

FAQs

The FAQs have been designed to ensure clear customer communication and are consistent across the plans within the product. Presence of a specific coverage question does not automatically make the customer eligible for that particular cover. Please read the Policy wordings in conjunction with the Customer Information Sheet and Policy certificate to understand Your Coverage

Coverage

1. What does my Golden Shield policy cover?

Golden Shield offers varying degrees of coverage. Please refer to the Key information sheet in this booklet to learn more about your policy coverage

2. What is annual sum insured?

Annual sum insured denotes maximum amount of cover available during each policy year of the policy period. It includes your base sum insured and additional sum insured.

3. Does my Golden Shield policy cover the diseases that I already have at the time of buying the policy?

There is a waiting period after which we can cover medical expenses related to diseases or ailments that you had before buying Golden Shield policy (Pre existing diseases or PED). Only the PEDs that were declared and accepted at the time you bought the policy are covered. The pre-existing disease waiting period is 2 years.

4. What is a Special Condition?

Special Condition is a disease (physical, medical or mental condition or treatment or service) which is permanently excluded from the scope of coverage under a policy and any claim pertaining to the said disease (physical, medical or mental condition or treatment or service) and any complications arising from the same are not paid under the policy. The disease (physical, medical or mental condition or treatment or service) is permanently excluded from the coverage basis the underwriting criteria with due consent of the proposer or person to be insured.

5. What is the difference between Date of Joining and Policy start date?

For a first-time policy, the policy start date and date of joining are the same. Only at the time of renewal, will the policy start date and date of joining differ. Date of joining is the date of inception of the first policy with us while the policy start date is the date from which your renewed policy starts. For fresh policy, policy start date will be the cheque date or documents inward date whichever is later. For a renewal policy, policy start date will be the cheque date or documents inward date or renewal date whichever is later.

6. What is additional sum insured (ASI)? Can I redeem it at the time of claim settlement?

ASI is the reward you get at the time of renewing your policy if you have not made any claim in the previous year. ASI is rewarded at 10% of base sum insured for each year and can go up to a maximum of 100% of the base sum insured. Even in case of a claim, the accrued additional sum insured shall not be reduced. The ASI along with the basic sum insured amount can be utilized at the time of claim settlement. ASI (CB) is given on a policy level and not on insured person level. In case a floater policy is split at the time of renewal, the CB will also be split in the same proportion as the sum insured

7. I have received a health care card along with the policy kit. Why do I need a health care card?

A health care card is given to all the people insured in your policy. This card has all the details of the insured along with the policy number, insured name and policy end date. You will have to produce this when you avail of the cashless hospitalization facility. It should also be carried along with the preventive health check-up coupon if you are availing of this facility at a diagnostic centre.

8. Does my policy have any room rent restrictions?

The Golden Shield policy has room rent capping depending on the plan opted by the customer. Please read

the Policy wordings in conjunction with the Customer Information Sheet and Policy certificate to understand Your Coverage

9. Does Golden Shield Policy cover pre and post hospitalization expenses?

The Golden Shield policy does cover pre and post hospitalization expenses depending on the plan opted by the customer. Please read the Policy wordings in conjunction with the Customer Information Sheet and Policy certificate to understand Your Coverage

10. In case I wish to move to my hometown Goa, post my retirement, will my premiums change basis my residence?

The Golden Shield policy has zone based premiums. Premiums are computed basis the zones chosen by the customer during policy issuance. The premium that would be applicable zone wise and the cities defined in each zone are as under:

- Zone A- NCR*, Mumbai, Thane District, Navi Mumbai, Gujarat, Kolkata
- Zone B- Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Navi Mumbai)
- Zone C- Rest of India.

