PROSPECTUS
HEALTH ELITE

I. SALIENT FEATURES OF THE POLICY

1. The policy covers You, Your Spouse/ Live-In Partner, Your Children, Your Parents, Your Dependent Siblings, Your daughter in law, Your son in law, Your parents in law, Your grandparents and Your grandchildren.

2. The policy will be issued for policy period 1 year, 2 years and 3 years. Other features are as follows:

Minimum Policy Term	1 year
Maximum Policy Term	3 Years
Minimum Age at entry	Child- 91 days, Adult- 18 years
Maximum Age at entry	65 years
Renewability	Lifelong
Sum insured options	₹ 75 Lacs, 1 Crore to 6 crores in multiples of 50 Lacs

3. Lifelong Renewals: The policy if renewed continuously without any break will be renewed lifelong.

4. Salient benefits covered under this policy are:
   i. Medical Hospitalization expenses
   ii. Medical Treatment Abroad
   iii. Emergency Ambulance Expenses
   iv. OPD Treatment
   v. Domiciliary Hospitalization expenses
   vi. Maternity expenses
   vii. New-Born Baby Expenses
   viii. Child Vaccination benefit
   ix. Organ Donor Expenses
   x. Restoration of Sum Insured
   xi. E-opinion in case of Illness or Injury
   xii. Alternative treatment
   xiii. Bariatric Surgery
   xiv. Prosthetic Implants
   xv. Additional Sum Insured on Accidental Hospitalization
   xvi. Accompanying person benefit
   xvii. Repatriation of mortal remains
   xviii. Wellness benefits - Fitness based incentives

5. Change in Sum insured, Optional Covers (Once Opted, Insured cannot opt out of the option for 3 years), Instalment Premium frequency, is allowed at the time of renewal only.

II. 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:

A. Standard Definitions

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

violent means.

2. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3. **AYUSH Treatment** refers to the medical and / or Hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems
4. **AYUSH Day Care Centre**:
   AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. **AYUSH Hospital:** An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching Hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
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.
7. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
8. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
   i. Internal Congenital Anomaly - Congenital Anomaly which is not in the visible and accessible parts of the body.
   ii. External Congenital Anomaly - Congenital Anomaly which is in the visible and accessible parts of the body.
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.
10. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
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-

i. has qualified nursing staff under its employment.
ii. has qualified medical practitioner(s) in charge.
iii. has fully equipped operation theatre of its own where surgical procedures are carried out.
iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

12. **Day Care Treatment** means medical treatment and/or surgical procedure which is:
    i. undertaken under General or Local Anesthesia in a hospital/ day care centre in less than 24 hours because of technological advancement; and
    ii. 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.
13. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
14. **Disclosure to Information Norm**
    The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
15. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital; or
    ii. the patient takes treatment at home on account of non- availability of room in a hospital.
16. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the Insured Person's health.
17. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
    Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
18. **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.
19. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
20. **Illness** means a sickness, or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    i. **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

ii. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
   a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
   b) it needs ongoing or long-term control or relief of symptoms
   c) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
   d) it continues indefinitely
   e) it recurs or is likely to recur

21. **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.
22. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
23. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
24. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
25. **Maternity Expenses** means:
   i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization),
   ii. expenses towards lawful medical termination of pregnancy during the policy period.
26. **Medical Advice** means any consultation or advice from a medical practitioner including the issue of any prescription or follow-up prescription.
27. **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.
28. **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.
29. **Medically Necessary Treatment** means any treatment, test, medication, or stay in hospital or part of stay in hospital which:
   i. is required for the medical management of the illness or injury suffered by the insured.
   ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity.
   iii. must have been prescribed by a medical practitioner.
   iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
30. **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.
31. **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.

32. **Newborn Baby** means baby born during the Policy Period and is aged upto 90 days.
33. **Non-Network Provider** means any Hospital, day care centre or other provider that is not part of the network.
34. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
35. **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.
36. **Pre-Existing Disease** means any condition, ailment or injury or disease:
    i. 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
    ii. 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.
37. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required; and
    ii. The In-Patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
38. **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.
39. **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required; and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the insurance company.
40. **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.
41. **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.
42. **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.
43. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include associated medical expenses.
44. **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.
45. **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.

B. Specific Definition

46. [1]**Alternative Treatment/Ayush Treatment** refers to the medical and / or Hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

[1] Specific Definition of Alternative Treatment modified to include "Yoga and Naturopathy" in accordance to AYUSH treatment

47. **Assistance Service Provider** means a Company engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
48. **Authority** means the Insurance Regulatory and Development Authority of India (IRDAI).
49. **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.
50. **Dependent Child** means Your child (natural or legally adopted), who is financially dependent on You and does not have his/her independent sources of income.
51. **Dependent Spouse** means Your legally married spouse as long as he/she continues to be married to You.
52. **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.
53. **Emergency / Life Threatening Medical Condition,** for medical treatment abroad benefit means a serious medical condition or symptom resulting from Injury or Sickness which arises suddenly and requires immediate care and treatment
    a. to avoid jeopardy to the life or
    b. serious damage to the health of an Insured Person.

    The emergency continues till the condition of the Insured Person stabilizes and the continuing medical condition or symptoms are not considered as an Emergency / Life Threatening Medical Condition anymore.
54. **Family means** the Primary Insured /Proposer's legally wedded 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 whose name is mentioned in the Policy schedule as an Insured Member
55. **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.
56. **Hazardous Activities** mean recreational or occupational activities which pose high risk of Injury.
57. **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.
58. **Indian Resident:** An individual will be considered to be resident of India, if he is in India for a period(s) amounting in all to one hundred and eighty-two days or more, in the immediately preceding 365 days.
59. **Insured Person** 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.
60. **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.
61. **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.

62. **LGBT** will mean and include a sexual orientation / 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 opposite 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
63. **Physiotherapist** means a person who possess a recognized qualification as per the RCI Act and/or by a State Government and is thereby entitled to practice physiotherapy within its jurisdiction; and is acting within its scope and jurisdiction of license. The Physiotherapist should not be the insured or an immediate family member. The Physiotherapist should not be the insured or close member of the family.
64. **Policy** means the complete documents consisting of the Proposal, Policy wording, Schedule, Endorsements and Annexures if any, as amended from time to time, and shall be read together. The Policy contains details of the extent of cover available to the Insured Person, applicable exclusions and the terms and conditions applicable under the Policy.
65. **Policy Period** means the period starting with the commencement date mentioned in the Schedule till either the end date mentioned in the Schedule or the date of cancellation of this Policy, whichever is earlier.
66. **Policy Year** means every annual tenure within the Policy Period starting with the commencement date.
67. **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 Us 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.
68. **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.
69. **Prospectus** means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products.
70. **Return Airfare** means economy airfare restricted to the cost of a flight ticket to a defined destination and back to the original departure point by the shortest route.
71. **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.
72. **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.
73. **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)
74. **We, Our, Company, GCI, GCICL** or **Us** means Generali Central Insurance Company Limited.
75. **You** or **Your** means the policyholder shown in the Schedule who has concluded the Policy with Us.

Please note

a) Insect and mosquito bites is not included in the scope of definition of Accident.

b) Medical Expenses would include both medical treatment and/ or surgical treatment

III. Scope of Cover

This Policy provides You certain Sum Insured options as specified in the Schedule of Benefits. The Schedule will specify the Sum Insured and Sub-limits which are in force for each of the Insured Persons. For a complete description of the Benefits available as well as any specific sub-limits on the amount payable under any particular Benefit, please refer to the "Schedule of Benefits" attached to this Policy at **Annexure I.**

Benefits: The Policy covers the Reasonable and Customary Charges necessarily incurred towards the Medically Necessary Treatment taken by the Insured Person towards the below benefits due to an Illness or Injury that occurs during the Policy Period. The cover under the following benefits are subject to the availability of the Sum Insured and any specific sub-limits specified in the Schedule of Benefits and the terms, conditions and exclusions specified in this Policy document.

A. Hospitalization Covers

Benefit 1. Hospitalization 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 in India for Medically Necessary Treatment required due to an Illness or Injury sustained during the Policy Period.

i. Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges.
ii. ICU Charges.
iii. Operation theatre expenses.
iv. Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anaesthetists treating the Insured Person.
v. Qualified Nurse charges.
vi. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner.
vii. Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized.
viii. Anaesthesia, blood, oxygen and blood transfusion charges.
ix. Cost of Pacemaker, Diagnostic materials and X rays.
x. Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Benefit 2. Medical Treatment Abroad

We will pay the Medical Expenses necessarily incurred by the Insured Person for treatment of the Insured Person outside India, in the manner specified and subject to the terms and conditions below. All claims admitted under this Benefit will be subject to 20% Co-payment.

2.1 Listed Critical Illnesses Treatment

a) For the purposes of this Section and the determination of the Company's liability under it, Listed Critical Illnesses treatment 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 subject to the Medical expenses having incurred towards the Medically Necessary Treatment taken by the Insured Person during the Policy Period, subject to terms and conditions given below

b) We will pay the following Medical expenses for medically necessary treatment, Reasonable and Customary Charges incurred towards following medical expenses subject to Pre-authorization given by Us
   i. In patient Hospitalization expense
   ii. Room /ICU rent, Board & Nursing Expenses as provided by the Hospital/ Nursing Home
   iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees
   iv. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Cost of Pacemaker, prosthesis/internal implants and any Medical expenses incurred which is integral part of the operation.
   v. Day Care expenses – We shall pay for expenses incurred under Day Care Treatment requiring less than 24 hours of Hospitalisation. We shall pay for Treatment at a day care clinic or independent welfare centre or a Hospital, but only if the treatment, Surgery or prescription is covered under listed Critical Illnesses.
   vi. The Pre-hospitalization Medical Expenses incurred within India, 60 days prior to Hospitalization due to Illness/ Injury sustained provided that, we have accepted a claim for In-Patient Hospitalization expense under Benefit 2 (Medical Treatment Abroad)- Section 2.1
   vii. Post-hospitalization Medical Expenses incurred in India for a maximum of 180 days

c) Cover for Medical Expenses under this Benefit is admissible where the Insured Person suffers from any of the Critical Illness(es) as specified below:

1. Primary treatment for specified cancer

We will cover the Medical expenses incurred towards Primary treatment of any newly diagnosed Cancer which is diagnosed to be at Stage II or above (as defined by AJCC cancer staging manual) and primary treatment of up to 2 confirmed relapses. Relapse will be preceded by a phase where Insured will be declared to be apparently free of disease which will be after Insured has completed standard protocol-based treatment for that Cancer.

1) The term Cancer includes leukemia, lymphoma and sarcoma.
2) Chronic Leukemia needs to be RAI Stage II or above & Lymphoma needs to be Ann Arbor stage II or above.
3) Primary treatment is defined as curative surgery and immediate chemo and radiotherapy

Specific exclusions

a) All non-melanoma skin cancers are excluded.
b) Diagnostic procedures; preparatory pre surgical radio and chemotherapy.
c) Ongoing cycles of radio or chemotherapy and long-term pain management and treatment taken in India are not covered.

2. Neurosurgery

We will cover the Medical expenses incurred towards the following provided the requirement of surgery must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques and certified by a neurosurgeon or qualified medical doctor of relevant specialty:

1. Surgery to intra cranial structures including the brain, requiring general anesthesia and a craniotomy. Keyhole surgery is included

2. Surgical Treatment of benign solid tumors located in the spinal cord.

3. Surgical Treatment for Benign Solid Brain Tumor

We will cover the Medical expenses incurred towards the surgical treatment of Benign solid brain tumor limited to:

i. Surgical Removal of solid brain tumor through Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.
ii. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain tumor.

