PROSPECTUS
VARISHTA BIMA

I. SALIENT FEATURES OF THE POLICY

1. Room, Boarding & Nursing Expenses
2. Surgeon/ Consultant/ Anesthetist/ specialist fees
3. Anaesthesia, blood, Oxygen, Operation Theatre fees
4. Pre and Post hospitalisation medical expenses
5. Day Care expenses
6. Road Ambulance charges
7. Free annual medical check-up

II. DEFINITIONS

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

I. Standard definitions

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

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

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

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

5. [2]**AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre

[1] Inserted definition of AYUSH Hospital
[2] Inserted definition of AYUSH Day Care Centre

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

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

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

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

8. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   a. **Internal Congenital Anomaly** -**Congenital Anomaly** which is not in the visible and accessible parts of the body.
   b. **External Congenital Anomaly** - **Congenital Anomaly** which is in the visible and accessible parts of the body.

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

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

11. **Day care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under -
    a. has qualified nursing staff under its employment;
    b. has qualified medical practitioner/s in charge;
    c. has fully equipped operation theatre of its own where surgical procedures are carried out;
    d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

12. **Day care treatment** means medical treatment, and/or surgical procedure which is:
    a. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    b. which would have otherwise required hospitalization of more than 24 hours.
    Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

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

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

16. **Domiciliary hospitalization** means medical treatment for an illness/ disease/ injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    ii) the patient takes treatment at home on account of non-availability of room in a hospital.

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

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

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

19. **Hospital**: A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii. has qualified medical practitioner(s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

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

21. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
    b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        (i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        (ii) it needs ongoing or long-term control or relief of symptoms

(iii) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
(iv) it continues indefinitely
(v) it recurs or is likely to recur

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

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

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

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

26. **Maternity expense means:**
    a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b. expenses towards lawful medical termination of pregnancy during the policy period.

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

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

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

30. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i. is required for the medical management of the illness or injury suffered by the insured;
    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. must have been prescribed by a medical practitioner;
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

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

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

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

37. **Portability** means the right accorded to an individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

38. **Post-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

40. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

41. **Qualified nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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

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

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

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

46. **Unproven/ Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India.

II. Specific definitions

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

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

49. **Family** means and includes You, Your Spouse/ Live-in partner in the Individual Policy or Family Floater Policy.

50. **Hazardous Activities** mean recreational or occupational activities which pose high risk of injury.

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

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

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

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

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

56. **Policy Year** means every annual period within the Policy Period starting with the commencement date.

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

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

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

60. **Schedule** means that portion of the **Policy** which sets out **Your** personal details, the type of insurance cover in force, the **period** and the sum insured. Any Annexure or Endorsement to the **Schedule** shall also be a part of the **Schedule**.

61. **Senior citizen** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

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

63. **We, Our, Us, Insurer GCICL** Means Generali central insurance company limited .

64. **You, Your, Yourself** means the Insured Person shown in the **Schedule**.

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

III. Scope of Cover

We shall pay the following **Medical expenses** for medically necessary treatment, **Reasonable and Customary Charges** incurred for **Hospitalisation**:

1. Room rent, Board & Nursing Expenses as provided by the Hospital/ Nursing Home

2. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees

3. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Cost of Pacemaker, prosthesis/internal implants and any Medical expenses incurred which is integral part of the operation

4. **Pre-Hospitalisation Medical Expenses – We** shall pay for **Medical expenses** incurred with respect to the **Insured Person** for up to 60 days immediately prior to date of admission of **Insured Person** into the **Hospital**, provided that We have accepted a claim for Inpatient- Hospitalisation Expenses

5. **Post hospitalisation Medical expenses – We** shall pay for **Medical expenses** incurred with respect to the **Insured Person** for up to 90 days after the date of discharge of **Insured Person** from the **Hospital**, provided that We have accepted a claim for Inpatient- Hospitalisation Expenses

   Pre and Post hospitalisation combined expenses are limited up to 2% of Sum Insured opted maximum up to ₹ 10000 for each hospitalisation.

