HEALTH XTRA
POLICY WORDINGS

PREAMBLE

This Policy is issued by "Generali Central Insurance Company Limited" (We, Insurer, Our, Company, GCI or Us) to the Policyholder (Proposer, You or Your) mentioned in the Policy Schedule to cover the Insured Persons named in the Policy Schedule. The Policy is based on the information, statements and declaration provided in the proposal form by the proposer and is subject to receipt of the requisite premium by Us.

OPERATIVE CLAUSE

If during the Policy Period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Center, following Medical Advice of a duly qualified Medical Practitioner, we shall indemnify Medically Necessary expenses towards the Coverage, as per the Sum Insured selected, and mentioned in the Schedule of Benefits.
Provided further that, any amount payable due to an admissible claim under the Policy shall be subject to the terms of coverage, exclusions, conditions, and definitions contained herein. Our maximum liability for all such claims, during the Policy Year, shall be up to the Sum Insured opted and specified in the Policy Schedule.

1. DEFINITIONS

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

1.1. STANDARD DEFINITIONS

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

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

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

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

a) Having qualified registered AYUSH Medical Practitioner(s) in charge;
b) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

c) Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

1.1.6. Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

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

1.1.8. Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

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

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

1.1.10. Critical Illness means the following disease/ illness:

A. <u>Cancer of Specified Severity</u>

I. A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
II. The following are excluded –
    i. All tumours which are histologically described as carcinoma in situ, benign, pre-

malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

B. <u>Myocardial Infarction (First Heart Attack of Specified Severity)</u>

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g., typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins, or other specific biochemical markers.

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

C. <u>Open Chest CABG (Coronary Artery Bypass Graft)</u>

I. 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 breastbone) 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.

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

D. <u>Open Heart Replacement or Repair of Heart Valves</u>

The actual undergoing of open-heart valve surgery is 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. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

E. Coma of Specified Severity

I. 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:
   i. no response to external stimuli continuously for at least ninety-six (96) hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least thirty (30) days after the onset of the coma.

II. The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

F. Kidney Failure Requiring Regular Dialysis

I. 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. Diagnosis has to be confirmed by a specialist Medical Practitioner.

G. Stroke Resulting in Permanent Symptoms

I. 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 three (3) months has to be produced.

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

H. Major Organ / Bone Marrow Transplant

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:
   Other stem-cell transplants
   Where only islets of langerhans are transplanted.

I. Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain

or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than three (3) months.

J. Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a specialist Medical Practitioner 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 (three) 3 months.

K. Multiple Sclerosis with Persisting Symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least six (6) months.

II. Neurological damage due to SLE is excluded.

L. Benign Brain Tumor

I. Benign 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.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least Ninety (90) consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:
   Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

M. End Stage Lung Failure

I. 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 three (3) occasions three (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); and
   iv. Dyspnea at rest.

N. End Stage Liver Failure

I. 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.

II. Liver failure secondary to drug or alcohol abuse is excluded.

O. Primary (Idiopathic) Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Catheterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:
   i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

P. Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% (twenty) of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% (twenty) of the body surface area.

Q. Surgery of Aorta

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:
   i. Computerized tomography (CT) scan
   ii. Magnetic Resonance Imaging (MRI) scan
   iii. Echocardiography (an ultrasound of the heart)
   iv. Angiography (Injecting X ray dye)
   v. Abdominal ultrasound

R. Primary Parkinson's Disease

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease before age 60 years, must be supported by the clinical confirmation of a Neurologist.

The diagnosis must be supported by all of the following conditions:

I. the disease cannot be controlled with medication;
II. signs of progressive impairment; and
III. inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

S. Alzheimer's Disease

Alzheimer's disease is a progressive degenerative Illness of the brain, characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis of the disease must be before age 60 years, must be supported by the clinical confirmation of a Neurologist, evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT scan, MRI, PET of the brain) and supported by Our appointed Medical Practitioner

The following conditions are however not covered:

- non-organic diseases such as neurosis and psychiatric Illnesses.
- alcohol related brain damage; and
- any other type of irreversible organic disorder/dementia not associated with Alzheimer's Diseasee.

T. Systemic Lupus Erythematosus

A multi-system autoimmune disorder characterized by the development of autoantibodies

directed against various self-antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a Registered Doctor specializing in Rheumatology and Immunology.

The WHO Classification of Lupus Nephritis:

I. Class I Minimal Change Lupus Glomerulonephritis
II. Class II Mesangial Lupus Glomerulonephritis
III. Class III Focal Segmental Proliferative Lupus Glomerulonephritis
IV. Class IV Diffuse Proliferative Lupus Glomerulonephritis
V. Class V Membranous Lupus Glomerulonephritis

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

1.1.12. Day Care Centre means any institution established for day care treatment of illness and/or injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner and must comply with all minimum criterion as under-

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

1.1.13. Day Care Treatment means medical treatment and/or surgical procedure which is:

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

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

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

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

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

1.1.16. Disclosure to Information Norm

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

1.1.17. Domiciliary Hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

a) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

b) the patient takes treatment at home on account of non- availability of room in a hospital.

1.1.18. Emergency Care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.

1.1.19. Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

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

1.1.20. Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a Hospital with the local authorities, under Clinical Establishments (Registration and Regulation) Act, 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:

a) has qualified nursing staff under its employment round the clock;

b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

c) has qualified medical practitioner(s) in charge round the clock;

d) has a fully equipped operation theatre of its own where surgical procedures are carried out;

e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

1.1.21. Hospitalization means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

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

a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1) it needs ongoing or long-term monitoring through consultations, examinations, check-

ups, and /or tests

2) it needs ongoing or long-term control or relief of symptoms
3) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4) it continues indefinitely
5) it recurs or is likely to recur

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

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

1.1.25. Intensive Care Unit means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

1.1.26. ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

1.1.27. Maternity Expenses means;

Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

a) expenses towards lawful medical termination of pregnancy during the policy period.

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

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

1.1.30. Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The Medical Practitioner should not be the insured or close member of the family.

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

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

1.1.32. Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

1.1.33. Network Provider Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

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

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

1.1.37. OPD Treatment means the one in which the Insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

1.1.38. 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.

1.1.39. Pre-Existing Disease means any condition, ailment or injury or disease:
a) That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement or
b) For which medical advice or treatment was recommended by, or received from,a physician within 36 months prior to the effective date of the policy or its reinstatement.

1.1.40. Pre-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b) The In-Patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

a) Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required, and
b) The In-patient Hospitalization claim for such Hospitalization is admissible by the insurance company.

1.1.42. Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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

1.1.44. Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

1.1.45. Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include associated medical expenses.

1.1.46. Surgery or Surgical Procedure means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

1.2. SPECIFIC DEFINITIONS

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

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

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

recognized qualifications as may be prescribed.

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

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

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

1.2.7. **Family Floater** means a Policy described as such in the Schedule where You and / or 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.

