AROGYA SANJEEVANI POLICY, ICICI LOMBARD PROSPECTUS

What is covered?

- **Basic Hospitalisation:** We will pay You for the in - patient Hospitalisation expenses such as room rent / boarding and nursing expenses up to 2% of sum insured subject to maximum of ₹ 5,000 day and intensive care unit charges up to 5% of sum insured subject to maximum of ₹ 10,000 day. We shall also pay You for surgeon's, doctor's fee, anaesthesia, blood, oxygen, operation theatre charges etc. incurred by You during Hospitalisation for a minimum period of 24 consecutive hours. Other expenses that will be covered include.
  - Expenses incurred on treatment of cataract subject to sub limits
  - Dental treatment, necessitated due to disease or injury
  - Plastic surgery, necessitated due to disease or injury
  - All day care treatments
  - Expenses incurred on road ambulance subject to a maximum of ₹ 2,000 per hospitalisation

- **AYUSH Treatment :** We will pay You for expenses incurred on Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy (AYUSH) in patient treatment up to the limit as specified in the policy schedule only when the treatment has been undergone in a AYUSH hospital or AYUSH day care centre.

- **Cataract Treatment:** We will pay You for the medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum insured or ₹ 40,000 whichever is lower, per eye in one policy year.

- **Pre Hospitalisation:** We will pay You pre - hospitalisation medical expenses incurred related to an admissible hospitalisation requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalisaiton covered under the policy.

- **Post Hospitalisation expenses:** We will pay You post - hospitalisation medical expenses incurred related to an admissible hospitalisation requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalisaiton covered under the policy.

Salient Features

- **Family Floater Benefit:** You can avail a floater cover and get Your immediate family (self, spouse, parents, parents - in - law, dependent children between the age of 3 months to 25 years. If the child above 18 years of age is financially independent, He / She shall be ineligible for coverage in subsequent renewals) covered for the same sum insured under a single Policy by paying one premium amount. Any individual above 3 months of age can be covered under the Policy provided 1 Adult is also covered under the Policy.

- **Premium Payment in Instalments:** You can avail an option to pay premium amount in Half yearly, Quarterly or monthly instalments with a grace period of 15 days. Please note that coverage will not be available from the instalment premium due date till the date of receipt of premium by company.

- **Cumulative Bonus:** You will be entitled for a cumulative bonus of 5% for each claim free policy year provided the policy has been renewed with the Company without a break subject to a maximum of 50% of sum insured. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

- **Cashless Hospitalisation:** You can avail of cashless Hospitalisation at any of our network providers / hospitals. A list of these hospitals / providers will be sent to You along with Your Policy.

- **Tax Benefit:** You can avail of tax benefit on premiums paid under Health sections of this Policy, as per Section 80D of Income Tax Act, 1961 and amendments made thereafter.

- **Policy Period:** The Policy Period is of one year

- **Free Look Period:** In case of all policies a free look period of 15 days would be available to You from the date of receipt of the Policy document, for reviewing its terms and conditions. If You disagree with any of its conditions, You may return the Policy within this free look period and We will refund You the premium subject only to a deduction of expenses incurred on medical examination and stamp duty charges. In case the request for cancellation comes 30 days after the Policy Period start date, pro-rata refund of premium would be paid to You.

- **Eligibility:**
  - **Entry Age:** This Policy can be offered to an individual with age between 18 years and 65 years, as a proposer. Proposer with higher age can obtain policy for family without covering self.
  - Children between age of 3 months to 25 years can be insured under a floater plan. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
  - Lifetime renewability

- **Pre - Policy Medical Check- up:** No medical tests will be required, if You approach us for insurance cover below the age of 45 years up to the Annual Sum Insured of ₹ 5 Lakh. However if You approach us for insurance when You are 45 years of age* or above, You will have to then compulsorily undergo medical tests at our designated diagnostic centres. If we accept Your proposal, we will reimburse 100% of the cost incurred by You in undertaking such pre - insurance medical tests.
  *This age limit may be relaxed for specific channels or plans upon approval from product head.