Benign solid brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull.
The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
This solid brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist:

a. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days; or
b. Undergone surgical resection or radiation therapy to treat the brain tumor

The following conditions are excluded:

a) Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, tumors of skull bones and tumors of the spinal cord.

4. Coronary Artery Bypass Graft (CABG)

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.

Specific Exclusion

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

5. Open Heart Replacement or Repair of Heart Valves

We will cover the Medical expenses incurred towards the medical expenses related to actual undergoing of open-heart valve 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.

Specific Exclusion

a) Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

6. Lung Transplant Surgery in case of End Stage Lung Disease

We will cover the Medical expenses incurred towards actual undergoing of

a Lung Transplant Surgery due to End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 <55mmHg);
iv. Dyspnea at rest.

The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner

7. **Kidney Transplant Surgery in case of End Stage Renal Failure**
We will cover the Medical expenses incurred towards the medical expenses towards actual undergoing of a Kidney Transplant Surgery due to End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out.
The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner

8. **Liver Transplant Surgery in case of End Stage Liver Disease**
We will cover the Medical expenses incurred towards the actual undergoing of a Liver Transplant due to Permanent and irreversible failure of liver function that has resulted in all three of the following:
i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic Encephalopathy.
The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.
Specific Exclusion
Liver failure secondary to drug or alcohol abuse.

9. **Heart Transplant**
We will cover the Medical expenses incurred towards the actual undergoing of a transplant of human heart due to irreversible end- stage failure of the heart. The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner

10. **Bone Marrow Transplant**
We will cover the Medical expenses incurred towards the actual undergoing of a transplant of Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

11. **Surgery to Aorta**
We will cover the Medical expenses incurred towards the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of “Aorta” shall mean the thoracic and abdominal aorta but not its branches.

The following conditions are excluded:

i. Surgery performed using only minimally invasive or intra-arterial techniques.
ii. Angioplasty and all other intra-arterial, catheter-based techniques, "keyhole" or laser procedures.

The diagnosis to be evidenced by any two of the following:

a) Computerized tomography (CT) scan
b) Magnetic Resonance Imaging (MRI) scan
c) Echocardiography (an ultrasound of the heart)
d) Angiography (Injecting X ray dye)
e) Abdominal ultrasound

12. Pulmonary artery graft surgery

We will cover the Medical expenses incurred towards the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

13. Stroke Treatment

We will cover the Medical expenses incurred towards any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. We will be covering surgical treatment of Stroke limited to:

a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.
b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke.

Specific Exclusion

a) Transient ischemic attacks (TIA).
b) Traumatic injury of the brain.
c) Vascular disease affecting only the eye or optic nerve or vestibular functions.

14. Skin Grafting Surgery for Major Burns

We will cover the Medical expenses incurred towards the undergoing of skin transplantation due to accidental major burns where major burns is as defined below:

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area. Skin grafting surgery for Major Burns should be medically required and not aesthetic/cosmetic in nature.

15. Surgical treatment of Coma

We will cover the Medical expenses incurred towards the surgical treatment of Coma limited to Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.

A state of unconsciousness with no reaction or response to external stimuli

or internal needs. This diagnosis must be supported by evidence of all of the following:

a. no response to external stimuli continuously for at least 96 hours.
b. life support measures are necessary to sustain life; and
c. The condition has to be confirmed by a specialist Medical Practitioner.

Specific Exclusions
Coma resulting directly from alcohol or drug abuse is excluded.

16. Surgery for Pheochromocytoma

We will cover the Medical expenses incurred towards the actual undergoing of surgery to remove the tumour. Presence of a neuroendocrine tumour of the adrenal or extra chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by an Endocrinologist.

17. Motor Neuron Disease with Permanent Symptoms

We will cover the Medical expenses incurred towards the surgical treatment for Motor neuron disease diagnosed by a specialist consultant as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis.

There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months

18. Cerebral aneurysm

We will cover the Medical expenses incurred towards the surgical treatment of Cerebral aneurysm which is diagnosed by Specialist Medical Practitioner supported with evidence of cerebral angiogram and/or magnetic resonance angiography and/or CT scan.

Treatment for a cerebral aneurysm using any one of the following:

i. Craniotomy
ii. Stereotatic radiotherapy
iii. Endovascular treatment by using coils to cause thrombosis (embolisation)

For the above definition the following are not covered:

a. Cerebral arteriovenous malformation.

19. Pneumonectomy – Removal of an entire lung

We will cover the Medical expenses incurred towards the undergoing of surgery to remove an entire lung due to disease or trauma. The diagnosis and undergoing of the surgery have to be confirmed by a specialist Medical Practitioner.

The following is not covered:

a) Partial removal of a lung (lobectomy) or lung resection or incision.

20. Surgical removal of an eyeball

We will cover the Medical expenses incurred towards the Surgical removal of a complete eyeball as a result of injury or disease. Provided the diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner

Specific Exclusion

a) Self- inflicted injuries

The specific terms and conditions applicable to any claim made under this Listed Critical Illnesses Benefit are

a. Benefit is available as both cashless and reimbursement facility, subject to mandatory pre-authorization in India.
b. The Critical Illness should be diagnosed in India by a certified Medical Practitioner.
c. Insured person is required to intimate to Us or Our Assistance service provider before considering medical treatment abroad.
d. Upon the insured persons intimation, Our Assistance service provider will further assist the insured 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. We will reimburse the Return Airfare incurred by the Insured Person for whom a claim has been accepted under this Benefit, subject to the sub-limit specified in Schedule of Benefits. This Return Airfare can be claimed only once in a Policy Year and will be deducted from the Sum Insured applicable for this Benefit.
g. An elective treatment can only be taken abroad if certified by treating Medical Practitioner in writing that:
    i. That person requires the specific treatment for the Critical Illness diagnosed as per the terms mentioned in policy contract.
    ii. The treating Medical Practitioner recommends the treatment to be undertaken abroad looking at the severity of disease or availability of treatment which is best in class
h. The payment of any claim under this Benefit will be based on the rate of exchange published by Reserve Bank of India (RBI) as on the date of payment to the Hospital and shall be used for conversion of foreign currency into Indian rupees for payment of claim.
i. Our total, cumulative and maximum liability in first Policy year since inception of the Policy with Us will be limited to 50% of Sum Insured. However, Co-payment of 20% shall also be applicable on such claims.
j. Claims related to Pre-existing Diseases
    (i) Waiting period of 2 years is applicable from the date of policy inception with Us,
    (ii) Our liability in respect of a claim arising due to any Pre-existing Diseases during the third year of continuous renewal is restricted to 50 % of the Sum Insured.
    (iii) We shall indemnify up to 100% of the sum insured in respect of a claim arising from any Pre-existing Diseases from the fourth year of continuous Renewal of the Policy with Us

The specific exclusions applicable to this Benefit are:

a) Costs incurred on any Critical Illness(es) not listed above.

b) Treatment of Illnesses in USA and Canada. This exclusion will not be applicable in case Benefit 25 (Treatment including USA and Canada) is opted.
c) Benefit associated with Return airfare for USA and Canada. This exclusion will not be applicable in case Benefit 25 (Treatment including USA and Canada) is opted.
d) Costs incurred for treatments other than allopathic treatment
e) Any additional Sum Insured with respect to accidental Hospitalization will not be available for treatment outside India.
f) Any costs or expenses incurred in relation to any persons accompanying the Insured Person during the period of Hospitalization, including such persons who are also Insured Persons under the Policy.

2.2 Emergency Treatments

a) We will also cover illnesses other than those specified under section 2.1 a) above, provided that the Insured Person is already outside India at the time of the illness or injury and Emergency/ Life Threatening medical condition requires immediate care to stabilize the Insured Person`s medical condition before any further travel is possible. It must be certified by treating Medical Practitioner in writing that the Insured Person needs such immediate care, or that the Insured Person has a Life-Threatening Medical Condition which requires an immediate treatment.
b) We shall pay the Reasonable and Customary Charges incurred towards following medical expenses for medically necessary treatment:
   i. In patient Hospitalization
   ii. Room /ICU rent, Board & Nursing Expenses as provided by the Hospital/ Nursing Home
   iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees
   iv. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Cost of Pacemaker, prosthesis/internal implants and any Medical expenses incurred which is integral part of the operation.

The specific terms and conditions applicable to any claim made under this Benefit are:

a) Benefit is available as both cashless and reimbursement facility.
b) Claim must be intimated to Us or Our Assistance service provider in no more than 2 days from the date of occurrence of the illness or Injury or admission to the Hospital, whichever is earlier.
c) It must be certified by treating Medical Practitioner in writing that Insured person has an Emergency/ Life-Threatening Medical Condition and requires an immediate treatment before any travel back to India.
d) Our Assistance service provider will assist the insured in confirming the admissibility of the claim and co-ordinate with the Hospitals for availing the Cashless facility.
e) In case the Cashless facility cannot be offered, the claims will be addressed on Reimbursement basis
f) The payment of any claim under this Benefit will be based on the rate of exchange published by Reserve Bank of India as on the date of payment to the Hospital and shall be used for conversion of foreign currency into Indian rupees.
g) For Emergency Treatments, we shall cover all expenses up to the sum insured from the first policy year, subject to 20% co-payment.

The specific exclusions applicable to this Benefit are:

a) Any treatment, which could reasonably be delayed until the Insured Person's return to the country of residence.
b) Pre-existing Diseases in the case of Emergency shall not be covered under this benefit.
c) Costs incurred towards any Pre-Hospitalization Medical Expenses and Post Hospitalization Medical Expenses in India and Abroad except for Emergency Ambulance Expenses outside India (Excluding USA and Canada)
d) Treatment of Illnesses in USA and Canada. This exclusion will not be applicable in case Benefit 25 (Treatment including USA and Canada") is opted.
e) Costs incurred for treatments other than allopathic treatment
f) Costs incurred for any airfare expenses incurred by the Insured person for availing the emergency treatment.

Benefit 3. Emergency Ambulance Expenses

3.1 Emergency Ambulance Expenses availed within India

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

a) Towards road Ambulance services of a Hospital or a registered service provider, wherever applicable
   i. towards transportation of the Insured Person from place of residence or the site of occurrence of the Injury to the nearest Hospital and;
   ii. from one Hospital to another Hospital provided that such transportation is medically necessary.
b) Towards Insured Person's necessary medical evacuation in an emergency by Air Ambulance of a Hospital or a registered service provider, provided that:
   i. the evacuation is recommended by a Medical Practitioner who certifies that the severity of the Insured Person's Injury or Illness warrants the medical evacuation for receipt of Emergency Care.
   ii. It is a Condition Precedent that these expenses are authorized by Us/ Assistance Service Provider if the evacuation is required in respect of an Insured Person's Illness and the medical evacuation is from the place of local Hospitalization to any other Hospital within India.
   iii. For medical evacuation following an Accident during the Policy Period, We will reimburse under this Benefit, expenses incurred for medical evacuation from the place where the Accident occurred or the place of local Hospitalisation immediately following the Accident to any other Hospital within India.
   iv. For medical evacuation following an Illness during the Policy period, We will reimburse under this Benefit, expenses incurred for medical evacuation from the place of local Hospitalisation to any other Hospital within India.
   v. In addition, where transportation of the Insured Person is for Emergency Care, We will also reimburse the Medical Expenses incurred by the Insured Person during the course of transportation towards Medically Necessary Treatment required to be provided to the Insured Person en-route.