Below family relations of the Policyholder are allowed to be covered under a Family Floater Policy:

a) Self
b) Legally married Spouse or Live-in Partner
c) Up to three dependent Children up to the age of 25 years
d) For Parent's, separate floater policy can be taken

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

Below family relations of the Policyholder are allowed to be covered under Individual / Non-Floater Policy:

a) Self
b) Legally married Spouse or Live-in Partner
c) Children
d) Parents
e) Parents-in-Law
f) Siblings
g) Daughter-in-law
h) Son-in-law
i) Grandparents
j) Grandchildren

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

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

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

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

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

1.2.13. **Material facts** shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

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

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

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

1.2.17. **Proposal form** means a form to be filled in by the prospect in written or electronic or any other

format as approved by the Authority, for furnishing all material information as required by the Insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

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

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

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

1.2.21. **Single Private Room** means any single hospital room with/without an air-conditioned facility where a single patient is accommodated and which has an attached toilet (lavatory and bath). The room should have the provision for accommodating an attendant. This excludes a suite room or executive suite room or any other rooms above the suite or executive suite category.

1.2.22. **Sum Insured/Base 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). The Sum Insured does not include Cumulative Bonus under its scope. The Cumulative Bonus as defined in the clause no. 1.1.11, shall be considered as an additional Sum Insured.

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

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

Please note:

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

2. SCOPE OF COVER

We will pay the benefits for the events described in the policy as detailed below. The benefits shall be available up to the Sum Insured limit as defined and applicable. For a complete description of the benefits available, please refer to the "Schedule of Benefits" attached to this Policy.

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

2.1. BASE COVER

The benefits available under the Basic Cover are in-built into the product. The Policy Schedule will specify the benefit details along with your chosen cover option / sublimit, which shall be in force for the Insured Persons during the Policy Period. The benefits available under the Basic Cover in this Policy are listed below.

2.1.1 Hospitalization Medical Expenses

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

a) Room Rent for accommodation in Hospital room and other boarding charges; up to the limits as specified in the Schedule of Benefits
b) ICU charges; up to the limits as specified in the Schedule of Benefits
c) Operation theatre charges;
d) Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anaesthetists;
e) Qualified Nurse charges;
f) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
g) Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized;
h) Anesthesia, blood, oxygen and blood transfusion charges, Surgical Appliances;
i) Prosthetic and other devices recommended by the attending Medical Practitioner that are implanted internally during a Surgical Procedure.

2.1.2 Day Care Treatment Expenses

We will pay the Reasonable and Customary Charges incurred towards Medically Necessary Treatment required by the Insured Person towards Day Care Treatments following an Illness or Injury that occurs during the Policy, up to the Sum Insured as specified in the Schedule of Benefit, provided that:

a) Day Care treatment requires hospitalization as an inpatient for less than 24 hours in a hospital.
b) We will also cover Medical Expenses incurred for procedures including but not limited to intravenous chemotherapy, radiotherapy, hemodialysis or any other therapeutic procedure,

which requires a period of specialized observation or medical care after completion of the procedure.

c) We will not cover any Out-Patient Treatment or diagnostic services under this Benefit.
d) Expenses associated with automation machine for peritoneal dialysis shall not be payable

2.1.3 Pre-Hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Pre- Hospitalization Medical Expenses incurred immediately prior to the date of the Insured Person's hospitalization for number of days as specified on the Policy Schedule, provided that We have accepted a claim under Section 2.1.1 (Hospitalization Medical Expenses) and Section 2.1.2 (Daycare Treatment Expenses)

2.1.4 Post-Hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Post- Hospitalization Medical Expenses incurred immediately following the Insured Person's discharge from Hospital for the number of days as specified on the Policy Schedule and applicable plan as given in the Schedule of Benefits, provided that We have accepted a claim under Section 2.1.1 (Hospitalization Medical Expenses) and Section 2.1.2 (Daycare Treatment Expenses)

2.1.5 Organ Donor Expenses

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

a) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act, 1994 and the organ donated is for the use of the Insured Person;
b) We will not pay the donor's screening expenses or pre and post Hospitalization expenses or for any other medical treatment for the donor consequent on the harvesting;
c) We have accepted claim under Section 2.1.1 (Hospitalization Medical Expenses) for the Insured Person and the Insured Person has been Medically Advised to undergo an organ transplant;
d) Costs directly or indirectly associated with the acquisition of the donor's organ will not be covered.

2.1.6 Modern Treatments Method and Advancement in Technologies:

We will pay the reasonable & customary charges for medical expenses incurred towards Modern Treatment Method and Advancement in Technologies under Hospitalization Medical Expenses (Section 2.1.1) or Day Care Treatment (Section 2.1.2) arising out of an Insured Person's Hospitalization following an Illness or Injury sustained during the Policy Year, up to the Sum Insured specified in the Schedule of Benefits.

We will cover medical expenses incurred on the following procedures:

a) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b) Balloon Sinuplasty
c) Deep Brain stimulation
d) Oral chemotherapy
e) Immunotherapy - Monoclonal Antibody to be given as injection.

f) Intra vitreal injections
g) Robotic surgeries
h) Stereotactic radio surgeries
i) Bronchical Thermoplasty
j) Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k) IONM - (Intra Operative Neuro Monitoring)
l) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

2.1.7 AYUSH Treatment

We will reimburse Reasonable and Customary Charges for Medical Expenses incurred towards Hospitalization for Ayurveda, Yoga and Naturopathy, Unani, Siddha or Homeopathy treatment, provided that the treatment has been undergone in an AYUSH Hospital.

The Specific Exclusions applicable to this Benefit are:

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

2.1.8 Accidental Hospitalization

We will increase the Sum Insured by 25% of the available balance Sum Insured if the Insured Person is hospitalized solely and directly due to an Accident which occurred during the Policy Year. Such increase of the Sum Insured shall not exceed ₹ 10,00,000 and it will only be available for claims arising under Section 2.1.1 (Hospitalization Medical Expenses).

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

2.1.9 Emergency Road Ambulance

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

We will reimburse payments under this Benefit provided that:

a) The ambulance services of a Hospital or a registered ambulance service provider is utilized.
b) The original Ambulance bills and payment receipt is submitted to Us.
c) We have accepted the claim under Section 2.1.1 (Hospitalization Medical Expenses) and Section 2.1.2 (Day Care Treatment Expenses).

2.1.10 Emergency Medical Evacuation (applicable for Sum Insured ₹ 15 lacs and above)

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

a) Medical evacuation following an Accident/injury/illness during the Policy Year, from the place where the Accidental Injury occurred or from the place of Hospitalization immediately following the Accident/injury/illness to any other Hospital within India.

b) The benefit under this cover shall only be applicable if no alternative method of transportation is available within the vicinity of occurrence of such accident/ injury/ illness leading to medical emergency.
c) For claims made under this Benefit, We will reimburse expenses for emergency evacuation/ transportation of the Insured Person and Medical Expenses incurred for treatment, during the course of evacuation, provided that such treatment is Medically Necessary and it is provided to the Insured Person en-route.

