HEALTHCARE PLUS POLICY

b. 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 issue 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 a of the Schedule 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.

c. DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth:

i. Standard Definitions (Definition whose wordings are specified by IRDAI)

"Accident" is a sudden, unforeseen and involuntary event caused by external and visible and violent means.

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

"**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.

"**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.

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

"Congenital Anomaly" means a condition(s) 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

"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 claim amount. A co-payment does not reduce the Sum Insured.

"Day care Centre" means any institution established for day care treatment of Illness and / or
injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria 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.

"***Day Care Centre includes an AYUSH Day Care Centre as defined below:***"

"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:

a) Having qualified registered AYUSH Medical Practitioner(s) in charge;
b) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
c) Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

"**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 hourrs because of technological advancement, and
ii. 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.

"Deductible" is 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.

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

"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

"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 moved to a hospital, or
ii. the patient takes treatment at home on account of non-availability of room in a hospital.

"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.

"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:
--has qualified nursing staff under its employment round the clock;
--has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
--has qualified medical practitioner(s) in charge round the clock;
--has a fully equipped operation theatre of its own where surgical procedures are carried out;
--maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

"***Hospital includes an AYUSH Hospital as defined below:***"

"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 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

"Hospitalization" Hospitalization 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.

"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:
   i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
   ii. it needs ongoing or long-term control or relief of symptoms
   iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
   iv. It continues indefinitely
   v. it recurs or is likely to recur

"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.

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

"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.

"Maternity Expenses" Maternity expenses shall include—
(a). medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
(b). expenses towards lawful medical termination of pregnancy during the policy period.

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

"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.

"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.

"Non- Network Provider" means any Hospital, day care centre or other provider that is not part of the Network.

"Notification of claim/Intimation of claims "- means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

"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.

"Pre-existing Disease" 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.

"Pre-hospitalization Medical Expenses" means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the insured person, provided that:
i. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

"Post-hospitalization Medical Expenses" means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital, provided that:
i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

"**Qualified Nurse"** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

"Reasonable and Customary charges" means 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

"Renewal" defines the terms on which the contract of insurance can be renewed on mutual consent 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.

"Room Rent" Means the amount charged by a hospital towards room and boarding expenses and shall include associated medical expenses.

"Subrogation" mean 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.

"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 of suffering or prolongation of life, performed in a hospital or day care centre by a Medical Practitioner.

"Unproven/Experimental treatment" -Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

"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.

"**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.

"Specific waiting period" means a period up t36monthsfrom 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.

ii. Specific Definitions (Definitions other than those mentioned under c(i) above)

"Claim" means a demand by You or on Your behalf, for payment of medical expenses or any other benefits as covered under the Policy.

"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 rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

"Company" means ICICI Lombard General Insurance Company Limited.

"Insured"/ "Insured Person" means the Individual(s) whose name(s) are specifically appearing as such in Part I of the Schedule to this Policy.

"Limit of Indemnity" means the sum stated as Annual Sum Insured in Part a of the Schedule against the name of each Insured, which sum represents the Company's maximum liability, under the Policy, for any and in aggregate of all Claims for that

Insured, regardless of the number of Claims made by that Insured or on his/her behalf during the Policy Year less the amount already claimed by the Insured from the Company under the Policy. However, the Limit of Indemnity will be reinstated to the extent any claim is rejected partly or wholly by the Company and there is no contingent or impending liability on the Company in respect of such Claim.

"Medical Practitioner" A Medical Practitioner is 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 the scope and jurisdiction of license.'

The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude the Insured and members of his/ her immediate family. Immediate family would comprise of Insured's spouse, children, brother(s), sister(s) and parent(s).

"Period of Insurance" shall mean the period from commencement of insurance cover to the end of the insurance cover and specifically appearing as such in Part a of the Schedule to this Policy.

"Policy" means the Policy booklet, the Schedule, any Extension and applicable endorsements under the Policy. The Policy contains details of the extent of cover available to the Insured, the exclusions under the cover and the terms and conditions of the issue of the Policy.

"Policy Year" means a period of twelve months beginning from the Period of Insurance Start Date, as specified in Part a of the Schedule, and ending on the last day of such twelve month period. For the purpose of subsequent years, following the first year of the Period of Insurance, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve month period, till the Period of Insurance End Date as specified in Part a of the Schedule.

