HEALTHCARE PLUS POLICY

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 I 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.

PART I OF THE SCHEDULE

Policy No. Issued at Stamp Duty

1. Name of the Proposer/Policyholder:
2. Mailing address of the Proposer/Policyholder:
3. Contact no. of the Proposer/Policyholder:
4. Email id of the Proposer/Policyholder:
5. Period of Insurance:
   - Start Date: DD/MM/YY & HH:MM
   - End Date: DD/MM/YY & HH:MM
6. Details of Previous Policy:
   Insurance Company
   Previous Policy No.
   Previous Policy Period
   Cover Period
   Claims (if any)

7. Scope of cover: The Policy provides indemnification of the Medical Charges incurred during Hospitalization which are in excess of the Deductible amount, subject to the terms & conditions laid down in the Policy. The policy shall not respond to any Medical Charges that are incurred prior to or after the Hospitalization.
   Territorial Scope:

8. Details of the Insured under the Policy:

Name of the Insured							
Address for correspondence							
Relationship with the Policy holder							
Nominee							

Relationship of the Nominee with the Insured							
Date of Birth MM/DD/YY							
Sex	□ M / □ F/ □ T	□ M/□ F / □ T	□ M / □ F / □T		□ M / □ F / □T	□ M / □ F / □ T	□ M / □ F/ □T
Pre-existing Illness							
Special condition: Any physical, medical condition or treatment or service which is permanently excluded under the Policy							
Annual Sum Insured							
Deductible amount per claim							
Total Premium (Rs.)							

9. Endorsements under the Policy:

Endorsements under the policy		
No.	Endorsements/ Optional covers	Yes/ No
(i)	HC 02A- Health Check Provision	
(ii) (iii)	HC 03-Maternity Cover without Pre/Post Natal Charges HC 05-Pre-existing Illness Coverage	
(iv)	HC 06-Premium Refunds for policies with tenure greater than 1 year	

Premium	**Amount (in INR)**
Basic Premium	
Optional covers premium	
Loading (if any)	
Discount (if any)	
Premium Installment Option (if opted)	
GST	
TOTAL PREMIUM	

Signed for and on behalf of the ICICI Lombard General Insurance Company Limited, at _____ on this date ☐☐☐☐☐☐☐☐

Authorised Signatory

Tax Certificate
To,
Name of Proposer
Address of Proposer

Subject: Premium Certificate for the purpose of Deduction u/s 80D of Income Tax Act, 1961 and any amendments made thereafter*

Dear (Name of the Proposer),

This is to certify that the Company has received the premium dated dd/mm/yyyy for Health insurance coverage under "Health Care Plus" with the following details.

Proposer's Name		Policy Number	
Policy Start Date		Policy End Date	
Plan Name		Total Premium Paid (₹)	
GSTIN Number (Customer)		GSTIN Reg.No (ICICI Lombard)	
Servicing Branch Name		Servicing Branch Address	

Premium Details (₹)						
Basic Premium	CGST		SGST		Total Tax Payable	Total Premium
	%	₹	%	₹		

Financial Year	**Amount (₹)**
2020-2021	
2021-2022	

The product is eligible for deduction u/s 80D of the Income Tax, 1961 and any amendments made there to.

Sincerely,

For **ICICI Lombard General Insurance Company Ltd.**

Authorised Signatory

Note:

- Details of the Policy are as per the Part II and III of this Policy.
- This certificate must be surrendered to the Insurance Company in case of Cancellation of the Policy.
- In the event of incorrect representation of this declaration, the liability shall be upon the proposer.
- In case You find any variations against Your proposal or any discrepancy in the Policy, please contact Us immediately on the numbers available on our website www.icicilombard.com Or call on our toll free no. 1800 2666

PART II OF THE SCHEDULE

1. DEFINITIONS

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

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

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

"**Break in policy**" occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

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

"**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.

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

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

"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.

"Day Care Treatment" refers to 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 hrs 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.

"Disclosure to information norm" means 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

"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 parts of the body

"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.

"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.

"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.

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.

"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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the 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.

"Hospitalization" 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 24consecutive hours.

"Illness**"** means a sickness or a 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** - 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 o f 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 your rehabilitation or for you to be specially trained to cope with it
iv. It continues indefinitely
v. it comes back or is likely to come back

"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.

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

"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 I 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 Advice" Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

"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 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.

"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 licence.'

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).

"Migration" means the right accorded to health insurance policyholders/proposers (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer

"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.

"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 "- is the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

"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.

"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 I of the Schedule to this 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.

"**Portability**" Portability means right accorded to an individual health insurance policyholder/proposers (including all members under family cover), to transfer the credit gained for pre-existing conditions and time-bound exclusions, from one insurer to another insurer.

"**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 You, what is excluded from the cover and the terms & conditions on which the Policy is issued to You.

"Policy Year" means a period of twelve months beginning from the Policy Period Start Date, as specified in Policy 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 I of the Schedule.