3.2 Emergency Ambulance Expenses Availed Abroad (Excluding USA and Canada)

In the event of Us accepting a claim under the Medical treatment abroad

Benefit, We will also 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

a) Towards road Ambulance services of a Hospital or a registered service provider, wherever applicable,
   i. towards transportation of the Insured Person from place of residence or the site of occurrence of the Injury to the nearest Hospital and;
   ii. from one Hospital to another Hospital provided that such transportation is medically necessary.
b) Towards Insured Person's necessary medical evacuation in an emergency Air Ambulance of a Hospital or a registered service provider, provided that:
   i. the evacuation is recommended by a Medical Practitioner who certifies that the severity of the Insured Person's Injury or Illness warrants the medical evacuation for receipt of Emergency Care.
   ii. It is a Condition Precedent that these expenses are authorized by Us / Assistance service provider, if the evacuation is required in respect of an Insured Person's Illness and the medical evacuation is from the place of local Hospitalization to any other Hospital.
   iii. For medical evacuation following an Accident during the Policy Period, We will reimburse under this Benefit, expenses incurred for medical evacuation from the place where the Accident occurred or the place of local Hospitalisation abroad immediately following the Accident to any other Hospital abroad excluding USA and Canada.
   iv. For medical evacuation following an Illness during the Policy period, We will reimburse under this Benefit expenses incurred for medical evacuation from the place of local Hospitalisation abroad to any other Hospital abroad excluding USA and Canada
   v. In addition, where transportation of the Insured Person is for Emergency Care, We will also reimburse the Medical Expenses incurred by the Insured Person during the course of transportation towards Medically Necessary Treatment required to be provided to the Insured Person en-route.
   vi. All expenses incurred for Emergency ambulance under this Benefit as mentioned in point a) and b) above shall be applicable in USA and Canada as per the policy terms and conditions if Insured has opted for Benefit 25 (Treatment including USA and Canada).

The specific terms and conditions applicable to this Benefit 3 are:

i. We will reimburse payments under this Benefit only in respect of Ambulance services of a Hospital or a registered service provider, and only upon receiving the bills in original.
ii. The necessity of use of an Air Ambulance must be certified by the treating Medical Practitioner.
iii. In case of claim under Benefit 2 (Medical Treatment Abroad) Section 2.1 Listed Critical Illnesses Treatment, this Benefit will be extended subject to the costs certified and authorized by Us/ Assistance service provider in advance.
iv. In case of claim under Benefit 2 (Medical Treatment Abroad) Section 2.2 Emergency Treatment, expenses towards Ambulance services, including Air Ambulance will be admissible subject to we have accepted the main Hospitalization claim.
v. Payment under this Benefit is subject to a claim for the same Illness or Injury being admitted by Us under Benefit 1(Hospitalization Expenses) and Benefit 2 (Medical

Treatment Abroad).

vi. En route medical expenses under emergency medical evacuation will only be covered if incurred in an Air Ambulance.

The specific exclusions applicable to this Benefit 3 are:

i. Costs under this Benefit associated with Ambulance services taken in or to USA and Canada. This exclusion will not be applicable in case "Treatment including USA and Canada" is opted.

ii. Ambulance service can be utilized for transportation within country only and will not be covered for transportation from one country to other country.

iii. In case of claim under Benefit 2 (Medical Treatment Abroad) Section 2.1 Listed Critical Illnesses Treatment, Ambulance Services Availed Abroad as in section 3.2 will not be covered if; these are taken for any Illnesses other than for which we have accepted a claim under Benefit 2 (Medical Treatment Abroad).

Benefit 4. OPD Treatment

We will reimburse the Reasonable and Customary Charges arising from Medical Expenses incurred on OPD Treatment for the Insured Person due to an Illness, Injury or maternity provided below conditions are fulfilled and prescribed by a Medical Practitioner.

a) Our total, cumulative and maximum liability for Cost towards consultation, diagnostic tests and medications prescribed by the Medical Practitioner is restricted up to 80% of admissible bill amounts. The expenses covered would be for the following:
   i. Any prescribed drugs/medicines.
   ii. Home visits by certified Medical Practitioners for consultations and diagnostics.
   iii. Qualified Nurses, including costs for injections and wound dressings.
   iv. Consultation and treatment with physiotherapists for physical therapies aimed at restoring Insured Person's normal physical function as prescribed by Medical Practitioner.

b) We will also cover the Medical Expenses incurred by the Insured Person for Dental Treatment up to 70% of admissible bill amounts towards:
   i. Fillings, root canal treatment, dentures, dental implants, x-ray, tooth extraction.
   ii. Restorative dental procedures including bridges, crowns and dental implants, only if required as part of treatment and not for cosmetic purpose

c) We will also cover the charges incurred by the Insured Person towards the cost of prescribed spectacles and contact lenses up to the Sub-limit specified in the Schedule of Benefits. This Benefit can be availed every alternate Policy Year.

d) We will also cover the charges incurred by the Insured Person towards the cost of hearing aids up to the Sub-limit specified in the Schedule of Benefits. This Benefit can be availed every alternate Policy Year

The specific terms and conditions applicable to this Benefit are:

i. Expenses under (a) to (d) individually or in aggregate cannot exceed the OPD Treatment Expenses Sub-limit specified in the Schedule of Benefits

ii. Only Allopathic treatment will be covered under this Benefit.

iii. This Benefit is available within the geographical territory of India only.

The specific exclusion applicable to this Benefit are:

a) Any expenses for consultation, diagnostics, medications which are not duly supported with medical documents from the Medical Practitioner mentioning:
   (i) Diagnosis;

(ii) Referral/Prescription for diagnostic test;
(iii) Prescription for medications.

b) Any claims under OPD benefits for dental expenses until the expiry of 6 months of continuous coverage after the date of inception of the first policy with Us.
c) Dental expenses incurred for cosmetic purposes like cleaning and scaling.
d) Any nursing expenses which are for rehabilitative care shall be excluded.

Benefit 5. Patient Care

We will pay for the Reasonable and Customary Charges incurred by the Insured Person towards a Qualified Nurse for the Insured Person for a period up to 10 continuous and consecutive days immediately following the Insured Person's discharge from Hospital 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 Period;
c) the treating Medical Practitioner has recommended that the nursing charges are medically necessary.

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only.

The specific exclusions applicable to this Benefit are:

i. We will not be liable to make payment under this benefit in excess of the per day sub-limits specified in the Schedule of Benefits;
ii. We will not be liable to make payment under this benefit for any Insured Person in excess of 30 days during a Policy Year.

Benefit 6. Domiciliary Hospitalization Expenses

We will pay the Reasonable and Customary Charges incurred by the Insured Person up to a maximum of 10% of the Sum Insured (excluding the Cumulative Bonus, if any) for Medical Expenses incurred on the Domiciliary Hospitalization of the Insured Person for an Illness or Injury sustained during a Policy Period provided that the Medically Necessary Treatment is required for a continuous period of at least 3 days.

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only.

The specific exclusions applicable to this Benefit are:

i. Expenses incurred for pre and post Domiciliary Hospitalization;
ii. Expenses incurred by the insured for medical treatment for the below conditions:
    (i) Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis, cough and cold or Influenza;
    (ii) Arthritis, Gout or Rheumatism;
    (iii) Chronic Nephritis or Nephritic Syndrome;
    (iv) Diarrhoea or any type of dysentery, including Gastroenteritis;
    (v) Diabetes Mellitus or Insipidus;
    (vi) Epilepsy;
    (vii) Hypertension;
    (viii) Psychiatric or Psychosomatic disorders of all kinds;
    (ix) Pyrexia of unknown origin

Benefit 7. Pre-hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Pre- hospitalization Medical

Expenses that are incurred by the Insured Person related to any claim admitted under Benefit 1 (Hospitalization Expenses) and Benefit 2.1 (Listed Critical illness treatment), for up to 60 days immediately prior to the date of the Insured Person's admission to Hospital.

The specific terms and conditions applicable to this Benefit are:
a) This Benefit is available within the geographical territory of India only.

Benefit 8. Post-hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Post- hospitalization Medical Expenses that are incurred by the Insured Person related to any claim admitted under Benefit 1 (Hospitalization Expenses) and Benefit 2.1 (Listed Critical illness treatment), for up to 180 days immediately following the Insured Person's discharge from Hospital.

The specific terms and conditions applicable to this Benefit are:
a) This Benefit is available within the geographical territory of India only.

Benefit 9. Maternity Expenses

We will pay the Reasonable and Customary Charges incurred towards Maternity Expenses for the Insured Person's delivery, subject to the following:

a) If You and Your Spouse are covered under the policy this Benefit will be applicable provided that We have received at least 3 continuous annual premiums under the Policy in respect of You and Your Dependent Spouse and provided that at least 24 months of continuous coverage has elapsed from the inception of the first Policy with Us.
b) If only You are covered and your spouse is not covered under the policy, this Benefit will be applicable provided that We have received at least 4 continuous annual premiums under the Policy in respect of You and provided that at least 36 months of continuous coverage have elapsed from the inception of the first 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) We will cover Reasonable and Customary Charges incurred by the Insured Person for Pre- Natal Medical Expenses incurred on Hospitalization for a period of 90 days immediately prior to the date of delivery, and the Reasonable and Customary Charges incurred by the Insured Person for Post-Natal Medical Expenses incurred on Hospitalization for up to a period of 45 days immediately following the date of delivery. The charges covered under this clause are restricted up to the sub limit specified against this Benefit in the Schedule of Benefits.
e) We will also cover the Medical Expenses incurred towards miscarriage and lawful medical termination of pregnancy.

The specific terms and conditions applicable to this Benefit are:
a) This Benefit is available within the geographical territory of India only.

The specific exclusions applicable to this Benefit are:
a) Any expenses related to Ectopic Pregnancy (abdominal operation for extra uterine pregnancy), which is proved by submission of Ultra Sonographic Report. Such claim would be considered a claim made under Benefit 1 (Hospitalization Expenses).

Benefit 10. Organ Donor Expenses

We will pay the Medical Expenses covered under Benefit 1 (Hospitalization Expenses) incurred by the Insured Person during the Policy Year for an organ donor's treatment for the harvesting of the donated organ where the Insured Person is the recipient, 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 (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable laws and/or regulations
b) We have accepted claim under Benefit 1 (Hospitalization Expenses) in respect of the Insured Person and the Insured Person has been advised by a Medical Practitioner to undergo the organ transplant;

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only.

The specific exclusions applicable to this Benefit are:

i. 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 to the harvesting;
ii. Costs directly or indirectly associated with the acquisition of the donor's organ
iii. Organ donor expenses shall not be covered under Benefit 2 (Medical Treatment Abroad).

Benefit 11. Day Care Treatment Expenses

We will pay the Reasonable and Customary Charges up to the sub-Limit specified in the Schedule of Benefits towards Medically Necessary Treatment incurred by the Insured Person towards Day Care Treatments following an Illness or Injury that occurs during the Policy Period as specified in the list of Day Care Treatments at Annexure II of the Policy.

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only, except to the extent as mentioned under Benefit 2.1(Listed Critical Illness Treatment).

Benefit 12. Accidental Hospitalization

We will increase the Sum Insured by 25% of the available balance of the Sum Insured (excluding the Cumulative Bonus, if any) in the event that the Insured Person is Hospitalized during the Policy Year solely and directly due to an Accident which occurred during the Policy Year provided that such increase of the Sum Insured will not exceed Rs.10,00,000.

The specific terms and conditions applicable to this Benefit are:

a) We have accepted claim under Benefit 1 (Hospitalization Expenses) in respect of the Insured Person.
b) This Benefit is available within the geographical territory of India only.