"**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.

"Specified Treatment" means any treatment or cure by a Medical Practitioner, for any one or more of the following Illnesses:

- Cataract
- Lithotripsy (Kidney stone removal)
- Tonsillectomy
- Eye Surgery
- Dialysis
- Dilatation & Curettage
- Chemotherapy
- Radiotherapy
- Coronary Angiography
- Cardiac catheterization

"**Annual Sum Insured**" means the maximum liability of the Company under the Policy for a Policy Year and as stated in Part a of the Schedule.

d. Benefits Covered under the Policy

In-patient Treatment
The Company will indemnify the Insured, subject always to the Limit of Indemnity and the Deductible amount, for the Medical Charges incurred by such Insured as an in-patient in a Hospital where the Hospitalization is for a minimum period of 24 consecutive hours, as a result of suffering Illness or Bodily Injury during the Period of Insurance, which on the written advice of a Medical Practitioner requires Hospitalization.

Notwithstanding anything contained herein, this Benefit shall not apply to any Medical Charges incurred by the Insured in any place or geographical area other than in India, unless otherwise agreed by the Company in writing by way of any Endorsement.

The following charges shall be reimbursable under the policy:

1. Room rent, boarding and nursing expenses as charged by the Hospital where the Insured availed medical treatment.

2. Intensive Care Unit (ICU) charges.

3. Surgeon, anaesthetist, Medical Practitioner, consultants, specialist fees.

4. Anaesthesia, blood, oxygen, operation theatre charges, surgical consumables, medicines and drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, cost of artificial limbs.

e. EXCLUSIONS

The Company shall not be liable for the Deductible amount as specified in Part a of the Schedule.

The Company shall not be liable or make any payment for any Claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

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

1. **Code- Excl01:** Pre-Existing Diseases
   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.
   In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   If the Insured Person is continuously covered without any break as defined under the portability norms of the relevant regulatory prescription, then waiting period for the same would be reduced to the extent of prior coverage
   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.

2. **Code- Excl02: Specified disease/procedure waiting period/Specific Waiting Period**

Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
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.
The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
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.

- Cataract
- Benign prostatic hypertrophy
- Myomectomy, endometriosis, hysterectomy unless because of malignancy
- All types of hernia, hydrocele
- Fissures &/or fistula in anus, haemorrhoids/piles
- Arthritis, gout, rheumatism and spinal disorders
- Joint replacements unless due to Accident
- Sinusitis and related disorders
- Stones in the urinary and biliary systems
- Dilatation and curettage
- All types of Skin and internal tumours/ cysts/nodules/ polyps of any kind including breast lumps unless malignant
- Dialysis required for chronic renal failure
- Surgery on tonsils, adenoids and sinuses
- Gastric and Duodenal ulcers
- Deviated nasal septum

3. **Code- Excl03:** 30-day waiting period
   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.
   This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
   The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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

   This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
   The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

5. **Code- Excl04:** Investigation & Evaluation

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

6. **Code- Excl05**: Rest Cure, rehabilitation and respite care
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
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.
Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

7. **Code- Excl06:** Obesity/ Weight Control
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
Surgery to be conducted is upon the advice of the Doctor
The surgery/Procedure conducted should be supported by clinical protocols
The member has to be 18 years of age or older and
Body Mass Index (BMI);
- greater than or equal to 40 or
- greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
  - Obesity-related cardiomyopathy
  - Coronary heart disease
  - Severe Sleep Apnea
  - Uncontrolled Type2 Diabetes

8. Code- Excl07: Change of Gender treatments
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

9. **Code- Excl08:** Cosmetic or plastic Surgery
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner

10. **Code- Excl09**: Hazardous or Adventure sports
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving

11. Code- Excl10: Breach of law
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

12. Code- Excl11: Excluded Providers
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders/proposers 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. The list of excluded providers/delisted hospitals is available on our website www.icicilombard.com

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

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

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

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

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

18. **Code- Excl17:** Sterility and Infertility: Expenses related to, sterility and infertility. This includes:
    - Any type of contraception, sterilization
    - Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    - Gestational Surrogacy
    - Reversal of sterilization

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

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

PERMANENT EXCLUSIONS

(i) Any physical, medical condition or treatment or service that is specifically excluded in the Policy in Part a of the Schedule under Special Conditions.

