HEALTH ABSOLUTE PROSPECTUS

SALIENT FEATURES OF THE POLICY

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1 Definitions

The following words or terms shall have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine shall include references to the plural and to the female wherever the context so permits:

1.1. STANDARD DEFINITIONS

1.1.1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

1.1.2. **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.

1.1.3. [1]**AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

1.1.4. **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:

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

1.1.5. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical

[1] Inserted definition of AYUSH treatment

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:
    1) Having at least 5 in-patient beds;
    2) Having qualified AYUSH Medical Practitioner in charge round the clock;
    3) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    4) Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

1.1.6. 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.

1.1.7. Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

1.1.8. Congenital Anomaly means a condition 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.

1.1.9. 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.

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

1.1.11. Day Care Centre means any institution established for day care treatment of illness and/or injuries or a medical set-up 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.

1.1.12. 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 hours 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.

1.1.13. Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Note: - Deductible shall apply on aggregate on all the admissible claims under the policy including claims related to any one illness.

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

1.1.15. 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.

1.1.16. 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:

a) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
b) the patient takes treatment at home on account of non- availability of room in a hospital.

1.1.17. 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.

1.1.18. 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 insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

1.1.19. **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) of the said act Or complies with all minimum criteria as under:

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

1.1.20. **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.

1.1.21. **Illness** means a sickness, or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    1) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
    2) it needs ongoing or long-term control or relief of symptoms
    3) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    4) it continues indefinitely
    5) it recurs or is likely to recur

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

1.1.23. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

1.1.24. **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.

1.1.25. **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 intensivist charges.

1.1.26. Maternity Expenses means;

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
b) expenses towards lawful medical termination of pregnancy during the policy period.

1.1.27. Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

1.1.28. Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

1.1.29. 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 Medical Practitioner should not be the insured or close member of the family.

1.1.30. Medically Necessary Treatment means any treatment, test, medication, or stay in hospital or part of stay in hospital which:

a) is required for the medical management of the illness or injury suffered by the insured;
b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c) must have been prescribed by a medical practitioner;
d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

1.1.31. 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.

1.1.32. Network Provider 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.

1.1.33. Newborn Baby means baby born during the Policy Period and is aged upto 90 days.

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

1.1.35. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

1.1.36. **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.

1.1.37. **Portability** means, the right accorded to 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.

1.1.38. **Pre-Existing Disease** means any condition, ailment or 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 or
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 or its reinstatement.

1.1.39. **Pre-Hospitalization Medical Expenses** means medical expenses incurred during pre-defined 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.

1.1.40. **Post-Hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the insured Person is discharged from the Hospital provided that:
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.

1.1.41. **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.

1.1.42. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/Injury involved.

1.1.43. **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.

1.1.44. **Room Rent** means the amount charged by a Hospital towards Room and Boarding

expenses and shall include associated medical expenses.

1.1.45. 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.

1.1.46. Unproven/Experimental treatment means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

1.2. SPECIFIC DEFINITIONS

1.2.1. [2]**Alternative Treatment/Ayush Treatment** refers to the medical and / or Hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

1.2.2. Authority means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of the IRDA Act 1999.

1.2.3. Bank Rate means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

1.2.4. Clinical psychologist means a person having a recognized qualification in Clinical Psychology from an institution approved and recognized, by the Rehabilitation Council of India, constituted under section 3 of the Rehabilitation Council of India Act, 1992; or having a Post-Graduate degree in Psychology or Clinical Psychology or Applied Psychology and a Master of Philosophy in Clinical Psychology or Medical and Social Psychology obtained after completion of a full time course of two years which includes supervised clinical training from any University recognized by the University Grants Commission established under the University Grants Commission Act, 1956 and approved and recognized by the Rehabilitation Council of India Act, 1992 or such recognized qualifications as may be prescribed.

1.2.5. Dependent Child refers to a child (natural or legally adopted),upto the age of 25 years who is financially dependent on the primary insured or proposer and does not have his/ her independent sources of income.

1.2.6. Dependent Spouse means Your legally married spouse as long as he/she continues to be married to You.

1.2.7. Diagnostic Centre means the diagnostic centers which have been empaneled by Us as per the latest version of the schedule of diagnostic centers maintained by Us, which is available to You on request.

1.2.8. Family means the Primary Insured /Proposer's legally wedded spouse/Live-in

[2] Definition of Alternative Treatment is modified to include "Yoga and Naturopathy" in the scope of cover

partner, natural or legally adopted child/children, parents and parents in law, siblings, daughter in law, son in law, grandparents and grandchildren whose name is mentioned in the Policy schedule as an Insured Member.

1.2.9. **Family Floater** means a Policy described as such in the Schedule where You and members of Your family named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents our maximum liability for any and all claims made by You and/
or members of Your family during the Policy Year. Deductible under Family Floater will be applicable on aggregate basis for all the admissible claims made by all insured persons under the policy including claims related to any one illness.

1.2.10. **Insured Person/ Insured** means a person named in the Schedule who is covered under this Policy, for whom the insurance is proposed and in respect of whom the applicable premium has been received in full.

1.2.11. Live-in Relationship shall, for the purpose herein, mean an arrangement between two unmarried adult persons, who consent to living together in a long term relationship, that is in the nature of a marriage.

1.2.12. Live-in partner shall, for the purpose herein, means either half of the two unmarried adult persons of any gender and irrespective of the sexual orientation, who have consensually chosen to reside jointly with the other adult person, in a long term relationship and in the same residence. For the purpose of clarity, it is, hereby, mentioned that this definition shall be construed to include persons belonging to the LGBT community, wherein the scope of LGBT shall be in accordance with the standings laws of India, as may be in force from time to time.

1.2.13. LGBT will mean and include a sexual orientation or a gender expression as defined below

a. Lesbian: means a woman who has the capacity to form enduring physical, romantic, and/ or emotional attractions or sexual attraction towards other woman.
b. Gay : means a man who has the capacity to form enduring physical, romantic, and/ or emotional attractions or sexual attraction towards other man
c. Bisexual: A person who has the capacity to form enduring physical, romantic, and/ or emotional attractions to those of the same gender or to those of another gender or more than one gender.
d. Transgender : means a person whose gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such person has undergone Sex Reassignment Surgery or hormone therapy or laser therapy or such other therapy), person with intersex variations, genderqueer and person having such socio-cultural identities as kinner, hijra, aravani and jogta.

1.2.14. **Material facts** 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.

1.2.15. Non Floater means a Policy where You and Your Family members named in the Policy Schedule are covered under this Policy as at the commencement date. The Sum Insured for Non-Floater is the amount shown in the Policy Schedule against each individual Insured Person which also represents Our maximum liability for that Insured Person.

1.2.16. Policy means the complete documents consisting of the Proposal, Policy wording, Schedule and Endorsements and attachments if any.

1.2.17. Policy Period means the period commencing with the start date mentioned in the Schedule till the end date mentioned in the Schedule.

1.2.18. Policy Year means every annual period within the Policy tenure starting with the commencement date.

1.2.19. Prospect means any person who is a potential customer of an insurer and likely to enter into an insurance contract either directly with the insurer or through a distribution channel.

1.2.20. Prospectus means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products.

1.2.21. Proposal form means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

1.2.22. Psychiatrist means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act.

1.2.23. Schedule means that portion of the Policy which sets out Your/Insured Person's personal details, the type of insurance cover in force, the period and the Sum Insured under the Policy. Any annexure or endorsement to the Schedule shall also be a part of the Schedule.

1.2.24. Schedule of Benefits means that portion of the Policy which sets out the Benefits available to You / Insured Person in accordance with the terms of the Policy.

1.2.25. **Sum Insured** means the amount specified in the Schedule which is Our maximum, total and cumulative liability under this Policy for any and all claims arising under this Policy in a Policy Year in respect of the Insured Person(s).

1.2.26. **We, Insurer, Our, Company, GCI or Us** means Generali Central Insurance Company Limited.

1.2.27. **You or Your** means the policyholder shown in the Schedule who has concluded the Policy with Us.

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.

2 Scope Of Cover

Insurance Plans: This Policy provides You options of 3 (three) plans namely Classic, Platinum, Signature with each plan having various Sum Insured options as specified in the Schedule of Benefits. The schedule will specify the Sum Insured and the plan which is in force for each of the Insured Persons. For a complete description of the benefits available, please refer to the "Schedule of Benefits" attached to this Policy.

Benefits: This Policy covers the Reasonable and Customary Charges incurred towards the medical treatment taken by the Insured Person following an Illness or Injury that occurs during the Policy Period, subject to the availability of the Sum Insured, any sublimits specified in the Schedule of Benefits and the terms, conditions and exclusions specified in this Policy document.

The benefits available under this Policy are listed below. The Schedule of Benefits will specify whether the benefit in respect of which a claim arises, is in force under the applicable Plan for the Insured Person.

2. 1 Hospitalization Medical Expenses

We will pay the Medical Expenses necessarily incurred, upto the Sum Insured specified in the Schedule of Benefits, for one or more of the following arising out of the Insured Person's Hospitalization, for Medically Necessary Treatment required due to an Illness or Injury sustained during the Policy Year .

a) Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges;
b) ICU charges;
c) Operation theatre charges ;
d) Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anaesthetists;
e) Qualified Nurse charges;
f) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
g) Investigative tests or diagnostic procedures directly related to the Injury/Illness for

which the Insured Person is Hospitalized;

h) Anaesthesia, blood, oxygen and blood transfusion charges, Surgical Appliances; .
i) Prosthetic devices and other devices recommended by the attending Medical Practitioner that are implanted internally during a Surgical Procedure.

2. 2 Day Care Treatment Expenses

We will pay the Reasonable and Customary Charges incurred towards Medically Necessary Treatment required by the Insured Person towards Day Care Treatments following an Illness or Injury that occurs during the Policy Year . The list of such Day Care Treatments are specified in Annexure I of the Policy.

2. 3 Pre-Hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Pre- Hospitalization Medical Expenses incurred immediately prior to the date of the Insured Person's hospitalization for 60 days, provided that We have accepted a claim for Hospitalization under Section 2.1 (Hospitalization Medical Expenses), Section 2.2 (Daycare Treatment Expenses) and Section 2.19 (Medical Treatment Abroad).

Provided that the Pre-Hospitalization Medical Expenses towards Section 2.19 (Medical Treatment Abroad) shall be covered only if such expenses are incurred in India.

2. 4 Post-Hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Post- Hospitalization Medical Expenses incurred immediately following the Insured Person's discharge from Hospital for the number of days specified under the applicable plan as given in the Schedule of Benefits, provided that We have accepted a claim for Hospitalization under Section 2.1 (Hospitalization Medical Expenses), Section 2.2 (Daycare Treatment Expenses) and Section 2.19 (Medical Treatment Abroad).

Provided that the Post-Hospitalization Medical Expenses towards Section 2.19 (Medical Treatment Abroad) shall be covered only if such expenses are incurred in India.