Benefit 13. Accompanying Person

We will pay the fixed amount specified in the Schedule of Benefits for each continuous and completed period of 24 hours of the Insured Person's Hospitalization in any Policy Year, up to a maximum of 30 days, towards the Accompanying Person of the Insured Person provided that the Insured Person is a Child who is less than 12 years of age and is undergoing Medically Necessary Treatment in a Hospital due to

an Injury or Illness that occurred during the Policy Period.

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only.

Benefit 14. Repatriation of mortal remains

In the event of death of the Insured Person, We shall reimburse the Policyholder or his/her nominee on reimbursement basis, up to sub-limit specified in the Schedule of Benefits, for the costs incurred towards repatriation of the mortal remains of the Insured Person back to the place of his/her residence in India; or for a local burial/ cremation at the place where the death has occurred.

The specific terms and conditions applicable to this Benefit are: This Benefit is available worldwide excluding USA and Canada. However, the exclusion for USA and Canada will not be applicable in case Benefit 25 (Treatment including USA and Canada) is opted.

Benefit 15. Child Vaccination Benefits

We will pay the Reasonable and Customary Charges incurred by the Insured Person for vaccinations of the Insured Person up to the per annum sub-limit specified in the Schedule of Benefits provided that the Insured Person is a Child who is up to 12 years of age.

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only.

Benefit 16. Newborn Baby Expenses

If We have accepted a claim under Benefit 9 (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 incurred towards the Medically Necessary Treatment of the Insured Person's Newborn Baby while the Insured Person is Hospitalized for delivery and We will cover the Newborn Baby until the expiry date of the Policy Year in which the Newborn Baby is born, up to the Sum Insured as applicable for the Insured Person (mother) without any additional premium.
b) Benefit 19 (Restoration on Sum Insured) is not applicable for this cover.
c) Costs incurred for vaccination of the Newborn Baby up to the specified sub-limit under the Schedule of Benefits for vaccinations, until the Newborn Baby completes one year of age. In the event that the Policy expires before the Newborn Baby has completed one year, then, We will cover such costs incurred for vaccinations until the Newborn Baby completes one year, provided that We have accepted the Newborn Baby as an Insured Person at the time of Renewal of the Policy and We have received the premium in full accordingly.

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only.
b) We have accepted claim under Benefit 9 (Maternity Expenses) in respect of the Insured Person
c) This cover will also be subject to applicability of all the waiting periods and exclusions under this Policy.
d) 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 years.

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

a) In the event that the Insured Person contracts an Illness or suffers an Injury during the Policy Period in respect of a claim which has been admitted under Benefit 1 (Hospitalization 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:

(i) It is entirely the sole and absolute decision of the Insured Person to obtain an e-opinion from a Medical Practitioner from Our panel and the use (if any) to which such e-opinion so obtained is put.

(ii) We do not provide an e-opinion or make any representation as to the adequacy or accuracy of any advice provided by such Medical Practitioner.

(iii) The e-opinion provided is not valid for any medico legal purposes.

(iv) 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 from 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.

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only.

Benefit 18. Alternative Treatment

[2]We will pay the Medical Expenses, up to the Sum Insured, incurred with respect to the Insured Person for Hospitalization under Alternative Treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha or Homeopathy at an AYUSH Hospital during the Policy Period.

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only.

The specific Exclusions applicable to this Benefit are:

a) All preventive and rejuvenation treatments (non-curative in nature) including without limitation that are not Medically Necessary Treatments.

b) [3]OPD Treatment Expenses

Benefit 19. Restoration of the Sum Insured

If the Sum Insured and Cumulative Bonus (if any) is exhausted due to claims incurred and paid during the Policy Year or incurred during the Policy Year and accepted as payable, then it is agreed that a Restore Sum Insured (equal to 100% of the base Sum Insured) will be automatically available for the particular Policy Year, provided that:

a) The Restore Sum Insured will be enforceable only after the Sum Insured and the Cumulative Bonus have been completely exhausted in that Policy Year.

b) The Restore Sum Insured can only be used for claims made by the Insured Person in respect of Benefit 1 (Hospitalization Expenses), Benefit 2 (Medical Treatment Abroad), Benefit 7 (Pre-hospitalization Medical Expenses), Benefit 8

[2] Benefit 18. Alternative Treatment is modified to extend the cover "up to the Sum Insured"

[3] Specific exclusions b) is modified to extend the scope of benefit to cover Pre-Hospitalization, Post-Hospitalization, and AYUSH Day Care Treatments

(Post-hospitalization Medical Expenses) and Benefit 11 (Day Care Treatment Expenses).

c) The Restore Sum Insured cannot be used for claims based on Maternity Expenses/Treatment.
d) The Restore Sum Insured can be used only for future claims made by the Insured Person in the current Policy Year. The Restore Sum Insured cannot be used against same/related claim for an Illness (including its complications) for which a claim has been paid/payable in the current/previous Policy Years under Benefit 1 (Hospitalization Expenses), Benefit 2 (Medical Treatment Abroad) and Benefit 11 (Day Care Treatment Expenses).
e) Only the Sum Insured (excluding Cumulative Bonus) will be considered as Restore Sum Insured.
f) The Restoration of Sum Insured will happen only once during a Policy year.
g) If the Policy is issued on Individual basis, then the Restoration will be available to each Insured Person.
h) If the Policy is issued on Floater basis, then the Restoration sum insured will be available on Floater basis for all Insured Persons covered in the Policy.
i) If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

Benefit 20. Prosthetic Devices

We will pay the Reasonable and Customary Charges incurred by the Insured Person towards installation of an external prosthetics required due to injury caused directly and solely by an accident during the policy period.

The specific terms and conditions applicable to this Benefit are:

a) For the purpose of this Benefit, external prosthetic means an artificial body part. Only the following external prosthesis will be covered under this benefit: -
   i. Transradial prosthesis: It is an artificial prosthesis limb which replaces the missing arm from under the elbow with an artificial limb.
   ii. Transhumeral prosthesis: It is the artificial prosthesis limb that replaces the missing arm above the elbow.
   iii. Transtibial prosthesis: It is the artificial prosthesis limb which replaces a missing leg, right below the knees.
   iv. Transfemoral prosthesis: It is the artificial prosthesis limb which replaces the missing leg above the knees.
   v. Facial prosthesis- It is the artificial replacement of Ear, Nose, Eyes. This prosthesis will be covered only when medically required and not for cosmetic purposes.
b) This Benefit is available within the geographical territory of India only.

The specific Exclusion applicable to this Benefit are:

a) Expenses incurred for any replacement prosthetic devices for insured including any replacement devices required in relation to a pre-existing condition.
b) Expenses incurred towards the procedure for replacement of prosthetic devices for which the claim has already been paid under this benefit.
c) Expenses incurred towards any external prosthetic devices required during surgical procedures apart from any accidental injury during the policy year.

Benefit 21. Bariatric Surgery

We will pay the Reasonable and Customary Charges incurred by the Insured Person maximum up to the limit specified under Schedule of benefits towards medical expenses incurred related to the Insured Person's Surgical Procedure for obesity,

subject to below conditions:

1) Surgery is conducted upon the written advice of the Medical Practitioner.
2) The Surgery/Surgical Procedure conducted should be supported by clinical protocols.
3) The Insured Person has to be 18 years of age or older and have a Body Mass Index (BMI) which is;
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

The specific terms and conditions applicable to this Benefit are:

a) This Benefit is available within the geographical territory of India only.

B. Renewal Cover

The additional Benefits available under the Policy are listed below and shall be available to all Insured Persons upon Renewal, with no additional premium payable, in accordance with the procedures set out in this Policy.

Benefit 22. Cumulative Bonus

Cumulative Bonus will be increased by 10% in respect of each claim free policy year (where no claims are reported) with the exception of any claim under Benefit 4 (OPD benefit) and Benefit 23 (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:

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

vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
viii. If a claim is made in the expiring Policy Year and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

C. Value Added Cover

Benefit 23. Wellness Benefits

The Insured Person will be eligible for "Wellness Benefits" 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 providers or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

I. Value Added Services

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

a. Tele counselling - Under this benefit Insured Person 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 through GCI mobile App.
b. Health Contents - Under this benefit Insured Person will have access to articles, blogs which provide information on Physical and Mental wellness related topics.
c. 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.
d. 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 lifestyle, diagnostics, medicines etc. The voucher details will be displayed on the GCI mobile App.
e. Health checkup
Insured Person will be eligible for "Health checkup" 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 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:

Tests
Complete Blood Count (CBC) , Glycosylated Hemoglobin(HbA1C), Electrocardiogram (ECG reported by an MD Physician), 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), Thyroid function (T3,T4,TSH), Calcium, Uric Acid, Vitamin D, Total Protein, Pulmonary Function Test, USG (Abdomen)

II. 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

- Age Eligibility - Everyone from 18 years onwards is eligible for earning wellness points.
- 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.
- Conditions for earning Reward Points wherever offered, will be the same for all the Insured Persons

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.	Enrolment to Wellness	Once/year	15
6.	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
	Total points		200

The points earned in a year will be equal to certain percentage of the applicable insured premium 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 Sum Insured policy

Family Type	2 Adult+1 child		
Policy period	01-Jan-2021 to 31 Dec 2021		
Relation	Self	Spouse/Live-in partner	Child
Sum insured	2 crores	2 crores	1 crore
Age Band	26-30	31-35	0-17
Individual premium	97,246	109,955	91,902
Family discounted premium	87,521	98,960	82,712
Points Earned	200	180	NA
% value of points earned	5%	4%	0%

Date	Self			Spouse/Live-in partner			Total		
	Points earned as on date	% value of points earned	Monetary value (Rs.)	Points earned as on date	% value of points earned	Monetary value (Rs.)	Monetary value (Rs.)	Balance available for utilization (in Rs.)	Burn/ Utilised on date (OPD/ Pharmacy/ NME) (in Rs.)
21-03-21	40	2%	1,750	30	2%	1,979	3,730		1,000
31-08-21	100	3%	2,626	60	2%	1,979	4,605	3,605	800
15-10-21	170	4%	3,501	150	4%	3,958	7,459	5,659	
31-12-21	200	5%	4,376	180	4%	3,958	8,334	6,534	

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

Relation	Self	Spouse/Live-in partner	Child	
Sum insured	2 crores			
Age Band	26-30	31-35	0-17	Premium total of eligible members
Floater Discounted premium	48,623	109,955	36,761	158,578
Points Earned	200	180	NA	Average of Points
				190
% value of points earned				5%
Monetary value of reward points				7,929

Date	Self	Spouse/Live-in partner				Balance available	Burn/

	Points earned as on date	Points earned as on date	Average of points earned	% value of points earned	Monetary value (Rs.)	for utilization (in Rs.)	Utilised (OPD/ Pharmacy/ NME) (in Rs.)
21-03-21	40	30	35	2%	3,172		1,000
31-08-21	100	60	80	2%	3,172	2,172	
15-10-21	170	150	160	4%	6,343	5,343	500
31-12-21	200	180	190	5%	7,929	6,429	Applied as renewal 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**
   The Insured Person has an option to take a telephonic Expert Wellness Assessment, with a registered psychologist through his/her account on GCI mobile App. This will help the Insured Person to understand his/ her mental health. 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 as a value-add services under Benefit 23 I.e. Points will be allotted basis the below parameters falling within normal limits.

	Condition	Health parameters	Points Allotted
1	HTN	Blood pressure Systolic Up to 140/ Diastolic up to 90 mm Hg	10
2	DM	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 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.
   - Daily Step tracking (monthly average of 10000 steps/day). The step count can be tracked either through our GCI mobile App. or Insured Person can sync his/her fitness device with our App.
   - Participation in Marathon, Cyclathon etc.- Insured can upload the completion certificate of the event

on the GCI mobile App.