6. **Day Care expenses** – **We** shall pay for expenses incurred under **Day Care Treatment** requiring less than 24 hours of **Hospitalisation** as per the attached list.

7. **Road Ambulance charges** - up to a maximum amount specified in the Schedule of Benefits, per **Hospitalisation** basis, which will be reimbursed to **You** on producing the bills in original.

8. **Free Annual medical check-up** - At the end of every continuous period of 1 year during which **You** have held **Our Policy** irrespective of claim free years, You may apply to Us for a free medical check-up (Physician's Consultation, ECG, Complete Blood Count, Fasting blood Sugar, Post Prandial Blood Sugar, Sr. Creatinine), at **Our** Diagnostic Center, the location of which **We** will specify at the time of **Your** application.

   If **Our** Diagnostic Centre is not available at **Your** location, **We** will arrange for free annual medical check-up at **Your** nearest diagnostic centre, after **Your** prior intimation to **Us**.

   For the avoidance of doubt, **We** shall not be liable for any other ancillary or peripheral costs or expenses (including but not limited to those for transportation, accommodation or sustenance). This option would be available to the policy holder once during the respective policy period from the second year onwards.

IV. Exclusions

1. **Waiting Periods**

   All **Illnesses** and treatments shall be covered subject to the waiting periods specified below:

   1. **Pre-Existing Disease- Excl 01**
      i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us.
      ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
      iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
      iv. Coverage under the policy after the expiry of 12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

   2. **Specified disease/procedure waiting period- Code- Excl02**
      i. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
      ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
      iii. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
      iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
      v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
      vi. List of specific diseases/procedures:

   I. 24 months waiting period:
      a) Cataract
      b) Glaucoma

c) Diseases of the anterior segment and posterior segment of the eyes
d) Surgery on ears
e) Diseases related to Thyroid
f) Varicose veins and Varicose ulcers
g) All diseases of Prostate
h) Stricture Urethra
i) All types of Hernia
j) Varicocele
k) Hydrocele
l) Fistula / Fissure in ano, Hemorrhoids
m) Pilonidal Sinus and Fistula
n) Rectal Prolapse
o) Stress Incontinence
p) Gall bladder and Pancreatic diseases
q) Gastric and duodenal ulcers and all treatments (conservative, interventional, laparoscopic and open) related to Hepatopancreato-biliary disease including Gall bladder and Pancreatic calculi
r) All types of management for Kidney and Genito-urinary tract calculi
s) All treatments (conservative, interventional, laparoscopic and open) related to all diseases of Uterus, Fallopian tubes, Cervix and Ovaries, Dysfunctional Uterine bleeding, Pelvic inflammatory diseases
t) Conservative, operative treatment and all types of intervention for diseases related to Tendon, Ligament, Fascia, Bones and Joint [other than caused by accident]
u) Degenerative disc and Vertebral diseases including replacement of Bones and Joints, Prolapse of intervertebral disc (other than caused by accident)
v) Degenerative diseases of the Musculo-skeletal system
w) All internal or external tumors/ cysts/ nodules/ polyps of any kind including breast lumps with exception of malignant tumour or growth.

II. 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

2. Standard Exclusions

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

a) **Obesity/ Weight Control: Code- Excl06**
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe Sleep Apnea
   iv. Uncontrolled Type2 Diabetes

b) **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.

c) **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.

d) **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, scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc **.**

e) **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.

f) **Excluded Providers: Code- Excl11**
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/ notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

i) **Code- Excl14**
Dietary supplements and substances which are available naturally and that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedures.

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

k) **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.

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

m) **Maternity : Code Excl 18**
i. Medical treatment expenses traceable to child birth (including complicated deliveries and caesarean section incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during policy period.