2. 5 Maternity Expenses

We will pay the Reasonable and Customary Charges incurred towards Maternity Expenses , subject to the following:

a) In case the female Insured Person along with spouse are covered under the policy, this benefit will be applicable only if We have received at least 3 continuous annual premiums in respect of them, under the Health Absolute Policy, and provided that at least 24 months of continuous coverage have elapsed from the inception of the first Health Absolute Policy with Us.
b) In case only the female insured person is covered and the spouse is not covered under the policy, this benefit will be applicable only if We have received at least 4 continuous annual premiums in respect of the female insured person, under the Health Absolute Policy, and provided that at least 36 months of continuous coverage have elapsed from the inception of the first Health Absolute Policy with Us.
c) Our Maximum liability per Pregnancy (delivery/termination) will be subject to the sub-limit specified in the Schedule of Benefits.
d) In case of birth of a girl child, the maternity sub limit will be enhanced by additional ₹ 10,000 per policy year, subject to maternity claim being admissible.
e) We will cover Reasonable and Customary Charges, for Pre- natal Medical Expenses

incurred towards hospitalization immediately prior to the date of delivery and Post-natal Medical Expenses incurred towards Hospitalization immediately following the date of delivery. However, Pre and post natal expenses incurred on OPD basis will be excluded from the scope of this cover .The period and charges for pre and post-natal medical expenses under the applicable Plan will be restricted up to the sub limit specified in the Schedule of Benefits.

f) Any expenses related to Ectopic Pregnancy (abdominal operation for extra uterine pregnancy), which is proved by submission of Ultra Sonographic Report, would not be covered under this Benefit, but would be considered as a claim made under Section 2.1 (Hospitalization Medical Expenses).

g) We will also cover the Medical Expenses incurred towards Miscarriage and lawful medical termination of pregnancy.

2. 6 Newborn Baby Expenses (applicable for Sum Insured ₹ 15 lacs and above)

If We have accepted a claim under Section 2.5 (Maternity Expenses), then We will also pay the Reasonable and Customary Charges incurred by the Insured Person during the Policy Year towards the following:

a) Medical Expenses for the Medically Necessary treatment of the Insured Person's Newborn Baby while Insured Person is hospitalized for delivery. The cover for the Newborn Baby will be available until the expiry date of the Policy Year in which the Newborn Baby is born. This cover is offered within the Sum Insured as applicable for the Insured Person (mother) without payment of any additional premium and is subject to the exclusions, terms and conditions of the Policy.

b) Vaccination expenses of the Newborn Baby up to the specified sublimit under the Schedule of Benefits for vaccinations, until the Newborn Baby completes one year of age. If the Policy ends before the Newborn Baby has completed one year then, We will cover such vaccinations until the Newborn Baby completes one year, only if We have accepted the Newborn Baby as an Insured Person at the time of Renewal of the Policy and We have received the premium accordingly.

c) The Newborn Baby can be covered as an Insured Person subject to Our acceptance of the proposal and the premium is received for subsequent Policy year immediately succeeding the Policy Year in which the Newborn Baby was born.

d) Section 2.22 (Restoration of Sum insured) is not applicable for this cover.

e) Clause 3.2.2.3 shall not apply to the extent of cover provided under this benefit

2. 7 Infertility Expenses

We will reimburse Reasonable and Customary charges for Medical Expenses incurred towards Medically Necessary Treatment of the Insured person during the Policy Year for Infertility on Hospitalization/Day care basis.

The benefit is subject to the following:

a) The treatment is undertaken at a healthcare facility/ centre duly registered in accordance with applicable law.

b) The treatment is taken on written advice of a specialist Medical Practitioner.

c) The Insured Person undergoes the treatment up to 45 years of age.

d) Insured has completed at least 36 months of continuous coverage from the first inception of the Health Absolute Policy with Us.

e) Our maximum liability per policy year, for claims under this benefit is subject to the limit specified under the Schedule of benefits

f) The Life time limit for this benefit is ₹ 1 Lakh under Platinum Plan and ₹ 2 Lakhs under Signature Plan.

g) Clause 3.2.1.14 shall not apply to the extent of cover provided under this benefit.

The Specific Exclusions applicable to this Benefit are:

a) Any expenses with respect to the Insured Person's use of third party surrogate or gestational carrier in pregnancy
b) Any expenses for consultation, diagnostic tests or procedure or any such other expenses for diagnosis of infertility
c) Any expenses incurred towards complications, arising out of the Infertility treatment.

2. 8 Organ Donor Expenses

We will pay the Reasonable and Customary Charges incurred for an organ donor's treatment for the harvesting of the organ donated provided that:

a) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act, 1994 and the organ donated is for the use of the Insured Person;
b) We will not pay the donor's screening expenses or Pre and post Hospitalization expenses or for any other medical treatment for the donor consequent on the harvesting;
c) We have accepted claim under Section 2.1 (Hospitalization Medical Expenses) for the Insured Person and the Insured Person has been Medically Advised to undergo an organ transplant;
d) Costs directly or indirectly associated with the acquisition of the donor's organ will not be covered.

2. 9 Patient Care

We will pay the Reasonable and Customary Charges incurred towards the nursing care taken by the insured person from a Qualified Nurse for a period up to 10 days immediately following the Insured Person's discharge from Hospital as specified under Schedule of benefits provided that:

a) The Insured Person is above 60 years of age;
b) The Insured Person's Hospitalization was due to Illness or Injury sustained during the Policy Year;
c) The treating Medical Practitioner has recommended that the nursing care is Medically Necessary;
d) We will not be liable to make payment under this Benefit for any Insured Person in excess of 30 days during a Policy Year and as specified in the Schedule of Benefits.
e) Clause 3.2.2.13 shall not apply to the extent of cover provided under this benefit

2. 10 Accidental Hospitalization

We will increase the Sum Insured by 25% of the available balance Sum Insured if the Insured Person is hospitalized solely and directly due to an Accident which occurred during the Policy Year. Such increase of the Sum Insured shall not exceed ₹ 10,00,000 and it will only be available for claims arising under Section 2.1 (Hospitalization Medical Expenses).

For the purpose of calculation, the amount of Sum Insured increase will be 25% of the available balance Sum Insured. Cumulative Bonus (if any) will not be considered for assessing the Sum Insured increase under this Benefit.

2. 11 Accompanying Person

We will make payment of the fixed amount as specified in the Schedule of Benefits, for

each completed day of Hospitalization of an Insured, towards the expenses of an Accompanying Person to take care of the Insured, provided that:

a) the Insured is a child of age 12 years or less
b) the child is undergoing Hospitalization due to an Injury or Illness that occurred during the Policy Year.
c) We will not make payment under this Benefit in respect of an Insured Person for more than 30 days during a Policy Year.

2. 12 Road Ambulance Charges

We will reimburse expenses incurred towards ambulance charges for transportation of an Insured person, from home to Hospital or between Hospitals, per Hospitalization up to a maximum of the amount as specified in the Schedule of Benefits.

We will reimburse payments under this Benefit provided that:

a. The ambulance services of a Hospital or a registered ambulance service provider is utilized.
b. The original Ambulance bills and payment receipt is submitted to Us.
c. We have accepted the claim under Section 2.1 (Hospitalization Medical Expenses) and Section 2.2 (Day care Treatment Expenses).

2. 13 Emergency Medical Evacuation (applicable for Sum Insured ₹ 15 lacs and above)

It is a Condition Precedent that these expenses are authorized by Us. We will reimburse the Insured Person up to the Sub-limit specified in the Schedule of Benefits, for the Reasonable and Customary Charges necessarily incurred by the Insured Person towards:

a) Medical evacuation following an Accident during the Policy Year, from the place where the Accidental Injury occurred or from the place of Hospitalization immediately following the Accident to any other Hospital within India.
b) Medical evacuation following an Illness during the Policy Year, from the place of Hospitalization to any other Hospital within India.
c) For claims made under this Benefit, We will reimburse expenses for transportation of the Insured Person and Medical Expenses incurred for treatment, during the course of evacuation, provided that such treatment is Medically Necessary and it is provided to the Insured Person en route.

2. 14 Home Health Care Expenses

We will cover the reasonable and customary charges up to a maximum of 20% of the Sum Insured (excluding the Cumulative Bonus, if any) towards Medical Expenses incurred for Home Health Care Services during the Policy Year and availed through Our empanelled Home Health Care Service Provider, on Cashless Facility basis, only if the following conditions are fulfilled:

a) The Home Health Care Expenses shall be covered only subject to Cashless authorization approved by Us.
b) Medical treatment for an Illness/ 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:
    1) The condition of the patient is such that he/she is not in a condition to be moved to a Hospital, or
    2) The patient takes treatment at home on account of non-availability of bed / room in a Hospital, or

3) Non-availability of Hospital Services due to any prevailing conditions /Government Notification.
4) Chemotherapy and dialysis at home.
5) For children up to the age of 15 years if treated at home instead of Hospitalization, if certified by the Medical Practitioner that the child needs Hospitalization for treatment but the same can be replicated at home with remote monitoring and nursing care.

c) The duration of Home Health Care treatment should be restricted to reasonable time and not more than the period of Hospitalization, the patient would have undergone otherwise.
d) Treatment under this benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
e) In case of medical treatment solely taken at home without any initial hospitalization , Pre and Post hospitalization expenses would be covered up to the overall limit of the cover under this benefit. The number of days for pre and post hospitalization cover will be applicable as per benefit 2.3 & 2.4 respectively.
f) In case of Post-surgical care through Home Health Care Services, where the initial Hospitalization for surgical management, the condition was at our empanelled network hospital and we have accepted an inpatient Hospitalization claim on cashless basis, then section 2.3 (Pre-Hospitalization Medical Expenses) and section 2.4 (Post-Hospitalization Medical Expenses) will apply
g) Only Allopathic treatment shall be covered under this Benefit.
h) Any sub limits applicable for Section 2.1 to Section 2.4 shall also be applicable under this Benefit.
i) This Benefit shall not cover any expenses incurred towards attendant/ nursing services
j) Section 2.9 (Patient Care) and Section 2.11 (Accompanying Person) are not applicable for claims admissible under this Benefit.
k) Clause 3.2.2.13 shall not apply to the extent of cover provided under this benefit.

2. 15 OPD Treatment

We will reimburse the Reasonable and Customary Charges arising from Medical Expenses incurred for OPD (outpatient) treatment of the Insured Person as specified below:

a) Under Classic Plan: OPD treatment expenses incurred towards consultations, diagnostic tests and medications arising due to Mental/Psychiatric Illness.
b) Under Platinum Plan: OPD treatment expenses incurred towards consultations, diagnostic tests and medications arising due to any illness (Physical or Mental/Psychiatric), Injury or a pregnancy.
c) Under Signature Plan: OPD treatment expenses incurred towards consultations, diagnostic tests and medications arising due to any illness (Physical or Mental/Psychiatric), Injury or a pregnancy.