2.1.11 Home Health Care Expenses

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

a) The Home Health Care Expenses shall be covered only subject to Cashless authorization approved by Us.
b) Medical treatment for an Illness/ Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:
    1) The condition of the patient is such that he/she is not in a condition to be moved to a Hospital, or
    2) The patient takes treatment at home on account of non-availability of bed / room in a Hospital, or
    3) Non-availability of Hospital Services due to any prevailing conditions /Government Notification.
    4) Chemotherapy and dialysis at home.
    5) For children up to the age of 15 years if treated at home instead of hospitalization, if certified by the Medical Practitioner that the child needs hospitalization for treatment but the same can be replicated at home with remote monitoring and nursing care.
c) The duration of Home Health Care treatment should be restricted to reasonable time and not more than the period of Hospitalization, the patient would have undergone otherwise.
d) Treatment under this benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
e) In case of medical treatment solely taken at home without any initial hospitalization, Pre and Post hospitalization expenses would be covered up to the overall limit of the cover under this benefit. The number of days for pre and post hospitalization cover will be applicable as per benefit 2.1.3 & 2.1.4 respectively.
f) In case of Post-surgical care through Home Health Care Services, where the initial hospitalization for surgical management, the condition was at our empanelled network hospital and we have accepted an inpatient hospitalization claim on cashless basis, then Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses will be applicable as per section 2.1.3 and 2.1.4 respectively.
g) Only Allopathic treatment shall be covered under this Benefit.
h) Any sublimits applicable for Section 2.1.1 to Section 2.1.4 shall also be applicable under this

Benefit.

i) This Benefit shall not cover any expenses incurred towards attendant/ nursing services

j) Section 2.1.12 (Patient Care) and Section 2.1.13 (Accompanying Person) are not applicable for claims admissible under this Benefit.

k) Clause 3.3.13 shall not apply to the extent of cover provided under this benefit.

2.1.12 Patient Care

We will pay the Reasonable and Customary Charges incurred towards the nursing care taken by the insured person from a Qualified Nurse for a period of 10 days as specified on the Schedule of Benefits, 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 Year;

c) The treating Medical Practitioner has recommended that the nursing care is Medically Necessary;

d) We will not be liable to make payment under this Benefit for any Insured Person in excess of 30 days during a Policy Year and as specified in the Schedule of Benefits.

e) Clause 3.3.13 shall not apply to the extent of cover provided under this benefit

2.1.13 Accompanying Person

We will make payment of the fixed amount as specified in the Schedule of Benefits, for each completed day of Hospitalization of an Insured, towards the expenses of an Accompanying Person to take care of the Insured, provided that:

a) The Insured is a child of age 12 years or less

b) the child is undergoing Hospitalization due to an Injury or Illness that occurred during the Policy Year.

c) We will not make payment under this Benefit in respect of an Insured Person for more than 30 days during a Policy Year.

2.1.14 OPD Treatment

We will reimburse the Reasonable and Customary Charges arising from Medical Expenses incurred due to OPD (outpatient) treatments of the Insured Person/s towards consultations and diagnostic tests arising due to any illness (Physical or Mental/Psychiatric) or Injury up to the limits specified in the Schedule of benefits.

Specific Conditions applicable to this benefit are:

a) Only Allopathic treatment will be covered under this Benefit.

b) 30% co-payment applicable on all expenses incurred for OPD treatments to be borne by the Insured Person

c) In case of expenses towards Mental/Psychiatric illness, only the following would be considered
   - Consultations and Counselling sessions with a Psychiatrist.
   - Diagnostics which have been prescribed by a Psychiatrist.

d) All expenses individually or in aggregate cannot exceed the OPD Treatment Expenses limit specified in the Schedule of Benefits.

e) Clause 3.3.11 shall not apply to the extent of cover provided under this benefit.

Specific Exclusions:

a) An initial waiting period of 30 days shall be applicable for this benefit during the first year of this Policy.
b) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until 36 months of continuous coverage after the date of inception of the first Policy.
c) Coverage under the Policy after the expiry of the waiting period of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.
d) If the cover under this benefit is not availed in the Policy year during the Policy Period, the benefit cannot be carried forward to the subsequent policy year
e) We will not pay for any expenses incurred in respect of any claims made under OPD Treatment, arising out of or howsoever related to any of the following:
    I. Cost of an Annual Health Check-up.
    II. Any expenses for consultation, diagnostics, or medications which are not duly supported with medical documents from the Medical Practitioner mentioning:
        1) Diagnosis;
        2) Referral for diagnostic test;
        3) Prescription for medications.

2.1.15 E-Opinion for Illness/Injury

If an Insured Person suffers an Illness or Injury during the Policy Year in respect of which a claim has been admitted under Section 2.1.1 (Hospitalization Medical Expenses), then at the Insured Person's request, We will arrange a maximum of two e-opinions (in a Policy Year) from a Medical Practitioner selected by the Insured Person from Our panel. The e-opinion will be based only on the information and documentation provided to the Medical Practitioner by or on behalf of the Insured Person.

While claiming under this Benefit and deciding to obtain an e-opinion, each Insured Person expressly agrees that:

a) It is entirely for the Insured Person to decide whether to obtain an E-opinion, from which Medical Practitioner in Our panel to take the E-opinion and the use (if any) to which the E-opinion so obtained is put.
b) We do not provide an E-opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other persons' reliance on the same, or the use to which the E-opinion is put.
c) We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations whatsoever made by any Medical Practitioner in Our Panel or in any E-opinion or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

2.1.16 Wellness Benefits

The Insured Person will be eligible for "Wellness Benefits" as per the Plan in force under the Policy. These wellness benefits will include Value added services and Wellness reward points. These

services would be conducted through Our Wellness partner and can be availed from our GCI mobile App.

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

While availing the wellness benefits, each Insured Person expressly agrees that:

a) All decisions regarding availing the wellness benefit, are to be solely made by the Insured Person.

b) We do not provide/assume responsibility for the wellness benefits or make any representation as to the adequacy or accuracy or quality of the same; any actual or alleged errors, omissions or representations whatsoever made by any of Our wellness service provider or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

A. Value Added Services

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

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

2) **Health Contents** - Under this benefit Insured will have access to articles, blogs which provide information on Physical and Mental wellness related topics.

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

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

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

Plan Name	Tests
5, 10L	Complete Blood Count (CBC) , Glycosylated Hemoglobin(HbA1C), Electrocardiogram (ECG reported by an MD Physician), Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index), Uric Acid, Total Protein, Pulmonary Function Test.
15,20,25,30,35L	Complete Blood Count (CBC) , Glycosylated Hemoglobin(HbA1C), Electrocardiogram (ECG reported by an MD Physician),Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High

	Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index), Serum Glutamic Oxaloacetic Transaminase(SGOT), Serum Glutamic Pyruvic Transaminase(SGPT), Serum Calcium, Uric Acid, Total Protein, Pulmonary Function Test, USG (abdomen)
50,75,100L	Complete Blood Count (CBC) , Glycosylated Hemoglobin(HbA1C), Electrocardiogram (ECG reported by an MD Physician),Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index), Serum Glutamic Oxaloacetic Transaminase(SGOT), Serum Glutamic Pyruvic Transaminase(SGPT),Vitamin D, Thyroid function (T3,T4,TSH), Serum Calcium, Uric Acid, Total Protein, Pulmonary Function Test, USG (abdomen)

B. Wellness Rewards points

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

Conditions applicable for earning the reward points

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

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

Sr. No.	Criteria	Frequency allowe	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 whe organized) and viewing of GCI Content around wel	As planned by GCI	20
4.	Lifestyle disease monitor • Hypertension – Blood pressure • Obesity -BMI • Diabetes – Hb A1C • Cardiac Health- Sr. Cholesterol , Triglycerides	Once/year	45
5.	Fitness/ Healthy Lifestyle tracking- (Any one activit • Daily Step tracking (monthly average of 10000 steps/day) • Burning average of 300 calories per day in a mor • Submission of monthly Gym /yoga membership c • Participation in Marathon, Cyclathon etc.	Monthly	60