"Pre-existing Disease" means any condition, ailment, injury or disease

a) That is/ are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement **OR**

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

"**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.

"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.

"Portability" means the right accorded to an individual health insurance policyholder/proposers (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer

"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

"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.

"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.

"**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 and denotes the maximum amount of cover available to You 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.

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

2.1 SCOPE OF THE COVER

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.

Extensions/Optional Covers available

1. <u>Health Check Provision</u>

Notwithstanding anything contrary contained in the Policy, the Company will provide a health check to the Insured as per Company's prescribed tests and designated centers on issuance of the Policy without any additional premium.

2. <u>Maternity Cover without Pre or Post Natal Charges</u>

Notwithstanding anything contrary contained in the Policy, coverage under Policy is extended to reimburse amount of Medical Charges incurred, subject always to the Limit of Indemnity and Deductible under the Policy in connection only with the maternity benefits as specified hereunder, for which a Claim is made by the Insured and admitted by the Company, provided always that:

a) These benefits are admissible only if the expenses are incurred in Hospital/nursing home as in-patients in India unless otherwise specified in Part I of the Policy.

b) The benefits under this Extension shall be admissible for any delivery after a period of 9 months from the date of inception of the Policy.

c) Claim in respect of delivery for only first two children and/or operations associated therewith will be considered in respect of any one Insured. Such other Insured who is/are already having two or more living children will not be eligible for this benefit.

d) Expenses incurred in connection with voluntary medical termination of pregnancy.

e) Pre-natal and postnatal expenses are not covered unless the same requires Hospitalisation.

Subject otherwise to the terms and conditions of this Policy.

3. Pre-existing Illness coverage

Notwithstanding anything to the contrary contained in the Policy, the scope of cover under Policy is extended to cover Pre-existing Illnesses, subject to the following conditions:

(i) The Insured has taken the HEALTH CARE PLUS Policy from the Company and has been covered under such Policy, without a break, for 4 consecutive years immediately preceding the Period of Insurance;
(ii) The Pre-existing Illnesses which are in the knowledge of the Insured/ Policyholder have been declared by the Insured and accepted by the Company in writing for the first Healthcare Plus Policy issued by the Company in favour of the Insured (as specified in (i) above);
(iii) The Permanent Exclusions mentioned under sub-clause 2.2 (iv) of Part II of the Policy shall not be covered in any case;
(iv) The liability of the Company shall be subject to the Deductible and Limit of Indemnity;
(v) Notwithstanding anything in clause (iv) above, if the Policy is renewed for an enhanced Sum Insured, then the benefit in respect of the Pre-existing Illnesses shall be restricted to the Sum Insured that is lowest under the prior Policies as specified in (i) above.

4. Premium Refunds for Policies with tenure greater than 1 year

The Company may at any time, cancel this Policy, by giving 15 days notice in writing by registered post/acknowledgement due post to the Policyholder at the address mentioned in the Schedule, in which case, the Company shall be liable to repay on demand to the Policyholder, a rateable proportion of the premium for the unexpired term from the date of the cancellation. The Policyholder may also give 15 days notice in writing to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice cancel the Policy and retain the

premium for the period for which this Policy has been in force at the Company's short period scales as mentioned herein below, provided that, no refund of premium shall be made if any claim has been made under the Policy by or on behalf of the Insured.

% Refund Premium				
	Policy Period (Years)			
Year of Cancellation calculated from Policy Start date (upto)	2	3		
0.25 years	70%	70%		
Year 1	20%	35%		
Year 2		10%		
Year 3				

No refunds of premium will be made under the Policy during the last year of the Period of Insurance.

Upon making any refund of premium under this Policy in accordance with the terms and conditions hereof in respect of the Insured, the cover in respect of that Insured shall forthwith terminate and the Company shall not be liable for any claims made by such Insured hereunder.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Insured where any Claim has been admitted by the Company or has been lodged with the Company.

2.2 EXCLUSIONS APPLICABLE TO POLICY

The Company shall not be liable for the Deductible amount as specified in Part I 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) Code- Excl01: Pre-Existing Diseases

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.

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

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

(ii)

a. 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
   i. Hypertension
   ii. Diabetes
   iii. Cardiac Conditions
b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

(iii) Code- Excl03: 30-day waiting period

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

(iv) Code- Excl02: Specified disease/procedure waiting period

a) 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.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

- 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

(iv) PERMANENT EXCLUSIONS

(i) Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy in Part I 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) **Code- Excl15:** Refractive Error: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

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

(v) Code- Excl04: Investigation & Evaluation

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

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

(vi) Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)

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

(viii) All dental treatment unless caused due to Accident.

(ix) **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

(x) **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.

(xi) **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.

(xii) Code- Excl17: Sterility and Infertility: Expenses related to, sterility and infertility. This includes:

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

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(xiii) 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.

(xiv) Cost of cochlear implant(s) unless necessitated by an Accident.

(xv) Personal comfort and convenience items and services.