(ii) Routine medical, eye and ear examinations, cost of spectacles, contact lenses or hearing aids, vaccinations, issue of medical certificates and examinations as to suitability for employment or travel or any other such purpose.

(iii) Treatment relating to external birth defects and external) congenital Illnesses or defects or anomalies.

(iv) Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
(v) All dental treatment unless caused due to Accident.
(vi) Prosthesis, corrective devices, durable medical equipments and items and medical appliances/apparatus/machines, which are not required intra-operatively or for the Illness for which the Insured required Hospitalisation.
(vii) Cost of cochlear implant(s) unless necessitated by an Accident.
(viii) Personal comfort and convenience items and services.
(ix) Any charge incurred prior to Hospitalisation or post Hospitalisation, including but not limited to, charges for nurses/attendants, etc.
(x) Circumcision unless necessary for treatment of a disease or necessitated due to an Accident.
(xi) Vaccination and inoculation of any kind.
(xii) Treatment by a family member and self-medication or any treatment that is not scientifically recognized.
(xiii) Any Injury/Illness sustained or contracted due to flying other than as a passenger on a scheduled regular carrier.
(xiv) Any Injury/Illness sustained or contracted due to war invasion, act of foreign enemies, hostilities (whether declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, riot, strike, lockout, military or popular uprising, civil commotion martial law, loot, sack or pillage.
(xv) Any losses directly or indirectly due to contamination caused by any act of terrorism, regardless of any contributory causes (if the Company alleges that by reason of these exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured.)
(xvi) Any Injury/Illness sustained or contracted due to nuclear weapons, materials ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
(xvii) Costs of donor screening or treatment including surgery to remove organs from a donor in case of transplant surgery.
(xviii) Treatment received outside the Geographical Scope of Cover mentioned in the Part a of the Policy.
(xix) Any travel or transportation expenses including ambulance charges.
(xx) Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
(xxi) Any treatment undertaken after the point at which it is certified by a Medical Practitioner that the condition is of such a nature that further medical treatment may serve to stabilize or maintain it but is unlikely to result in a material improvement within a reasonable time frame.
(xxii) Domiciliary Hospitalisation
(xxiii) Any consequential or indirect loss or expenses arising out of or related to the Hospitalization.
(xxiv) Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council.
(xxv) Any treatment related to sleep disorder or sleep apnoea syndrome.

f. General terms and Clauses

i. Standard General Terms and Clauses (General terms and clauses whose wordings are defined by IRDAI)

1. Disclosure of Information
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 by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk

2. 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.

3. 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.

4. 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.

In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions.

5. 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 and the premium paid shall be forfeited.
Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any

other party acting on behalf of the insured person, 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 claim and / or forfeit the policy benefits on the ground of 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 misstatement of or suppression of material fact are within the knowledge of the insurer.

6. Cancellation/ termination

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

i. 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.

ii. 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

Note: Above mentioned refund clause shall not be applicable for policies with freelook period; Premium refund for cancellations during the freelook period will be provided as per the Free look clause.

Notwithstanding anything contained herein or otherwise, n o 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.

ii. The Company may cancel the Policy at any time on grounds of established fraud by the Insured Person, by giving 7 days' written notice.There would be no refund of premium on cancellation on grounds of established fraud

iii.

7. Migration

In case of migration of this policy with the Company, 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 monthslf such person is presently covered and has been continuously covered without any lapses

under any health insurance product plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per the relevant regulatory prescriptions on migration.

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

8. Renewal of Policy

The policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to Moratorium conditions as provided in the policy.

The Company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.

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

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.

ii.

iii. No loading shall apply on renewals based on individual claims experience.

iv. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.

9. 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 asLoyalty Bonus, waiver of waiting period. as per regulatory prescriptions, provided the policy has been maintained without a break.

10. Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. 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.

ii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iii. No interest will be charged lf the instalment premium is not paid on due date

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

v. In the event of a claim, all subsequent premium instalment Shall Immediately become due and payable

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

11. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the Company 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.Possibility of Revision of Terms of the Policy lncluding the Premium Rates

The Company, with prior approval of lRDAI, 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.

