ICICI Lombard General Insurance Company Limited
Corporate Office : ICICI Lombard House, 414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400 025.

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> Part II of Policy

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.

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, and visible and violent means.
2. **Admission** means admission of the insured in a Hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness.
3. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and include Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
4. **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.
5. **Any One Illness** means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.
6. **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.
7. **Congenital Anomaly** refers to 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
8. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
9. **Co-payment** is 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.
10. **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.
11. **Cumulative Bonus** shall mean any increase in the sum insured granted by the insurer without an associated increase in premium.
12. **Day Care Treatment** refers to medical treatment, and/or Surgical Procedure which is:
    a) Undertaken under General or Local Anesthesia in a Hospital/Day care centre in less than 24 hrs because of technological advancement, and
    b) Which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.
13. **Day care centre** means any institution established for day care treatment of Illness and / or injuries or a medical set - up 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:-
    a) has qualified nursing staff under its employment;
    b) has qualified medical practitioner(s) in charge;
    c) has a fully equipped operation theatre of its own where surgical procedures are carried out
    d) maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

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14. **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. This is to clarify that a deductible does not reduce the sum insured. Deductible shall be applicable per year, per life or per event as stated in Part I of the Policy and specific deductible to be applied shall be as Part I of the Policy.
15. **Domiciliary hospitalization** 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 o f the following circumstances:
    a) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    b) the patient takes treatment at home on account of non availability of room in a hospital.
16. **Dental treatment** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.
17. **Disclosure to information norm** means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
18. **Emergency Care** means management for a severe 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.
19. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre existing diseases. Coverage is not available for the period for which no premium is received.
20. **Hospital/Nursing home** 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 the Clinical Establishments (Registration and Regulations) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR comply with all minimum criteria as under:
    a) Has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
    b) Has qualified nursing staff under its employment round the clock;
    c) Has qualified medical practitioner(s) in charge round the clock;
    d) Has a fully equipped operation theatre of its own where surgical procedures are carried out
    e) Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.
21. **Hospitalisation** means admission in a Hospital for a minimum period of 24 In patient Care consecutive hours except for specified Procedures/Treatments, where such admission could be for a period of less than 24 consecutive hours.
22. **Inpatient care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
23. **Illness** means a sickness or disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.
    a) **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** is defined as a disease, illness, or injury that has one or more of the following characteristics:-
        - It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
        - It needs ongoing or long-term control or relief of symptoms

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- It requires rehabilitation of the insured or for the insured to be specially trained to cope with it
- It continues indefinitely- it comes back or is likely to come back.

24. **Injury** means any accidental physical bodily harm occurring during the Policy Period, excluding illness or disease solely and directly cased by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

25. **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. **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

27. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

28. **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.

29. **Medical Practitioner** is a person who holds a valid registration from 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 his license. The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude the insured and his/her Immediate Family.

"Immediate Family would comprise of spouse, dependent children, brother(s), sister(s) and dependent parent(s) of the insured.

30. **Medically Necessary** treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

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

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

c) appropriate medical care in scope, duration, or intensity;

d) must have been prescribed by a medical practitioner;

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

31. **New born Baby** means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

32. **Network Provider** means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility. The list of the Network Providers is available with the Company/ TPA and is subject to amendment from time to time.

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

34. **Notification / Intimation of Claim** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

35. **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.

36. **OPD treatment** is 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.

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37. **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.
38. **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, what is excluded from the cover and the terms & conditions on which the Policy is issued to the insured.
39. **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).
40. **Policy Period** means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Schedule.
41. **Policy Year** means a period of twelve months beginning from the Policy Period Start Date 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 beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.
42. **Portability** means transfer by an individual health insurance policyholder (including Family cover) of the credit gained for pre- existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.
43. **Pre-existing Disease** means any condition, ailment or injury or related condition(s) for which the insured had signs or symptoms, and / or were diagnosed, and / or received medical advice/ treatment, within 48 months prior to the first policy issued by the insurer.
44. **Post Hospitalisation Medical Expenses** means medical expenses incurred immediately after the Insured Person is discharged from the hospital, 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 Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
45. **Pre Hospitalisation Medical Expenses** means medical expenses incurred immediately before the Insured Person is hospitalized, 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 Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
46. **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.
47. **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 all waiting periods.
48. **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 Illness/injury involved.
49. **Room Rent** means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.
50. **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.
51. **Subrogation** shall 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.
52. **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.

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53. **Third Party Administrator (TPA)** means the services rendered by a TPA to an insurer under an agreement in connection with health insurance business but does not include the business of an insurance company or the soliciting either directly or indirectly, of health insurance business or deciding on the admissibility of a claim or its rejection.

54. **Unproven/Experimental treatment** means any treatment including drug experimental therapy which is not based on established medical practice in India.

55. **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:

(i) Cancer of Specified Severity

a) A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

b) The following are excluded -

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumours in the presence of HIV infection.

(ii) First Heart Attack-of Specified Severity

a) The first occurrence of 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 this will be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

b) The following are excluded:

- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
- Other acute Coronary Syndromes
- Any type of angina pectoris.