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

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

Points earned per member per year	**Value of points earned**
185- 200	20%
150-184	15%
100-149	5%
15-99	2%

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

Family Type	2 Adult+1 child		
Policy period	01-Jan-2021 to 31 Dec 2021		
Relation	Self	Spouse	Child
Sum insured (₹)	10L	10L	10L
Age Band	31	26	0-17
Individual premium (₹)	11,220	10,292	8,904
Family discounted premium (₹)	10,098	9,263	8,015
Points Earned	200	180	NA
% value of points earned	20%	15%	0%
Monetary value of reward points (₹)	2020	1389	0

Detail breakup of reward point calculation (Earning and burning)

Date	**Self**			**Spouse**			**Total**		
	Points earned as on date	**% value of points earned**	**Monetary value (₹)**	**Points earned as on date**	**% value of points earned**	**Monetary value (₹)**	**Monetary value (₹)**	**Balance available for utilization (₹)**	**Burn/Utilised on date (OPD/ Pharmacy/ NME) (₹)**
21-03-2026	40	2%	202	30	2%	185	387		100
31-08-2026	100	5%	505	60	2%	185	690	590	200
15-10-2026	170	15%	1515	150	15%	1389	2904	2604	
31-12-2026	200	20%	2020	180	15%	1389	3409	3109	
Balance monetary value of reward points (₹)3,109 would be applied as discount at renewal									

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

Relation	Self	Spouse	Child	
Sum insured (₹)	10L			
Age Band	31	26	0-17	Premium total of eligible members
Floater Discounted premi	11,220	5,146	3,562	16,366
Points Earned	200	180	NA	190 (Average of Points)

% value of points earned	20%
Monetary value of reward points (₹)	3,273

Detail breakup of reward point calculation (Earning and burning)

Date	Self	Spouse	Average of points earned	% value of points earned	Monetary value (₹)	Balance available for utilization (₹)	Burn/Utilised (OPD/ Pharmacy/ NME) (₹)
	Points earned as on date	Points earned as on date					
21-03-2026	40	30	35	2%	327		100
31-08-2026	100	60	80	2%	327	227	
15-10-2026	170	150	160	15%	2,455	2,355	200
31-12-2026	200	180	190	20%	3,273	2,973	Applied as discount at renewal
Balance monetary value of reward points (₹) 2,973/- would be applied as discount at renewal							

1) Stress & Happiness Index score

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

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

2) Expert Wellness Assessment

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

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

3) Participation in GCI organized events

Insured Person has an option to participate in GCI organized events and view wellness content through GCI mobile App. The reward points would be awarded for participation in a campaign or event organized by Us or viewing the wellness content. We will provide the information on health and wellness training, health related applications etc.

4) Lifestyle disease monitor

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

	Condition	Health parameters	Points Allotted
1	Blood Pressure	Blood pressure Systolic Up to 140/ Diastolic up to 90 mm Hg	10
2	Glycosylated Haemoglobin	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.
   a) Daily Step tracking (monthly average of 10000 steps/day). The step count can be tracked either through our GCI mobile App. or insured can sync his/her fitness device with our App.
   b) Participation in Marathon, Cyclathons etc.: Insured can upload the completion certificate of the event on the GCI mobile App.
   c) Burning average of 300 calories per day in a month. The calorie burning count can be tracked either through the GCI mobile App. or insured can sync his/her fitness device with our App.
   d) Submission of monthly Gym/Yoga membership detail - Insured can upload the monthly membership receipts on the GCI mobile App.
   e) Wellness points will be allotted basis the activity details submitted by the insured at the end of 30 days

Conditions applicable for burning of points:

1) The points earned will float among all members of the family irrespective of the persons who have contributed for earning the points.
2) Points earned in first year can be carried forward to 2nd or 3rd year in case of long term policies.
3) The points can be burned for utilization of following benefits
   i. Availing Out-patient Consultations through the Wellness Partner network clinics
   ii. Diagnostic tests, preventive tests through the Wellness Partner network clinics
   iii. Purchase of Prescribed medicines through online pharmacy having tie up with Our Wellness Partner
   iv. Reimbursement of Non-medical expenses in case of claim under Section 2.1.1 (Hospitalization Medical expenses)
   v. Renewal Discount –

a) Insured Person /Policy holder has an option to utilize the balance reward points as discount in premium at the time of renewal of the Policy.

b) If the insured does not opt for Renewal discount, then the insured has an option to redeem the wellness reward points for availing the services as mentioned in point no. i, ii & iii above. The accrued wellness points can be utilized up to a period of 3 months from the policy expiry date

In case the wellness points earned are not utilized within 3 months from policy expiry date, then the amount equivalent to the total accrued wellness points, shall either be refunded to the policyholder or the policyholder shall be allowed to encash the points through vouchers under wellness programs.

c) After the renewal of the Policy with applicable wellness discount, the insured can continue to earn and accrue wellness reward points till the policy expiry date. The wellness points earned post renewal, that results in change of slab with respect to "Value of points earned", can be utilized for availing the services as mentioned in point no. i, ii & iii above. Such wellness points can be utilized up to a period of 3 months from the policy expiry date.

In case the wellness points earned post renewal of policy is not utilized within 3 months from policy expiry date, then the amount equivalent to the difference between the slab considered for wellness discount at renewal and the new slab, shall either be refunded to the policyholder or the policyholder shall be allowed to encash the points through vouchers under wellness programs.

4) In case of cancellation of the policy or if the policy is not renewed with Us, any wellness reward points earned by the Insured can be utilized up to 3 months from the policy cancellation date or policy end date for the following benefits only.

i. Availing Out-patient Consultations through Our Wellness Partner network clinics
ii. Diagnostic tests, preventive tests through Our Wellness Partner network clinics
iii. Purchase of Prescribed medicines through online pharmacy having tie up with Our Wellness Partner

2.1.17 Cumulative Bonus

Cumulative Bonus shall be increased by 50% in respect of each claim free policy year (where no claims are reported) with the exception of any claim under Section 2.1.14 (OPD treatment) and Section 2.1.16 (Wellness Benefits), provided the policy is renewed with Us without a break subject to maximum up to 100% of the Sum Insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, Sum Insured will be maintained and will not be reduced in the policy year.

Notes:

a) In case where the policy is on Individual / Non Floater basis, the CB shall be added and available individually to the Insured Person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.

b) In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.

c) CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
d) If the Insured Persons on the expiring policy are covered on an individual / Non Floater basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
e) In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/ individual policies, or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion to the Sum Insured of each Renewed Policy.
f) If the Sum insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
g) If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
h) If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of renewal premium any awarded CB shall be withdrawn.

2.1.18 Restoration of the Sum Insured

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

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

a) The Restore Sum Insured can be used for claims made for same illness/new illness in respect of Section 2.1.1 to Section 2.1.4;
b) The Restore Sum Insured will happen only once during a Policy Year;
c) If the Restore Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
d) If the Policy is issued on Individual / Non Floater basis, then the restore sum insured will be available to each Insured Person.
e) If the Policy is issued on Floater basis, then the restore sum insured will be available on Floater basis for all Insured Persons in the family.