- 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 Person can sync his/her fitness device with our App.
- Submission of monthly Gym /yoga membership detail - Insured can upload the monthly membership receipts on the GCI mobile App.

Wellness points will be allotted basis the activity details submitted by the insured at the end of every 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 Benefit 1 (Hospitalization 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

D. Optional Covers

Optional Covers are available on payment of additional premium, the details of optional covers are mentioned below:

Benefit 24. Co-pay waiver for Benefit 2 (Medical treatment Abroad)

The Insured Person will have an option to waive the co-payments applicable under Benefit 2 (Medical treatment abroad) at inception or at subsequent renewals. The waiver of co- payment will be applicable at the policy level for all Insured Persons covered under the policy irrespective of individual or floater sum insured options. Once opted there will be a lock-in period of 3 years during which the insured cannot opt out of the Co-pay waiver option.

Benefit 25. Treatment including USA and Canada

The Insured Person will have an option to extend the scope of Benefit 2 (Medical Treatment Abroad), Benefit 3 (Emergency Ambulance Expenses) and Benefit 14 (Repatriation of mortal remains) to include USA and Canada as well at inception or at subsequent renewals. The option to include USA and Canada cover will be applicable at the policy level for all Insured Persons covered under the policy irrespective of individual or floater sum insured options. Once opted there will be a lock-in period of 3 years during which the Insured Person cannot opt out of this option.

IV. Exclusions

Exclusions (applicable for all Benefits other than Benefit 4 (OPD Treatment))

A. 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 (other than for a claim made under Benefit 4 (OPD Treatment):

a) Pre-Existing Disease- Excl 01

i. 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.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. 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.
iv. 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.

b) Specified disease/procedure waiting period- Code- Excl02

i. 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.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. 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.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. 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.
vi. List of specific diseases/procedures:

I. **Waiting period of 36 months**:
   a) Rheumatoid Arthritis
   b) Gout
   c) Joint replacement Surgery due to degenerative condition
   d) Age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is Medically Necessary due to Injury.

II. **Waiting period of 24 months**:
   a) Cataract
   b) Benign Prostatic Hypertrophy
   c) Hernia of all types
   d) Deviated Nasal Septum
   e) Hypertrophied Turbinate
   f) Hydrocele
   g) All types of nasal and para nasal sinus related disorders
   h) Fistulae, hemorrhoids, fissure-in-ano
   i) Dysfunctional uterine bleeding, Fibromyoma, Endometriosis, Hysterectomy,
   j) All internal or external tumors/cysts/nodules/polyps of any kind including breast lumps with exception of malignant tumor or growth
   k) Surgery for prolapsed inter vertebral disc unless arising from Accident
   l) Surgery of varicose veins and varicose ulcers
   m) Any types of gastric or duodenal ulcers
   n) Stones in the urinary and biliary systems
   o) Surgery on ears and tonsils.
   p) Genetic Disorders

c) 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.

B. Standard Exclusions

1. Exclusions applicable for all Benefits

We will not pay for any claims made under the Policy in respect of the Insured Person, caused by, arising out of or howsoever related to any of the following:

a) Investigation & Evaluation- Code- Excl04

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

Please note that this exclusion will not be applicable for Benefit 4 (OPD Treatment).

b) Rest Cure, rehabilitation and respite care- Code- Excl05

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

c) Obesity/ Weight Control: Code- Excl06

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

d) 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.

e) Cosmetic or Plastic Surgery: Code- Excl08

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

f) 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.

g) 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.

h) Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by 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.

i) Code- Excl12

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

j) Code- Excl13

Treatments received in heath hydros, nature cure clinics, spas or similar establishments

or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

k) 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 procedures.

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

m) 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.

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

C. Specific Exclusions
In addition to the foregoing general exclusions, We will not pay for any expenses incurred in respect of any claims made under the Policy in respect of the Insured Person, caused by, arising out of or howsoever related to any of the following:
a) 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).
b) Circumcision, unless necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an Accident.
c) Vaccination/inoculation (except as post bite treatment) except to the extent covered under Benefit 15 (Child Vaccination Benefits) and Benefit 16 (Newborn Baby).
d) Charges incurred in connection with cost of 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, 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.
e) Venereal /Sexually Transmitted disease other than HIV/AIDS.
f) External Congenital Anomaly and related illness/ defect.
g) Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.
h) Stem cell storage.
i) Non-prescribed drugs and medical supplies, hormone replacement therapy.
j) Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
k) Outpatient diagnostic, medical and Surgical Procedures or treatments. However, this exclusion will not be applicable to the extent of coverage mentioned under Benefit 4 (OPD Treatment)
l) Dental Treatment or Surgery of any kind unless requiring Hospitalization as a result of Injury.

However, this exclusion will not be applicable to the extent of coverage mentioned under Benefit 4 (OPD Treatment).

m) A Medical Practitioner's home visit charges during pre and post Hospitalization period and attendant nursing charges, except to the extent covered under Benefit 4 (OPD Treatment) and 5 (Patient Care).
n) Intentional self-Injury.
o) Standard list of excluded items as mentioned in Annexure III and on our website https://generalicentralinsurance.com
p) Any specific exclusion(s) applied by Us, specified in the Schedule and accepted by the Insured Person.
q) Treatment outside India except as specified under Benefit 2 (Medical Treatment Abroad), Benefit 3 (Emergency Ambulance Expenses) and Benefit 14 (Repatriation of mortal remains)

V. Loadings and Discounts under the Policy

i. **Single Payment Discount for Long Term Policies** – If the policyholder pays premium in single installment for multi-year policies, 7.5% discount is applicable for 2-year policies and 10% discount for 3-year policies.
ii. **Family discount –** 10 % discount is applicable in case of policies with more than 1 member covered under single proposal with Individual sum insured option.
iii. **Loading for Co-pay Waiver Cover:** This product also offers an optional cover where the insured can opt to remove the mandatory co-payment of 20% which is applicable in the benefit "Medical treatment abroad". If the insured opts for the same, the percentage loadings as mentioned in the table given in Annexure 1 by Age and Sum Insured will be applied.
(Note: The option to select for Co-Pay Waiver will be applicable at the policy level for both individual and floater sum insured policies. Once opted there will be a lock-in period of 3 years)
iv. **Loading for Treatment including USA and Canada** – If an Insured opts for "Treatment including USA and Canada" cover, then the loading as mentioned in the table given in Annexure 1 by age and sum insured shall be applicable on the premium payable by the Insured Person.
(Note: The option to select for "Treatment including USA and Canada" cover will be applicable at the policy level for both individual and floater sum insured policies. Once opted there will be a lock-in period of 3 years).
v. **Loading on claims experience** – There will be no loading on premium for adverse claims experience.
vi. **Family Floater Discount-** As per table given in Annexure I.
vii. **Employee discount –** 7.5% discount in case the insured is an employee of the company.
viii. **Website discount –** 7.5% discount in case the proposal comes through websales.

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

VI. General Terms and Clauses

1) Standard General Terms and Clauses

1. Disclosure to Information Norm
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability
The terms and conditions of the policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the policy.

3. **Free Look Period**

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

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

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

4. **Complete Discharge**

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

5. **Multiple Policies**

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

6. **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.

7. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

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.

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.

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.

11. Redressal of Grievance

In case of any grievance the Insured Person may contact the company through
Website: https://generalicentralinsurance.comToll Free: 1800-220-233 / 1860-500-3333 / 022-67837800
Email: GCIcare@generalicentral.com
Courier: Grievance Redressal Cell, Generali Central Insurance Company Limited
Lodha I –Think Techno Campus, B Wing –2nd Floor, Pokhran Road –2, Off Eastern Express Highway Behind TCS, Thane West – 400607

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at GCIGRO@generalicentral.com or call at: 7900197777

For updated details of grievance officer, kindly refer the link
https://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/

2) Specific General Terms and Clauses

(A) Condition Precedent to the contract

1. Migration

i. The Insured Person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company; the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

ii. Migration Benefit is applicable for all the benefits under this policy except Benefit 2 (Medical Treatment Abroad) and Benefit 9 (Maternity Expenses)

iii. In case the Insured Person is migrating from a similar Policy with Us, the Migration guidelines 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.

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

2. Portability

i. 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.

ii. Portability is applicable for all waiting periods under this policy except Benefit 2 (Medical Treatment Abroad) and Benefit 9 (Maternity Expenses).

iii. 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.

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

(B) Conditions applicable during the contract

3. Due Care

Where this Policy requires You to do or not to do something, then the complete satisfaction of that requirement by You or someone claiming on Your behalf is a precondition to any obligation under this Policy. If You or someone claiming on Your behalf fails to completely satisfy that requirement, then We may refuse to consider Your claim. You will cooperate with Us at all times.

4. Insured Persons

The following persons shall be eligible to be Insured Persons under the Policy:

- Family can include Self, Spouse/ Live-in partner, Children, Parents, Parents in law, Dependent Siblings, Daughter in law, Son in law, Grandparents and Grandchildren.
- Maximum of 15 members can be covered under one policy on either individual or floater Sum insured basis.

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 Benefit 16 (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.

5. Cost of Pre-Insurance Medical Examination

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

6. 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.

7. Policy Period

The Policy Period offered under this product is One year, Two years and Three years.

8. Territorial Limits and Law

a) Except as provided in Benefit 2 (Medical Treatment Abroad), Benefit 3 (Emergency Ambulance Expenses) and Benefit 14 (Repatriation of Mortal Remains), 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.

9. Cancellation

a) The policyholder may cancel this policy by giving 7 days written notice.

b) In case the Policyholder requests for cancellation of the Policy, where no claims are reported under the Policy, the Company shall refund premium for the unexpired policy/ instalment period as detailed below:

i. **Single Premium Payment (1/2/3 years Policy Term)** – There shall be refund of proportionate premium for the unexpired policy period on 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.

10. Premium Payment in installments

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or 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)

i. Grace Period of 15 days would be given to pay in case of monthly instalment premium and grace period of 30 days shall be given to pay in case of quarterly / Half Yearly installment premiums, due for the policy.

ii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the

stipulated grace period.

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

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

v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vi. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy

vii. The payment will be accepted through ENACH / ACH/ ECS / any other mode approved by Government of India.

viii. 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

ix. 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.

x. In case there is failure in transaction in E-NACH / ACH/ ECS / 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.

xi. If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered.

(C) Condition when a claim arises

1. Claims Procedures

If the Insured Person suffers 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:

(i) For availing cashless at a Network Provider, 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.

(ii) 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.

(iii) Where 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 submitted to the Network Provider. Pre-authorisation does not guarantee that all costs and expenses incurred by the Insured Person will be covered. We reserve the right to review such 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 of the Cashless Facility, then:

(i) We must be given Notification of Claim in writing immediately and in any event within 48 hours of the diagnosis of/sustaining the Illness or Injury. The Insured Person must

immediately consult a Medical Practitioner and follow the Medical advice and treatment that he/she recommends.

(ii) 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.

(iii) The Insured Person must submit to examination by Our medical advisors should We so require, the cost for which will be borne by Us.

(iv) 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.

