HEALTH XTRA
PROSPECTUS

1. SALIENT FEATURES OF THE POLICY

BASE COVERS

- Hospitalization Medical Expenses
- Day Care Treatment Expenses.
- Pre-Hospitalization Medical Expenses.
- Post-Hospitalization Medical Expenses.
- Organ Donor Expenses.
- Modern Treatment Methods and Advancement in Technologies
- AYUSH Treatment
- Accidental Hospitalization
- Emergency Road Ambulance
- Emergency Medical Evacuation
- Home Health Care Expenses
- Patient Care.
- Accompanying Person
- OPD Treatment
- E-Opinion for illness or injury
- Wellness Benefits
- Cumulative Bonus
- Restoration of Sum Insured
- Bariatric Surgery

OPTIONAL COVERS

- Voluntary Deductible
- Consumables/Non-Medical Expenses Cover
- Cumulative Bonus Booster
- Critical illness Booster
- PED Coverage for ABCD Illness
- Accident Care
- Mandatory Co-pay Waiver

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 when organized) and viewing of GCI Content around well	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 (₹)3109 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	264	
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 generalicentralinsurance.com/customer-service/grievance-redressal
If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
Kindly refer the annexure on Grievance Redressal Procedures.

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

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 at least 30 days in advance from the due date.

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.

4.2.9 Cost of Pre-Policy Medical Examination

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

4.2.10 Discounts & Loadings:

a) Long Term Discount - (applicable in case of single payment for policy term of more than one year)

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

b) Individual SI Option – 10% Family discount in case of more than one insured covered under the same policy.

c) Web sales / Tele sales discount -

A discount of 5% in lieu of intermediary commissions if policy is sourced directly from the Company's website or through leads generated via Tele sales channel.

d) Discount if currently covered under any Group policy by GCI - 10% Discount if currently covered under Group Health Insurance product of GCI.

e) Employee discount -

We shall accord a discount of 5% on the premium amount, against proposals received from the following categories of individuals, provided that the respective individual, at least till the date of issuance of the policy cover, continues to be in/of such capacity:

a) Employed with Generali Central Insurance Co. Ltd., recorded through its official rolls/register.
b) Employed with Generali Central Life Insurance Co. Ltd., recorded through its official rolls/register.
c) Contracted for provision of services directly by Generali Central Insurance Co. Ltd., recorded through appointment/engagement letter or like document.
d) Contracted for provision of services directly by Generali Central Life Insurance Co. Ltd., recorded through appointment/engagement letter or like document. Towards entitlement of the discount, each eligible proposer shall have to submit with Generali Central Insurance Co. Ltd., alongside the proposal, a self-certified copy of the identification card or appointment/engagement letter or such document that may have

been issued in favour of the proposer to evidence the relationship, which bears an identification mark/logo of the issuing entity.

Note: - Either Websales/Telesales/Employee discount would apply in a single policy

f) Floater discount –

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

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

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

<table>
<tr><td colspan="4">Sum insured is 10,00,000</td></tr>
<tr><td></td><td>Self (Male)</td><td>Spouse (Female)</td><td>Child (Female)</td></tr>
<tr><td>Age (in years)</td><td>35</td><td>31</td><td>0-17</td></tr>
<tr><td>Premium as per Individual rate table (in ₹)</td><td>12,786</td><td>11,220</td><td>8,904</td></tr>
<tr><td rowspan="2">Applicable premium (in ₹)</td><td rowspan="2">12,457</td><td>6,171</td><td>3562</td></tr>
<tr><td>(45% discount applied on the respective person’s premium)</td><td>(60% discount applied on the respective person’s premium)</td></tr>
<tr><td rowspan="2">Total Premium to be charged (in ₹)</td><td colspan="3">12,457+6,171+3,562</td></tr>
<tr><td colspan="3">22,519</td></tr>
</table>

g) Instalment Loading - Insured has an option to pay a premium on an instalment basis. Given below are the loadings applicable on Standard premiums in case of instalments.

Instalment Frequency	Loading on standard premiums
Monthly	5%

Quarterly	4%
Half Yearly	3%

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

Eligibility

a) Policy Options: Individual/Non-Floater and Family Floater.

b) Policy Tenure: 1,2 & 3 Years

c) Age Eligibility:

Minimum Entry Age	Dependent Child - 91 Day
	Adult - 18 years
Maximum Entry Age	Dependent Child – 25 Years
	Adult – 65 Years
Maximum Renewal Age	Life Long

d) Family Definition:

Individual/Non-Floater - Self, Legally married spouse/Live-in Partner, Children, Parents, Parents in law, Siblings, Daughter-in-law, Son-in-law, Grandparents, Grandchildren
Individual/Non-Floater –
Up to 10 lac SI - Max 4 adults and 3 children can be covered under single policy.
Above 10 lac SI - Max 15 members under single policy

Family Floater - Self, Legally married spouse/Live-in Partner, up to 3 dependent children.
For Parents separate floater policy can be take.
Family Floater – Max 5 members can be covered under single policy.

e) Sums Insured Available in the product are as below:

Sum Insured (In ₹)	₹ 5L, ₹10L, ₹15L, ₹25L, ₹30L, ₹35L, ₹50L, ₹75L, ₹100L

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 to Prospectus –

A. Schedule of Benefit (Refer Policy Wordings)
B. Annexure I: List of Non-Medical Expense (Refer Policy Wordings)
C. Grievance Redressal Procedures (Refer Policy Wordings)

This is only for ready reference and is indicative in nature. For complete terms of this product, please refer to the Policy Wordings. For assistance, please visit our website at https://generalicentralinsurance.com/customer-service/downloads or call us at 1800 103 8889.