The Specific Conditions applicable to this benefit are:

a) Only Allopathic treatment will be covered under this Benefit.
b) In case of expenses towards Mental/Psychiatric illness, only the following would be considered
   1) Consultations with a Psychiatrist

2) Medications and diagnostics which have been prescribed by a Psychiatrist
3) Counselling sessions with a Clinical Psychologist which have been prescribed by Psychiatrist

c) In case of bills for any prescribed drugs/ medicines, Our liability shall be restricted to 80% of admissible bills.
d) In case of dental consultations and all prescribed diagnostics, Our liability shall be restricted to 70% of admissible bills.
e) All expenses individually or in aggregate cannot exceed the OPD Treatment Expenses limit specified in the Schedule of Benefits.
f) In case of Platinum and Signature Plans, upon complete exhaustion of the OPD Treatment Expenses limit, 100% reinstatement of the limit will be done once during a policy year .This reinstated limit will be available for expenses incurred towards Mental/ Psychiatric illness only.
g) Clause 3.2.2.11 and 3.2.2.12 shall not apply to the extent of cover provided under this benefit

2. 16 Child Vaccination Benefits (applicable for sum insured 50 Lakhs and above only)

We will cover Reasonable and Customary Charges for vaccinations of the Insured Person up to the per annum limit as specified in the Schedule of Benefits, provided that the Insured Person is a Child of age 12 years or less .Clause 3.2.2.3 shall not apply to the extent of cover provided under this benefit

2. 17 E-Opinion in respect of an Illness or Injury

a) If an Insured Person suffers an Illness or Injury during the Policy Year in respect of which a claim has been admitted under Section 2.1 (Hospitalization Medical Expenses), then at the Insured Person's request We will arrange a maximum of two e-opinions (in a Policy Year) from a Medical Practitioner selected by the Insured Person from Our panel. The e-opinion will be based only on the information and documentation provided to the Medical Practitioner by or on behalf of the Insured Person.
b) While claiming under this Benefit and deciding to obtain an e-opinion, each Insured Person expressly agrees that:
   1) It is entirely for the Insured Person to decide whether to obtain an E-opinion, from which Medical Practitioner in Our panel to take the e-opinion and the use (if any) to which the e-opinion so obtained is put.
   2) We do not provide an e-opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other persons' reliance on the same, or the use to which the E-opinion is put.
   3) We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations whatsoever made by any Medical Practitioner in Our Panel or in any e-opinion or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

2. 18 Alternative Treatment

[3]We will reimburse Reasonable and Customary Charges for Medical Expenses incurred towards Hospitalization for Ayurveda, Yoga and Naturopathy, Unani, Siddha or

[3] Alternative Treatment modified to include "Yoga and Naturopathy" in the scope of the cover, Specific exclusions b) is modified to extend the scope of benefit to cover Pre-Hospitalization, Post-Hospitalization, and AYUSH Day Care Treatments

Homeopathy treatment, provided that the treatment has been undergone in an AYUSH Hospital.

The Specific Exclusions applicable to this Benefit are:

a) All preventive and rejuvenation treatments (non-curative in nature)
b) Outpatient Medical Expenses.

2. 19 Medical Treatment Abroad (applicable for sum insured 50 Lakhs and above only)

a) We shall reimburse the Charges for Medical Expenses necessarily incurred by the Insured Person, for treatment / surgical procedure of the below listed condition/diseases, outside India subject to the maximum sum assured as specified in the policy schedule and subject to the conditions precedent as specified in the policy document and more particularly herein.
b) The benefits under this Section will be available if the Insured Person has been continuously covered under Signature Plan of Health Absolute policy for a continuous period of 36 months from the inception of the first Absolute Signature Plan Policy with Us.
c) We shall cover only those Medical Expenses that would otherwise have been payable under Section 2.1(Hospitalization Medical Expenses). For the purpose of this Benefit, Hospital (outside India) means an institution (including nursing homes) established outside India for indoor medical care and treatment of illness and injuries which has been registered and licensed with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a Medical Practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, old age home.
d) Upon the Insured Person's intimation, Our Assistance service provider will further assist the Insured Person in confirming the admissibility of the claim and co-ordinate with the Hospitals for availing the Cashless Facility for the Medically Necessary Treatment abroad within 7 working days from date of intimation.
e) In case the cashless facility is not available or the hospital is not available within the Network of Our Assistance Service Provider the claim can be addressed on reimbursement basis.
f) Any payments under this Benefit shall always be, in Indian rupees. The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of Hospitalization, shall be used for conversion of foreign currency amounts into Indian rupees for payment of any claim under this Benefit. If on the date of Hospitalization the RBI rates are not published, the rates next published by the RBI shall be considered for conversion.
g) Clause 3.2.2.14 shall not apply to the extent of cover provided under this benefit
h) For the purposes of this Benefit and the determination of the Company's liability under it, Listed treatment / surgical procedure in relation to the Insured, shall mean any Illness, medical event or Surgical Procedure as specifically defined below, for which the insured opts to take treatment abroad. The cover is offered during the Policy Year, subject to terms and conditions given below:

1) **Craniotomy & Craniectomy: only as a treatment for cancers-**
The actual undergoing of surgery to the brain as a result of Cancerous growth, under general anaesthesia during which a Craniotomy or Craniectomy is been performed.
This requirement of surgery must be supported by unequivocal findings on

Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques and certified by a specialist medical practitioner.

2) **Lung Lobectomy that involves complete removal of one of the five lobes of the lungs for lung cancer:**
We will cover the Medical expenses incurred towards the actual undergoing of a complete Lung Lobectomy due to cancerous growth in any of the lung characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues.
The diagnosis has to be confirmed and evidenced by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques and certified by qualified medical doctor of relevant specialty and histological evidence of malignancy.

3) **Liver Lobectomy that involves removal of 70% of liver mass in case of liver failure:**
We will cover the Medical expenses incurred towards the actual undergoing of liver lobectomy involving removal of 70% of liver mass due to failure of liver functions.
The diagnosis and the surgical procedure has to be confirmed by a specialist Medical Practitioner.
Liver Lobectomy as a result of liver failure due to consumption of alcohol or drug abuse is excluded.

4) **Major organ transplant**
The actual undergoing of a transplant of one of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ.
The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:
a. Where only islets of langerhans are transplanted
b. Other Stem-Cell Transplant

5) **Bone marrow transplant;**
The actual undergoing of a transplant for Human bone marrow using hematopoietic stem cells.
The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

6) **Repair of Aortic Aneurysm**
We will cover the Medical expenses incurred towards the actual undergoing of major Surgery to repair or correct aneurysm. For the purpose of this cover the definition of “Aorta” shall mean the thoracic and abdominal aorta but not its branches.

The diagnosis to be evidenced by any two of the following:
1) Computerized tomography (CT) scan
2) Magnetic Resonance Imaging (MRI) scan
3) Echocardiography (an ultrasound of the heart)

4) Angiography (Injecting X ray dye)
5) Abdominal ultrasound

7) **Heart valve replacement:**
We will cover the Medical expenses incurred towards the actual undergoing of surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s).

The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

8) **Coronary Artery Bypass Graft.**
We will cover the Medical expenses incurred towards the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures.
The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

a) Angioplasty and/or any other intra-arterial procedures are excluded.

2. 20 Wellness Benefits

The Insured Person will be eligible for "Wellness Benefits" as per the Plan in force under the Policy. These wellness benefits will include Value added services and Wellness reward points. These services would be conducted through Our Wellness partner and can be availed from our GCI mobile App.

All Insured Person above 18 years are eligible to avail the Wellness benefits. The Insured Person would have to register into the GCI mobile App with his/her unique mobile number and the policy number for availing the benefits.

While availing the wellness benefits, each Insured Person expressly agrees that:
a) All decisions regarding availing the wellness benefit, are to be solely made by the Insured Person.
b) We do not provide/assume responsibility for the wellness benefits or make any representation as to the adequacy or accuracy or quality of the same; any actual or alleged errors, omissions or representations whatsoever made by any of Our wellness service provider or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

A. Value Added Services

Under this benefit Insured Person is eligible for availing the following benefits via the GCI mobile App:-

1) **Tele counselling** - Under this benefit Insured will have access to two tele counselling sessions with a clinical psychologist to maintain and improve the quality of his/her life. The bookings for the tele counselling sessions would be thorough GCI mobile App.

2) **Health Contents** - Under this benefit Insured will have access to articles, blogs which

provide information on Physical and Mental wellness related topics.

3) **Webinars** - Under this benefit Insured Person will have access to webinars held on the GCI mobile App on topics related to Physical and Mental wellness.

4) **Vouchers (Fitness / Sports Memberships, Wellness centers, Diagnostic centers)** Under this benefit Insured Person will have access to discount vouchers as per partner tie-ups which can be utilized for aspects pertaining to a healthy life style, diagnostics, medicines etc. The voucher details will be displayed on the GCI mobile App.

5) **Health checkup**
Insured Person will be eligible for "Health checkup" as per the Plan in force under the Policy. Everyone from 18 years onwards is eligible for availing the Health Checkup. The health checkup can be conducted from 1st year of the Health Absolute policy with Us. Health checkup will be provided at Our Wellness partner empaneled Diagnostic Centres only. The health checkup would include tests as given below as applicable for respective plans.

Plan Name	**Tests**
Classic Plan	Complete Blood Count (CBC) , Glycosylated Hemoglobin(HbA1C), Electrocardiogram (ECG reported by an MD Physician),Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index),Uric Acid, Total Protein, Pulmonary Function Test.
Platinum Plan	Complete Blood Count (CBC) , Glycosylated Hemoglobin(HbA1C), Electrocardiogram (ECG reported by an MD Physician),Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index), Serum Glutamic Oxaloacetic Transaminase(SGOT), Serum Glutamic Pyruvic Transaminase(SGPT), Serum Calcium, Uric Acid, Total Protein, Pulmonary Function Test, USG (abdomen)
Signature Plan	Complete Blood Count (CBC) , Glycosylated Hemoglobin(HbA1C), Electrocardiogram (ECG reported by an MD Physician),Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index), Serum Glutamic Oxaloacetic Transaminase(SGOT), Serum Glutamic Pyruvic Transaminase(SGPT),Vitamin D,Thyroid function (T3,T4,TSH), Serum Calcium, Uric Acid, Total Protein, Pulmonary Function Test, USG (abdomen)

B. Wellness Rewards points
Insured Person will be eligible for earning of Reward Points under the Policy. This benefit will help Insured Person to assess his/ her health status and aid in improving the overall well-being. Insured Person would have to earn these points by performing an array of wellness activities listed below. These activities done by Insured Person will determine the points that can be earned.

Conditions applicable for earning the reward points

a) Age Eligibility - Everyone from 18 years onwards is eligible for earning wellness points.
b) There will be no limitation to the number of programs one can enroll however maximum reward points that one can earn in a single Policy Year will be limited to 200/Insured Person.
c) Conditions for earning Reward Points wherever offered, will be the same for all the Insured Persons irrespective of plan opted.