2.1.19 Bariatric Surgery

We will pay the Reasonable and Customary Charges for Medical Expenses incurred towards Surgical Procedure for obesity up to the Sum Insured limits specified in the Schedule of Benefits, subject to below conditions:

a) Our obligation to make payment in respect of Bariatric Surgery (after 36 months of continuous coverage from the first policy inception) shall be restricted to 50% of the Sum Insured, maximum up to the amount mentioned in the Schedule of Benefits per policy Year.

b) The claim related to Bariatric Surgery shall be payable only for expenses related to the surgical treatment of obesity that fulfil below conditions:
    1) Surgery to be conducted is upon the advice of the Medical Practitioner
    2) The surgery/Procedure conducted should be supported by clinical protocols
    3) The Insured Person has to be 18 years of age or older and
    4) Body Mass Index (BMI);
        i. greater than or equal to 40 or
        ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
            a. Obesity-related cardiomyopathy
            b. Coronary heart disease
            c. Severe Sleep Apnea
            d. Uncontrolled Type2 Diabetes

c) Clause 3.2.3 shall not apply to the extent of cover provided under this benefit

2.2. Optional Covers

The benefits available under the Optional Cover are to be selected by You based on Your requirement. Such selected benefits will be included in the Policy on payment of additional premium to Us. The Policy Schedule will specify such selected benefit details along with Your chosen cover limit / sublimit, which shall be in force for the Insured Persons during the Policy Period.

2.2.1 Voluntary Deductible

If a Voluntary Deductible has been opted for and is in force under the Policy, Our liability would be over and above the Voluntary Deductible amount on an aggregate basis for all the admissible claims under the policy.

The deductible shall not be applicable to the following benefits:

- Accidental Hospitalization
- Emergency Road Ambulance
- Emergency Medical Evacuation
- Home Health Care
- OPD Treatment
- Wellness Benefit
- Bariatric Surgery

2.2.2 Consumables / Non-Medical Expenses Cover

We will cover expenses incurred towards consumables and non-medical expenses which are listed in “List I – Items for which coverage is not available in the Policy” under Annexure I. Our maximum liability under this benefit shall be up to 15% of the admissible claims amount

Special Conditions:

a) Such consumables are utilized or consumed during the in-patient treatment related to the Insured Person's medical or surgical treatment.
b) We have accepted a claim for Hospitalization under Section 2.1.1 (Hospitalization Medical Expenses), Section 2.1.2 (Daycare Treatment Expenses) and provided that the expenses

on Non-Medical Items pertain to the same Illness/injury admitted by us.

c) This benefit can be opted at inception or at subsequent renewals.
d) Pre and post hospitalization expenses will be excluded from this cover.

2.2.3 Cumulative Bonus Booster

The Cumulative Bonus shall be increased by 50% in respect of each claim free policy year (where no claims are reported) with the exception of any claim under Section 2.1.14 (OPD treatment) and Section 2.1.16 (Wellness Benefits), provided the policy is renewed with Us without a break, subject to maximum of 500%/1000% of the expiring Sum or the renewal Sum Insured, whichever is lower.

a) If a claim is made in any particular Policy 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.
b) In case where the policy is on Individual / Non Floater basis, the CBB shall be added and available individually to the Insured Person if no claim has been reported.
c) In case where the policy is on floater basis, the CBB shall be added and available to the family on a floater basis, provided no claim has been reported from any member of the family.
d) CBB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
e) If the Insured Persons on the expiring policy are covered on an individual / Non Floater basis as specified in the Policy Schedule and there is an accumulated CBB 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 CBB 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.
f) In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/ individual policies, or in cases where the policy is split due to the child attaining the age of 25 years, the CBB of the expiring policy shall be apportioned to such Renewed Policies in the proportion to the Sum Insured of each Renewed Policy.
g) If the Sum insured has been reduced at the time of Renewal, the applicable CBB shall be reduced in the same proportion to the Sum Insured in current Policy.
h) If the Sum Insured under the Policy has been increased at the time of Renewal the CBB shall be calculated on the Sum Insured of the last completed Policy Year.

At the time of renewal, if the policyholder chooses not to renew the stated optional benefit, the accrued CBB under the expiring policy will be forfeited.

2.2.4 Critical illness Booster

We will double Sum Insured for Medical Expenses incurred in case the Insured Person is hospitalized due to any of the listed Critical Illness (as mentioned and defined under clause 1.1.10) which occurred during the Policy Year. Such increase of the Sum Insured shall be available for claims arising under Section 2.1.1 (Hospitalization Medical Expenses).
This benefit is subject to the following conditions:

a) Cumulative Bonus and Cumulative Bonus Booster (if any) will not be considered for assessing the Sum Insured increase under this Benefit.
b) The benefit can be utilized by the Insured Person diagnosed with a Critical Illness during the Policy Year and such diagnosed Critical Illness occurs or manifests itself as a first incidence.
c) The Insured Person diagnosed with a particular Critical Illness during any Policy Year shall not be allowed to claim under this benefit for the same Critical Illness in any subsequent Policy Year. The benefit is available only once in a lifetime of the Policy.
d) We have accepted the claim under Section 2.1.1(Hospitalization Medical Expenses)
e) Any unutilized amount cannot be carried forward to the next Policy Year.
f) The additional Sum Insured shall be available on exhaustion of the Policy Sum Insured and Cumulative Bonus (If any)
g) The Insured should be covered along with this benefit included for a continuous period of 36 months, before this benefit comes into effect.
h) If the Policy is issued on Individual / Non-Floater basis, then the Critical illness Booster will be available to each Insured Person.
i) If the Policy is issued on Floater basis, then the Critical illness Booster will be available on Floater basis for all Insured Persons in the family.
j) In case of an admissible claim, the sequence of Sum Insured applicability shall be –
   1 Base Sum Insured
   2 Cumulative Bonus/Cumulative Bonus Booster (if any)
   3 Restoration of the Sum Insured
   4 Critical Illness Booster

2.2.5 PED Coverage for ABCD Illness (A-Asthma, B-High Blood Pressure, C-High Cholesterol, D- Diabetes)

This benefit shall waive off the applicable PED Waiting Period on Asthma, High Blood Pressure, Cholesterol and Diabetes and the coverage shall start from the 31st day of Policy start day (after serving initial waiting period of 30 days), provided

a) The PED is declared by the Insured Person and accepted by Us at the inception of the policy or has been detected during Pre-policy medical examination and accepted by Us
b) Once this optional cover is opted, it cannot be opted out in the subsequent renewal.
c) This benefit shall apply to claims incurred under Section 2.1.1 (Hospitalization Medical Expenses) and Section 2.1.2 (Daycare Treatment Expenses)
d) This Benefit will be available only at the time of inception of the first policy or addition of the new member.
e) A waiting period of 30 days shall apply on the incremented Sum Insured in case the Sum Insured is increased at the time of subsequent renewals.
f) Clause no 3.1.1 shall not be applicable to the extent of the listed conditions (Asthma, High Blood Pressure, Cholesterol and Diabetes) under this benefit.