12. Free Look Period:

The"Every insured of new individual 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. Redressal of Grievances

ln case of any grievance the insured person may contact the Company through Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com

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

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

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. For branch details, please visit https://www.icicilombard.com/docs/default-source/policy-wordings-product-brochure/final-gro-mapping.pdf.

If Insured person is not satisfied with the redressal of grievance ,insured person may contact the grievance redressal 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 of India (IRDAI) 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 IRDAI website: www.irdai.gov.in, or on the Company's website at www.icicilombard.com or on https://www.cioins.co.in/Ombudsman

The details of Insurance Ombudsman are available below:

Office Details	**Jurisdiction of Office Union Territory,District)**
AHMEDABAD - **Shri Kuldip Singh** 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@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - **Smt. Neerja Shah** 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@ecoi.co.in	Karnataka.

Office Details	Jurisdiction of Office Union Territory,District)
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Mr Atul Jerath Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Insurance Ombudsman Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504	Delhi.

Office Details	**Jurisdiction of Office Union Territory,District)**
Email: bimalokpal.delhi@ecoi.co.in	
GUWAHATI - Shri Kiriti .B. Saha 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@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu 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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
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** Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.

Office Details	**Jurisdiction of Office Union Territory,District)**
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.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.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.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, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar,

Office Details	**Jurisdiction of Office Union Territory,District)**
	Saharanpur.
PATNA - Shri N. K. Singh Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

"For updated list of ombudsman details kindly visit https://www.cioins.co.in/Ombudsman"

The updated details of Insurance Ombudsman are also available on IRDA website: www.irdaindia.org, on the website of General Insurance Council: www.generalinsurancecouncil.org.in, website of the company www.icicilombard.com or from any of the offices of the Company

14. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy

ii. Specific Terms and Clauses (terms and clauses other than those mentioned above under f.(i) above.)

1. **Reasonable Care**
   The Insured shall take all reasonable steps to safeguard the interests of the Insured against Accidental loss or damage that may give rise to the Claim.

2. **Material change**
   The Insured shall immediately notify the Company in writing of any material change in the risk and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

3. **Records to be maintained**
   The Insured shall keep an accurate record containing all relevant medical records and shall allow the Company to inspect such record. The Insured shall furnish such information as the Company may require in relation to the Claim within reasonable time limit and within the time limit specified in the Policy.

4. **No constructive Notice**
   Any knowledge or information of any circumstances or condition in connection with the Insured in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

5. **Overriding effect of Part d of the Schedule**
   The terms and conditions contained herein and in Part d of the Schedule 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 d of the Schedule, 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 d of the Schedule and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

6. **Duties of the Insured on occurrence of loss**
   On the occurrence of any loss, within the scope of cover under the Policy the Insured shall:
   Forthwith file/submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in Part g of the Schedule.
   (ii) Assist and not hinder or prevent the Company or any of its agents from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.
   If the Insured does not comply with the provisions of this Clause or other obligations cast upon the Insured under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at the option of the Company.

7. **Subrogation**
   In the event of payment under this Policy, the Company shall be subrogated to all the Insured's rights or recovery thereof against any person or organisation, and the Insured shall execute and deliver instruments and papers necessary to secure such rights.
   The Insured and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after

Insured's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated.

8. Cause of Action/ Currency for payments

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

9. Contribution

If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would but for the existence of this Policy) and the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, in the same Claim (in whole or in part), then We shall not be liable to pay or contribute more than Our rateable proportion of any Claim.

However, this condition shall not be applicable for all the benefit based covers under the Policy, as applicable

10. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

11. Policy alignment

Policy Alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy.

Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.

12. Arbitration clause

If any dispute or difference shall arise as to the quantum to be paid by 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 here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising 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, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy,

iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such

arbitrator/arbitrators of the amount of expenses shall be first obtained.

13. Notices

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

In case of the Insured, at the address specified in Part a of the Schedule.