NCR* includes Delhi and the following districts: Faridabad, Gurgaon/Gurugram, Mewat, Rohtak, Sonipat, Panipat, Jhajjar, Palwal, Karnal, Ghaziabad, Noida/Gautam Budh Nagar, Bulandshahr, Baghpat, Hapur, Shamli, Muzaffarnagar

Additional zone based Co-Payment would be levied on each and every claim (over and above the base co-payment opted by the Insured person) in case medically necessary treatment has been taken in a zone higher (Zone A being the highest followed by Zone B and then Zone C) than the zone for which premium has been paid on issuance of the policy. Zone based co-payment shall not be applicable in case of medically necessary treatment taken for road traffic accidents.

The additional zone based co-payment that will be levied will be as per tables mentioned below

Additional Zone based Co-Payment Grid			
Treatment taken in Zone	Zone opted at policy issuance		
	A	B	C
A	0%	15.0%	25.0%
B	Nil additional co-payment	0%	12.0%
C	Nil additional co-payment	Nil additional co-payment	0%

11. Is there any mandatory base co-payment that I shall have to bear at the time of claim?

The Golden Shield product has a mandatory base co-payment of 50%. However, the customer has the choice to reduce it to 40% or 30% or 20% depending on the plan opted.

12. Does the Golden Shield product have any sub-limits?

While the Golden Shield product covers a host of ailments, some conditions/ailments/modern treatments are subject to sub-limits basis the plan opted by the customer. Please read the Policy wordings in conjunction with the Customer Information Sheet and Policy certificate to understand Your Coverage

13. I and my spouse recently opted for vaccination against pneumococcal disease. Are there any benefits associated with the same?

We provide an additional 2.5% discount on premium (fresh or renewal) for customers who have taken the Pneumococcal vaccine or any equivalent vaccine which helps prevent pneumococcal disease. All members covered under floater policy should have been vaccinated in the past one year (1 year) from policy start date to avail this discount. i.e. if policy start date is 1st January 2022, all insured persons under the policy should have been vaccinated against Pneumococcal disease in the period from 1st January 2021 to 31st December 2021. This discount shall be provided lifetime as long as the insured person continues to renew this policy

Tax Benefit

14. What tax benefit do I get for making premium payments?

The premium you pay for yourself, your spouse, your dependent children and dependent parents, up to the limit of ₹30,000 (₹50,000 for those aged 60 years or more), excluding taxes, is eligible for deduction under section 80D. This deduction is eligible under the prevailing tax laws, which are subject to change.

15. Is the claim amount subject to tax?

No, the claim amount you receive under your health policy is not subject to tax.

Endorsements

16. What if I need to change any of the details currently reflected in the policy document?

Should you find that there are any inaccuracies in your policy certificate it is very important that you contact us to rectify them so as to ensure all material facts relating to your coverage are correct. Changes in the details of your policy can be of 2 types.

- No change in premium: Some changes, such as a spelling of name and change of address, change of date of joining or contact details will not have any impact on the premium you have paid.
- Change in premium: Some changes such as the date of birth, addition or deletion of pre-existing diseases might require the policy to be reviewed again and might change the premium on the policy.

These changes can be endorsed in the policy either by contacting us at our toll free number 1800 2666 or by e-mailing us at customersupport@icicilombard.com.

17. What is the procedure for increasing the Sum Insured (SI) at the time of renewing the policy?

Sum insured can be increased at the time of renewing the policy either online or by visiting our branch, subject to approval by medical underwriter if required. It is important to note that the waiting period will be applicable to enhanced SI from the date of enhancement, but not to the base sum insured. Premium payable is subject to change according to enhance SI also we apply a risk based loading on the premium payable.

18. Can I add or remove family members from this policy?

Yes, you can add or remove family members to your policy only during renewal. Mid-term addition is not permitted. The additions cannot increase the policy limit to more than 2 adults. In the case of an individual policy, the insured cannot be replaced by any other person. Please note that fresh waiting period will be applicable to the person(s) added.

19. Can extended family members be covered under my health policy?

Your policy has been exclusively designed to cover only your- self and your spouse.

20. I had not declared a pre-existing disease when I had bought the policy earlier. Can I do so now? What is the impact on my policy?