2.2.6 Accident Care (AD, PTD and PPD)

If an Insured Person suffers an Injury due to an Accident during the Policy Year, and that Injury solely results in Death, Permanent Total Disablement OR Permanent Partial Disability of Insured

Person within 365 days from the date of the Accident, We will pay the Sum Insured as specified in Policy Schedule and the percentage of Sum Insured as given in the table below.
This cover is available only for Insured Person/s aged 3 to 65 years, during first time issuance of the policy.
Irrespective of individual or floater policy this benefit shall be available on individual basis.

	Lumpsum benefit	
Sr no	**Event**	**Percentage of Sum Insured**
1	**Accidental Death**	100%
2	**Permanent Total Disablement**	
	Permanent total loss of sight of both Eyes	100%
	Permanent total loss of sight of one eye and physical separation of or the loss of ability to use either one hand or foot	100%
	Permanent total loss or physical separation of or the loss of ability to use both hands or both feet	100%
	Permanent total loss or physical separation of or the loss of ability to use one hand and foot	100%
3	**Permanent Partial Disability**	
	An arm at the shoulder joint	75%
	An arm above the elbow joint	70%
	A hand at the wrist	50%
	An arm beneath the elbow joint	60%
	A thumb	25%
	An index Finger	10%
	Any other Finger	5%
	A leg above mid-thigh	75%
	A leg up to mid-thigh	60%
	A leg up to beneath the knee	50%
	A leg up to mid-calf	45%
	A foot at the ankle	40%
	A large Toe	5%
	Any other Toe	2%
	Sight of one eye	50%
	Hearing of one ear	25%
	Hearing of both ears	75%
	Sense of smell	10%
	Sense of taste	5%
	Shortening of leg by at least 5%	7%
	Any other Permanent Partial Disablement	Percentage as certified by Government Civil Surgeon in India

2.2.7 Mandatory Co-pay Waiver

This Optional Cover, when opted for and is in force under the Policy, shall waive the Co-payment applicable for any Insured Person aged 61 years and above, being covered for the first time in the Policy.

Specific Conditions applicable to this benefit are:

a) This Cover can be opted at inception of the first Policy or at subsequent Renewals.
b) Once the Mandatory Co-payment Waiver is opted and subsequently opted out at any future renewal, then it cannot be re-opted again by the Insured Person thereafter.
c) Clause no 5.7 shall not be applicable to the extent of cover applicable under this benefit.

3. EXCLUSIONS

3.1 Waiting Periods

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

3.1.1 Pre-Existing Disease- Excl 01

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with Us.
b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

3.1.2 Specified disease/procedure waiting period- Code- Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures:

A. Waiting period of 36 months:

i. Rheumatoid Arthritis
ii. Gout

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

B. Waiting period of 24 months:

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

3.1.3 30 days waiting period Excl-03

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

3.2 Standard Exclusions:

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

3.2.1 Investigation & Evaluation- Code- Excl04

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

3.2.2 Rest Cure, rehabilitation and respite care- Code- Excl05

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

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

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

3.2.3 Obesity/ Weight Control: Code- Excl06

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

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

3.2.4 Change-of-Gender treatments: Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

3.2.5 Cosmetic or Plastic Surgery: Code- Excl08

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

3.2.6 Hazardous or Adventure sports: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

3.2.7 Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

3.2.8 Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Us and disclosed in Our website/ notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

3.2.9 Code- Excl12

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

3.2.10 Code –Excl 13

Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is

arranged wholly or partly for domestic reasons.

3.2.11 Code- Excl14

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

3.2.12 Refractive Error: Code- Excl15

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

3.2.13 Unproven Treatments: Code- Excl16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

3.2.14 Sterility and Infertility: Code- Excl17

Expenses related to, sterility and infertility. This includes:

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

3.2.15 Maternity: Code-Excl 18

Medical treatment expenses traceable to child-birth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Period.

3.3 Specific Exclusions

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

3.3.1 Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not).

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

3.3.3 Vaccination/ inoculation (except as post bite treatment)

3.3.4 Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, durable medical equipment (including but not limited to cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and oxygen concentrator for asthmatic condition, wheel chair, crutches, artificial limbs, belts, braces, stocking, Glucometer and the like), namely that equipment used externally for the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose, such cost of all appliances/devices whether for diagnosis or treatment after discharge from the Hospital.

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

3.3.6 External Congenital Anomaly and related Illness/ defect.
3.3.7 Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.
3.3.8 Stem cell storage.
3.3.9 Non-prescribed drugs and medical supplies, hormone replacement therapy.
3.3.10 Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
3.3.11 Outpatient diagnostic, medical and Surgical Procedures or treatments.
3.3.12 Dental Consultations, Dental Treatment or Surgery of any kind unless requiring Hospitalization as a result of Injury.
3.3.13 A Medical Practitioner's home visit charges during pre and post Hospitalization period and attendant nursing charges.
3.3.14 Treatment outside India.
3.3.15 Intentional self-Injury.
3.3.16 Any complications arising out of the Infertility treatment.
3.3.17 Any specific exclusion(s) applied by Us, specified in the Schedule and accepted by the insured.

4. General Terms and Clauses

4.1 Standard General Terms and Clauses

4.1.1 Disclosure to Information Norm

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

4.1.2 Condition Precedent to Admission of Liability

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

4.1.3 Material Change

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

4.1.4 Records to be Maintained.

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

4.1.5 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.

4.1.6 Notice & Communication

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

4.1.7 Territorial Limits and Law:

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.
The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law.
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.

4.1.8 Multiple Policies

a) 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.
b) Where an Insured Person holds policies from more than one Insurer to cover the same risk on an indemnity basis, the Insured Person shall only be indemnified for treatment costs in accordance with the terms and conditions of the chosen policy.
c) In the case of multiple indemnity policies taken by an Insured Person during a period from one or more Insurers, the Insured Person shall have the right to require settlement of their claim under any of their policies, subject to proper disclosure of information about their multiple policies to the chosen Insurer, either at the policy inception or at the time of claim intimation.
d) Upon a claim, the Insurer chosen by the Insured for claim settlement shall be treated as the Primary Insurer and shall be obligated to settle the claim within the limits and terms of the chosen policy. If the available coverage under the chosen policy is less than the admissible claim amount, the Primary Insurer shall co-ordinate with other Insurer to ensure settlement of the balance amount as per the policy contract.

4.1.9 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

4.1.10 Automatic change in Coverage under the policy:

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

a) In the case of his/ her (Insured Person) demise.
However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardians or guardians appointed by court. All relevant particulars in respect of such a person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.
b) Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

4.1.11 Territorial Jurisdiction:

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

4.1.12 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.

4.1.13 Free Look Period

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

The Insured Person shall be allowed free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

a) a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or
b) Where the risk has already commenced and the option of return of the policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or

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

A request received by insurer for cancellation of the Policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request.

In the case of delay in the refund, the Company shall refund such amounts along with interest at the bank rate plus 2% on the refundable amount, from the date of receipt of the request for free look cancellation till the date of refund.

4.1.14 Endorsements (Changes in Policy)

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

4.1.15 Withdrawal of Policy

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.

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.

4.1.16 Moratorium Period

a) 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.
b) 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.

4.1.17 Nomination

a) 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.
b) 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.