Details of reward points that can be accrued are listed below.

Sr. No.	Criteria	Frequency allowed	Max. Points
1.	Stress & Happiness Index score	2 times /year	20
2.	Expert Wellness Assessment	Once/year	40
3.	Participation in GCI organized events (as and when organized) and viewing of GCI Content around wellness	As planned by GCI	20
4.	Lifestyle disease monitor • Hypertension – Blood pressure • Obesity -BMI • Diabetes – Hb A1C • Cardiac Health- Sr. Cholesterol , Triglycerides	Once/year	45
5.	Fitness/ Healthy Lifestyle tracking- (Any one activity) • Daily Step tracking (monthly average of 10000 steps/day) • Burning average of 300 calories per day in a month • Submission of monthly Gym /yoga membership detail • Participation in Marathon, Cyclathon etc.	Monthly	60
6.	Enrolment to Wellness	Once/year	15
	Total points		**200**

The points earned in a year will be equal to certain percentage of the premium specific to the Insured person, as per table below.

Points earned per member per year	Value of points earned
185- 200	5%
150-184	4%
100-149	3%
15-99	2%

Illustration 1:- Reward point calculations in Individual/Non Floater Sum Insured policy

Family Type	2 Adult+1 child		
Policy period	01-Jan-2025 to 31 Dec 2025		
Relation	Self	Spouse	Child
Sum insured (₹)	20L	20L	20L
Age Band	26-30	31-35	0-17
Individual premium (₹)	17,860	18,306	14,032
Family discounted premium (₹)	16,074	16,475	12,629
Points Earned	200	180	NA
% value of points earned	5%	4%	0%
Monetary value of reward points (₹)	804	659	0

Detail breakup of reward point calculation (Earning and burning)

Date	**Self**			**Spouse**			**Total**		
	Points earned as on date	**% value of points earned**	**Monetary value (₹)**	**Points earned as on date**	**% value of points earned**	**Monetary value (₹)**	**Monetary value (₹)**	**Balance available for utilization(₹)**	**Burn/Utilised on date (OPD/ Pharmacy/ NME) (₹)**
21/03/2025	40	2%	321	30	2%	330	651		100
31/08/2025	100	3%	482	60	2%	330	812	712	200
15/10/2025	170	4%	643	150	4%	659	1302	1002	
31/12/2025	200	5%	804	180	4%	659	1463	1163	
Balance monetary value of reward points (₹) 1163 would be applied as discount at renewal									

Illustration 2:- Reward point calculations in Floater Sum Insured policy

Relation	Self	Spouse	Child	
Sum insured (₹)	20L			
Age Band	26-30	31-35	0-17	Premium total of eligible members
Floater Discounted premium (₹)	17,860	10,068	5,613	27,928
Points Earned	200	180	NA	190 (Average of Points)
% value of points earned				5%
Monetary value of reward points (₹)				1,396

Detail breakup of reward point calculation (Earning and burning)

Date	Self	Spouse	Average of points earned	% value of points earned	Monetary value (₹)	Balance available for utilization (₹)	Burn/Utilised (OPD/ Pharmacy/ NME) (₹)
	Points earned as on date	Points earned as on date					
21/03/2025	40	30	35	2%	559		100
31/08/2025	100	60	80	2%	559	459	
15/10/2025	170	150	160	4%	1,117	1,017	200
31/12/2025	200	180	190	5%	1,396	1,096	
Balance monetary value of reward points (₹) 1,096 would be applied as discount at renewal							

1) **Stress & Happiness Index score**
   Stress & Happiness Index score is an online questionnaire for evaluation of health and quality of life. It helps the Insured Person to review the personal lifestyle practices which may impact his/ her health status. Insured Person can log into his/her account on GCI mobile App and take Stress & Happiness Index score. This can be undertaken twice per policy year at an interval of 6 months.

   The reward points will be allotted only for participating in the online Stress & Happiness Index score Assessment.

2) **Expert Wellness Assessment**
   Insured Person has an option to take a telephonic Expert Wellness Assessment, with a Clinical psychologist. This will help the Insured Person to understand his/ her mental health. Insured Person can log into the account on GCI mobile App and ask for Expert Wellness Assessment. This can be undertaken once per policy year per insured person.

   The reward points will be allotted only for taking the expert wellness assessment. Confidentiality of the assessment will be maintained.

3) **Participation in GCI organized events**
   Insured Person has an option to participate in GCI organized events and view wellness content through GCI mobile App. The reward points would be awarded

for participation in a campaign or event organized by Us or viewing the wellness content. We will provide the information on health and wellness training, health related applications etc.

4) **Lifestyle disease monitor**
Insured Person can earn wellness reward points on undergoing the Health Checkup included in Value Added Services (Point A. 5 above) under Wellness Benefit. Reward points will be allotted basis the below parameters falling within normal limits.

	Condition	Health parameters	Points Allotted
1	Blood Pressure	Blood pressure Systolic Up to 140/ Diastolic up to 90 mm Hg	10
2	Glycosylated Hemoglobin	HbA1C Up to 6.5 mg/dl	15
3	Lipids	Serum Triglycerides Less than 175 (mg/dL), or less than 1.7 (mmol/L)	5
		Serum Cholesterol - Desirable - < 200	5
4	BMI	BMI between 18 – 32	10

5) **Enrolment to Wellness**
Insured Person can also earn reward points by enrolling into the Wellness Program. To enroll into the Wellness program, the Insured Person shall need to complete the registration in the GCI mobile App.

6) **Fitness / Healthy lifestyle tracking** – We aim at encouraging a healthy fitness regime for all age groups.
Insured Person can earn wellness points every month by completing any one of the following activities.
   a) Daily Step tracking (monthly average of 10000 steps/day) .The step count can be tracked either through our GCI mobile App. or insured can sync his/her fitness device with our App.
   b) Participation in Marathon, Cyclathons etc.: Insured can upload the completion certificate of the event on the GCI mobile App.
   c) Burning average of 300 calories per day in a month. The calorie burning count can be tracked either through the GCI mobile App. or insured can sync his/her fitness device with our App.
   d) Submission of monthly Gym/Yoga membership detail - Insured can upload the monthly membership receipts on the GCI mobile App.
   e) Wellness points will be allotted basis the activity details submitted by the insured at the end of 30 days

Conditions applicable for burning of points:
1) The points earned will float among all members of the family irrespective of the persons who have contributed for earning the points.
2) Points earned in first year can be carried forward to 2nd or 3rd year in case of long term policies.
3) The points can be burned for utilization of following benefits
   i. Availing Out-patient Consultations through the Wellness Partner network clinics

ii. Diagnostic tests, preventive tests through the Wellness Partner network clinics
iii. Purchase of Prescribed medicines through online pharmacy having tie up with Our Wellness Partner
iv. Reimbursement of Non-medical expenses in case of claim under Section 2.1 (Hospitalization Medical expenses)
v. Renewal Discount –
   a) Insured Person /Policy holder has an option to utilize the balance reward points as discount in premium at the time of renewal of the Policy.
   b) If the insured does not opt for Renewal discount, then the insured has an option to redeem the wellness reward points for availing the services as mentioned in point no. i, ii & iii above. The accrued wellness points can be utilized up to a period of 3 months from the policy expiry date
   In case the wellness points earned are not utilized within 3 months from policy expiry date, then the amount equivalent to the total accrued wellness points, shall either be refunded to the policyholder or the policyholder shall be allowed to encash the points through vouchers under wellness programs.

   c) After the renewal of the Policy with applicable wellness discount, the insured can continue to earn and accrue wellness reward points till the policy expiry date. The wellness points earned post renewal, that results in change of slab with respect to "Value of points earned", can be utilized for availing the services as mentioned in point no. i, ii & iii above. Such wellness points can be utilized up to a period of 3 months from the policy expiry date.
   In case the wellness points earned post renewal of policy is not utilized within 3 months from policy expiry date, then the amount equivalent to the difference between the slab considered for wellness discount at renewal and the new slab, shall either be refunded to the policyholder or the policyholder shall be allowed to encash the points through vouchers under wellness programs.

4) In case of cancellation of the policy or if the policy is not renewed with Us, any wellness reward points earned by the Insured can be utilized up to 3 months from the policy cancellation date or policy end date for the following benefits only.
   i. Availing Out-patient Consultations through Our Wellness Partner network clinics
   ii. Diagnostic tests, preventive tests through Our Wellness Partner network clinics
   iii. Purchase of Prescribed medicines through online pharmacy having tie up with Our Wellness Partner

2. 21 Cumulative Bonus

Cumulative Bonus shall be increased by 50% in respect of each claim free policy year (where no claims are reported) with the exception of any claim under Section 2.15 (OPD treatment) and Section 2.20 (Wellness Benefits), provided the policy is renewed with Us without a break subject to maximum of 100% 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:

a) In case where the policy is on individual / Non Floater 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.
b) 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.

c) CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
d) If the Insured Persons on the expiring policy are covered on an individual / Non Floater 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.
e) 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.
f) 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.
g) 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.
h) 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.

2. 22 Restoration of the Sum Insured

Under this benefit a Restore Sum Insured (equal to 100% of the base Sum Insured excluding Cumulative Bonus-if any) will automatically be available for the particular Policy year on a second claim being reported during the Policy Year and accepted as payable by Us.

The Restoration of Sum insured will be triggered irrespective of the Sum Insured and Cumulative Bonus (if any) is completely or partially exhausted due to the claim incurred, and is subject to following conditions:

a) The Restore Sum Insured can be used for claims made for same illness/new illness in respect of Section 2.1 to Section 2.4 ;
b) The Restore Sum Insured can be used by an Insured person, once in a life time, for claims related to Chemotherapy and Dialysis under this Policy
c) The Restore Sum Insured cannot be used for claims based on Maternity Expenses.
d) The Restore Sum Insured will happen only once during a Policy Year;
e) If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
f) If the Policy is issued on Individual basis, then the restore sum insured will be available to each Insured Person.
g) If the Policy is issued on Floater basis, then the restore sum insured will be available on Floater basis for all Insured Persons in the family.