- **Annual Sum Insured:** This denotes the maximum amount of cover available to You for a Policy Period of one year.
  Minimum Sum Insured: ₹ 1,00,000
  Maximum Sum Insured: ₹ 5,00,000 (in multiples of fifty thousand)

Loss Sharing

- **Sub Limits:**
  - Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of ₹ 5,000 per day.
  - Intensive Care Unit (ICU) charges / Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of ₹10,000 per day.
  - Cataract: Up to 25% of SI or ₹40,000 whichever is lower
  - Modern treatments and advances in technology - Up to 50%of Sum Insured

- **Co - Payment:**
  Each and every claim under the policy shall be subject to Co - payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the policy.

What is not covered?

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

- **Pre - Existing Diseases (Code - Excl0l)**
  - 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 us.
  - In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum insured increase.
  - If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
  - 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 us.

- **First Thirty Days Waiting Period (Code - Excl03)**
  - Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
  - This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
  - The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

- **Specific Waiting Period: (Code - Excl02)**
  - Expenses related to the treatment of the following listed conditions, surgeries / treatments shall be excluded until the expiry of 24 / 48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
  - In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
  - If any of the specified disease / procedure falls under the waiting period specified for pre - existing diseases, then the longer of the two waiting periods shall apply.
  - The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
  - If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
    - **24 Months waiting period**
      - Benign ENT disorder
      - Tonsillectomy
      - Adenoidectomy
      - Mastoidectomy
      - Tympanoplasty
      - Hysterectomy
      - All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
      - Benign prostate hypertrophy
      - Cataract and age related eye ailments
      - Gastric / Duodenal Ulcer
      - Gout and Rheumatism
      - Hernia of all types
      - Hydrocele
      - Non Infective Arthritis
      - Piles, Fissures and Fistula in anus
      - Varicose Veins and Varicose Ulcers
      - Internal Congenital Anomalies
      - Pilonidal sinus, Sinusitis and related disorders
      - Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
      - Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.

- **48 Months waiting period**
  - Treatment for joint replacement unless arising from accident
  - Age - related Osteoarthritis and Osteoporosis

- **Investigation and Evaluation (Code - Excl04)**
  - Expenses related to any admission primarily for diagnostics and evaluation purposes.
  - Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

- **Rest Cure, rehabilitation and respite care (Code - Excl05)**
  Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
  - Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
  - Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

- **Obesity / Weight Control (Code - Excl06)**
  Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
  - Surgery to be conducted is upon the advice of the Doctor
  - The surgery / Procedure conducted should be supported by clinical protocols
  - The member has to be 18 years of age or older and
  - Body Mass Index (BMI);
    - Greater than or equal to 40 or
    - Greater than or equal to 35 in conjunction with any of the following severe co morbidities following failure of less invasive methods of weight loss:
      - Obesity - related cardiomyopathy
      - Severe Sleep Apnea
      - Coronary heart disease
      - Uncontrolled Type 2 Diabetes

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

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

- **Hazardous or Adventure sports (Code - Excl09)**
  Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, 1110tor racing, horse racing or scuba diving, hand gliding, sky diving, deep - sea diving.

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

- **Excluded Providers (Code - Excl11)**
  Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilisation are payable but not the complete claim.

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

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

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

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

- **Unproven Treatments (Code - Exc116)**
  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.

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

- **Maternity Expenses (Code - Excl18)**
  - 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.

- War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

- Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
  - Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile / fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
  - Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
  - Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro - organisms and / or biologically produced toxins (including genetically modified organisms and chemically synthesised toxins) which are capable of causing any Illness, incapacitating disablement or death.

- Any expenses incurred on Domiciliary Hospitalisation and OPD treatment.
- Treatment taken outside the geographical limits of India.
- In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

Loading

We may apply a risk based loading on premium payable (based upon the declarations made and the health status of the person proposed for insurance). The maximum risk loading applicable shall not exceed 200% of base premium.

This risk based loading will be applicable, to the extent as applied at the time of first policy, at renewals as well.

We will not apply any additional loading at renewal based on claim experience.

We will inform you about the applicable risk loading through a counter offer letter at the time of Your risk assessment before first policy. You need to revert to us with consent and additional premium, if any within 15 days of issuance of such counter offer letter. If You neither accept the counter offer letter nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid. Please note that We will issue policy only after getting Your consent.