3. Specific exclusions

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

n) Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an Accident.
o) Vaccination/ inoculation (except as post bite treatment)
p) 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), 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.
q) Dental treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental Bodily Injury.
r) Convalescence, general debility or rest cure, intentional self-Injury, venereal/ Sexually Transmitted disease other than HIV/AIDS.
s) Congenital External Illness/ disease/ defect anomaly.
t) [3]Costs incurred on all methods of treatment except AYUSH and Allopathic treatment.
u) Stem cell storage.
v) Expenses related to donor screening, treatment, including Surgery to remove organs from the donor in case of a transplant Surgery. We will also not pay donor's pre and post Hospitalisation expenses or any other medical treatment for the donor consequent to Surgery.
w) Outpatient Diagnostic, Medical and Surgical Procedures or OPD treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.
x) Medical Practitioner's home visit charges during pre and post Hospitalisation period, Attendant Nursing charges.
y) Domiciliary hospitalisation, treatment received outside India.
z) Injury or Disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not).
aa) Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.

[3] **Modified the wording to cover AYUSH treatment into the scope of the Product**

bb) Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
cc) Standard list of excluded items as mentioned in Annexure 4 and on our website https://generalicentralinsurance.com
dd) Any specific exclusion(s) applied by Us, specified in the Schedule and accepted by the insured.

V. Eligibility

Minimum Policy Term	1 year
Maximum Policy Term	3 Year
Entry age (minimum maximum)	60 years and above
Renewal	Lifelong
Maximum members that can be covered in a policy	2 Insured person
Family Definition	Insured and Insured spouse /Live-in partner In case of Individual policy, we shall not be able to offer cover to the spouse/Live-in partner of age less than 60 years. However he/ she can still be covered under Family Floater option, provided the age of Self (primary insured) is 60 years and above.

Pre-insurance medical examination:

- Sum Insured 2L, 3L, 4L and 5L, no pre-insurance medical test is applicable unless there is a medical declaration in the proposal form. Tests are mandatory for Sum Insured 7.5 L and 10 L.
- Insured is eligible for 50% reimbursement of pre-insurance medical tests charges, subject to policy issuance and 64 VB compliance.
- All pre-insurance medical tests will have to be done at the Generali Central empanelled diagnostic centers only.
- The test reports would be valid for a period of 30 days from the date of test conducted.
- Underwriting loading will be applicable on the individual member's premium based on health status of the proposed Insured person in consideration to the adverse health conditions declared on the proposal form and findings of medical tests conducted.
- In case of Family Floater option, if there is a medical loading for spouse/Live-in partner of age less than 60 years, the loading shall be applied on the individual premium for age of 60 years.

VI. Sum Insured

Sum Insured options available in the product are – ₹ 2, 3, 4, 5, 7.5, 10 L

VII. General Terms and Clauses

I. Standard general terms and clauses

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

2. **Condition Precedent to Admission of Liability**

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

3. **Free Look Period**

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

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

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

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

4. **Portability**

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/ Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

5. **Migration**

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

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

6. **Complete Discharge**

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

7. **Multiple Policies**

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall

have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

8. **Fraud**

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/ policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b. the active concealment of a fact by the insured person having knowledge or belief of the fact;
c. any other act fitted to deceive; and
d. any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

9. **Withdrawal of Policy**

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

10. **Moratorium Period**

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

11. **Nomination:**

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

shall be treated as full and final discharge of its liability under the policy.

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.

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

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at GCIGRO@generalicentral.com or call at: 7900197777
For updated details of grievance officer, kindly refer the link
https://Generalicentralinsurance.com/customer-service/grievance-redressal

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Kindly refer the annexure on Grievance Redressal Procedures.

