

POLICY WORDINGS

AROGYA SANJEEVANI POLICY, Generali Central Insurance Company Limited

1. PREAMBLE

This Policy is a contract of insurance issued by *Arogya Sanjeevani Policy, Generali Central Insurance Company Limited*. (hereinafter called the 'Company') to the Proposer mentioned in the Schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The Policy is based on the statements and declaration provided in the Proposal Form by the Proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the Policy Period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Center, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically Necessary, expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the Policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

3. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where , the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

i. Standard Definitions

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

3.2. Any one Illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

3.3. AYUSH Treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

3.4. AYUSH Hospital:

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

- a) Central or State Government AYUSH Hospital; or
- b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
- c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.5. **AYUSH Day Care Centre:**

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

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

3.6. Cashless facility 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 is approved.

3.7. Condition Precedent shall mean a **Policy** term or condition upon which the **Insurer's** liability under the **Policy** is conditional upon.

3.8. Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

- a. **Internal Congenital Anomaly -Congenital Anomaly** which is not in the visible and accessible parts of the body.
- b. **External Congenital Anomaly - Congenital Anomaly** which is in the visible and accessible parts of the body.

3.9. Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

3.10. Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

3.11. Day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under -

- a. has qualified nursing staff under its employment;
- b. has qualified medical practitioner/s in charge;
- c. has fully equipped operation theatre of its own where surgical procedures are carried out;
- d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

3.12. Day care treatment means medical treatment, and/or surgical procedure which is:

- a. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
- b. which would have otherwise required hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

3.14. **Disclosure to information norm:**

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event

of misrepresentation, mis description or non-disclosure of any material fact.

- 3.15. Domiciliary hospitalization** means medical treatment for an illness/ disease/ injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
- the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
 - the patient takes treatment at home on account of non-availability of room in a hospital.
- 3.16. Emergency care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.
- 3.17. Grace period** means the specified period of time immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
- Provided the insurer shall offer coverage during the grace period, if the premium is paid in installments during policy period.
- 3.18. Hospital:** A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and 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;
- 3.19. Hospitalization** means admission in a **Hospital** for a minimum period of 24 consecutive '**In-patient Care**' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
- 3.20. Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
- 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.
 - Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
 - it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
 - it needs ongoing or long-term control or relief of symptoms
 - it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 - it continues indefinitely
 - it recurs or is likely to recur
- 3.21. 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.

- 3.22. Inpatient Care** means treatment for which the insured person has to stay in a **Hospital** for more than 24 hours for a covered event.
- 3.23. 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.
- 3.24. ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges.
- 3.25. Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
- 3.26. 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.
- 3.27. Medical Practitioner** means 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 its scope and jurisdiction of license. The registered practitioner should not be the insured or close Family members.
- 3.28. Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
- is required for the medical management of the illness or injury suffered by the insured;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a medical practitioner;
 - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- 3.29. Migration** means, the right accorded to health insurance policyholders (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
- 3.30. Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility
- 3.31. Non-Network Provider** means any hospital, day care center or other provider that is not part of the network.
- 3.32. Notification of claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
- 3.33. OPD treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

- 3.34. Portability** means the right accorded to an individual health insurance policyholders (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.
- 3.35. Pre-existing Disease** means any condition, ailment, injury or disease:
- a) That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.
 - b) For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.
- 3.36. Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
- a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
 - b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- 3.37. Post-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
- a. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
 - b. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
- 3.38. Qualified nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
- 3.39. Renewal** means 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.
- 3.40. Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
- 3.41. 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 from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

ii. Specific Definitions

- 3.42. Age** means age of the Insured Person on last birthday as on date of commencement of the Policy.
- 3.43. Associated 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. In case of copayment associated with room rent higher than the entitled room rent limit, Associated Medical Expenses will not include :
- a) Cost of pharmacy and consumables;
 - b) Cost of implants and medical devices
 - c) Cost of diagnostics