4.1.18 Redressal of Grievance

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

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

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

For updated details of grievance officer, kindly refer the link
https://generalicentralinsurance.com/customer-service/downloads
If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
Kindly refer the annexure on Grievance Redressal Procedures.

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

4.2 Specific General Terms and Clauses

4.2.1 Change of Sum Insured:

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.
You can submit a request for the changes by filling the Proposal before the expiry of the Policy

4.2.2 Terms and conditions of the Policy:

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

4.2.3 Migration

a) The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get all the accrued continuity benefits in waiting periods as below:
b) The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance

Policy.

c) For the purpose of this product the Migration benefit is applicable only for the waiting periods.

4.2.4 Portability

a) The insured person will have the option to port the policy to other insurers at the time of renewal by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal 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 under

b) The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

c) Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured

d) For the purpose of this product the Portability is applicable only for the waiting periods.

4.2.5 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.

4.2.6 Renewal of Policy

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

a) The Company shall give notice for renewal to all policyholders except on grounds of fraud, misrepresentation by the Insured Person
b) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
c) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
e) No loading shall apply on renewals based on individual claims experience

4.2.7 Premium Payment in Instalment

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

a) Grace Period of 15 days would be given to pay in case of monthly instalment premium and Grace Period of 30 days shall be given to pay in case of quarterly / Half Yearly installment premiums, due for the
b) policy.
c) 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.
d) No interest will be charged If the instalment premium is not paid on due date
e) In case the instalment premium due, is not received within the grace period, the policy will get cancelled.
f) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
g) The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
h) The payment will be accepted through E-NACH / ACH/ ECS / any other mode approved by Government of India.
i) 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.
j) 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.

k) In case there is failure in transaction in E-NACH/ ACH/ ECS mode/ any other mode approved by Government of India or the instalment premiums are not received within the grace period, the Policy will get cancelled. A fresh policy with all waiting periods would be issued.
l) If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered.

4.2.8 Proportionate Deduction

In case the Insured Person is admitted to a Room at rates above the admissible Room Rent limits as specified in the Policy Schedule, then We will reimburse / pay all other associated medical expenses incurred at the Hospital as per the proportion of the admissible rate per day to the actual rate per day of Room Rent.

Proportionate Deductions shall not be applied to the following:

a) in respect of Hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on room category.
b) to ICU Charges
c) in respect of the Policy where the Policyholder has opted for Room Rent without any capping.

5. Claims Procedures

5.1 Procedures for Cashless Claims

Cashless Facility is only available at a Network Provider. In order to avail Cashless Facility, the following procedure must be followed:

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

5.2 Procedure for Reimbursement Claim

If a pre-authorisation request is denied by Us or if treatment is taken in a Hospital other than a Network Provider or if You/ Insured Person does not wish to avail Cashless Facility, then:

1) We must be given Notification of Claim immediately and in any event within 48 hours of the admission to the Hospital.
2) The Insured Person must take reasonable steps or measures in good faith to minimise

the quantum of any claim that may be made under this Policy.

3) The Insured Person must submit to examination by Our medical advisors if We ask, the cost for which will be borne by Us.

5.3 Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

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

5.4 Documents to be submitted

We must be given promptly, and in any event within 15 days of the Insured Person's discharge from a Hospital, the documentation including written details of the quantum of any claim along with all original supporting documentation, including but not limited to the following, and other information We ask for to investigate the claim for Our obligation to make payment for it:

1) The claim form specified by Us duly completed and signed by the claimant or a family member;
2) First consultation letter;
3) First prescription from the Medical Practitioner;
4) Original vouchers/ invoice of original bill ;
5) Original Hospital bills giving a detailed break up of all expense heads mentioned in the bill;
6) Money receipt duly signed with a revenue stamp;
7) Birth/Death certificate (as applicable);
8) The original Hospital discharge card/ summary;
9) All original laboratory and diagnostic test reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram, etc
10) If medicines have been purchased in cash and if this has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner and the supporting medicine bill from the chemist;
11) If diagnostic or radiology tests have been paid for in cash and it has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner advising the tests, the actual test reports and the bill from the diagnostic centre for the tests.
12) Copy of proposer`s photo ID proof & address proof
13) NEFT Form with photocopy of cancelled cheque with printed name of proposer
14) Copy of Operation theatre Notes, if applicable
15) Copy of the Claim Intimation, if any
16) Copies of health insurance policies held with any other insurer covering the insured persons.
17) 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.
18) 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:
19) In the event of Your/Insured Person's death, You/Insured Person's nominee/legal heir claiming on his/her behalf must inform Us immediately and send Us a copy of the postmortem report (if any).

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

5.5 Payment of Claim

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

5.6 Claim settlement

1) The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of the last necessary document.
2) 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.
3) 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.
4) 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.
5) In case of 'pending' claims, We will ask for submission of incomplete documents.
6) 'Rejected' claims will be informed to the Insured Person in writing with reasons for rejection.

5.7 Co-Payments Applicable under the Policy

The mandatory Co-Payment of 20% shall be applicable on each and every claim, subject to the following:

1) The mandatory Co-Payment will be applicable for all the Insured Persons who are aged 61 years and above at the time of issuance of the first Policy with Us.
2) The mandatory Co-Payment applicable to the Insured Person at the inception of the first policy will also be applicable on all subsequent renewals.
3) The mandatory Co-Payment shall not be applicable to the following benefits:
    - OPD treatment
    - Wellness Benefits

5.8 Voluntary Deductible Applicable under the Policy

1) If a Voluntary Deductible has been opted and is in force under the Policy, Our liability would be over and above the Voluntary Deductible amount on aggregate basis for all the admissible claims under the policy other than Section 2.1.14 (OPD Treatment) and Section 2.1.16 (Wellness Benefits) including claims related to any one illness
2) Wherever Co-payments are applicable, as per Clause 5.7 above, the same would be applied on the admissible claim amount after the application of Voluntary Deductible, if any.

Annexure : Schedule of Benefits

Eligibility	Sum Insured (In ₹)	5 L, 10 L	15 L, 20 L, 25 L, 30 L, 35 L	50 **L**, 75 **L**, 1 Crore
	Minimum Entry Age	Child - 91 Day	Child - 91 Day	Child - 91 Day
		Adult - 18 years	Adult - 18 years	Adult - 18 years
	Maximum Entry Age	Child - 25 years	Child - 25 years	Child - 25 years
		Adult – 65 year	Adult - 65 year	Adult - 65 year
	Maximum Renewal Age	Life Long	Life Long	Life Long
	Cover Type	- Individual / Non-Floater/ Family Floater	- Individual / Non-Floater/ Family Floater	- Individual / Non-Floater/ Family Floater
	Family Definition	For all business– Family Floater – Self + Spouse + 3 Children (Up To 25 Years) For parents separate policy can be taken	For all business– Family Floater – Self + Spouse + 3 Children (Up To 25 Years) For parents separate policy can be taken	For all business– Family Floater – Self + Spouse + 3 Children (Up To 25 Years) For parents separate policy can be taken
Hospitalization Medical Expenses		Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
Room Rent Limit - Normal		Single Pvt Room	Single Pvt Room	Single Pvt Room
Room Rent Limit - ICU		Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
Day Care Treatment Expenses		Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
Pre-Hospitalization Medical Expenses		60/ 90 Days	60/ 90 Days	60/ 90 Days
Post-Hospitalization Medical Expenses		90/ 120 Days	120/ 150 Days	150/ 180 Days
Organ Donor Expenses		Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
Modern Treatment Methods & Advancement in Technologies		Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
AYUSH Treatments		Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
Accidental Hospitalization		Covered	Covered	Covered
		In Case Of Accidental Hospitalization Increase In- 25% Of Available Balance Sum Insured, Subject To Maximum Of ₹10 Lakh		
Emergency Road Ambulance		₹ 1500/ hospitalization	₹ 2000/ hospitalization	₹ 5000/ hospitalization
Emergency Medical Evacuation		Not Applicable	Up to 5% of the SI	Up to 5% of the SI
Home Healthcare Expenses		Up to 20% of SI	Up to 20% of SI	Up to 20% of SI