2. 23 Bariatric Surgery

We will pay the Reasonable and Customary Charges for Medical Expenses incurred towards Surgical Procedure for obesity, subject to below conditions:

a) Our obligation to make payment in respect of Bariatric Surgery (after 36 months of continuous coverage from the first inception of the Health Absolute Policy with Us), shall be restricted to 50% of the Sum Insured, maximum up to the amount mentioned

in the schedule of benefits per Policy Year.

b) The claim related to Bariatric Surgery shall be payable only for expenses related to the surgical treatment of obesity that fulfil below conditions:
   1) Surgery to be conducted is upon the advice of the Medical Practitioner
   2) The surgery/Procedure conducted should be supported by clinical protocols
   3) The Insured Person has to be 18 years of age or older and
   4) Body Mass Index (BMI);
      i. greater than or equal to 40 or
      ii. 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:
         a. Obesity-related cardiomyopathy
         b. Coronary heart disease
         c. Severe Sleep Apnea
         d. Uncontrolled Type2 Diabetes

3 EXCLUSIONS

3.1 Exclusions applicable for all Benefits other than Section 2.15 (OPD Treatment)

3.1.1 Waiting Periods

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

3.1.1.1 Pre-Existing Disease- Excl 01

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 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 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

3.1.1.2 Specified disease/procedure 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 us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures:

A. Waiting period of 36 months:

i. Rheumatoid Arthritis
ii. Gout
iii. Joint replacement Surgery due to degenerative condition
iv. Age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is Medically Necessary due to Injury.
v. Lasik Surgery

B. Waiting period of 24 months:

i. Cataracts
ii. Benign Prostatic Hypertrophy
iii. Hernia of all types
iv. Deviated Nasal Septum
v. Hypertrophied Turbinate
vi. All types of nasal and para nasal sinus related disorders
vii. Hydrocele
viii. Fistulae, hemorrhoids, fissure in ano
ix. Dysfunctional uterine bleeding, Fibromyoma, Endometriosis, Hysterectomy,
x. All internal or external tumors/cysts/nodules/polyps of any kind including breast lumps with exception of malignant tumor or growth
xi. Surgery for prolapsed inter vertebral disc unless arising from Accident
xii. Surgery of varicose veins and varicose ulcers
xiii. Any types of gastric or duodenal ulcers
xiv. Stones in the urinary and biliary systems
xv. Surgery on ears and tonsils.

3.1.1.3 30 days waiting period Excl -03

i. 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.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

3.2 Exclusions applicable for all Benefits

3.2.1 Standard Exclusions:

We will not pay for any expenses incurred in respect of any claims made under the Policy, arising out of or howsoever related to any of the following:

3.2.1.1 Investigation & Evaluation- Code- Excl04

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

3.2.1.2 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:

a) 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.
b) Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs.

3.2.1.3 Obesity/ Weight Control: Code- Excl06

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

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

3.2.1.4 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.

3.2.1.5 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.

3.2.1.6 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.

3.2.1.7 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.

3.2.1.8 Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Us and disclosed in Our 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.

3.2.1.9 Code- Excl12

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

3.2.1.10 Code –Excl 13

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

3.2.1.11 Code- Excl14

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

3.2.1.12 Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

3.2.1.13 Unproven Treatments: Code- Excl16

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.

3.2.1.14 Sterility and Infertility: Code- Excl17

Expenses related to, sterility and infertility. This includes:

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

3.2.2 Specific Exclusions

We will not pay for any expenses incurred in respect of any claims made under the Policy, arising out of or howsoever related to any of the following:

3.2.2.1 Injury or Illness 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).

3.2.2.2 Circumcision, unless necessary for treatment of an Illness or necessitated due to an Accident.

3.2.2.3 Vaccination/ inoculation (except as post bite treatment)

3.2.2.4 Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, durable medical equipment (including but not limited to cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and oxygen concentrator for asthmatic condition, wheel chair, crutches, artificial limbs, belts, braces,

stocking, Glucometer and the like), namely that equipment used externally for the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose, such cost of all appliances/devices whether for diagnosis or treatment after discharge from the Hospital.

3.2.2.5 Venereal /Sexually Transmitted disease other than HIV/AIDS.

3.2.2.6 External Congenital Anomaly and related Illness/ defect.

3.2.2.7 Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.

3.2.2.8 Stem cell storage.

3.2.2.9 Non-prescribed drugs and medical supplies, hormone replacement therapy.

3.2.2.10 Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

3.2.2.11 Outpatient diagnostic, medical and Surgical Procedures or treatments.

3.2.2.12 Dental Treatment or Surgery of any kind unless requiring Hospitalization as a result of Injury.

3.2.2.13 A Medical Practitioner's home visit charges during Preand Post Hospitalization period and attendant nursing charges.

3.2.2.14 Treatment outside India.

3.2.2.15 Intentional self-Injury.

3.2.2.16 Any complications arising out of the Infertility treatment.

3.2.2.17 Standard list of excluded items as mentioned in Annexure III and on our website https://generalicentralinsurance.com

3.2.2.18 Any specific exclusion(s) applied by Us, specified in the Schedule and accepted by the insured.

3.3 Specific Exclusions for OPD Treatment claims

We will not pay for any expenses incurred in respect of any claims made under Benefit 15(OPD Treatment), arising out of or howsoever related to any of the following:

a) Cost of an Annual Health Check-up.
b) Any expense which are not related to Mental/ Psychiatric illness in case of Classic Plan
c) Any expenses for consultation, diagnostics, medications which are not duly supported with medical documents from the Medical Practitioner mentioning:
   1) Diagnosis;
   2) Referral for diagnostic test;
   3) Prescription for medications.

4 Eligibility:

4.1 Policy Options: Individual and Family Floater

4.2 Age Eligibility:

Minimum Age At Entry	1 day
Maximum Age At Entry	None
Maximum Renewal Age	Life Long
Minimum policy term	1 year
Maximum Policy term	3 years

4.3 Family Definition:

Policy type	Classic	Platinum	Signature
Individual	Self, Spouse/Live-in partner, 3 Dependent Children (upto 25 years of Age) , Parents	Extended Family up to 15 members	Extended Family up to 15 members
Floater	Self, Spouse/Live-in partner, 3 Dependent Children (upto 25 years of Age)	Self, Spouse/Live-in partner, Children*, Parents, Parents in law	Self, Spouse/Live-in partner, Children* , Parents, Parents in law

*There is no restriction on the number of children under family in Signature and Platinum plans.

Family means the Primary Insured /Proposer's legally wedded spouse/Live-in partner, natural or legally adopted child, parents and parents in law, siblings, daughter in law, son in law, grandparents

4.4 Sums Insured Available in the product are as below

Classic (in ₹)	Platinum (in ₹)	Signature (in ₹)
3 Lakhs, 5 Lakhs, 10 Lakhs	15 Lakhs, 20 Lakhs, 25 Lakhs, 30 Lakhs, 35 Lakhs	50 Lakhs, 75 Lakhs,1 Crore

4.5 Dependent Sum Insured Criteria:

In case of individual Sum Insured option, dependents sum insured can be up to two Sums Insured lower than Self /Proposer's sum insured (in applicable plan(s))

For Example:

Family Member	Self-Plan	Self-Sum Insured (₹)	Dependent Eligible Plan	Dependent Eligible Sum Insured (₹)
Self	Signature	1crore	Signature	1 Crore / 75 Lakhs / 50 Lakhs
Self	Platinum	25 Lakhs	Platinum	25 Lakhs/ 20 Lakhs/ 15 Lakhs
Self	Platinum	15 Lakhs	Platinum	15 Lakhs
			Classic	10 Lakhs /5 Lakhs

4.6 Change In Sum Insured/ Plan

a) All proposals wherein change in sum insured or plan is required, need to be referred to Retail Health Underwriters.
b) Fresh proposal form to be filled.
c) No increase/decrease in Sum Insured/Plan during the currency of the policy.
d) Increase in Sum Insured
    1) Can be allowed up to three slabs higher.
    2) For age group above 60 years, increase in sum insured would not be allowed.
    3) For **Classic** Plan (sum insured up to Rs 10 Lacs)
    4) For age group up to 50 years increase in sum insured can be allowed without medical examination (subject to no claim/ no health declaration).
    5) For age group above 50 years increase in sum insured can be allowed only with medical examination
    6) For **Platinum** / **Signature** Plans (Sum Insured above 10 Lakhs), medical examination is required irrespective of age

e) Decrease in Sum Insured allowed up to one slab lower only, in case of no claim in any preceding Health Absolute policies.
f) The **Dependent Sum insured criteria** will apply for enhancement of sum insured for dependent.
g) Sum insured enhancement would be allowed for age group lower than 50 years in case of portable policies.
h) For every Sum insured enhancement the following wording to appear on the face of the policy **"For the enhanced Sum Insured, the waiting periods will apply afresh".**
i) In case of SI enhancement for the age group 50 years and above or proposals with positive declarations, they should be referred 1 month prior to the renewal date for test advice, so that the renewal is in time and there is no break. This applies for our company and other company renewals.

4.7 Copayment Applicability:

Any Insured Person aged 61 years and above , being covered for the first time in a Health Absolute Policy shall bear 20% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum. The co-payment shall be applicable for claims under all Benefits other than Section 2.15 (OPD Treatment) and Section 2.20 (Wellness Benefits). This Co-payment will be continued in all the subsequent renewal policies.

5 Discounts/ Other Loadings Applicable Under The Product

a) **Family discount** – 10% Family discount in case of more than one insured covered under the same policy on individual sum insured basis.

b) **Long-term discount** (applicable in case of single payment for policy term of more than one year)

Number of years	Discount
1 year	Nil
2 years	7.5%
3 years	10%

c) **Voluntary deductible discount –** In case a deductible is opted under the policy, corresponding discount will be applicable as per table below. The deductible is applicable on aggregate basis.

Classic		Platinum		Signature	
Deductible	**Discounts**	**Deductible**	**Discounts**	**Deductible**	**Discounts**
₹10,000	8%	₹ 50,000	15%	₹ 1,00,000	15%
₹ 25,000	15%	₹ 75,000	20%	₹2,50,000	20%
₹ 50,000	20%	₹ 100,000	25%	₹ 5,00,000	25%

d) **Web sales / Tele sales discount:** A discount of 15% in lieu of intermediary commissions if policy is sourced directly from the Company's website or through leads generated via Tele sales channel.

e) **Employee discount :** we shall accord a discount of 15 %, on the premium amount, against proposals received from the following categories of individuals, provided that the respective individual, at least till the date of issuance of the policy cover, continues to be in/of such capacity:

a. Employed with Generali Central Insurance Co. Ltd., recorded through its official rolls/register
b. Employed with Generali Central Life Insurance Co. Ltd., recorded through its official rolls/register
c. Contracted for provision of services directly by Generali Central Insurance Co. Ltd., recorded through appointment/engagement letter or like document
d. Contracted for provision of services directly by Generali Central Life Insurance Co. Ltd., recorded through appointment/engagement letter or like document

Towards entitlement of the discount, each eligible proposer shall have to submit with Generali Central Insurance Co. Ltd., alongside the proposal, a self-certified copy of the identification card or appointment/engagement letter or such document that may have been issued in favour of the proposer to evidence the relationship, which bears an identification mark/logo of the issuing entity.

Note: - Either Website/Employee discount would apply in a single policy.

f) **Floater discount:**
Applicable discount is as per following table:

Age Band	**Discount Rates**	**Age Band**	**Discount Rates**
0-17	60%	51-55	40%
18-25	55%	56-60	35%
26-30	50%	61-65	35%
31-35	45%	66-70	35%
36-40	45%	71-75	35%
41-45	40%	76-80	25%
46-50	40%	81-85	25%
		>85	20%

Premium applicable for the primary insured will be the standard individual premiums from the premium table. For remaining dependent members, floater discounts applicable on their respective premium is as per table above.