(iii) Open Chest CABG

a) The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

b) The following are excluded:

- Angioplasty and/or any other intra-arterial procedures
- Any key-hole or laser-surgery

(iv) Kidney Failure Requiring Regular Dialysis

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.

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(v) Major Organ /Bone Marrow Transplant

a) The actual undergoing of a transplant of:

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

b) The following are excluded:

- Other stem-cell transplants
- Where only islets of langerhans are transplanted

(vi) Stroke Resulting In Permanent Symptoms

a) Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial 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.

b) The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

(vii) Permanent Paralysis of Limbs

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.

(viii) Open Heart Replacement or Repair of Heart Valves

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.

(ix) Coma of Specified Severity

a) A state of unconsciousness with no reaction of response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- No response to external stimuli continuously for at least 96 hours
- Life support measures are necessary to sustain life; and
- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma

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

(x) Motor Neurone Disease with Permanent Symptoms

Motor neurone 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.

(xi) Multiple Sclerosis with Persisting Symptoms

a. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

- Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and

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- Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart

b. Others causes of neurological damage such as SLE and HIV are excluded.

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 coverages mentioned in Part I of the Policy only if the Insured purchases the same in terms of the policy.

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:

1. Such diseases, which were pre-existing at the time of proposing this insurance.
2. Any disease other than those stated in Exclusion (iii) below, contracted by the Insured Person during the first 30 days from the commencement date of the policy. This exclusion shall not however, apply if in the opinion of Panel of Medical Practitioners constituted by the company for the purpose, the Insured person could not have known of the existence of the Disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the company.
3. The expenses on treatment of diseases, or illness such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagisa or Fibromyoma, Hernia, Hydrocele, Congenital Internal Diseases, Fistula in anus, piles, Sinusitis and related disorders during the first year of operation of this policy. If these diseases, or illnesses are pre-existing at the time of proposal, they will not be covered during subsequent renewal of the policy.
4. 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).
5. 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.
6. The cost of spectacles and contact lenses, hearing aids.
7. Dental treatment or surgery of any kind unless requiring hospitalisation.
8. Convalescence, general debility, run-down condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-injury (whether arising from an attempt to suicide or otherwise) and use of intoxicating drugs and/or alcohol.
9. All expenses arising out of any condition directly or indirectly caused to or associated with Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV - III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.
10. 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.

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11. Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Medical Practitioner.
12. 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.
13. Treatment arising from or traceable to pregnancy, childbirth including caesarean section.
14. Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.
15. Naturopathy treatment.

ADD-ONS/ EXTENSIONS

Insured may also avail the following additional covers/add-ons 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, Preexisting Diseases shall be covered after 1 year (or as stated in Part I of the Policy.)
   For the purpose of avoidance of doubt, it is to be clarified that, the term 'Pre-existing Disease' means any condition, ailment or injury or illness or related condition (s) for which Insured had developed signs or symptoms, and/or were diagnosed and/or received medical advice/treatment, within 48 months prior to the first Policy with the Company.
2. **Maternity Expenses:** This add-on provides cover for medical expenses incurred for delivery, during hospitalization or lawful medical termination of pregnancy during the Policy Period This coverage may be offered with or without any waiting period. The cover also extends to provide child birth related expenses upto 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 homeopathic, Ayurvedic, Siddha, Unani, acupressure, acupuncture, yoga and naturopathy treatment provided that such treatment is administered by medical practitioner.

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

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

b. For Reimbursement Settlement

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

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

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

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

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

a) The Insured shall give immediate notice thereof in writing to the Company.

b) The Insured shall deliver to the Company, within 30 days from the date of completion of treatment, a detailed statement in writing as per the claim form together with bills, vouchers and any other material particular, relevant to the making of such claim.

c) The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

2. Basis of assessment of claims

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;

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(ii) Nursing Expenses;

(iii) Fee paid to Medical Practitioner, Surgeon, Anaesthetics, Consultants and Specialist

(iv) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & drugs, Diagnostic Materials and X - Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and similar expenses; and /or

(v) Pre Hospitalisation and Post Hospitalisation expenses, wherever applicable.

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 Hospitalization 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.

3. Settlement/Rejection of Claim - The settlement of claims would be done by the Company within 30 days, after the receipt of last necessary documents. The claim shall be paid through Electronic Fund Transfer mode.
The role of TPA (if any, as mentioned in Part 1 of the Policy) would be limited to facilitate the flow of information between the insured and the Company.
Penal interest provision shall be as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2002.

LIMITATION PERIOD

In no case whatsoever shall the Company be liable for any claim under the Policy, if the requirement of Clause V (1) (b) (iii) (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.

POLICY RELATED TERMS AND CONDITIONS

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

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

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

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

e) Low Claim Ratio Discount (Bonus): Low Claim Ratio Discount will be allowed on the total premium at renewal depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Insurance Policy as mutually agreed by the insured and the insurer.

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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.