- 3.44. Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
- 3.45. Family** means, the Family that consists of the proposer and any one or more of the family members as mentioned below:
- Legally wedded spouse.
 - Parents and Parents-in-law.
 - Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
- 3.46. Insured Person** means person(s) named in the schedule of the Policy.
- 3.47. Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person
- 3.48. Policy period** means period of one policy year/ two policy years/ three policy years as mentioned in the schedule for which the Policy is issued.
- 3.49. Policy Schedule** means the Policy Schedule attached to and forming part of Policy.
- 3.50. Policy year** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.
- 3.51. Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.
- 3.52. Sum Insured** means the pre-defined limit and Cumulative Bonus (if any) specified in the Policy Schedule that represents, the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.
- 3.53. Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or remuneration, by whatever name called and as may be mentioned in the agreement, for providing health services.
- 3.54. Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

Please note

- Insect and mosquito bites is not included in the scope of definition of **Accident**.
- Medical Expenses** would include both medical treatment and/ or surgical treatment

4. COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

4.1. Hospitalization

The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured specified in the Policy Schedule, for,

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs. 5000/-, per day.
- ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.
- iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.
- iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

4.1.1. Other expenses

- i. Expenses incurred on treatment of cataract subject to the sub limits
- ii. Dental treatment, necessitated due to disease or injury
- iii. Plastic surgery necessitated due to disease or injury
- iv. All the day care treatments
- v. Expenses incurred on road Ambulance subject to a maximum of Rs. 2000/- per hospitalization.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case of admission to a room at rates exceeding the aforesaid limits, the reimbursement/ payment of all other expenses incurred at the Hospital, with the exception of cost of pharmacy, consumables, implants, medical devices and diagnostics shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges.
3. Proportionate deductions is not applicable in case of admission in an ICU room with rates exceeding the defined limit.
4. Proportionate deductions for opting a Non –ICU room with higher room rent limit is not applicable for those hospitals where differential billing based on the room category is not adopted.

4.2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

4.3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs. 40,000/-, whichever is lower, per each eye in one policy year.

4.4. Pre Hospitalization

The Company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

4.5. Post Hospitalization

The Company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the Hospital, following an admissible hospitalization covered under the policy.

- 4.6. The following procedures will be covered (wherever medically indicated) whether as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

- A. Uterine Artery Embolization and HIFU (High Intensity Focused Ultrasound)
- B. Balloon Sinuplasty
- C. Deep Brain stimulation
- D. Oral chemotherapy
- E. Immunotherapy- Monoclonal Antibody to be given as injection
- F. Intra vitreal injections
- G. Robotic surgeries
- H. Stereotactic radio surgeries
- I. Bronchical Thermoplasty
- J. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- K. IONM - (Intra Operative Neuro Monitoring)
- L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

In case there are multiple claims falling for the procedures mentioned above, the maximum liability will be restricted to 50% of Sum Insured for all claims put together.

- 4.7. The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

5. Cumulative Bonus (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. 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.

Notes:

- i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
- ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
- iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
- iv. If the Insured Persons on the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
- v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/ individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion to the Sum Insured of each Renewed Policy.
- vi. If the Sum insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
- vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
- viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

6. EXCLUSIONS

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:

A. Waiting Period

The company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

6.1. Pre-Existing Diseases (Code – Excl01)

- a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
- 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

6.2. First Thirty Days Waiting Period (Code – Excl03)

- 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.

6.3. Specific Waiting Period: (Code – Excl02)

- a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/ 36 months of continuous coverage 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.
- 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.

i. 24 months waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal or external benign tumors, cysts, polyps of any kind, including benign breast lumps
8. Benign Prostate Hypertrophy
9. Cataract and age related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis

15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and bile duct, excluding malignancy
19. Varicose Veins and Varicose Ulcers

ii. **36 months waiting period**

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

B. Standard Exclusions

The Company will not pay for any expenses incurred by You in respect of claims arising out of or howsoever related to any of the following:

7.1. Investigation & Evaluation (Code- Excl04)

- a) Expenses related to any admission primarily for diagnostics and evaluation purposes.
- b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

7.2. 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:

- 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 medical, physical, social, emotional and spiritual needs.

7.3. Obesity/ Weight Control (Code- Excl06)

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);
 - a) greater than or equal to 40 or
 - b) 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:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

7.4. 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.

7.5. 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 medically necessity, it must be certified by the attending Medical Practitioner.