For example – In case of a family of Self, spouse and 1 child, the premium for floater for Sum Insured ₹ 10,00,000 would be charged in the following manner –

Sum insured is 1000000			
	Self	Spouse	Child
Age band (in years)	36-40	31-35	0-17
Premium as per Individual rate table (in ₹)	15,294	14,299	12,382
Applicable premium (in ₹)	15,294	7,864 (45% discount applied on the respective person's premium)	4953 (60% discount applied on the respective person's premium)

Total Premium to be charged (in ₹)	15294+7864+4953
	28,111

g) **Instalment Loading:**
Premium Payment facility on instalment basis is available. Given below are the loadings applicable on Standard premiums in case of instalments:

Instalment frequency	Loading on standard premiums
Monthly	5%
Quarterly	4%
Semi- annually	3%
Annually	0%

h) **Loading On Claim Experience**: There will be no loading on premium for adverse claims experience.

i) **Underwriting Loading:**

	Condition	Underwriting Decision
1	**Diabetes**	
a	Pre-Diabetic/ Not a know case of Diabetes (HbA1c 5.9 - 6.49%)	Exclusion#
b	Known case of Diabetes (HbA1c up to 5.9 - 6.49%)	10% loading with Exclusion for pre existing
c	Diabetic level (HbA1c 6.5% - up to 8%)	15% loading with Exclusion for pre existing
d	Diabetic level (HbA1c >8%)	Decline
2	**Hypertension**	
a	Known / not known Hypertensive (140 mmHg Systolic /90 mmHg diastolic)	10% loading with Exclusion for pre existing
b	Known / not known Hypertension (141 to 150 mmHg Systolic / 91 to 100 mm Hg diastolic)	15% loading with Exclusion
c	Known / not known Hypertension (Above 150 mmHg Systolic / Above 100 mm Hg diastolic)	Decline
3	**Serum Cholesterol**	
a	Above +25 mg/dl to +50 mg/dl above the maximum *Normal range	10% loading
b	+51 mg/dl to +100 mg/dl above the maximum *Normal range	20% loading
4	**Serum Triglycerides**	
	Above +20 mg/dl to + 45 mg/dl above the maximum *Normal range up to 100 mg/dl	10% loading
	Above+46 mg/dl to 75 mg/dl of the maximum* Normal range	20% loading
5	**Serum creatinine**	
a	up to 0.3 mg/dL above the maximum *Normal range	10% loading
b	From 0.5 up to 0.8 mg/dL above the maximum*Normal range	15% loading

6	**Asthma**	
a	Asthma (not on steroids)	10% loading
b	Asthma (on steroids)	20% loading
7	**Smoking**	5% loading
8	**Tobacco chewing/ Ghutka**	5% loading
9	**BMI**	
a	BMI from 32 to 34	15% loading
b	BMI from 34.1 to 36	25% loading
c	36.1 and above	Decline
10	**Combination of any two or more conditions**	To be Reviewed for Acceptance/ Declinature
11	**Positive history of any other ailment(s)/ disease(s)**	To be Reviewed for Acceptance/ Declinature

*** Normal range** of values of the respective Laboratory where tests were conducted.
#The exclusion can be waived if insured provides a report with lower than HbA1c 5.9 at renewal

6 General Terms and Clauses

6.1 Standard General terms and Clauses:

6.1.1 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.

6.1.2 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.

6.1.3 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

a) 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
b) 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
c) Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

6.1.4 Complete Discharge

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

6.1.5 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.

6.1.6 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.

6.1.7 Withdrawal of Policy

a) 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.
b) 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.

6.1.8 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.

6.1.9 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.

6.1.10 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.

6.1.11 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 Ltd.
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://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.

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

6.2 Specific General Terms and Clauses

6.2.1 Conditions applicable during the contract

6.2.1.1 Insured Persons

The following relations of the Primary Insured/Proposer shall be eligible to be Insured Persons under the Policy:

a) For Classic Plan:
   1) Individual Sum insured policy – Self, Spouse/Live-in partner,3 Dependent Children (upto 25 years of Age) and Parents;
   2) Floater Sum Insured policy – Self, Spouse/Live-in partner, 3 Dependent Children (up to 25 years of Age)

b) For Platinum Plan & Signature Plan :
   1) Individual Sum insured policy – Self, Spouse/Live-in partner, Children, Parents, Siblings, Daughter in law, Son in law, Parents in law, Grandparents and Grandchildren.
   2) Floater Sum Insured policy – Self, Spouse/Live-in partner, Children, Parents, Parents in law

Only those persons named as Insured Persons in the Schedule shall be covered under this Policy with exception to a newborn baby who is covered as defined under Section 2.6 (Newborn Baby Expenses). A person may be added as an Insured Person during the Policy Period after his/her application has been accepted by Us, an additional premium has been received and Our agreement to extend cover has been indicated by Us issuing an endorsement confirming the addition of such person as an Insured Person.

6.2.1.2 Cost Of Pre-Insurance Medical Examination

We will reimburse 100% of the cost of any pre-insurance medical examination conducted at our empaneled diagnostic center, once the Proposal is accepted and the Policy is issued for that Insured Person.

6.2.1.3 Communications

a) Any communications, notifications or declarations meant for Us must be in writing and delivered to Our address specified in the Schedule.
b) Any communication meant for You will be sent by Us to Your address shown in the Schedule. You must notify Us immediately of any change in Your address.
c) Our agents are not authorized to receive communications, notices or declarations on Our behalf.

6.2.1.4 Policy Period

The Policy Period offered under this product is one year, two years three years.

6.2.1.5 Territorial Limits and Law

a) Except as provided in Section 2.19 (Medical Treatment Abroad), We shall cover only treatment and investigations covered in terms of this Policy that is taken during the Policy Period and takes place anywhere in the territory of India.
b) The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law.
c) The Policy constitutes the complete contract of insurance between Us and You/Insured Person. No change or alteration shall be valid or effective unless approved in writing by Us, where approval shall be evidenced by an endorsement on the Schedule.

6.2.1.6 Portability

a) 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.

b) In case the Insured Person is porting a similar Policy from Us /another insurance company, portability if requested by the Insured Person, shall be applicable to the previous policy along with enhanced sum insured (base sum insured+ Cumulative Bonus) acquired under the previous policies. The premium applicable would be for the enhanced sum insured (Sum Insured + Cumulative Bonus) and if the same is not available, to the next higher Sum Insured available if requested by the Insured Person. However, portability shall be applicable to the previous sum insured and the cumulative bonus.

c) For the purpose of this product the Portability is applicable only for the waiting periods. Portability is not applicable to Section 2.5 (Maternity Expenses), Section 2.7(Infertility Expenses) and claims related to Section 2.23 (Bariatric Surgery).

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

6.2.1.7 Migration

a) 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.

b) For the purpose of this product the Migration benefit is applicable only for the waiting periods. Migration is not applicable to Section 2.5 (Maternity

Expenses), Section 2.7(Infertility Expenses) and claims related to Section 2.23 (Bariatric Surgery).

c) In case the Insured Person is migrating a similar Policy from Us company, migration if requested by the Insured Person, shall be applicable to the previous policy along with enhanced sum insured (base sum insured+ Cumulative Bonus) acquired under the previous policies. The premium applicable would be for the enhanced sum insured (Sum Insured + Cumulative Bonus) and if the same is not available, to the next higher Sum Insured available if requested by the Insured Person. However, migration shall be applicable to the previous sum insured and the cumulative bonus.

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

6.2.1.8 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 prorate 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 prorate 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.

6.2.1.9 Premium Payment in Instalment

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

a) 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.
b) 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.
c) No interest will be charged If the instalment premium is not paid on due date
d) In case the instalment premium due, is not received within the grace period, the policy will get cancelled.
e) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
f) The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
g) The payment will be accepted through E-NACH / ACH/ ECS / any other mode approved by Government of India.
h) On successful registration for the mandate/ E-NACH/ any other mode approved by Government of India, the premium shall be auto debited as per the frequency opted.
i) In case of withdrawal of E-NACH/ ACH/ ECS / any other mode approved by Government of India, a written communication will be required from policyholder.
j) In case there is failure in transaction in E-NACH/ ACH/ ECS mode/ any other

mode approved by Government of India or the instalment premiums are not received within the grace period, the Policy will get cancelled. A fresh policy with all waiting periods would be issued.

k) If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered. This provision will not apply to claims arising under Section 2.15 (OPD Treatment) and Section2.20 (Wellness Benefits).

6.2.2 Condition when a claim arises

6.2.2.1 Claims Procedures

If the Insured Person meets with any Injury or contracts an Illness that may result in a claim under the Policy, then as a Condition Precedent to Our liability, the following must be complied with:

a) Cashless Facility is only available at a Network Provider. In order to avail Cashless Facility, the following procedure must be followed:
   1) We must be called at Our call centre and a request for pre-authorisation must be made by way of the written form prescribed by Us.
   2) After considering the request and obtaining any further information or documentation that We have sought, We may, if satisfied, send the Network Provider an authorisation letter. The authorisation letter, the ID card issued to the Insured Person along with this Policy and any other information or documentation that We have specified must be produced to the Network Provider identified in the pre-authorisation letter at the time of the Insured Person's admission to the Hospital.
   3) If the above procedure is followed, the Insured Person will not be required to directly pay for those Medical Expenses to the Network Provider that We are liable to indemnify under this Policy. The original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-authorisation does not guarantee that all costs and expenses that are incurred will be covered. We reserve the right to review each claim for Medical Expenses incurred and accordingly coverage will be determined according to the terms, conditions and exclusions of this Policy. All other costs and expenses that are not covered under this Policy must be settled directly with the Network Provider and We shall have no liability in this regard.

b) If a pre-authorisation request is denied by Us or if treatment is taken in a Hospital other than a Network Provider or if You/ Insured Person does not wish to avail Cashless Facility, then:
   1) We must be given Notification of Claim immediately and in any event within 48 hours of the admission to the Hospital.
   2) The Insured Person must take reasonable steps or measures in good faith to minimise the quantum of any claim that may be made under this Policy.
   3) The Insured Person must submit to examination by Our medical advisors if We ask, the cost for which will be borne by Us.

c) We must be given promptly, and in any event within 15 days of the Insured Person's discharge from a Hospital, the documentation including written details of the quantum of any claim along with all original supporting documentation, including but not limited to the following, and other information We ask for to investigate the claim for Our obligation to make payment for it:
   1. The claim form specified by Us duly completed and signed by the claimant

or a family member;

