellation

The insured may cancel the policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall

a. refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

b) The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, established fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or established fraud.

9. Multiple Policies

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 treated as the primary Insurer and 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.

10. Premium Payment in installments:

If the insured person has opted for Payment of Premium on an installment basis as per regulatory prescription and mentioned in Your Policy Schedule/certificate of insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy):

I. The grace period for payment of premium for all types of insurance policies shall be fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during grace period, if the premium is paid in installments during the policy period.

II. The insured person will get the accrued continuity benefit in respect of the 'Waiting Periods', 'Specified Disease/ Procedure Waiting Period/ Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period

III. No interest will be charged If the installment premium is not paid on due date.

IV. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

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

VI. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

11. Free Look Period

Every insured of new health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the insured and stamp duty charges."13**.**

12. Portability:

a. The insured has the choice to port his / her policies from one Insurer to another. An Insured desirous of porting his/her policy to another insurer shall apply to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal.

b. The insured is entitled to transfer the credits gained to the extent of the sum insured and the benefits available in the previous policy, subject to the underwriting policy of the Company

c. The Company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines.

d. This benefit is not applicable for enhanced sum insured.

13. Migration:

In case of migration of indemnity based health insurance policy (except Personal Accident and Travel Policies) with the same Insurer, the insured can transfer the credits gained to the extent of the Sum Insured and benefits available in the

previous policy to the migrated policy. The Company may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

14. Claim Settlement (provision for Penal Interest)

a. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of claim. receipt of last necessary document.

b. 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.

c. 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.

d. 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.

Turn Around Time(TAT) for claim settlements-

TAT for Pre-Authorization of Cashless Facility is within 1 hours from the receipt of last necessary document from Hospital.

TAT for final cashless final bill authorization is within 3 Hours from the receipt of last necessary document from hospital.

15. 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

16. 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.

17. Cause of Action/ Currency for payment

No Claims shall be payable under this policy unless the cause of action arises in India, unless otherwise specifically provided in Part II of the Policy to this policy. All claims shall be payable in India in Indian Rupees only.

18. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law. Each party agrees to submit to the exclusive jurisdiction of the High Court of Mumbai and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

19. Withdrawal of Policy

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

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

20. Moratorium

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first

policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

21. Arbitration clause

If any dispute or difference shall arise as to the quantum to be paid under the 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 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 and 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 preferable to arbitrations as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained

22. Renewal notice

The policy shall ordinarily be renewable except on misrepresentation by the insured person on grounds of established fraud. 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 as per regulatory prescriptions 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.

23. Notices

Any notice, direction or instruction given under this policy shall be in writing to:

- In case of the Insured, at the address specified in Part I of the Policy.

- In case of the Company:

ICICI Lombard General Insurance Company Limited
ICICI Lombard House
414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025
Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery or e-mail.

24. Customer Service

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

25. Redressal of Grievance:

In case of any grievance the insured person may contact the Company through

Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com

Address: ICICI Lombard General Insurance Co. Ltd. Ground floor- Interface 11, Sixth floor- Interface 16 , Office no 601 & 602, New linking Road, Malad (West), Mumbai – 400064.

There is an interactive voice response (IVR) facility for senior citizens' grievance redressal for easy and faster resolution

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance, insured person may contact the grievance officer at the details provided in the below

link:

https://www.icicilombard.com/grievanceredressal.com

If Insured person is not satisfied with the redressal of grievance, the insured person may also approach Insurance Regulatory and Development Authority (IRDA) through the Bima Bharosa Portal - https://bimabharosa.irdai.gov.in/ or IRDA Grievance Call Centre(IGCC) at their toll free no. 1800 4254 732 / 155255

Insured may also approach Insurance Ombudsman, subject to vested jurisdiction, for the redressal of grievance. Details of Insurance Ombudsman offices are available at IRDA website: www.irdai.gov.in, or on the Company's website at www.icicilombard.com.

26. Insurance Ombudsman

You can also approach the Insurance Ombudsman, depending on the nature of grievance and the financial implication, if any. Information about Insurance Ombudsmen, their jurisdiction and powers is available on the website of the Insurance Regulatory and Development Authority of India (IRDAI) at www.irdai.gov.in, or of the General Insurance Council at www.generalinsurancecouncil.org.in, the Consumer Education Website of the IRDAI at http://www.policyholder.gov.in, or from any of Our Offices.

The details of Insurance Ombudsman are available below:

S no.	Name of office of insurance Ombudsman	Territorial Area of jurisdiction
1	AHMEDABAD Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
2	BENGALURU Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
3	BHOPAL Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
4	BHUBANESWAR Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
5	CHANDIGARH Mr Atul Jerath Insurance Ombudsman Office Of The Insurance Ombudsman,	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and

	Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Bahadurgarh), Himachal Pradesh, Union Territory of Jammu & Kashmir, Ladakh & Chandigarh.
6	CHENNAI Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
7	Delhi Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following District of Haryana – Gurugram, Faridabad, Sonepat and Bahadurgarh
9	GUWAHATI Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
10	Hyderabad Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and Part of Territory of Puducherry.
11	Jaipur Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141-2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
12	KOCHI Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
13	Kolkata Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.	West Bengal, Sikkim, Andaman & Nicobar Islands.

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14	Lucknow Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
15	MUMBAI Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region Excluding (Navi Mumbai & Thane).
16	NOIDA Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur
17	PATNA Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
18	Pune Insurance Ombudsman Office of the Insurance Ombudsman,	Maharashtra, Area of Navi Mumbai and Thane

	Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	(excluding Mumbai Metropolitan Region).		Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	

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 extend to ten lakh rupees.