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:

a. The claim form specified by Us duly completed and signed by the claimant or a family member;
b. First consultation letter;
c. First prescription from the Medical Practitioner;
d. Original vouchers;
e. Original Hospital bills giving a detailed break up of all expense heads mentioned in the bill;
f. Original Money receipt duly signed with a revenue stamp;
g. Birth/Death certificate (as applicable);
h. The original Hospital discharge card;
i. All original laboratory and diagnostic test reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram, etc.;
j. 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;
k. 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.
l. Copy of proposer photo ID proof & address proof
m. NEFT Form with photocopy of cancelled cheque with printed name of proposer
n. Copy of Operation Theatre Notes, if applicable
o. Copy of the Claim Intimation, if any
p. In the event of Your/Insured Person's death, You /Insured Person's nominee/legal heir claiming on his/her behalf must inform Us in writing immediately and send Us a copy of the postmortem report (if any).
q. For:
    a. Maternity claims - Discharge Summary mentioning LMP, EDD & Gravida
    b. Cataract claims -IOL sticker
r. Copies of health insurance policies held with any other insurer covering the insured persons.
s. 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.
t. For domiciliary hospitalization claims, a certificate from the attending doctor confirming that the condition of the patient is such that he/she is not in a condition to be removed to a hospital.

u. Additional documents for Benefit 2 (Medical Treatment Abroad) – Insured Person Passport, Visa, Tickets and Boarding Passes.
v. Additional Documents to be submitted for any Claim under 'Air Ambulance Cover' which is a part of Benefit 3 (Emergency Ambulance Expenses):
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:
a) 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.
b) Original Bills for expenses incurred towards availing Air Ambulance services.
w. Additional Documents to be submitted for any Claim under Benefit 14(Repatriation of the mortal remains).
It is a condition precedent to Our liability under this benefit that the following information and documents shall be submitted to Us or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the claim under this Benefit:
a. Copy of the death certificate providing details of the place, date, time, and the circumstances and cause of death;
b. Copy of the postmortem certificate, if conducted;
c. Documentary proof for expenses incurred towards disposal of the mortal remains;
d. In case of transportation of the body of the deceased to the Place of Residence, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased.

c) In the event of Your/Insured Person's death, You/Insured Person's nominee/legal heir claiming on his/her behalf must inform Us in writing immediately and send Us a copy of the postmortem report (if any).
d) If 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.

2. Further Claims Procedure requirements for Benefit 2 (Medical Treatment Abroad)

1) Process for cashless facility on International Medical Treatment through pre-authorization by Us shall be subject to the following;
(i) In the event of the diagnosis, the Insured Person should call Us or Our Assistance Service Provider in any event before the commencement of the travel for treatment overseas, request for pre-authorisation of treatment by way of written form prescribed by Us, at least 15 days prior to planned date to admission for treatment of listed critical illnesses.
(ii) We or Our Assistance Service provider will evaluate the request and the eligibility of the Insured Person and call for more information or details, if required.
(iii) In case the Hospital consents to consider cashless facility, We or Our Assistance Service provider will communicate directly to the Hospital and the Insured Person whether the request for pre-authorization has been approved or denied.
(iv) Where the pre-authorization request is approved, We or Our Assistance Service provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by Us or Our Assistance Service provider shall be borne by the Insured Person.
(v) If such pre-authorisation request is denied, We shall not be liable for the claim under the Policy for such Benefit. However, Our liability under such claim in respect of any

other section under this Policy, will continue irrespective of denial of pre-authorization under this section.

(vi) Pre-authorization shall not be mandatory only in case the Insured Person has a Life-Threatening Medical Condition and is admitted under Benefit 2 (Medical Treatment Abroad), Section 2.2 Emergency Treatment and the Insured Person (or his representatives) arranges for the treatment at their own expense, then We will reimburse such costs incurred in accordance with the terms of Benefit 2 (Medical Treatment Abroad)..

3. Basis of Claims Payment

a) Claims related to Pre-existing Diseases:
We shall indemnify up to 50% of the sum insured in respect of a claim arising from any Pre-existing Diseases that are specifically listed in the Schedule where the claim arises during the third year of continuous Renewal of the Policy with Us for the same Sum Insured and benefits in force under the Policy. We shall indemnify up to 100% of the sum insured in respect of a claim arising from any Pre-existing Diseases that are specifically listed in the Schedule from the fourth year of continuous Renewal of the Policy with Us for the same Sum Insured. The above clause is applied subject to portability regulations.

b) Claims related to Surgery for cataracts: Our obligation to make payment in respect of Surgery for cataracts (after the expiry of the two years waiting period, shall be restricted to a maximum of Rs.1,00,000/- per eye.

c) Claims Related to listed Mental Healthcare/ Psychiatric illness treatment: Our obligation to make payment for Medical expenses incurred by the Insured Person with respect to below listed Mental/ Psychiatric conditions be restricted either up to the sum insured, or maximum of Rs. 1,00,00,000, which ever lower

a) F01 Vascular dementia
b) F20 Schizophrenia
c) F30 Manic episode
d) F31 Bipolar affective disorder
e) F32-33 Depressive disorders
f) F41 Other anxiety disorders
g) F50 Eating disorders
h) F60 Specific personality disorders
i) F84 Pervasive developmental disorders
j) F40.9 Phobic anxiety disorder, unspecified
k) F05 Delirium, not induced by alcohol and other psychoactive substances

d) Claims related to Any One Illness: All claims relating to Any One Illness shall be deemed to be part of the same original claim.

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

f) The payment of any claim under Benefit 2 (Medical Treatment Abroad), Benefit 3 (Emergency Ambulance Expenses) and Benefit 14 (Repatriation of Mortal Remains) will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

4. Co-Payments Applicable under the Policy

The following Co-payment shall be applicable for claims under all Benefits other than Benefit 4 (OPD Treatment):

a) Any Insured Person aged 61 years to 65 years, being covered for the first time in this policy

shall bear 20% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum. There is no option to waive off this co-payment. This co-payment will be applicable for all subsequent renewal policies.

b) All claims admitted under "Medical Treatment Abroad" Benefit will be subject to 20% Co-payment. The Insured has an option to waive off this co-payment on payment of additional premium under Co-pay waiver "optional Cover.

5. Policy Currency

We shall make payment in Indian rupees and in India only except under Benefit 2 (Medical Treatment Abroad), Benefit 3 (Emergency Ambulance Expenses) and Benefit 14 (Repatriation of Mortal Remains).

6. 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.

7. Claim settlement (provisions on Penal Interest)

i. Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified in Section VI.2. C.1.
ii. 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.
iii. 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.
iv. 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.
v. 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.
vi. In case of 'pending' claims, We will ask for submission of incomplete documents
vii. 'Rejected' claims will be informed to the Insured Person in writing with reason for rejection.

8. Other terms on Renewal

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
v. Coverage is not available during the grace period.
vi. No loading shall apply on renewals based on individual claims experience.
vii. For Renewal proposal received after completion of Grace Period of 30 days, all Waiting Periods, would apply afresh.
viii. This Policy shall be renewable lifelong provided the Insured Persons continue to be Indian Nationals and resident of India at subsequent renewals of this plan.
ix. The policy would be issued based on the insured declaration of nationality and Indian

resident status while taking this policy. If there is change in this status, then insured is required to inform us in writing at renewal.

x. 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.

xi. No increase/ decrease in Sum Insured 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

xii. In case of enhancement of Sum Insured the Waiting Period shall apply afresh to the extent of sum insured increase.

9. Endorsements (Changes in Policy)

i. 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.

ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

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

VII. Schedule of Benefits

Sum Insured Range	Rs. 75L, 1 Cr to 6Cr in multiples of Rs.50L

S. No.	Product Features	Included in base SI or Additional SI	Coverage / Limits
	Section A: Hospitalization Covers		
1	Hospitalization Expenses	In Base Sum Insured	Up to Sum Insured
2	Medical Treatment Abroad (Excluding USA and Canada)	In Base Sum Insured	**Listed Critical Illnesses Treatment** 1. Return Airfare (Once per policy year) Covered Up to Rs 3,00,000; 2. Covered Up to 50% of Sum Insured in 1st Policy year, 100% thereafter; 3. All claims subject to 20% Co-Payment;
			Emergency Treatments 1. All Claims Subject to 20% Co-Payment; 2. Up to 100% of Sum Insured from 1st Policy year for Emergency Purposes,
3	Emergency Ambulance Expenses (Within India and outside India)	In Base Sum Insured	1. Up to Rs 50,000 for Road ambulance 2. Up to Rs 5,00,000 for Air ambulance
4	OPD Treatment	In Base Sum Insured	Up to Rs. 50,000 per policy per year irrespective of Individual or Floater Sum insured.
A	Consultation, diagnostic tests and medications		80% of bills
B	Dental treatment		70% of bills; 6 months waiting period
C	Hearing and Optical Aid		1. Optical Aid covered up to Rs. 6,500 2. Hearing Aid covered up to 30% of OPD benefit sub-limit 3. Claim can be made every alternate policy year.
D	Home Visit Cover		80% of bills
E	Qualified Nurses		80% of bills
F	Physiotherapists		80% of bills
5	Patient Care	In Base Sum Insured	1. Up to Rs 1000/ Day, 2. Up to 10 Days after discharge (Limited to a maximum of 30 Days per policy year)
6	Domiciliary Hospitalization Expenses	In Base Sum Insured	Up to 10% of SI only If treatment for more than 3 days.
7	Claims Related to listed Mental Healthcare/ Psychiatric illness treatment Cover	In Base Sum Insured	1. For Sum Insured 75 L –up to Sum Insured 2. For Sum Insured 1 Cr and above – Maximum up to Rs. 1 Cr.
8	Pre-Hospitalization Medical Expenses	In Base Sum Insured	60 Days
9	Post-Hospitalization	In Base	180 Days

S. No.	Product Features	Included in base SI or Additional SI	Coverage / Limits
	Medical Expenses	Sum Insured	
10	Maternity Expenses (24/36 months waiting)	In Base Sum Insured	1. Normal Delivery + Pre Natal + Post Natal expenses- Up to Rs. 1,00,000 2. Caesarean Delivery+ Pre Natal+ Post Natal expenses- Up to Rs. 2,00,000
A	Pre- natal Medical Expenses		90 Days (Up to limit mentioned for maternity expenses benefit)
B	Post-natal Medical Expenses		45 Days (Up to limit mentioned for maternity expenses benefit))
11	Organ Donor Expenses	In Base Sum Insured	Up to Sum Insured
12	Day Care Treatment expenses	In Base Sum Insured	Up to Sum Insured
13	Accompanying Person	In Base Sum Insured	Up to Rs. 500 per day; Maximum of 30 days per policy year
14	Repatriation of mortal remains	In Base Sum Insured	Up to Rs 1,00,000
15	Child Vaccination Benefits	In Base Sum Insured	Up to Rs 10,000 (Age Up to 12 yrs.)
16	Newborn Baby Expenses	In Base Sum Insured	Up to Sum Insured Vaccination Benefit - Up to Rs 10,000
17	E-Opinion in respect of an Illness or Injury	In Base Sum Insured	2 per policy year
18	Alternative Treatment	In Base Sum Insured	Up to sum insured,
19	Prosthetic Devices	In Base Sum Insured	Up to Rs 10,00,000
20	Cataract *(24 months waiting period)*	In Base Sum Insured	Up to Rs 1,00,000 per eye
21	HIV	In Base Sum Insured	Up to Sum Insured
22	Bariatric Surgery	In Base Sum Insured	Up to Rs 10,00,000
23	Accidental Hospitalization	Additional Sum	Increase by 25% Of Available Balance Sum Insured Up To Rs 10,00,000 (Excluding Cumulative Bonus)