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,
Toll-free number: 1800-2666

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

14. **Non Payables**

Below are the non payable items applicable in the policy. The list may be updated as per the direction of Authority, For updated list please visit Our website: www.icicilombard.com

List of Non Payable Items as per IRDAI	
Sr. No	**Items**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS

20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	RECOVERY KIT, ETC]ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT,
59	KIDNEY TRAY
60	MASK

61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

g. Other Terms and Conditions

CLAIMS PROCEDURE

1. CASHLESS HOSPITALIZATION FACILITY

The Company may provide a health card to the Insured under this Policy to avail of cashless hospitalization facility. The Insured can avail of cashless hospitalization facility under this Policy at the time of admission into any Hospital which has a tie-up with the Company by production of this health card subject to the terms and conditions for the usage of the health card as communicated to the Insured by the Company.

Cashless hospitalization facility will not be available if treatment is taken in a Hospital where the Company does not have any tie-up to provide such facility. The Company shall have the right to deny cashless hospitalization facility in case accurate and complete information is not forthcoming for the Illness or Bodily Injury for which cashless hospitalization facility is sought. It shall be at the sole discretion of the Company to provide this cashless hospitalization facility under the above mentioned circumstances as it so deems fit.

2. TERMS AND CONDITIONS APPLICABLE TO THE POLICY

i. WHEN AND HOW TO MAKE A CLAIM

It is a condition precedent to the Company's liability that upon the discovery or happening of any Illness or Bodily Injury that may give rise to a Claim under this Policy, the Insured or (if the Insured is incapacitated or a minor, then his representative) shall undertake the following:

ii. CLAIM NOTIFICATION

The Insured or his representative, as the case may be, shall give immediate notice to the Company by calling the toll free number 18002666 as specified in the health card/ Policy provided to the Insured and also in writing at the address of the Company with particulars as below:

- Policy Number;
- Name of the Insured availing treatment;
- Policyholder's relation to the Insured;
- Nature of Illness or Bodily Injury;
- Name and address of the attending Medical Practitioner and the Hospital; and
- Any other information that may be relevant to the Illness/ Bodily Injury/ Hospitalisation.

The above information needs to be provided to the Company immediately and prior to availing treatment and in any case within 7 days from date of admission/date of availing treatment

iii. PRIOR AUTHORIZATION

Prior to taking treatment and/ or incurring Medical Expenses at a Network Provider, You must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, 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. You must request preauthorization 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, you are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card Or You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. We will consider Your request after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalization facility is sought by You and We will confirm Your request in writing. If You notify pre-authorization request for cashless facility through any of Our empaneled network hospitals along with complete set of documents & information, We will respond within 1 hour of the actual receipt of such pre-authorization request. Further, we shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital

iv. CLAIM PROCESSING

The Company will process the Claim and make all payments.

The claim will be processed within 15 days of receipt of claim along with claim form and documents.

The Policyholder or the Insured shall deliver, at their own costs, to the Company, within 90 days of the Insured's discharge from Hospital, any and all information and documentation in original concerning the Claim or the Company's liability for it, including but not limited to:

- Duly completed Claim form(s).
- Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner.
- Original bills from chemists supported by proper prescription.
- Original investigation test reports and payment receipts.
- Indoor case papers
- Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.
- Any other document as required by the Company to investigate the Claim or Our obligation to make payment for it.

The relevant documents can 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

If so requested by the Company, the Insured will have to submit to a medical examination by the Company's nominated Medical Practitioner as and when the Company considers reasonable and necessary. The cost of such examination shall be borne by the Company.

In the event of Insured's death, written notice accompanied by a copy of the post mortem report (if any) should be given to the Company within 14 days regardless of whether any prior notice has been given to the Company.

3. PAYMENT OF CLAIMS

i. The Deductible amount shall be applicable to each and every Claim separately

ii. No indemnity under this Policy is available if the period of Hospitalization is less than 24 hours except in the case of Specified Treatment.

4. GENERAL CONDITIONS APPLICABLE TO THE POLICY
It is hereby declared and agreed that:

a) Any notice or declaration for the attention of any Insured shall be deemed served if sent by the Company to the Policyholder at his/her address given in the Schedule.

b) Any payment due to any Insured under this Policy shall be paid by the Company to the Policyholder and the receipt by the Policyholder shall be complete discharge of the Company's liability against the Claim. The Company shall not be responsible for any liability arising out of the Policyholder's delay or default in making payment to any Insured. However, the Company reserves its right to pay the Claim directly to the Insured in whose respect the Claim has been lodged.

.4