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

II. Specific terms and clauses

1. **Condition Precedent to the contract**

(i) **Co-Payments Applicable under the policy**

a) 50% co-payment is applicable on each and every claim related to Pre-existing disease, on the admissible hospitalisation bill, excluding claim related to pre and post hospitalisation. The Insured will have no option to waive off this co-payment.
b) 25% co-payment is applicable on each and every claim for all other claims, on the admissible hospitalisation bill, excluding claim related to pre and post hospitalisation. However the Insured have an option to waive off this co-payment on payment of additional loading of 20% on the standard premium.
c) The above co-payment shall continue lifelong.

(ii) **Sub limits Applicable under the policy**

a) **Sub limits for Listed procedures applicable under the policy**
Sub limits will be applicable for listed procedures as mentioned in Annexure 3 (Sub-limits table). In case of claim for specified procedures, the maximum liability of claim payment (including pre and post hospitalisation), shall be limited to the amount mentioned in the sublimit table.

b) **Mandatory Sub limits for Modern Treatment Methods and Advancement in Technologies**
The Medical Expenses incurred for the below listed treatments or procedures, as inpatient or as day care treatment (inclusive of pre and post hospitalization), is restricted to 50% of the sum insured opted, per policy period. These Sub limits are applicable for all Plans under the product. Claims related to conditions for which sub limits are already included, any expense towards Modern Treatment Methods and Advancement in Technologies are restricted to the applicable sublimit or 50% of Sum Insured whichever is lower.

i. Uterine Artery Embolization and HIFU
ii. Balloon Sinuplasty
iii. Deep Brain stimulation
iv. Oral chemotherapy
v. Immunotherapy- Monoclonal Antibody to be given as injection
vi. Intra vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. Bronchical Thermoplasty
x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

Co-payments mentioned in Section VII. II. 1. (i) a) and b) will not be applicable in case there is a claim for the listed procedures mentioned in the Sub-limits section.

2. **Conditions applicable during the contract**

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

(ii) **Insured**
You and Your spouse /Live-in partner with entry age of 60 years and above can be covered in the Policy on Individual basis.
However if the spouse / Live-in partner is of age less than 60 years, she/ he can still opt under Family Floater policy, provided the age of Self is 60 years and above.
Only those persons named, as the Insured in the **Schedule** shall be covered under this **Policy**.

(iii) **Cost of pre-insurance medical examination**
We will reimburse 50% of the cost of any pre-insurance medical examination conducted at our empanelled diagnostic center, once the Proposal is accepted and the Policy is issued for that Insured Person.

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

(v) **Policy Period**
The **Policy** can be issued for tenure of 1 year, 2 years and 3 years.

(vi) **Territorial Limits and Law**

a) **We** cover Accidental Bodily **Injury** or sickness sustained by the Insured Person during the **Policy Period** anywhere in India.
b) All medical/ surgical treatments including investigations under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency (Indian Rupees).
c) The construction, interpretation and meaning of the provisions of this **Policy** shall be determined in accordance with Indian Law.
d) The **Policy** constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by **Us**, which approval shall be evidenced by an endorsement on the **Schedule**.

(vii) **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.

(viii) **Premium Payment in Instalment**.

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

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

(ii) The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

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

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

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

(vi) The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.
(vii) The payment will be accepted through E-NACH/ ACH/ ECS / any other mode approved by Government of India.
(viii) On successful registration for the mandate/ E-NACH/ any other mode approved by Government of India, the premium shall be auto debited as per the frequency opted.
(ix) In case of withdrawal of E-NACH /ACH/ ECS/ any other mode approved by Government of India, a written communication will be required from policyholder.
(x) In case there is failure in transaction in E-NACH/ACH/ ECS 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.
(xi) If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered.
(xii) Given below are the loadings applicable on Standard premiums in case of installments

Instalment frequency	**Loading on standard premiums**
Monthly	5%
Quarterly	4%
Half-yearly	3%

(ix) **[4]AYUSH Coverage:**

Expenses incurred on hospitalization due to accident and illnesses, under AYUSH systems of medicine shall be covered. However, all preventive and rejuvenation treatments which are non-curative in nature shall not be covered.