S. No.	Product Features	Included in base SI or Additional SI	Coverage / Limits
		Insured	
24	Restoration of the Sum Insured	Additional Sum Insured	Up to 100% Of Base Sum Insured, Applicable to all the subsequent claims in the current policy year but for different/unrelated illness only
Section B: Renewal Benefit			
1	Cumulative Bonus	Additional Sum Insured	1. 10% of the base Sum Insured in the Current Policy Year. 2. Limited to a maximum of 100% of the base Sum Insured in the Current Policy Year.
Section C: Value Added Cover			
1	Wellness Benefits	Additional Sum Insured maximum up to 5% of Premium.	Value added services and Wellness Reward points
A	Value Added Services		Insured is eligible for following benefits as in the policy wordings: • Tele Counselling • Health Contents • Webinars • Vouchers (Fitness / Sports Memberships, Wellness centers, diagnostic centers) • Health checkups
B	Wellness Reward Points		Under this benefit, Insured will be eligible for earning of Reward Points by performing an array of wellness activities as listed in the policy wordings. These reward points can be used as per conditions in the policy wordings.
Section D: Optional Covers			
1	Co-pay waiver	-	Under this optional cover, the Insured will have an option to waive the mandatory Co-payment applicable under Benefit 2(Medical treatment Abroad).
2	Treatment including USA and Canada	-	Under this optional cover, the Insured will have an option to extend the scope of Benefit 2 (Medical Treatment Abroad), Benefit 3 (Emergency Ambulance Expenses) and Benefit 14 (Repatriation of Mortal Remains) to include USA and Canada.
Section E: Waiting Periods			
1	General waiting period	-	30 days
2	Specified disease/procedure waiting period	-	6/24/36 months
3	Pre Existing Disease waiting Period	-	24 months
4	Maternity Expenses	-	24 Months if Self and Spouse are covered /36 Months if only Self covered

Others	
Policy Tenure	1 years, 2years & 3 years.

<table>
<tr><td>Sum Insured Basis</td><td>Individual & Family Floater</td></tr>
<tr><td>Installment Options</td><td>Single Premium, Half Yearly; Quarterly, Monthly & Annually in case of long-term policies</td></tr>
<tr><td>Discounts</td><td>• Single Payment Discount for Long Term Policies - 7.5% for 2-year policies and 10% discount for 3-year policies.
• Family discount – 10 % discount if more than 1 member covered under single proposal with Individual sum insured option.
• Employee discount – 7.5% discount in case the insured is an employee of the company.
• Family Floater Discount- As per table given in Product brochure.
• Website Discount – Discount of 7.5% will be applicable in case the proposal comes through websales.
• Wellness Discount – Discount equal to monetary value of maximum up to 200 reward points (5% of existing policy premium) in single policy year.</td></tr>
<tr><td>Loadings</td><td>Loading for Co-pay Waiver Cover: If the insured opts for a copay waiver, the following percentage loadings by Age and Sum Insured will be applied:
<table>
<tr><th>Age band</th><th>Sum Insured (in Rs.) 75 Lacs and 1 crore</th><th>Sum Insured (in Rs.) above 1 crore</th></tr>
<tr><td>0 to 35 years</td><td>0.20%</td><td>0.60%</td></tr>
<tr><td>36-55 years</td><td>0.60%</td><td>1.40%</td></tr>
<tr><td>Above 55 years</td><td>1.20%</td><td>2.70%</td></tr>
</table>
Loadings for USA and Canada - As per table given in Product brochure

Loading for Instalment Facility
Insured has an option to pay premium on instalment basis. The instalment options available are monthly, quarterly, semi-annual basis and Annual basis. The following percentage loadings are applicable in case premium payment on instalment basis is opted.
<table>
<tr><td>Instalment Frequency</td><td>Percentage Loading</td></tr>
<tr><td>Monthly</td><td>5%</td></tr>
<tr><td>Quarterly</td><td>4%</td></tr>
<tr><td>Semi-Annually</td><td>3%</td></tr>
<tr><td>Annually</td><td>0%</td></tr>
</table></td></tr>
<tr><td>Co-pay for higher ages</td><td>Any Insured Person aged 61 years to 65 years, being covered for the first time in this policy shall bear 20% of each and every admissible claim. In case the optional cover of “Co-pay waiver” is opted, the insured will have no option to waive off this co-payment.</td></tr>
<tr><td>Family Definition</td><td>You, Your Spouse/ Live-in partner, Your Children, Your Parents, Your Dependent Siblings, Your daughter in law, Your son in law, Your parents in law, Your grandparents and Your grandchildren.</td></tr>
<tr><td>Max Renewal Age</td><td>Lifelong</td></tr>
<tr><td>PPC</td><td>All Policyholders, 18 years and above</td></tr>
</table>

Entry Age			
	Proposer	**Adult**	**Child**
Minimum	18 years	18 years	91 Days
Maximum	65 years	65 years	N/A

VIII. Payment of Premium

a) As per table Annexure I

IX. This prospectus shall form part of your proposal form, hence please sign as you have noted the contents ofthis 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 claims please contact:

In case of any claims within India please contact:

Claims Department
Generali Central Health (GCH)
Generali Central Insurance Company Limited.
Qubix Business Park, Building No. Block IT – 1, Ground Floor,
Plot No. 2, Blueridge Township, Near Rajiv Gandhi Infotech Park, Phase – 1,
Village Hinjawadi, Taluka Mulshi, Pune, Maharashtra - 411057.
Toll Free Number: 1800 103 8889
Toll Free Fax: 1800 103 9998
Email: GCIH@generalicentral.com

In case of any claims for Benefit 2 (Medical Treatment Abroad), Benefit 3 (Emergency Ambulance Charges- Outside India), Benefit 14 (Repatriation of Mortal Remains) please contact

Europ Assistance India Pvt. Ltd.
7th Floor, Star Hub, Bldg No. 2, Near ITC Maratha Hotel,
Sahar Andheri East, Mumbai – 400059
India Helpline Number: 18002092333
Worldwide Helpline Number: +91 2267347841
Email ID: gci@europ-assistance.in

Annexure I

Premium with Copay for individuals who enter the policy after age 60 years (in ₹, exclusive of Goods and Services Tax)*

Age band	Sum Insured											
	75 Lacs	1 crore	1.5 crore	2 crore	2.5 crore	3 crore	3.5 crore	4 crore	4.5 crore	5 crore	5.5 crore	6 crore
0-17	63,884	70,986	82,556	91,902	99,916	107,013	113,423	119,305	124,752	129,845	134,641	139,180
18-25	65,335	72,619	84,440	93,970	102,141	109,377	115,913	121,910	127,464	132,657	137,547	142,176
26-30	67,668	75,209	87,417	97,246	105,674	113,138	119,879	126,065	131,793	137,150	142,194	146,968
31-35	76,092	84,740	98,715	109,955	119,594	128,129	135,838	142,912	149,463	155,588	161,357	166,816
36-40	82,767	92,411	107,884	120,281	130,910	140,323	148,826	156,628	163,853	170,608	176,970	182,991
41-45	94,869	106,300	124,403	138,804	151,153	162,088	171,966	181,030	189,423	197,271	204,661	211,657
46-50	121,865	136,908	160,495	179,157	195,158	209,328	222,128	233,873	244,749	254,919	264,495	273,560
51-55	152,850	172,264	202,401	226,113	246,446	264,451	280,714	295,638	309,457	322,379	334,547	346,065
56-60	185,029	209,222	246,338	275,345	300,217	322,243	342,138	360,395	377,300	393,107	407,993	422,083
61-65	227,780	258,182	304,479	340,505	371,395	398,750	423,459	446,133	467,129	486,761	505,248	522,747
66-70	278,023	316,004	373,283	417,600	455,601	489,252	519,648	547,541	573,369	597,520	620,262	641,789
71-75	397,129	451,260	533,245	596,841	651,371	699,661	743,278	783,304	820,367	855,024	887,659	918,550
76-80	564,427	640,911	757,356	847,961	925,650	994,448	1,056,589	1,113,615	1,166,418	1,215,793	1,262,288	1,306,298
81-85	735,190	835,079	987,128	1,105,424	1,206,857	1,296,682	1,377,815	1,452,269	1,521,210	1,585,676	1,646,380	1,703,842
>85	830,453	945,581	1,119,088	1,253,287	1,368,357	1,470,256	1,562,297	1,646,760	1,724,969	1,798,102	1,866,967	1,932,154

Premium without Copay for individuals who enter the policy before age 60 years (in ₹, exclusive of Goods and Services Tax)*

Age band	Sum Insured											
	75 Lacs	1 crore	1.5 crore	2 crore	2.5 crore	3 crore	3.5 crore	4 crore	4.5 crore	5 crore	5.5 crore	6 crore
0-17	63,884	70,986	82,556	91,902	99,916	107,013	113,423	119,305	124,752	129,845	134,641	139,180
18-25	65,335	72,619	84,440	93,970	102,141	109,377	115,913	121,910	127,464	132,657	137,547	142,176
26-30	67,668	75,209	87,417	97,246	105,674	113,138	119,879	126,065	131,793	137,150	142,194	146,968
31-35	76,092	84,740	98,715	109,955	119,594	128,129	135,838	142,912	149,463	155,588	161,357	166,816
36-40	82,767	92,411	107,884	120,281	130,910	140,323	148,826	156,628	163,853	170,608	176,970	182,991
41-45	94,869	106,300	124,403	138,804	151,153	162,088	171,966	181,030	189,423	197,271	204,661	211,657
46-50	121,865	136,908	160,495	179,157	195,158	209,328	222,128	233,873	244,749	254,919	264,495	273,560
51-55	152,850	172,264	202,401	226,113	246,446	264,451	280,714	295,638	309,457	322,379	334,547	346,065
56-60	185,029	209,222	246,338	275,345	300,217	322,243	342,138	360,395	377,300	393,107	407,993	422,083
61-65	236,220	267,764	315,798	353,177	385,227	413,609	439,245	462,770	484,554	504,923	524,104	542,261
66-70	288,349	327,756	387,185	433,166	472,593	507,508	539,045	567,985	594,782	619,840	643,436	665,771
71-75	411,926	468,090	553,152	619,135	675,713	725,815	771,070	812,599	851,053	887,010	920,870	952,921
76-80	585,505	664,860	785,676	879,682	960,288	1,031,668	1,096,143	1,155,308	1,210,094	1,261,323	1,309,562	1,355,225
81-85	762,678	866,317	1,024,074	1,146,810	1,252,052	1,345,248	1,429,427	1,506,676	1,578,205	1,645,091	1,708,074	1,767,692
>85	861,517	980,967	1,160,987	1,300,224	1,419,613	1,525,338	1,620,834	1,708,468	1,789,613	1,865,491	1,936,941	2,004,575

Notes:

- Premium exclusive of Goods and Services tax; Age in completed years

Loading for USA and Canada:

If an Insured opts for an USA and Canada cover, then the following loading by age and sum insured shall be applicable on the premium payable by the Insured Person