Any pre-existing disease (PED) not declared at the time of policy inception will be considered as non-disclosure of the material facts and may lead to policy cancellation. To avoid this, all material facts related to PEDs should be declared before the policy issuance. However, should you need to declare any PED after policy issuance, please visit our branch office. The acceptance of the PED will be subject to our underwriting guidelines.

21. How can I cancel my policy before the expiry date?

Free look period: (applicable only for new individual health insurance policies and not on renewals or at the time of porting/migrating the policy)

- You can cancel and return your policy within 15 days of receiving it by sending us the free look request form available on our website or by submitting written notice to the company either via registered post or from your registered email address. You can also call us at our toll free number 1800 2666 and let us know if you would like to cancel the policy. If you avail of this feature, the premium will be returned to you.

- b. Should you wish to cancel the policy after the free look period but before the expiry date, you can do so by following the same process as above. We shall refund premium on the short term rates (as specified in policy wordings f. general terms and clauses) for the policy period remaining.
- c. Premium refund will be done through NEFT mode only, please fill up and send us the NEFT form available on our website.

22.Can ICICI Lombard cancel my policy before the expiry date?

We may cancel your policy in the case of misrepresentation, fraud, non-disclosure of material facts or non-cooperation of the insured/ policyholder. Prior to cancelling the policy, we will send a written notice to this effect via registered post, giving 15 days' notice to the policyholder.

Covers

23.What expenses shall be covered under donor expenses?

Medical Expenses incurred in respect of the donor for any of the organ transplant surgery will be covered up to Sum Insured, provided the organ donated is for the insured person's use and We have admitted the In-patient Hospitalization Claim for the same. Screening expenses in respect of the organ donor shall not be covered. The limit for this cover is up to annual sum insured and will be restricted to maximum of 10 Lacs

24.When can I claim under Domiciliary Hospitalization?

Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken at home. You can claim under this cover up to annual sum insured in case your condition is such that you cannot be moved to the hospital or there are no beds available in the hospital.

25.Does my policy cover air ambulance charges?

Expenses incurred on air ambulance services offered by a healthcare or an air ambulance service provider to transfer You to the nearest Hospital with adequate emergency facilities shall be covered up to annual sum insured provided the same is for a life-threatening emergency health condition and will be within the geographical scope of India.

26.What expenses shall be paid under the Claim Protector cover?

For your in- patient hospitalization claim, You may have noticed expenses for certain items like oxygen mask, attendant charges, Gloves etc are deducted and not settled. In case, You opt for the claim protector cover, these expenses can be claimed under this cover within the overall annual sum insured

27.What is meant by voluntary deductible? Can I opt for the same?

Voluntary Deductible is a cost sharing requirement that provides that the insurer will not be liable for specified rupee amount. For example, base sum insured of 25L and voluntary deductible of 5L – which indicates that the Golden Shield policy will be triggered only if the aggregate of all hospitalization expenses in a policy year has to cross 5L. In case voluntary deductible has been opted for, base co-payment shall not be chosen. Zone based co-payment shall be applicable in case medically necessary treatment (Except medically necessary treatment for road traffic accidents) has been taken in a zone higher (Zone A being the highest followed by Zone B and then Zone C) than the zone for which premium has been paid on issuance of the policy.

Care Management Program

28.What is Care Management Program?

Care Management Program aims to provide solutions which will solve everyday challenges/issues faced by You, promote holistic wellbeing and empower You to lead independent and enriching lives. You shall have access to a host of benefits under the Care management program on downloading and registering on our mobile application.

29.What are all benefits do I get from care management program?

ICICI Lombard General Insurance Company Limited

IRDA Reg. No. 115

Mailing Address:

ICICI Lombard General Insurance Company Limited,
Interface Building No.: 16, 601 / 602, 6th Floor, New
Link Road, Malad (West), Mumbai - 400 064.