(xvi) Any charge incurred prior to Hospitalisation or post Hospitalisation, including but not limited to, charges for nurses/attendants, etc.

(xvii) **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

(xviii) 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.

(xix) Circumcision unless necessary for treatment of a disease or necessitated due to an Accident.

(xx) Vaccination and inoculation of any kind.

(xxi) 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.

(xxii) Treatment by a family member and self-medication or any treatment that is not scientifically recognized.

(xxiii) Any Injury/Illness sustained or contracted due to flying other than as a passenger on a scheduled regular carrier.

(xxiv) 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.

(xxv) 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.

(xxvi) 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.)

(xxvii) 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.

(xxviii) **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.

(xxix) Costs of donor screening or treatment including surgery to remove organs from a donor in case of transplant surgery.

(xxx) AYUSH treatment.

(xxxi) Treatment received outside the Geographical Scope of Cover mentioned in the Part I of the Policy.

(xxxii) Any travel or transportation expenses including ambulance charges.

(xxxiii) Treatment taken from persons not registered as Medical Practitioners under respective medical councils.

(xxxiv) Code- Excl06: Obesity/ Weight Control

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
5) greater than or equal to 40 or
6) 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

(xxxv) **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

(xxxvi) **Code- Excl05**: Rest Cure, rehabilitation and respite care

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
    I. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
    II. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

(xxxvii) 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.

(xxxviii) Domiciliary Hospitalisation

(xxxix) Any consequential or indirect loss or expenses arising out of or related to the Hospitalization.

(xl) 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.

(xli) Any treatment related to sleep disorder or sleep apnoea syndrome.

2.3 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.

3. TERMS AND CONDITIONS APPLICABLE TO THE POLICY

3.1 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:

3.1.1 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

3.1.2 PRIOR AUTHORIZATION

For cashless Hospitalization, the Insured must contact the Company at least 48 hours before a planned Hospitalization. In an emergency situation the Company should be contacted within 24 hours of Hospitalization.

3.1.3 CLAIM PROCESSING

The Company will process the Claim and make all payments.

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.

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.

3.2 PAYMENT OF CLAIMS

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

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

3.3 Settlement/Rejection of Claim –The Settlement of claims would be done by Us within 30 days after receipt of last necessary documents, any rejections if done, would be provided with proper reasons by Us.

Penal interest provision shall be as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2017.

4. GENERAL CONDITIONS APPLICABLE TO THE POLICY

4.1 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.

PART III OF THE SCHEDULE

Standard Terms and Conditions

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. **Claim Settlement (provision for Penal Interest)**
   i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
   ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
   iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document
   iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

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

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

6. 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.

7. Observance of terms and conditions

The due observance and fulfilment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by the Insured, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

8. 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.

9. 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.

10. 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.

11. Notice of charge etc.

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

12. Overriding effect of Part II of the Schedule

The terms and conditions contained herein and in Part II 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 II 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 II of the Schedule and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

13. 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. Grace Period of 15days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. 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.

iv. No interest will be charged If the instalment premium is not paid on due date

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

14. 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:

(i) Forthwith file/submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in Part II 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.

15. 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.

16. 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.

17. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If 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 IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

18. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link.
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

19. Renewal of Policy

The policy shall ordinarily be renewable except on misrepresentation by the insured person.

grounds of fraud,

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. 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.
v. No loading shall apply on renewals based on individual claims experience.

20. Cancellation/ termination

i. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

PERIOD ON RISK	RATE OF PREMIUM REFUND
Up to 1 month	75% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	25% of annual rate

Exceeding six months NIL

21. Withdrawal of Policy

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

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

22. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

23. 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 I to the Schedule or Extensions to this Policy. All claims payable in India shall be in Indian Rupees only.

24. 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

25. 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.

26. 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.

27. 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

28. Arbitration clause

i. 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).

ii. 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. 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.

29. 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 1 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.

30. Free Look Period:

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

i. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

31. Redressal of Grievances

In case of any grievance the insured person(including senior citizens) may contact the company through

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

- Insured person may also approach the grievance cell at any of the company's branches with the details of grievance If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at

Manager- Service Quality,
Corporate Manager- Service Quality,
National Manager- Operations & finally

Director-services and Business development at the following address:
ICICI Lombard General Insurance Company Limited,
ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400025

For updated details of grievance officer, kindly refer the link https://www.icicilombard.com/grievance-redressal

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the ombudsman have been provided as an annexure to the policy wordings

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/ligms. irda.qov. in/

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,	Gujarat, Dadra & Nagar Haveli,

Office Details	Jurisdiction of Office Union Territory,District)
Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	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.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. 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 Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.

Office Details	Jurisdiction of Office Union Territory,District)
Email: bimalokpal.chandigarh@ecoi.co.in	
CHENNAI - Shri M. Vasantha Krishna Office of the 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 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
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,	Rajasthan.

Office Details	Jurisdiction of Office Union Territory,District)
Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
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),	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.

Office Details	Jurisdiction of Office Union Territory,District)
Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	
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, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 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.

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

32. 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