7.6. 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, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7.7. 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.

7.8. 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 stabilization are payable but not the complete claim.

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

7.10. Treatments received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or a Hospital where the Hospital has effectively become the Insured Person's home or permanent abode or where admission is arranged wholly or partly for domestic reasons. (Code- Excl13)

7.11. Dietary supplements and substances which are available naturally and 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 hospitalization claim or day care procedures. (Code- Excl14)

7.12. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters. (Code- Excl15)

7.13. 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. (Code- Excl16)

7.14. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

- (i) Any type of contraception, sterilization
- (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- (iii) Gestational Surrogacy
- (iv) Reversal of sterilization

7.15. Maternity Expenses: (Code- Excl18)

- (i) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- (ii) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

C. Specific Exclusions

The Company will not pay for any expenses incurred by **You** in respect of claims arising out of or howsoever related to any of the following:

7.16. Injury or Disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not).

7.17. Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.

7.18. Outpatient Diagnostic, Medical and **Surgical Procedures or OPD treatments**

7.19. Domiciliary hospitalization/ treatment.

7.20. Treatment received outside India.

- 7.21.** 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.

7. GENERAL TERMS & CLAUSES

I. Standard General Terms and Clauses

1. Disclosure to information norm:

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact 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. 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 thirty 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.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. 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;

4. 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://generalicentralinsurance.com/portability-and-migration>

5. 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 all the accrued continuity benefits in waiting periods as per the IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
<https://generalicentralinsurance.com/portability-and-migration>

6. 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.

7. Multiple Policies

- a) 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.
- b) 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.
- c) 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.
- d) 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.

8. 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.

9. Cancellation

- a) The policyholder may cancel this policy by giving 7 days written notice.
- b) In case the Policyholder requests for cancellation of the Policy, where no claims are reported under the Policy, the Company shall refund premium for the unexpired policy/ instalment period as detailed below:
 - i. **Single Premium Payment (1/2/3 years Policy Term)** – There shall be refund of proportionate premium for the unexpired policy period on prorated basis.
 - ii. **Premium paid in multiple instalments (1/2/3 years Policy Term)** - There shall be refund of proportionate premium for the unexpired instalment period on prorated basis.

- c) In case the Policyholder requests for cancellation of the Policy, where there are claims reported under the Policy, then the Company shall refund premium for the unexpired/ instalment policy period as detailed below:

i. Single Premium Payment

- 1) 1 year Policy Term - There shall be no refund of premium for the unexpired policy period.
- 2) 2/3 years Policy Term – There shall be no refund of premium for the current Policy Year in which the claim got reported. However, the premium for the unutilized subsequent Policy Years (if any), shall be refunded.

ii. Premium paid in multiple instalments –

- 1) 1/2/3 years Policy Term - There shall be no refund of premium for the unexpired instalment period.
- d) The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud or non-cooperation by the insured person by giving 15 days' written notice. There would be no refund of premium upon cancellation on the abovementioned grounds.
- e) In the event of death of an Insured Person, We shall refund the premium for the unutilized Policy / Instalment period based on the guidelines for various scenarios as mentioned below:

Scenario 1 – In case of no claim reported under the policy-

A. Policy Term – 1 / 2 / 3 Years; Payment Mode – Single Premium Payment

- 1) Non-Floater Policy - the corresponding premium pertaining to the deceased insured person for the unutilized Policy period shall be refunded on pro rata basis.
- 2) Floater policy - the premium for pertaining to the deceased Insured person for the unutilized Policy Period shall be refunded on pro rata basis.

B. Policy Term – 1/ 2 / 3 Years; Payment Mode – Multiple Instalments

- 1) Floater / Non-Floater Policy - the instalment premium pertaining to the deceased Insured Person for the unutilized instalment period shall be refunded on pro-rata basis.

Scenario 2 – In case of claim reported under the policy –

A. Policy Term – 1 Year; Payment Mode – Single Premium Payment

- 1) Non-Floater Policy
 - i. Claims incurred by the deceased Insured Person in the current Policy Year, The premium pertaining to the deceased Insured Person for the unutilized current Policy Year shall not be refunded.
 - ii. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Policy Year- The premium pertaining to the deceased shall be refunded on pro-rata basis.
- 2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Policy Year, The premium for the deceased Insured Person for the unutilized Policy Period, will not be refunded.