TERMS OF RENEWAL

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

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

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> 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 fulfillment of the terms, conditions and endorsement of this policy in so far as they relate to anything to be done or complied with by the 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.

7. 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, teleservice 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.

8. Fraudulent Claims

If any claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured or anyone acting on his behalf to obtain any benefit under this policy, or if a claim is made and rejected and no

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court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this policy shall be forfeited.

9. Cancellation/Termination

a. **Disclosure to information norm**
The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

b. Insured or the Company may cancel this Policy by giving the Company or the insured, as the case may be, 15 days written notice for the cancellation of the Policy, and then the Company shall refund premium on short term rates (if initiated by the insured) or pro rata rates (if initiated by the Company) for the unexpired Policy Period. The Company shall follow the below short period scale unless otherwise mutually agreed.

Short Period Scales- Policy Cancellation*	
Covered Upto Days	% of Refund
7	Up to 90%
30	Up to 75%
60	Up to 65%
90	Up to 50%
120	Up to 40%
180	Up to 25%
240	Up to 15%
Exceeding 240	Up to 0%

*The table is applicable only when Free Look Period is not applicable

10. Free Look Period

The insured shall be given a period of 15 days (Free Look Period) from the date of receipt of the Policy to review its terms and conditions. Where the Policy Holder disagrees to any of the terms or conditions of the Policy, he has the option to return the Policy stating the reasons for his objection, when he shall be entitled to a refund of the premium paid, subject only to a deduction of the expenses incurred by the Company on medical examination of the Insured Person(s) and the stamp duty charges.

11. 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 II of the Schedule to this policy. All claims shall be payable in India in Indian Rupees only.

12. 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.

13. Arbitration Clause

If any dispute or difference shall arise as to the quantum to be paid under this policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

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

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 the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

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14. Renewal Notice

a) The Company shall ordinarily renew the policy except on grounds of moral hazard, misrepresentation or fraud or non cooperation by the Insured. The Company shall not be bound to give notice that the renewal premium is due. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to Insured that may result to enhance Company's risk under the guarantee hereby given. Any change in the risk will be intimated by Insured to the Company. Nothing herein or otherwise shall affect the Companies right to impose any additional terms and conditions on renewal or restrict any renewal terms as to premium or otherwise.

b) The policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the previous year policy.

15. 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.

16. 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:

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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.

17. 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.

18. Grievances

In case the Insured is aggrieved in any way, the Insured may contact the Company at the specified address, during normal business hours.

(i) Call the Company at toll free number: 1800 2666 or email us at customersupport@icicilombard.com

(ii) If the Insured is not satisfied with the resolution then the insured may successively write to The Manager - Service Quality, Corporate Manager - Service Quality, National Manager - Operations & finally Director - Services and Business Development at the following address:

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Near Siddhi Vinayak Temple,Prabhadevi, Mumbai 400025

If the issue still remains unresolved, the insured may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.

The details of Insurance Ombudsman are available below:

Ombudsman Offices	
Delhi, Rajasthan	2/2 A, 1st Floor, Universal Insurance Bldg., Asaf Ali Road, New Delhi - 110 002
West Bengal, Bihar	29, N. S. Road, 3rd Fl., North British Bldg. Kolkata -700 001
Maharashtra	3rd Flr., Jeevan Seva Annexe, S.V. Road, Santa Cruz (W), Mumbai - 400 054
Tamil Nadu, Pondicherry	Fatima Akhtar Court, 4th Flr., 453(old 312), Anna Salai, Teynampet, Chennai -600 018
Andhra Pradesh	6-2-46, 1st Floor, Moin Court, LaneOpp.SaleemFunctionPalace A.C. Guards, Lakdi-Ka-pool, Hyderabad - 500 004.

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Gujarat	2nd Flr., Ambica House, Nr.C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad - 380 014
Kerala, Karnataka	2nd Flr., CC 27/ 2603, PulinatBuilding, Opp. Cochin Shipyard, M.G. Road, Ernakulam - 682 015
North Eastern States	Aquarius, Bhaskar Nagar, R.G. Baruah Rd. Guwahati
Uttar Pradesh	Jeevan Bhawan, Phase 2, 6th Floor, Nawal Kishore Rd., Hazartganj, Lucknow - 226 001
Madhya Pradesh	1st Floor, 117, Zone II, (Above D.M. Motors Pvt. Ltd.) Maharana Pratap Nagar, Bhopal - 462 011
Punjab, Haryana,Himachal Pradesh,J & K, Chandigarh	S.C.O. No. 101,102 & 103, 2nd Floor, Batra Building, Sector 17-D, Chandigarh - 160 017
Orissa	62, Forest Park, Bhubaneswar - 751 009

The updated details of Insurance Ombudsman are 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 can be obtained from any of the offices of the Company.

ICICI Lombard General Insurance Company Limited

IRDA Reg. No. 115

CIN : U67200MH2000PLC129408

Mailing Address :
401 & 402, 4th Floor, Interface 11, New Linking Road, Malad (West), Mumbai - 400 064.

Registered Office :
ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400 025.

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