3. **Conditions when a claim arises**

A. **Claims Procedure**

If You meet with any accidental Bodily Injury or suffer an Illness that may result in a claim, then as a condition precedent to Our liability, You must comply with the following:

a) Cashless treatment is only available at a Network Provider. In order to avail cashless treatment, the following procedure must be followed by **You**:
   (i) For availing **cashless** at a **Network Provider**, We must be called at **Our** call centre and a request for pre-authorisation must be made by way of the written form prescribed by **Us**.
   (ii) After considering the request and obtaining any further information or documentation that **We** have sought, We may, if satisfied, send the **Network Provider** an authorisation letter. Such pre-authorization shall be issued by **Us** within 24 hours of receiving the complete information.
   (iii) The authorisation letter, the ID card issued to **You** 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**.
   (iv) If the above procedure is followed, **You** will not be required to directly pay for those Medical Expenses to the Network Provider that We are liable to indemnify under this **Policy**. The original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-authorisation does not guarantee that all costs and expenses that are incurred will be covered. We reserve the right to review each claim for **Medical Expenses** incurred and accordingly coverage will be determined according to the terms, conditions and exclusions of this Policy. All other costs and expenses that are not covered under this Policy must be settled directly with the **Network Provider** and **We** shall have no liability in this regard.

b) If pre-authorisation as above is denied by **Us** or if treatment is taken in a **Hospital** which is Non-

[4] Clause number IX newly inserted to cover AYUSH treatments at par with Allopathic Treatments, wherever applicable, in the product to provide an option for the Insured Persons to choose treatment of their choice

Network or if **You** do not wish to avail cashless facility, then:

(i) **We** must be given Notification of Claim in writing immediately and in any event within 48 hours of the commencement of the Illness or Injury. You must immediately consult a Medical Practitioner and follow the advice and treatment that he/she recommends. **You** must take reasonable steps or measures in good faith to minimise the quantum of any claim that may be made under this **Policy**.

(ii) **You** must have **Yourself** examined by **Our** medical advisors if **We** ask, the cost for which will be borne by **Us**.

(iii) **You** or someone claiming on **Your** behalf must promptly and in any event within 15 days of discharge from a **Hospital** give **Us** the necessary documents, including written details of the quantum of any claim along with all original supporting documentation, including but not limited to the following, and other information **We** ask for, to investigate the claim for **Our** obligation to make payment for it:

a. the claim form specified by Us duly completed and signed by the claimant or a family member;
b. first consultation letter;
c. first prescription from the Medical Practitioner;
d. original vouchers;
e. original Hospital bills giving a detailed break up of all expense heads mentioned in the bill;
f. Money receipt duly signed with a revenue stamp;
g. birth/death certificate (as applicable);
h. the original Hospital discharge card;
i. all original laboratory and diagnostic test Reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram etc;
j. If medicines have been purchased in cash and if this has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner and the supporting medicine bill from the chemist;
k. If diagnostic or radiology tests have been paid for in cash and it has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner advising the tests, the actual test reports and the bill from the diagnostic centre for the tests.

(iv) In the event of **Your**/**Insured Person**'s death, **You**/**Insured Person**'s nominee/legal heir claiming on his/her behalf must inform Us in writing immediately and send **Us** a copy of the post mortem report (if any) within 14 days.

(v) 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.

(vi) The periods for intimation as stipulated under 3. A. b (i), or submission of any documents as stipulated under 3. A. b (i), (iii) and (iv) will be waived in case of any hardships being faced by the insured or his representative which is supported by some documentation.