CIN: L67200MH2000PLC129408

Registered Office:

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

Golden Shield

Toll free no.: 1800 2666

Alternate No.: +918655 222 666 (chargeable)

Email: customersupport@icicilombard.com

Website: www.icicilombard.com

UIN - ICIHLP22012V012223

Other than reward points that you can redeem against discounts on various services, you will also be entitled for services of health coach, unlimited tele-consultations, dietician e-consultation, e-counselling sessions etc.

30. What do I get for my wellness points earned through care management program? Can I use them to get discounts while renewing my policy?

You can redeem your wellness points against discounts for a host of services/products including but not limited to diagnostic tests/health supplements/medical equipment/virtual health and wellness sessions AYUSH products/Fitness & wellness related activities & products etc. at our empaneled diagnostic centres, drugs/medicines ordered from pharmacies etc. offered by our network providers/ health service providers. No discounts would be offered on premium amount on renewal against wellness points.

31. What are some of the benefits associated with care management plus program?

Coverage for Out-patient consultations within our empaneled network of providers, coverage for routine diagnostic and minor procedure cover, coverage for purchase of medicines recommended by doctors in our cashless network are some of the additional benefits associated with care management plus program. Please read the Policy wordings in conjunction with the Customer Information Sheet and Policy certificate to understand Your Coverage

Please note that all Optional covers i.e. from Q No. 27 to Q No 32 are available on payment of extra premium and depending on plan opted. (In case customer opts for voluntary deductible, He/She shall be eligible for discount on premium)

Claims

32. How can I file a claim?

If you need to make a claim, you must intimate us in any of the following ways:

- a) Call us at our 24*7 customer care toll free number 1800 2666
- b) Text message HEALTHCLAIM to 575758 (charged at ₹3 per SMS)
- c) Email us at ihealthcare@icicilombard.com.

Do ensure that you intimate us of a planned hospitalization at least 48 hours before admission. In the case of an emergency, we must be informed within 24 hours of admission. You can download claim form from our website - www.icicilombard.com.

33. How can I track my claim for current claim status details?

Once a claim is submitted, its status can be tracked on our website. You can log in to your personal section on our website - www.icicilombard.com - and check for the claim status.

34. How soon can I file a hospitalisation claim on my policy?

- a. There is a waiting period of 30 days from the start of the first time you buy the policy before which a claim cannot be made for any illness, except for hospitalisation due to injury or accident.
- b. Apart from this, there are some illnesses for which you cannot make a claim for the first 2 years (refer to e. exclusions of the policy wordings for this list).
- c. Additionally, in the case of claims relating to pre-existing illnesses, you cannot make a claim for the first 2 years.
- d. There is also a waiting period of 90 days from first policy commencement date for Hypertension, Diabetes and Cardiac conditions. In case, these conditions are pre-existing ailments, then they shall be excluded for a period of 2 years

35. What is the difference between a cashless and a reimbursement claim? Cashless and reimbursement are two different ways to settle a claim:

- 1. Cashless claim is a claim where we pay the agreed claim amount directly to the hospital. You need not to pay the hospital for the claim amount. You are required to inform us about the procedure or treatment and send us all the related paper work.

2. Reimbursement claim is a claim where you settle the bill with the hospital and then send us the relevant documents. We will reimburse you for the agreed claim amount.

36. Can I file multiple claims in the year?

Yes, you may file multiple claims in the year, subject to the total amount of the claims not exceeding the sum insured on your policy.

37. Will my policy cover medical treatment at any hospital I choose?

ICICI Lombard has an extensive network of hospitals with which it works to offer cashless and reimbursement facilities for your treatment. However, there are some hospitals that are delisted and ICICI Lombard will not cover any medical expenses for treatment taken in these hospitals. These delisted hospitals list is available with your policy document. The updated list of delisted hospitals is also available on our website www.icicilombard.com. Please call us at our toll free number 1800 2666 should you need more information on this.