2. First consultation letter;
3. First prescription from the Medical Practitioner;
4. Original vouchers/ invoice of original bill ;
5. Original Hospital bills giving a detailed break up of all expense heads mentioned in the bill;
6. Money receipt duly signed with a revenue stamp;
7. Birth/Death certificate (as applicable);
8. The original Hospital discharge card/ summary;
9. All original laboratory and diagnostic test reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram, etc
10. If medicines have been purchased in cash and if this has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner and the supporting medicine bill from the chemist;
11. If diagnostic or radiology tests have been paid for in cash and it has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner advising the tests, the actual test reports and the bill from the diagnostic centre for the tests.
12. Copy of proposer`s photo ID proof & address proof
13. NEFT Form with photocopy of cancelled cheque with printed name of proposer
14. Copy of Operation theatre Notes, if applicable
15. Copy of the Claim Intimation, if any
16. For:
    i. maternity claims - Discharge Summary mentioning LMP, EDD & Gravida
    ii. Cataract claims -IOL sticker
17. Copies of health insurance policies held with any other insurer covering the insured persons.
18. If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that Original claim documents are retained at their end.
19. For claims made under Section 2.14 (Home Health Care Expenses), a certificate from the attending doctor confirming that the condition of the patient is such that he/she cannot be moved to a hospital.
20. Additional documents for Section 2.19 (Medical Treatment Abroad) - Insured Person`s passport and visa.
21. Additional Documents to be submitted for any claim with respect to Air Ambulance covered under Section 2.13 (Emergency Medical Evacuation):
22. It is a condition precedent to Our liability under this Benefit that the following information and documentation shall be submitted to Us immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
23. Medical reports and transportation details issued by the air ambulance service provider, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirming the necessity of air ambulance services.
24. Original Bills for expenses incurred towards availing Air Ambulance services.

d) In the event of Your/Insured Person's death, You/Insured Person's nominee/legal heir claiming on his/her behalf must inform Us immediately and send Us a copy of the post mortem report (if any).
e) I We are not given notice/documentation within the time frames set out above, then We may accept the claim notice/ documentation if it is demonstrated to Us that the delay was for reasons beyond the control of the claimant.

6.2.2.2 Basis Of Claims Payment

a) Claims related to Surgery for cataracts: Our obligation to make payment in respect of Surgery for cataracts (after the expiry of the two years period referred to in point B of clause 3.1.1.2 above, shall be restricted to 10% of the Sum Insured for each eye, and a maximum up to the amount specified in the schedule of benefits .

b) Claims related to Modern Treatment Methods and Advancement in Technologies: Our obligation to make payment in respect of the Medical Expenses incurred for the below listed treatments or procedures, as inpatient or as day care treatment (inclusive of Pre and Post Hospitalization), shall be maximum up to the sum insured as specified in the Policy Schedule..
   1) Uterine Artery Embolization and HIFU
   2) Balloon Sinuplasty
   3) Deep Brain stimulation
   4) Oral chemotherapy
   5) Immunotherapy- Monoclonal Antibody to be given as injection
   6) Intra vitreal injections
   7) Robotic surgeries
   8) Stereotactic radio surgeries
   9) Bronchical Thermoplasty
   10) Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
   11) IONM - (Intra Operative Neuro Monitoring)
   12) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

c) Claims related to Lasik's Surgery: Our obligation to make payment in respect of Lasik Surgery (after the expiry of the three years period referred to in point A of Clause 3.1.1.2 above will be restricted only for refractive error more than or equal to 7.5 diopters and shall be covered only once during the entire tenure of policy with Us. Our liability to pay for any claims towards Lasik's surgery under the applicable Plan will be restricted up to the sub limit as specified in the Schedule of Benefits.

d) Claims related to Bariatric Surgery: Our obligation to make payment in respect of Bariatric Surgery (after 36 months of continuous coverage from the first inception of the Health Absolute Policy with Us), shall be restricted to 50% of the Sum Insured, maximum up to the amount mentioned in the schedule of benefits per policy period.

e) Claims related to Any One Illness: All claims relating to Any One Illness shall

be deemed to be part of the same original claim.

f) Claims for Day Care Treatment: The Day Care Treatments listed are subject to the exclusions, terms and conditions of the Policy and will not be treated as independent coverage under the Policy.

6.2.2.3 Co-Payments Applicable under the Policy

Any Insured Person aged 61 years and above , being covered for the first time in a Health Absolute Policy shall bear 20% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum. The co-payment shall be applicable for claims under all Benefits other than Section 2.15 (OPD Treatment) and Section 2.20 (Wellness Benefits). This Co-payment will be continued in all the subsequent renewal policies.

6.2.2.4 Voluntary Deductible Applicable under the Policy

a) If a Voluntary Deductible has been opted and is in force under the Policy, Our liability would be over and above the Voluntary Deductible amount on aggregate basis for all claims made under the policy other than Benefit 2.15 (OPD Treatment)and Benefit 2.20 (Wellness Benefits) including claims related to anyone illness.

b) Wherever Co-payments are applicable, as per Clause 4.2.2.3 above, the same would be applied on the admissible claim amount after the application of Voluntary Deductible, if any.

6.2.2.5 Policy Currency

We shall make payment in Indian rupees and in India only.

6.2.2.6 Reimbursement Claims

For reimbursement claims, the payment will be made to You/ Insured Person. In the event of Your/Insured Person's death, We will pay the nominee (as named in the Schedule) and in case the nominee is deceased or untraceable, payment to Your/Insured Person's legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and where discharge shall be treated as full and final discharge of Our liability under the Policy.

6.2.2.7 Claim settlement

a) 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.
b) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
c) 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.
d) 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.

e) Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified in Clause 4.2.2.1 above
f) In case of 'pending' claims, We will ask for submission of incomplete documents.
g) 'Rejected' claims will be informed to the Insured Person in writing with reasons for rejection.

6.2.3 Conditions for renewal of the contract

6.2.3.1 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. Coverage is not available during the grace period.
e) No loading shall apply on renewals based on individual claims experience.
f) Health Absolute Policy shall be renewable lifelong.
g) The brochure/ prospectus mentions the premiums as per the age slabs/ Sum Insured and the same would be charged as per the completed age at every Renewal.
h) The premiums as shown in the brochure/ prospectus are subject to revision as and when approved by the IRDAI. However such revised premiums would be applicable only from subsequent Renewals and with due notice whenever implemented.
i) Any Change (increase/ decrease) in Sum Insured is not allowed during the currency of the Policy. However increase/decrease in Sum Insured or change in cover, will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal before the expiry of the Policy.
j) In case of enhancement of sum insured, the waiting periods shall apply afresh to the extent of sum insured increase.

6.2.3.2 Dispute Resolution

Any and all disputes or differences under or in relation to this Policy shall be subject to the exclusive jurisdiction of the Indian Courts and subject to Indian law.

6.2.3.3 Endorsements (Changes in Policy)

1) This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
2) 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.

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

7 Schedule of Benefits –

PLANS		CLASSIC	PLATINUM	SIGNATURE
Eligibility	Sum Insured (In ₹)	3 L, 5 L, 10 L	15 L, 20 L, 25 L, 30 L, 35 L	50 **L**, 75 **L**, 1 Crore
	Minimum Entry Age	Child - 1 Day	Child - 1 Day	Child - 1 Day
		Adult - 18 years	Adult - 18 years	Adult - 18 years
	Maximum Entry Age	Child - 25 years	Child - 25 years	Child - 25 years
		Adult – No limit	Adult – No limit	Adult – No limit
	Maximum Renewal Age	Life Long	Life Long	Life Long
	Cover Type	Individual / Non-Floater/ Family Floater	Individual / Non-Floater/ Family Floater	Individual / Non-Floater/ Family Floater
	Family Definition	Individual / Non-Floater – S+ Sp / LP + 3 C (Up To 25 Years) + 2 P Family Floater – Self + Sp / LP + 3 C (Up To 25 Years)	Individual / Non-Floater – *Extended Family Up To 15 Members #Family Floater - S + Sp / LP + C + 2 P + 2 PIL	Individual / Non-Floater – *Extended Family Up To 15 Members #Family Floater - S+ S / LP + C + 2 P + 2 PIL
Hospitalization Benefits	Hospitalization Medical Expenses	Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
	Day Care Treatment Expenses	Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
	Pre-Hospitalization Medical Expenses	60 Days	60 Days	60 Days
	Post-Hospitalization Medical Expenses	90 Days	120 Days	180 Days
	Restoration of Sum Insured	Available	Available	Available
		-Equal to 100% of the base Sum Insured excluding Cumulative Bonus, if any. -Available for the particular Policy year for a second claim irrespective of the Sum Insured and Cumulative Bonus (if any) is completely or partially exhausted.		
	Maternity Expenses -	3 L S.I - ₹ 25000	15 L S.I - ₹ 40000	50 L, 75 L, 1 Cr S.I – ₹ 1,00,000

	Normal Delivery	5 L, 10 L S.I – ₹ 30,000	20 L ,25 L ,30L, 35L S.I – ₹ 50,000	
		In case of birth of a girl child, the Maternity sublimit will be enhanced by additional ₹ 10,000 per Policy Year, subject to maternity claim being admissible.		
	Maternity Expenses - Caesarean Delivery	3L S.I – ₹ 25,000 5L S.I – ₹ 35,000 10L S.I – ₹ 50,000	15 L S.I - ₹ 60,000 20 L ,25 L ,30L 35L S.I - ₹ 1,00,000	50 L, 75l, 1 Cr S.I – ₹ 2,00,000
		In case of birth of a girl child, the Maternity sublimit will be enhanced by additional ₹ 10,000 per Policy Year, subject to maternity claim being admissible.		
	Pre-Natal Hospitalization (Within Maternity Limits)	30 Days	60 Days	90 Days
	Post-Natal Hospitalization (Within Maternity Limits)	45 Days	45 Days	45 Days
	Newborn Baby Expenses	Not Applicable	Automatic Cover Within Mother's / Floater Sum Insured Up To Expiry Date Of Policy Year	Automatic Cover Within Mother's / Floater Sum Insured Up To Expiry Date Of Policy Year
	Newborn Baby Expenses: Reasonable Vaccination Benefits	Not Applicable	Maximum ₹ 5000/-, Up To 1 Year Of Age	Maximum ₹ 10,000/-, Up To 1 Year Of Age
	Infertility Expenses (Over And Above Maternity Limit)- Covered After Waiting Period Of 3 Years	Not Available	Maximum Up To ₹ 50,000 Per Policy Year Lifetime Indemnity Limit Of ₹ 1,00,000	Maximum Up To ₹ 1,00000 Per Policy Year Lifetime Indemnity Limit Of ₹ 2,00,000
	Organ Donor Expenses	Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
	Patient Care (Above 60	Maximum Up To ₹ 350/Day	Maximum Up To ₹ 500/Day	Maximum Up To ₹ 1,000/Day