Sum Insured / Age in Years	75 L	1 Cr	1.5 Cr	2 Cr	2.5 Cr	3 Cr	3.5 Cr	4 Cr	4.5 Cr	5 Cr	5.5 Cr	6 Cr
0-17	171	365	713	1,130	1,234	1,326	1,410	1,486	1,557	1,623	1,685	1,744
18-25	223	477	932	1,477	1,614	1,734	1,843	1,943	2,036	2,122	2,204	2,281
26-30	262	561	1,096	1,738	1,898	2,040	2,169	2,286	2,395	2,497	2,593	2,684
31-35	328	701	1,371	2,173	2,373	2,550	2,711	2,858	2,994	3,121	3,241	3,355
36-40	486	1,038	2,028	3,215	3,512	3,775	4,012	4,229	4,431	4,619	4,797	4,965
41-45	827	1,768	3,454	5,475	5,980	6,427	6,831	7,201	7,545	7,866	8,168	8,454
46-50	1,338	2,862	5,592	8,864	9,682	10,406	11,059	11,659	12,215	12,735	13,224	13,687
51-55	2,047	4,377	8,552	13,557	14,807	15,914	16,914	17,832	18,682	19,477	20,225	20,933
56-60	3,018	6,454	12,609	19,988	21,831	23,464	24,938	26,291	27,544	28,715	29,819	30,863
61-65	4,317	9,232	18,036	28,591	31,228	33,563	35,672	37,608	39,400	41,076	42,654	44,147
66-70	6,010	12,851	25,108	39,802	43,473	46,723	49,659	52,353	54,848	57,181	59,378	61,457
71-75	8,175	17,481	34,154	54,141	59,134	63,556	67,549	71,214	74,608	77,781	80,769	83,598
76-80	10,878	23,261	45,447	72,043	78,687	84,571	89,885	94,762	99,278	103,500	107,477	111,240

81-85	14,238	30,444	59,481	94,291	102,986	110,687	117,642	124,025	129,935	135,462	140,666	145,592
>85	18,332	39,199	76,585	121,405	132,601	142,516	151,471	159,689	167,299	174,415	181,115	187,458

All Sum insured and Premiums are in ₹

Loading for Co-pay Waiver Cover:

This product also offers an optional cover where the insured can opt to remove the mandatory co-payment of 20% which is applicable in the benefit "Medical treatment abroad". If the insured opts for the same, the following percentage loadings by Age and Sum Insured will be applied:

Age band	Sum Insured (in Rs.) 75 Lacs and 1 crore	Sum Insured (in Rs.) above 1 crore
0 to 35 years	0.20%	0.60%
36-55 years	0.60%	1.40%
Above 55 years	1.20%	2.70%

Floater Premium rates:

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 below:

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

 # Illustration 1: 3-year Family policy where Coverage is opted on individual basis without Optional Covers

In case of a Family of self and child where Coverage is opted on individual basis and the adult is suffering from Diabetes (Known case of Diabetes (HbA1c 5.9 - 6.49%)), the premium is paid on monthly instalment basis would be charged in the following manner:

Policy Details		
	Self	**Child**
Policy term (in years)	3	3

Sum Insured	2,00,00,000	2,00,00,000
Age Band	31-35	0-17
Instalment Frequency	Monthly premium	

	Self (33 years)	Child (3 years)
A. Premium as per individual rate table (in ₹)	109,955	91,902
B. Treatment Including USA and Canada	0	0
C. Co-Pay Waiver - Opted	0%	0%
Premium [(A+B) *(1+C)}	109,955	91,902
D. Medical Loading for Known case of Diabetes (HbA1c 5.9 - 6.49%)	10%	0%
Premium [(A+B) *(1+C)*(1+D)]	120951	91902
E. Family Discount 10%	10.00%	10.00%
Premium [(A+B) *(1+C) *(1+D)*(1-E)]	108855.45	82711.80
F. Website/Employee Discount 7.5%	0%	0%
G. Total premium to be charged for 1 year policy [(A+B) *(1+C) *(1+D)*(1-E)*(1-F)]	108855.45	82711.80
H. Total premium to be charged for 3 year policy [(A+B) *(1+C) *(1+D)*(1-E)*(1-F)*Policy Term]	326566	248135
Loading for Instalment – Monthly	342895	260542
Final Premium without GST	**603,437**	
Final Premium with GST 18%	**712,055**	
Monthly Premium to be paid by insured	**59,338**	

 # Illustration 2: 3-year Policy where Coverage is opted on individual basis with Optional Covers
In case of a Family of self and child where Coverage is opted on individual basis with both Optional Covers (Treatment in USA and Canada and Co-Pay Waiver) and the adult is suffering from Diabetes (Known case of Diabetes (HbA1c 5.9 - 6.49%)), the complete premium paid in single instalment for would be charged in the following manner:

Policy Details		
	Self	**Child**
Policy term (in years)	3	3
Sum Insured	2,00,00,000	2,00,00,000
Age Band	31-35	0-17

	Self (33 years)	Child (3 years)
A. Premium as per individual rate table (in ₹)	109,955	91,902
B. Treatment Including USA and Canada	2,173	1,130
C. Co-Pay Waiver - Opted	0.60%	0.60%
Premium [(A+B) *(1+C)}	112,801	93,590
D. Medical Loading for Known case of Diabetes (HbA1c 5.9 - 6.49%)	10%	0%
Premium [(A+B) *(1+C)*(1+D)]	124081	93590
E. Family Discount 10%	10.00%	10.00%
Premium [(A+B) *(1+C)*(1+D)*(1-E)]	111672.76	84231.17
F. Website/Employee Discount 7.5%	0%	0%
G. Total premium to be charged for 1 year policy [(A+B) *(1+C)*(1+D)*(1-E)*(1-F)]	111672.76	84231.17
H. Total premium to be charged for 3 year policy [(A+B) *(1+C)*(1+D)*(1-E)*(1-F)*Policy Term]	335018	252694

Discount for premium payment in single instalment	301516	227424
Final Premium without GST	**528,941**	
Final Premium with GST 18%	**624,150**	

 # Illustration 3: Premium Charged for a 3-year where Coverage is opted on Family Floater basis without Optional Covers

In case of a Family of self and child where Coverage is opted on Family Floater basis with both Optional Covers (Treatment in USA and Canada and Co-Pay Waiver), the adult is suffering from Diabetes (Known case of Diabetes (HbA1c 5.9 - 6.49%)) and premium paid in single instalment, the premium for would be charged in the following manner:

Policy Details		
	Self	**Child**
Policy term (in years)	3	3
Sum Insured	2,00,00,000	2,00,00,000
Age Band	31-35	0-17
Instalment Frequency	Monthly premium	

	Self (33 years)	**Child (3 years)**
A. Premium as per individual rate table (in ₹)	109,955	91,902
B. Treatment Including USA and Canada	0	0
C. Co-Pay Waiver - Not Opted	0%	0%
Premium [(A+B) *(1+C)}	109,955	91,902
D. Medical Loading for Known case of Diabetes (HbA1c 5.9 - 6.49%)	10%	0%
Premium [(A+B) *(1+C) *(1+D)]	120951	91902
E. Family Floater discount	0%	60%
Premium [(A+B) *(1+C) *(1+D) *(1-E)]	120951	36761
F. Website/Employee Discount 7.5%	7.5%	7.5%
G. Per person premium to be charged for 1 year policy [(A+B) *(1+C) *(1+D)*(1-E)*(1-F)]	111879	34004
H. Per person premium to be charged for 3 year policy [(A+B) *(1+C)*(1+D)*(1-E)*(1-F)*Policy Term]	335638	102011
Loading for Installment - Monthly	352420	107112
Final Premium without GST	**459,531**	
Final Premium with GST 18%	**542,247**	
Monthly Premium to be paid by insured	**45,187**	

 # Illustration 4: 3-year policy where Coverage is opted on Family Floater basis with Optional Covers

In case of a Family of self and child where Coverage is opted on Family Floater basis with both Optional Covers (Treatment in USA and Canada and Co-Pay Waiver) , the adult is suffering from Diabetes (Known case of Diabetes (HbA1c 5.9 - 6.49%)) and premium paid in single instalment, the premium for would be charged in the following manner:

Policy Details		
	Self	**Child**
Policy term (in years)	3	3
Sum Insured	2,00,00,000	2,00,00,000
Age Band	31-35	0-17

	Self (33 years)	Child (3 years)
A. Premium as per individual rate table (in ₹)	109,955	91,902
B. Treatment Including USA and Canada	2,173	1,130
C. Co-Pay Waiver - Opted	0.60%	0.60%
Premium [(A+B)*(1+C)}	112,801	93,590
D. Medical Loading for Known case of Diabetes (HbA1c 5.9 - 6.49%)	10%	0%
Premium [(A+B)*(1+C)*(1+D)]	124081	93590
E. Family Floater discount	0.00%	60.00%
Premium [(A+B)*(1+C)*(1+D)*(1-E)]	124080.84	37436.08
F. Website/Employee Discount 7.5%	0%	0%
G. Total premium to be charged for 1 year policy [(A+B)*(1+C)*(1+D)*(1-E)*(1-F)]	124080.84	37436.08
H. Total premium to be charged for 3 year policy [(A+B)*(1+C)*(1+D)*(1-E)*(1-F)*Policy Term]	372243	112308
Discount for premium payment in single instalment	335018	101077
Final Premium without GST	**436,096**	
Final Premium with GST 18%	**514,593**	

Premium Illustration in respect of policies offered on individual and family floater basis Sum Insured ₹10,000,000:

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (in ₹)	Sum insured (in ₹)	Premium (in ₹)	Discount, if any	Premium after discount (in ₹)	Sum insured (in ₹)	Premium or consolidated premium for all members of family (in ₹)	Floater discount, if any	Premium after discount (in ₹)	Sum insured (in ₹)
50 years	136,908	10,000,000	136,908	13691	123,217	10,000,000	136,908	0	136,908	10,000,000
42 years	106,300	10,000,000	106,300	10630	95,670	10,000,000	106,300	42520	63,780	
17 years	70,986	10,000,000	70,986	7099	63,887	10,000,000	70,986	42592	28,394	
20 years	72,619	10,000,000	72,619	7262	65,357	10,000,000	72,619	39940	32,679	
27 years	75,209	10,000,000	75,209	7521	67,688	10,000,000	75,209	37605	37,605	
27 years	75,209	10,000,000	75,209	7521	67,688	10,000,000	75,209	37605	37,605	
32 years	84,740	10,000,000	84,740	8474	76,266	10,000,000	84,740	38133	46,607	
35 years	84,740	10,000,000	84,740	8474	76,266	10,000,000	84,740	38133	46,607	
36 years	92,411	10,000,000	92,411	9241	83,170	10,000,000	92,411	41585	50,826	
40 years	92,411	10,000,000	92,411	9241	83,170	10,000,000	92,411	41585	50,826	
52 years	172,264	10,000,000	172,264	17226	155,038	10,000,000	172,264	68906	103,358	
57 years	209,222	10,000,000	209,222	20922	188,300	10,000,000	209,222	73228	135,994	
65 years	267,764	10,000,000	267,764	26776	240,988	10,000,000	267,764	93717	174,047	

65 years	267,764	10,000,000	267,764	26776	240,988	10,000,000	267,764	93717	174,047	
70 years	327,756	10,000,000	327,756	32776	294,980	10,000,000	327,756	114715	213,041	
Total Premium for all members of the family is ₹2,136,303/-, when each member is covered separately.			Total Premium for all members of the family is ₹1,922,673/-when they are covered under a single policy.				Total Premium when policy is opted on floater basis is ₹1,332,323/-			
Sum insured available for each individual is ₹1,00,00,000			Sum insured available for each family member is ₹1,00,00,000				Sum insured of ₹1,00,00,000 is available for the entire family.			

Note

- This is just an illustration of premium calculation. Persons entered the Policy before the age of 61 years (premium considered is without co-payment).
- Premiums may vary with respect to Sum Insured opted by the insured.
- Premium rates specified in the above illustration are the standard premium rates without considering any loading and/or discounts like – Website discount etc.
- Premium rates are exclusive of Goods and Services Tax applicable.

Annexure II

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

Sl 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 BYHOSPITAL)
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 FOOTWEAR
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

Sl 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

Sl 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

Sl 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