38. How long will ICICI Lombard take to settle my claim?

Once all necessary documents have been sent to us and queries have been answered, we will process your claim. If you are availing of the cashless facility, your claim will be settled within 4 hours directly with the hospital. In case of a reimbursement facility, your claim will be settled through NEFT within 14 days of submission of all the required documents.

Illustrations for claim settlement

Illustration 1 – Customer opted for base co-payment

Heading	Particulars	Scenario 1	Scenario 2	Scenario 3
A	Annual Sum Insured	₹ 10,00,000	₹ 10,00,000	₹ 10,00,000
B	Base Co-payment opted at time of policy issuance	20%	20%	20%
	Zone opted	B (Goa)	B (Goa)	B (Goa)
	Hospitalization Diagnosis	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease
	Treatment taken in	Goa (Zone B)	Mumbai (Zone A)	Guwahati (Zone C)
C	Hospitalisation expenses Amount	₹ 4,00,000	₹ 5,00,000	₹ 3,00,000
D	Pre and Post hospitalisation expenses	₹ 35,000	₹ 50,000	₹ 20,000
E	Total claimed Expenses* [C+D]	₹ 4,35,000	₹ 5,50,000	₹ 3,20,000
F	Zone based co-payment	0%	15%	0%
G	Claimed amount after application of zone based co-payment [E*F]	₹ 4,35,000	₹ 4,67,500	₹ 3,20,000
H	Sub-limit for cardiovascular diseases	₹ 3,50,000	₹ 3,50,000	₹ 3,50,000
I	Insured Person liability after application of base co-payment [G*B]	₹ 87,000	₹ 93,500	₹ 64,000
J	ICICI Lombard Liability after deduction of co-payment [G-I]	₹ 3,48,000	₹ 3,74,000	₹ 2,56,000
K	Final payable amount to Insured Person [lesser amount out of G, H, J]	₹ 3,48,000	₹ 3,50,000	₹ 2,56,000

G	Claimed amount after application of zone based co-payment [E*F]	₹ 4,35,000	₹ 4,67,500	₹ 3,20,000
L	Balance Annual Sum Insured [A-K]	₹ 6,52,000	₹ 6,50,000	₹ 7,44,000

*It has been assumed that total claimed expenses are same as total payable expenses. i.e. there are no deductions in the claimed amount

Illustration 2 – Customer opted for voluntary deductible

Heading	Particulars	Scenario 1	Scenario 2	Scenario 3
A	Annual Sum Insured	₹ 20,00,000	₹ 20,00,000	₹ 20,00,000
B	Voluntary deductible opted at time of policy issuance	₹ 4,00,000	₹ 4,00,000	NA
C	Base Co-payment	NA	NA	
	Zone opted	B (Goa)	B (Goa)	B (Goa)
	Hospitalization Diagnosis	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease	Heart Attack/ PTCA done/ Cardiovascular disease
	Treatment taken in	Goa (Zone B)	Mumbai (Zone A)	Guwahati (Zone C)
D	Hospitalisation expenses Amount	₹ 4,00,000	₹ 5,00,000	₹ 3,00,000
E	Pre and Post hospitalisation expenses	₹ 35,000	₹ 50,000	₹ 20,000
F	Total claimed Expenses*[D+E]	₹ 4,35,000	₹ 5,50,000	₹ 3,20,000
G	Zone based co-payment	0%	15%	0%
H	Claimed amount after application of zone based co-payment [F*G]	₹ 4,35,000	₹ 4,67,500	₹ 3,20,000
I	IL Liability after application of voluntary deductible[H-B]	₹ 35,000	₹ 67,500	NA as expenses have not crossed voluntary deductible amount
J	Sub-limit for cardiovascular diseases	₹ 3,50,000	₹ 3,50,000	₹ 3,50,000
K	Final payable amount to Insured Person [lesser amount out of I,J]	₹ 35,000	₹ 67,500	₹ -
L	Balance Annual Sum Insured [A-K]	₹ 19,65,000	₹ 19,32,500	₹ 20,00,000