B. Policy Term – 2 / 3 Years; Payment Mode – Single Premium Payment

- 1) Non-Floater Policy
 - i. Claims incurred by the deceased Insured Person in the current Policy Year –The premium pertaining to the deceased Insured Person for the unutilized current Policy Year shall not be refunded. However, premium pertaining to the deceased Insured Person for the unutilized subsequent Policy Years (if any), shall be refunded.
 - ii. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Policy Year- The premium pertaining to the deceased Insured Person for the unutilized Policy Period, shall be refunded on pro-rata basis.
- 2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Policy Year – The premium for the deceased Insured Person for the unutilized current Policy Year, will not be refunded. Premium pertaining to the

deceased Insured Person for the unutilized subsequent Policy Years (if any), shall be refunded.

C. Policy Term – 1 / 2 / 3 Years; Payment Mode – Multiple Instalments

1) Non-Floater Policy

- i. Claims incurred by the deceased Insured Person in the current Instalment Period, the instalment premium pertaining to the deceased Insured Person for the unutilized current instalment period shall not be refunded.
- ii. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Instalment Period –The premium pertaining to the deceased Insured Person for the unutilized instalment Period, shall be refunded on pro-rata basis.

2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Instalment Period, the instalment premium pertaining to the deceased Insured Person for the unutilized current instalment period shall not be refunded.

10. Premium Payment in instalments

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

- i. Grace Period of 15 days would be given to pay in case of monthly instalment premium and grace period of 30 days shall be given to pay in case of quarterly / Half Yearly installment premiums, due for the policy.
- ii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
- iii. No interest will be charged If the instalment premium is not paid on due date
- iv. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vi. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

11. 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.

12. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

13. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- a) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

- b) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- c) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- d) 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.
- e) Coverage is not available during the grace period.
- f) No loading shall apply on renewals based on individual claims experience

14. Nomination

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

15. 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

16. Redressal of Grievance

In case of any grievance the insured person may contact the company through

Website: <https://generalicentralinsurance.com>

Toll Free: 1800-220-233 / 1860-500-3333 / 022-67837800

Email: GCicare@generalicentral.com

Courier: Grievance Redressal Cell, Generali Central Insurance Company Limited.

Lodha I –Think Techno Campus, B Wing –2nd Floor, Pokhran Road –2, Off Eastern Express Highway Behind TCS, Thane West – 400607

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 GCIGRO@generalicentral.com or call at: 7900197777

For updated details of grievance officer, kindly refer the link <https://www.generalicentralinsurance.com/customer-service/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. Kindly refer the annexure on Grievance Redressal Procedures.

Grievance may also be lodged at IRDAI Bima Bharosa (an Integrated Grievance Management System) - <https://bimabharosa.irdai.gov.in/>

II. Specific General Terms and Clauses

1. Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

2. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

3. Notice & Communication

- i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
- iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

4. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

5. Automatic change in Coverage under the policy

The coverage for the Insured Person shall automatically terminate:

1. In the case of his/ her (Insured Person) demise.
However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the Insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy will be effective.
2. 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.

6. 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.

7. Endorsements (Changes in Policy)

- i. This Policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including the insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
- ii. 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.

8. Change of Sum Insured

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

9. Terms and condition of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

III. CLAIM PROCEDURE

1. Procedure for Cashless claims:

- (i) Treatment may be taken in a network provider and is subject to pre authorization by the Company.
- (ii) Cashless request form available with the network provider shall be completed and sent to the Company for authorization.
- (iii) The Company upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.
- (iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
- (v) The Company reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
- (vi) 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.

2. Procedure for reimbursement of claims

For reimbursement of claims the insured person may submit the necessary documents to Company within the prescribed time limit as specified hereunder

Sl No.	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

3. Notification of Claim

Notice with full particulars shall be sent to the Company as under:

- i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
- ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

4. Documents to be submitted

The reimbursement claim is to be supported with the following original documents and submitted within the prescribed time limit.