	Years) - Per Day Benefit	Limited To 10 Days Per Hospitalization And 30 Days Per Policy Year.		
	Accompanying Person (Up To 12 Years)	₹ 500 /Day; Maximum Of 30 Days	₹ 750 /Day; Maximum Of 30 Days	₹ 1000 /Day; Maximum Of 30 Days
	Accidental Hospitalization	Covered	Covered	Covered
		In Case Of Accidental Hospitalization Increase In- 25% Of Available Balance Sum Insured, Subject To Maximum Of ₹10 Lakh		
	Home Health Care Expenses	Covered	Covered	Covered
		Maximum Up To 20% Of Sum Insured		
	AYUSH Treatment	Covered On Reimbursement Basis Only	Covered On Reimbursement Basis Only	Covered On Reimbursement Basis Only
Medical Treatment Abroad		Not Applicable	Not Applicable	Covered After Waiting Period 3 Years
Road Ambulance Charges - (Reimbursement Up To A Maximum)		₹ 1,500 Per Hospitalization	₹ 2,000 Per Hospitalization	₹ 5,000 Per Hospitalization
Emergency Medical Evacuation - (Reimbursement – Maximum Up To 5% of SI)		Not Applicable	Covered	Covered
E-Opinion For Illness / Injury (Maximum 2 Per Policy Year)		Available	Available	Available
OPD Treatment (Reimbursement Up To A Maximum of ₹)		₹ 3,000 Per Person For A Policy Issued on Individual/ Non-Floater Basis ₹ 5000 Per Policy Issued On Family Floater Basis. Will cover for consultations, diagnostics and medications related to Mental / Psychiatric Illness only. All Diagnostics are restricted to 70% of admissible bills. Our Liability for prescribed	₹ 5,000 Per Person For A Policy Issued on Individual/ Non-Floater Basis ₹ 10,000 Per Policy Issued On Family Floater Basis. Dental Consultations and all Diagnostics, restricted to 70% of admissible bills. Our Liability for prescribed drugs / medicines will be restricted to 80% of	₹ 15,000 Per Person For A Policy Issued on Individual/ Non-Floater Basis ₹ 30,000 Per Policy Issued On Family Floater Basis. Dental Consultations and all Diagnostics, restricted to 70% of admissible bills. Our Liability for prescribed drugs / medicines will be restricted to 80% of admissible bills.

		drugs / medicines will be restricted to 80% of admissible bills. There will be no reinstatement of OPD Limit under this plan.	admissible bills. On Complete Exhaustion of OPD Limit, the OPD Limit will be reinstated for future claims related to mental illness. Such reinstatement can happen only once during the Policy Year.	On Complete Exhaustion of OPD Limit, the OPD Limit will be reinstated for future claims related to mental illness. Such reinstatement can happen only once during the Policy Year.
Child Vaccination Benefits - For Child Aged 12 Years Or Less (Reimbursement Up To A Maximum) (In ₹)		Not Applicable	Not Applicable	5,000 Per Annum
Wellness Benefits		Available	Available	Available
Family Discount Of 10% (applicable only when 2 or more members are covered in the single Policy on Non-Floater basis)		Available	Available	Available
Voluntary Deductible (applicable on annual aggregate basis)		Available	Available	Available
Waiting Periods	Pre-Existing Disease Waiting Period			
	Pre-Existing Disease Waiting Period	2 Years	2 Years	2 Years
	General Waiting Periods			
	30-Days	Applicable	Applicable	Applicable
	2-Years - For Listed Conditions	Applicable	Applicable	Applicable
	3 Years - For Listed Conditions	Applicable	Applicable	Applicable
Compulsory Co-Pay - 20% Co-Payment Where Entry Age Is 61years And Above		Applicable	Applicable	Applicable
Sub Limits	Cataract	10% Of SI, Maximum Of ₹ 75,000/- Per Eye.	10% Of SI, Maximum Of ₹ 1, 50,000/- Per Eye.	10% Of SI, Maximum Of ₹ 2, 00,000/- Per Eye.
	Lasik – Covered After Waiting Period	Covered Up To ₹ 30,000 For Both Eyes	Covered Up To ₹ 50,000 For Both Eyes	Covered Up To ₹ 1 L For Both Eyes

	Of 3 Years	Covered After Waiting Period Of 3 Years Only Once During The Entire Tenure Of Policy With Us		
	Modern Treatment Methods and Advancement in Technologies	Up to Sum Insured	Up to Sum Insured	Up to Sum Insured
	Bariatric Surgery	Up To 50% SI, Max Up To ₹ 5 L	Up To 50% SI, Max Up To ₹ 7.5 L	Up To 50% SI, Max Up To ₹ 10 L

All benefits are given within the base Sum Insured except Accidental Hospitalization and Restoration of Sum Insured.
SI: Sum insured, S: Self, Sp: Spouse, LP: Live-in partner C: Child, P: Parent, PIL: Parents in law
As per family definition, there is no restriction on the number of children covered under Signature and Platinum plan.
* Extended family – Self, spouse/Live-in partner, natural or legally adopted child/children, parents and parents in law, siblings, daughter in law, son in law, grandparents and grandchildren

Annexure I – Premium rates exclusive of Goods & Services Tax (age in completed years)

A. Individual Premium

Without Copay for individuals who enter the policy before age for the first time, on or before the age of 60 years

Age Band	3 Lakhs	5 Lakhs	10 Lakhs	15 Lakhs	20 Lakhs	25 Lakhs	30 Lakhs	35 Lakhs	50 Lakhs	75 Lakhs	1 Crore
0-17	7,544	9,610	12,382	13,579	14,032	15,628	17,288	19,125	25,153	30,209	33,836
18-25	8,103	10,381	13,429	16,911	17,510	19,244	21,048	23,046	30,307	35,794	39,726
26-30	8,382	10,780	13,986	17,244	17,860	19,687	21,587	23,691	30,859	36,639	40,778
31-35	8,581	11,043	14,299	17,675	18,306	20,182	22,134	24,296	31,639	37,575	41,827
36-40	9,142	11,790	15,294	18,667	19,335	21,357	23,457	25,784	33,387	39,775	44,350
41-45	10,034	12,974	16,868	20,272	21,004	23,249	25,583	28,169	36,220	43,317	48,399
46-50	12,804	16,664	21,788	24,658	25,583	28,538	31,608	35,012	43,830	53,162	59,837
51-55	20,156	25,995	33,764	36,092	37,350	41,847	46,522	51,705	62,681	76,878	87,032
56-60	26,931	34,985	45,716	48,282	50,015	56,219	62,667	69,815	84,206	1,03,781	1,17,777
61-65	48,451	63,486	83,535	86,996	90,226	1,01,800	1,13,834	1,27,172	1,52,467	1,88,984	2,15,080
66-70	68,334	89,872	1,18,610	1,22,775	1,27,398	1,43,979	1,61,217	1,80,327	2,15,634	2,67,940	3,05,313
71-75	84,196	1,10,926	1,46,596	1,51,322	1,57,056	1,77,632	1,99,024	2,22,737	2,66,034	3,30,936	3,77,307
76-80	1,00,059	1,31,978	1,74,579	1,79,866	1,86,713	2,11,283	2,36,827	2,65,143	3,16,430	3,93,928	4,49,296
>81	1,03,986	1,37,188	1,81,504	1,86,931	1,94,053	2,19,611	2,46,181	2,75,637	3,28,907	4,09,520	4,67,114

With Copay for individuals who enter the policy for the first time, after age of 60 years

Age Band	3 Lakhs	5 Lakhs	10 Lakhs	15 Lakhs	20 Lakhs	25 Lakhs	30 Lakhs	35 Lakhs	50 Lakhs	75 Lakhs	1 Crore
0-17	7,544	9,610	12,382	13,579	14,032	15,628	17,288	19,125	25,153	30,209	33,836
18-25	8,103	10,381	13,429	16,911	17,510	19,244	21,048	23,046	30,307	35,794	39,726
26-30	8,382	10,780	13,986	17,244	17,860	19,687	21,587	23,691	30,859	36,639	40,778
31-35	8,581	11,043	14,299	17,675	18,306	20,182	22,134	24,296	31,639	37,575	41,827
36-40	9,142	11,790	15,294	18,667	19,335	21,357	23,457	25,784	33,387	39,775	44,350
41-45	10,034	12,974	16,868	20,272	21,004	23,249	25,583	28,169	36,220	43,317	48,399
46-50	12,804	16,664	21,788	24,658	25,583	28,538	31,608	35,012	43,830	53,162	59,837
51-55	20,156	25,995	33,764	36,092	37,350	41,847	46,522	51,705	62,681	76,878	87,032
56-60	26,931	34,985	45,716	48,282	50,015	56,219	62,667	69,815	84,206	1,03,781	1,17,777
61-65	39,268	51,296	67,331	70,470	73,054	82,316	91,944	1,02,617	1,23,290	1,52,513	1,73,398
66-70	55,174	72,407	95,392	99,093	1,02,793	1,16,061	1,29,852	1,45,142	1,73,826	2,15,680	2,45,587
71-75	67,866	89,251	1,17,782	1,21,931	1,26,522	1,42,984	1,60,098	1,79,072	2,14,148	2,66,079	3,03,185
76-80	80,556	1,06,092	1,40,169	1,44,768	1,50,247	1,69,905	1,90,341	2,12,998	2,54,468	3,16,475	3,60,779
>81	83,698	1,10,263	1,45,710	1,50,422	1,56,120	1,76,569	1,97,827	2,21,393	2,64,453	3,28,952	3,75,037

*Premiums exclusive of Goods & Services Tax.
**Age in completed years

*** For Family Floater, premium applicable for the primary insured will be the standard individual premiums. For the remaining dependent members, floater discounts will be applicable on their respective premium.
**** Insured has an option to change the plan, and sum insured at the time of renewal of the policy, subject to underwriting
***** The premiums above are subject to revision as and when approved by the regulator. However such revised premiums would be applicable only from subsequent renewals and with due notice whenever implemented.

Disclaimer: For detailed information on this product, terms and conditions etc., please refer to the product policy clause, consult your advisor or visit our website before concluding a sale. Tax Benefits are subject to change due to change in tax laws. *Insurance is the subject matter of solicitation.*

This prospectus shall form part of your proposal form, hence please sign as you have noted the contents of this prospectus.

"I agree to undergo medical tests as advised by the Insurance Company. I agree to a medical underwriting loading as per underwriting guidelines of the Company."

Signature	Place
Name	Date

In case of any claims please contact:
Claims Department
Generali Central Health (GCH)
Generali Central Insurance Co. Ltd.
Qubix Business Park, Building No. Block IT – 1,
Ground Floor, Plot No. 2, Blueridge Township,
Near Rajiv Gandhi Infotech Park, Phase – 1,
Village Hinjewadi, Taluka Mulshi, Pune, Maharashtra - 411057.
Toll Free Number: 1800 103 8889
Toll Free Fax: 1800 103 9998
Email: GCH@generalicentral.com

Annexure II

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

S. 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.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	VASOFIX SAFETY

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

S. 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

S. 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

S. No.	Item
1.	ADMISSION/REGISTRATION CHARGES
2.	HOSPITALIZATION 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 |
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