*It has been assumed that total claimed expenses are same as total payable expenses. i.e. there are no deductions in the claimed amount

The claim amount assessed above would be deducted from the following amounts in the following progressive order:

1. Annual Sum Insured
2. Additional Sum Insured/Cumulative Bonus (if accrued and available)
3. Reset Sum Insured (If applicable)

Renewal

40. When do I have to renew my policy?

You should renew your policy prior to the expiry date of your policy. We give you a grace period of 30 days after expiry date of the policy, within which you can renew the policy without making a fresh application. During this period, you will not be covered for any ailments or accidents but the same policy can be continued. However, it is in best of your interest to pay your renewal premium while your policy is still in force so that you can enjoy uninterrupted coverage.

41. How can I renew my policy?

You can renew your policy either by paying the renewal premium online or by calling us at our toll free number 1800 2666. Alternatively, you may also visit your closest ICICI Lombard branch.

42. Will the premium be the same when I renew my policy?

Your premium depends on your age and the extent of coverage you have opted for in your policy.

- If you move to a higher age band at the time of renewal, the premium will change as per new age band. In case of an individual policy, the age of individual is checked. For floater policies, age of the senior most member is considered.
- If, at the time of renewal, you upgrade your product to a higher sum insured or make changes to the number of people covered, your premium will change.
- Addition of any optional covers
- Change in any policy conditions such as – floater/ individual, any deductible opted, policy tenure, etc.
- Change in any tax laws by the Government

Value added services

43. How can I use the preventive health checkup coupons that I have received in the policy kit?

*For the preventive health checkup, all you need to do is to call us at our toll free number, 1800 2666, to schedule an appointment at the diagnostic centre of your choice within our network. Please keep your ICICI Lombard Health care Card handy when you call our number and also when you go to the diagnostic centre for your tests. Alternately, you can also download our mobile application and utilize the coupons provided

Reset Benefit

44. How Reset Benefit works?

Examples of Reset Benefit:

		Scenario 1	Scenario 2
Sum Insured	Sum Insured	8,00,000	8,00,000
	Additional Sum Insured (if any)	-	1,60,000
	Total Sum Insured	8,00,000	9,60,000
1st Claim	Reason	Organ Transplant	Accident
	First claim payable amount (₹)	4,00,000	4,00,000
	Balance Sum Insured	4,00,000	5,60,000
2nd Claim	Reason	Heart Attack	Organ Transplant
	Second claim payable amount	2,50,000	7,00,000
	Will the Reset trigger?	No - Since the available Sum Insured is enough to pay the claim, reset won't trigger.	Yes - Reset to 800,000 - Since the available Sum Insured is not enough to pay the claim
	Balance Sum Insured	1,50,000	1,00,000
3rd Claim	Reason	Accident	Cancer
	Third claim payable amount (₹)	6,00,000	7,00,000

3rd Claim	Will the Reset trigger?	Yes reset to 800,000 including available balance sum insured - Since the available Sum Insured is not enough to pay the claim.	Yes reset to 800,000 including available balance sum insured - Since the available Sum Insured is not enough to pay the claim.
	Balance Sum Insured	₹2,00,000	Nil
4th Claim	Reason	Cancer	Cancer
	Fourth claim payable amount (₹)	6,00,000	6,00,000
	Will the Reset trigger again?	Yes reset to 800,000 including available balance sum insured - Since the available Sum Insured is not enough to pay the claim and the Reset will trigger unlimited times.	Yes reset to 800,000 including available balance sum insured - Since the available Sum Insured is not enough to pay the claim., and the Reset will trigger once for same illness.
5th Claim	Reason	Angioplasty	Cancer
	Fifth claim payable amount (₹)	6,00,000	6,00,000
	Will the Reset trigger again?	Yes reset to 800,000 including available balance sum insured - Since the available Sum Insured is not enough to pay the claim and Reset will trigger unlimited times.	No, as reset benefit triggers only once for same illness
All Claims are in the same policy year.			