Moratorium period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

How to make a claim?

- **Procedure for Cashless claims:**
  - Treatment may be taken in a network provider and is subject to pre authorisation by the Company,
  - Cashless request form available with the network provider shall be completed and sent to the Company for authorisation.
  - The Company upon getting cashless request form and related medical information from the insured person / network provider will issue pre - authorisation letter to the hospital after verification.
  - At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non - medical and inadmissible expenses.
  - The Company reserves the right to deny pre - authorisation in case the insured person is unable to provide the relevant medical details,
  - In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company for reimbursement.

- **Procedure for reimbursement of claims:**
  For reimbursement of claims the insured person many submit the necessary documents to Company within the prescribed time limit as specified hereunder.

Type of Claim	Prescribed Time limit
Reimbursement of hospitalisation, day care and pre hospitalisation expenses	Within thirty days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within fifteen days from completion of post hospitalization treatment

- **Notification of Claim**
  Notice with full particulars shall be sent to the Company as under:
  - Within 24 hours from the date of emergency hospitalisation required or before the Insured Person's discharge from Hospital, whichever is earlier.
  - At least 48 hours prior to admission in Hospital in case of a planned Hospitalisation.

- **Documents to be submitted:**
  The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.
  - Duly Completed claim form
  - Photo Identity proof of the patient
  - Medical practitioner's prescription advising admission
  - Original bills with itemized break - up
  - Payment receipts
  - Discharge summary including complete medical history of the patient along with other details.
  - Investigation / Diagnostic test reports etc. supported by the prescription from attending medical practitioner
  - OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
  - Sticker / invoice of the Implants, wherever applicable.
  - MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.
  - NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
  - KYC (Identity proof with Address) of the proposer, where claim liability is above ₹ 1 Lakh as per AML Guidelines
  - Legal heir / succession certificate, wherever applicable
  - Any other relevant document required by Company for assessment of the claim.

Note:

- The company shall only accept bills / invoices / medical treatment related documents only in the Insured Person's name for whom the claim is submitted
- In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.
- Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

Co - payment

Each and every claim under the Policy shall be subject to a Co - payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co - payment.

Claim Settlement (provision for Penal Interest)

- 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.
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- 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 the claim within 45 days from the date of receipt of last necessary document.
- In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Payment of Claim

All claims under the policy shall be payable in Indian currency only.

Terms of Renewal

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

- Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
- Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
- At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
- If not renewed within Grace Period after due renewal date, the Policy shall terminate.

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 affected.

Endorsements (Changes in Policy)

- This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
- The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir / immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his / her demise or him/her moving out of India.

Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

Migration Benefits

You will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to 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, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

- The waiting periods specified in Section 6 in the policy wordings shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
- Migration benefit will be offered to the extent of sum of previous insured and accrued bonus / multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on migration, kindly refer the link:
https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo3986&flag=1

Portability Benefits

You will have the option to port the Policy to other insurers as per extant Guidelines related to portability, If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

- The waiting periods specified in Section 6 in the policy wordings shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
- Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on portability, kindly refer the link:
https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo3986&flag=1

Cancellation

- You may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Refund %	
Refund of Premium (basis Policy Period)	
Type of Claim	**Prescribed Time limit**
Timing of Cancellation	1 Year
Up to 30 days	75.00%
31 to 90 days	50.00%
3 to 6 months	25.00%
6 to 12 months	0.00%

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

- The Company may cancel the Policy at any time on grounds of mis - represenation, non - disclosure of material facts, fraud by You, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis - represenation, non - disclosure of material facts or fraud.

Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

- In the case of his / her (Insured Person) demise.
- Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

Nomination

You are 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. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee

Redressal of Grievance

- In case of any grievance relating to servicing the Policy, You may submit in writing to the Policy issuing office or regional office for redressal. For details of grievance officer, kindly refer our website www.icicilombard.com
- IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/
- Insurance Ombudsman - You may also approach the office of Insurance Ombudsman of the respective area / region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided in the policy wordings.

Annexure:

Rate charts for Individual and Floater policies are attached.

List of Non payable items.

ICICI Lombard General Insurance Company Limited

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