6. Premium Tables exclusive of Goods & Services Tax (age in completed years)

6.1 INDIVIDUAL PREMIUM (BASE COVERS):

Age band	5L	10L	15L	20L	25L	30L	35L	50L	75L	100L
0 - 17	7,918	8,904	10,957	11,768	12,733	13,313	13,893	16,299	18,028	19,626
18 - 25	8,290	9,384	11,791	12,681	13,745	14,383	15,021	17,770	19,672	21,433
26 - 30	9,085	10,292	12,825	13,803	14,976	15,676	16,377	19,307	21,393	23,325
31 - 35	9,902	11,220	13,884	14,954	16,236	17,001	17,766	20,878	23,152	25,260
36 - 40	11,269	12,786	15,668	16,889	18,357	19,231	20,106	23,526	26,119	28,523
41 - 45	12,773	14,530	17,774	19,157	20,831	21,825	22,821	26,692	29,638	32,369
46 - 50	16,940	19,276	23,240	25,090	27,327	28,652	29,978	34,832	38,746	42,378
51 - 55	23,273	26,488	31,633	34,192	37,283	39,111	40,941	47,265	52,650	57,647
56 - 60	33,230	37,801	44,565	48,247	52,682	55,298	57,919	66,485	74,178	81,323

Premium for individuals who enter the policy for the first time at the age 60 years or below										
61 - 65	51,495	58,471	68,382	74,043	80,838	84,853	88,872	1,02,305	1,14,081	1,25,005
66 - 70	72,746	82,612	95,992	1,04,066	1,13,730	1,19,438	1,25,151	1,43,374	1,60,092	1,75,607
71 - 75	93,874	1,06,639	1,23,457	1,33,924	1,46,430	1,53,822	1,61,219	1,84,191	2,05,820	2,25,889
76 - 80	1,19,035	1,35,249	1,56,144	1,69,461	1,85,340	1,94,738	2,04,138	2,32,727	2,60,194	2,85,672
Above 80	1,39,792	1,58,851	1,83,075	1,98,740	2,17,395	2,28,446	2,39,497	2,72,663	3,04,933	3,34,859

Premium for individuals who enter the policy for the first time after the age of 60 years										
61 - 65	41,196	46,777	54,706	59,235	64,671	67,882	71,098	81,844	91,265	1,00,004
66 - 70	58,197	66,090	76,794	83,253	90,984	95,550	1,00,121	1,14,699	1,28,074	1,40,486
71 - 75	75,099	85,311	98,766	1,07,140	1,17,144	1,23,058	1,28,976	1,47,353	1,64,656	1,80,711
76 - 80	95,228	1,08,200	1,24,915	1,35,569	1,48,272	1,55,790	1,63,311	1,86,181	2,08,155	2,28,537
Above 80	1,11,833	1,27,081	1,46,460	1,58,992	1,73,916	1,82,757	1,91,598	2,18,130	2,43,947	2,67,888

Optional Covers

- Loading for Consumables - 10%
- Voluntary Aggregate Deductible (discount)

Sum Insure	10K	25K	50K	75K	1L	2.5L	5L
5L	10%	15%	25%				
10L	8%	15%	20%				
15L			15%	20%	25%		
20L			15%	20%	25%		
25L			15%	20%	25%		
30L			10%	15%	20%		
35L			5%	10%	15%		
50L					15%	20%	25%
75L					15%	20%	25%
100L					15%	20%	25%

- Accident Care –

0.45	per mille

- Cumulative Bonus Booster -

Sum Insured	5L	10L	15L	20L	25L	30L	35L	50L	75L	100L
Loading for CBB up to 500%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Loading for CBB up to 1000%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%

- Critical Illness Booster - 5.00%

- Loading for increase in Pre-post hospitalisation coverage (increase in no of days) –

+ 30 days in pre-hospitalisation coverage	0.80%
+ 30 days in post-hospitalisation coverage	1.60%
+ 30 days in both pre-hospitalisation & post-hospitalisation coverage	2.30%

- Loading for reduction in PED waiting period to 30 days - 35%
- Loading for waiving mandatory co-pay for members entering policy above age 60 – 25%

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

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

Signature	Place
Name	Date

In case of any claims, 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/PRS/001