- i. Duly completed claim form
- ii. Photo identity proof of the patient
- iii. Medical practitioner's prescription advising admission
- iv. Original bills with itemized break-up
- v. Payment receipts
- vi. Discharge summary including complete medical history of the patient along with other details
- vii. Investigation/ Diagnostic tests reports etc. supported by the prescription form attending medical practitioner
- viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
- ix. Sticker/ Invoice of the Implants, wherever applicable
- x. MLR (Medico Legal Report) copy if carried out and FIR (First Information Report) if registered, wherever applicable

- xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
- xii. KYC (Identity proof with address) of the proposer, where claim liability is above Rs. 1 Lakh as per AML guidelines
- xiii. Legal heir/ succession certificate, wherever applicable
- xiv. Any other relevant document required by Company for assessment of the claim.

Note:

1. The company shall only accept bills/ invoices/ medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. 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
3. 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.

5. Co-payment

Each and every claim under the Policy shall be subject to a Copayment 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 copayment.

6. Claim Settlement (provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 15 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 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)

7. Payment of Claim

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

No loading shall apply on renewals based on individual claims experience. Insurance is the subject matter of solicitation.

8. TABLE OF BENEFITS

Name	Arogya Sanjeevani Policy, Generali Central Insurance Company Limited.
Product Type	Individual/ Floater
Category of Cover	Indemnity
Sum insured	INR On Individual basis – SI shall apply to each individual family member. On Floater basis – SI shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65 years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Policy can be availed for Self and the following family members. i. Legally wedded spouse ii. Parents and Parents-in-law iii. Dependent Children (i.e. naturally or legally adopted) between age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	15 days would be given to pay in case of monthly instalment premium and grace period of 30 days shall be given to pay in case of quarterly / Half Yearly installment premiums, due for the policy
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Center
Pre Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/ doctors fee	1. 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 Rs. 5000/- per day 2. Intensive Care Unit (ICU) charges / Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital/ Nursing Home up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.
Cataract Treatment	Up to 25% of Sum insured or Rs. 40,000/-, whichever is lower, per eye, under one policy year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to sum insured, during each Policy year as specified in the policy schedule.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the Insurer shall be covered after a waiting period of 3 years
Cumulative bonus	Increase in sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate.
Co Pay	5% co pay on all claims

Annexure - A

List I – Items for which coverage is not available in the Policy

SI No.	Item
1.	BABY FOOD
2.	BABY UTILITES 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 CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVENYANCE 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.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLEY COVER
66.	UROMETER, URINE JUG
67.	VASOFIX SAFETY

List II – Items that are to be subsumed into room charges

SI No.	Item
1.	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU-DE-COLOGNE / ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP
19.	DISINFECTANT LOTIONS
20.	LUXURY TAX
21.	HVAC
22.	HOUSE KEEPING CHARGES
23.	AIR CONDITIONER CHARGES
24.	IM IV INJECTION CHARGES
25.	CLEAN SHEET
26.	BLANKET/WARMER BLANKET
27.	ADMISSION KIT
28.	DIABETIC CHART CHARGES
29.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30.	DISCHARGE PROCEDURE CHARGES
31.	DAILY CHART CHARGES
32.	ENTRANCE PASS / VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES

35.	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36.	PATIENT IDENTIFICATION BAND / NAME TAG
37.	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

SI No.	Item
1.	HAIR REMOVAL CREAM
2.	DISPOSABLES RAZORS CHARGES (for site preparations)
3.	EYE PAD
4.	EYE SHEILD
5.	CAMERA COVER
6.	DVD, CD CHARGES
7.	GAUSE SOFT
8.	GAUZE
9.	WARD AND THEATRE BOOKING CHARGES
10.	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS
11.	MICROSCOPE COVER
12.	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER
13.	SURGICAL DRILL
14.	EYE KIT
15.	EYE DRAPE
16.	X-RAY FILM
17.	BOYLES APPARATUS CHARGES
18.	COTTON
19.	COTTON BANDAGE
20.	SURGICAL TAPE
21.	APRON
22.	TORNIQUET
23.	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into cost of treatment