Cataract (Waiting Period – 24 months)		10% Of SI, Maximum Of ₹ 75,000/- Per Eye	10% Of SI, Maximum Of ₹ 1.5 Lac Per Eye	10% Of SI, Maximum Of ₹ 2 Lac Per Eye
LASIK (Waiting Period – 36 months)		Covered Up To ₹ 30,000 for Both Eyes	Covered Up To ₹ 50,000 for Both Eyes	Covered Up To ₹ 1 Lac for Both Eyes
		Only Once During the Entire Tenure Of Policy With Us		
Patient Care (Above 60 Years) - Per Day Benefit		Maximum Up To ₹ 350/Day	Maximum Up To ₹ 500/Day	Maximum Up To ₹ 1,000/Day
		Limited To 10 Days Per Hospitalization And 30 Days Per Policy Year		
Accompanying Person (Up to 12 Years)		₹ 500/- per day	₹ 750/- per day	₹ 1000/- per day
		Maximum of 30 days per policy year		
OPD Treatment		Not Applicable	₹ 7.5 K	₹ 10 K
		Consultations/ Diagnostics are covered. 30% Co-Pay applicable. 1st 30 days & PED Waiting Periods shall be applicable.		
E-Opinion for Illness/ Injury (Per Policy Year)		Twice	Twice	Twice
Wellness Benefits		Available	Available	Available
Cumulative Bonus		50% per claim free policy year; max accumulation of 100%; CB shall be reduced in case of claims	50% per claim free policy year; max accumulation of 100%; CB shall be reduced in case of claims	50% per claim free policy year; max accumulation of 100%; CB shall be reduced in case of claims
Restoration of Sum Insured		Available	Available	Available
		-Equal to 100% of the base Sum Insured excluding Cumulative Bonus, if any. -Available once for the particular Policy year for a second claim irrespective of the Sum Insured and Cumulative Bonus (if any) is completely or partially exhausted.		
Bariatric Surgery (Waiting-36 months)		50% of SI up to a maximum of ₹ 5 Lac	₹ 7.5 Lac	₹ 10 Lac
Waiting Periods	Pre-Existing Disease Waiting Period			
	Pre-Existing Disease Waiting Period	3 Years	3 Years	3 Years
	General Waiting Periods			
	30-Days	Applicable	Applicable	Applicable
	2-Years - For Listed Conditions	Applicable	Applicable	Applicable
	3 Years - For Listed Conditions	Applicable	Applicable	Applicable
Compulsory Co-Pay - 20% Co-Payment Where Entry Age Is		Applicable	Applicable	Applicable

61years And Above			
Optional Covers			
Voluntary Deductible (Annual Aggregate)	₹ 10K/25K/ 50K	₹ 50K/75K/ 1 Lac	₹ 1/ 2.5 /5 Lac
Consumables / Non-Medical Expenses Cover	Up 15% of the admissible claims amount	Up 15% of the admissible claims amount	Up 15% of the admissible claims amount
Cumulative Bonus Booster	Available	Available	Available
	CB equivalent to 50% of the SI can be earned for a claim free policy year and such CB can accumulated max. up to 2 options (500%/ 1000%). In the event of claim, it shall be reduced by 50%.		
Critical Illness Booster (Waiting Period-36 months)	Double Sum Insured for named Critical Illness	Double Sum Insured for named Critical Illness	Double Sum Insured for named Critical Illness
	The benefit is available only once in a lifetime of the Policy		
PED Coverage for ABCD Illness (A-Asthma, B-High Blood Pressure, C-High Cholesterol, D-Diabetes)	Available	Available	Available
Accident Care (AD, PTD & PPD)	₹ 5L/10 Lac	₹ 5L/10L/15/20 Lac	₹ 5L/10L/15/20 Lac
	Entry age - Adult Min 18 Years & Max 65 Years		
Mandatory Co-pay Waiver	Available	Available	Available

Annexure I

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

S. No.	Item
1.	BABY FOOD
2.	BABY UTILITES CHARGES
3.	BEAUTY SERVICES
4.	BELTS/ BRACES
5.	BUDS
6.	COLD PACK/HOT PACK
7.	CARRY BAGS
8.	EMAIL / INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE

17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVENYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG/ SHORT/ HINGED)
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53.	SUGAR FREE TABLETS
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS

62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	VASOFIX SAFETY

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

S. No.	Item
1.	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU-DE-COLOGNE / ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP
19.	DISINFECTANT LOTIONS
20.	LUXURY TAX
21.	HVAC
22.	HOUSE KEEPING CHARGES
23.	AIR CONDITIONER CHARGES
24.	IM IV INJECTION CHARGES
25.	CLEAN SHEET
26.	BLANKET/WARMER BLANKET
27.	ADMISSION KIT
28.	DIABETIC CHART CHARGES
29.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30.	DISCHARGE PROCEDURE CHARGES
31.	DAILY CHART CHARGES
32.	ENTRANCE PASS / VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES
35.	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36.	PATIENT IDENTIFICATION BAND / NAME TAG
37.	PULSEOXYMETER CHARGES

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

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

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

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

In case of any claims, contact:

Claims Department
Generali Central Health (GCH)
Generali Central Insurance Co. Ltd.
Qubix Business Park, Building No. Block IT – 1, Ground Floor, Plot No. 2, Blueridge Township, Near Rajiv Gandhi Infotech Park, Phase – 1, Village Hinjawadi, Taluka Mulshi,
Pune, Maharashtra - 411057

Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | IRDAI Regn. No.: 132 | CIN: U66030MH2006PLC165287
| Website: www.generalicentralinsurance.com | Email ID: gcicare@generalicentral.com| Toll-free Phone: 1800 220 233 / 1860 500 3333/ 022 6783 7800
ISO No: GCH/HP/HFT/PWG/001

GRIEVANCE REDRESSAL PROCEDURE

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

We request you to read the policy document including the terms and conditions carefully. This will help you understand your plan and drive maximum benefits. We want to ensure the plan is working for you and welcome your feedback.

What is a grievance?

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

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

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

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

By when will my grievance be resolved?

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

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

- You may write to our Grievance Redressal Officer at **GCIGRO@generalicentral.com**

- You may send a physical letter to our Grievance Redressal Cell, Head Ofice at the below address:

GENERALI CENTRAL INSURANCE COMPANY LIMITED (Formerly known as Future Generali India Insurance Company Limited)

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

What if I am not able to register my grievance?

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

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

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

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

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

Insurance Ombudsman:

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

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