SI No.	Item
1.	ADMISSION/REGISTRATION CHARGES
2.	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3.	URINE CONTAINER
4.	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5.	BIPAP MACHINE
6.	CPAP/ CAPD EQUIPMENTS
7.	INFUSION PUMP - COST
8.	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9.	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10.	HIV KIT
11.	ANTISEPTIC MOUTHWASH
12.	LOZENGES
13.	MOUTH PAINT
14.	VACCINATION CHARGES
15.	ALCOHOL SWABES
16.	SCRUB SOLUTION/STERILLIUM
17.	GLUCOMETER & STRIPS
18.	URINE BAG



Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | IRDAI Regn. No.: 132 | CIN: U66030MH2006PLC165287 | Website: www.generalicentralinsurance.com | Email ID: gcicare@generalicentral.com | Toll-free Phone: 1800 220 233 / 1860 500 3333/ 022 6783 780
ISO No: GCH/HP/FAS/PWG/001

GRIEVANCE REDRESSAL PROCEDURE

Dear Customer,

At Generali Central Insurance, we continuously strive for service excellence to give you exceptional customer experience. This helps us build trust and long-term relationship with you.

We request you to read the policy document including the terms and conditions carefully. This will

help you understand your plan and drive maximum benefits. We want to ensure the plan is working for you and welcome your feedback.

What is a grievance?

"Complaint" or "Grievance" means written expression (includes communication in the form of electronic mail or voice based electronic scripts), of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.

"Complainant" means a policyholder or prospect or any beneficiary of an insurance policy who has led a complaint or grievance against an insurer or a distribution channel.

We are always here for your help. You may use any of the following channels to reach us-

Helpline	Website	Email	Branch GRO	Complaint Form
<p>Call us on</p> <p>1800 220 233/ 1860 500 3333/022- 67837800</p> <p>Senior citizens can avail priority support by choosing the senior citizen option from the helpline menu.</p>	<p>Click here to know more</p>	<p>Write to us at</p> <p>GCIcare@generalicentral.com</p> <p>Senior citizens can avail priority support by writing to</p> <p>care.assure@generalicentral.com</p>	<p>Click here to know your nearest branch.</p>	<p>Click here to raise complaint.</p>

By when will my grievance be resolved?

- You will receive grievance acknowledgement from us immediately for your complaint.
- Final resolution will be shared with you within 2 weeks of receiving your complaint.
- Your complaint will be considered as closed if we do not receive any reply from you within 8 weeks from the date of receipt of response.

How do I escalate my complaint if I don't receive a response on time?

- You may write to our Grievance Redressal Officer at **GCI GRO@generalicentral.com**
- You may send a physical letter to our Grievance Redressal Cell, Head Office at the below address:
GENERALI CENTRAL INSURANCE COMPANY LIMITED (Formerly known as Future Generali India Insurance Company Limited)

Lodha I – Think Techno Campus, B Wing – 2nd Floor, Pokhran Road – 2, Off Eastern Express Highway Behind TCS, Thane West – 400607

GRIEVANCE REDRESSAL PROCEDURE

What if I am not able to register my grievance?

You can comfortably raise a grievance via any of the above-mentioned avenues. If you face any challenge, you may write to the provided email IDs for help.

If you still face any challenge, you may use any of the below options to raise a complaint with the Insurance Regulatory and Development Authority of India (IRDAI).

- Call on toll-free number: **155255**
- **Click here** to register complaint online

Is there any special provision for senior citizen to raise grievance?

We understand our customers and their needs. Thus, have a separate channel to address the grievances of senior citizens. The concerns will be addressed to the senior citizen's channel (**care.assure@generalicentral.com**) as complaints for faster attention or speedy disposal of grievance, if any.

Insurance Ombudsman:

If you are still dissatisfied with the grievance redressal, you may approach the Office of the Insurance Ombudsman located in your vicinity, provided the same is under their purview. The guidelines for taking up a complaint with the Insurance Ombudsman, are available on the website a (**<https://www.cioins.co.in/About>**) of the Insurance Ombudsman. **Click here** to access the list of insurance Ombudsman offices.

You can also lodge an online complaint through the website of the Council for Insurance Ombudsmen (CIO): **<https://www.cioins.co.in/>**

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