B. **Basis of claims payment**

a) **Claims for Day Care Treatment**

The Day Care Treatments listed are subject to the exclusions, terms and conditions of the **Policy** and will not be treated as independent coverage under the **Policy**.

b) **Co-Payments and sub limits for specified procedures applicable under the policy**

Co-Payments and sub limits for specified procedures, as mentioned in Section VII. II. 1. (i) a) , b) and (ii) a), b) will be applicable under the **Policy**.

c) **Reimbursement Claims**

For reimbursement claims, the payment will be made to **You**. In the event of **Your** death, **We** will pay the nominee (as named in the **Schedule**) and in case the nominee is deceased or untraceable, payment

to Your legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and where discharge shall be treated as full and final discharge of Our liability under the **Policy**.

d) **Claim Settlement**

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest 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.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)
v. Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified in Section 3. A. b (iii) above
vi. In case of 'pending' claims, We will ask for submission of incomplete documents.
vii. 'Rejected' claims will be informed to the Insured Person in writing with reason for rejection.

C. **Policy Currency**

We shall make payment in Indian Rupees only.

D. **Dispute Resolution**

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

4. **Conditions for renewal of the contract**

(i) **Renewal of Policy**

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

a) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
b) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
c) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
e) Coverage is not available during the grace period.
f) No loading shall apply on renewals based on individual claims experience
g) Your Varishta Bima Policy shall be renewable lifelong
h) In case of a Renewal within Grace Period of 30 days Policy will be considered as continuous for the purpose of all waiting periods and Health Check-up benefit.
i) For Renewal Proposal received after completion of Grace Period of 30 days, all waiting periods would apply afresh.
j) The brochure/ prospectus mentions the premiums as per the age slabs/ Sum Insured and the same would be charged as per the completed age at every Renewal.
k) The premiums as shown in the brochure/ prospectus are subject to revision as and when approved by the IRDAI. However such revised premiums would be applicable only from subsequent Renewals

and with due notice whenever implemented.

l) No increase/ decrease in Sum Insured during the currency of the Policy. However increase/decrease in Sum Insured or change in cover, can be requested at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal before the expiry of the Policy.

m) In case of enhancement of sum insured the waiting period shall apply afresh to the extent of sum insured increase

VIII. Mandatory Disclosures

a) **Your** Varishta Bima **Policy** shall be renewable lifelong if renewed continuously without any break in insurance.

b) The brochure/ prospectus mentions the premium rates as per the age slabs/ Sum Insured.
   i. For individual plan Insured would be charged as per the completed age at every renewal.
   ii. For Family floater plan premium would applicable as per the completed age of the eldest member in the family at every renewal.

c) The premiums as shown in the prospectus/ brochure are subject to revision as and when approved by the regulator. However such revised premiums would be applicable only from subsequent **Renewal**s and with due notice whenever implemented.

d) **Renewals** will not be refused or cancellation will not be invoked by **US** except on grounds of fraud, moral hazard, misrepresentation or non-cooperation by the insured. If **You** prefer to cancel the **Policy** the cancellation will be on short period basis.

e) There will be no loading on premium for adverse claims experience.

f) Medical loading will be applicable on the individual member's premium based on the findings in pre-insurance medical examination and/or declaration provided in the proposal form.

g) In case of Family Floater policy, the loading of premium will be applicable on the floater premium.

h) Family discount of 10% is available in case more than one member is covered in the same **Policy** on individual sum insured basis. The family discount of 10% will not be applicable in case of only single person being covered at **Renewal**.

i) Long term discount will be applicable as mentioned below, in case of single premium payment for policy term of more than one year.

Number of years	Discount
1 year	Nil
2 years	5%
3 years	10%

j) Direct sales discount – A discount of 15% in lieu of intermediary commissions if policy is taken directly from the insurer and /or Online.

k) No increase/ decrease in Sum Insured during the currency of the **Policy**. However increase/decrease in Sum Insured or change in cover, addition/deletion of Insured Persons, etc will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy.

l) Detailed exclusions are given under Section IV of the Prospectus.

IX. Payment of Premium

a) As per table annexed

X. 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
Name

Place
Date

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

Individual – Adult

Age Band	2 Lakhs	3 Lakhs	4 Lakhs	5 Lakhs	7.5 Lakhs	10 Lakhs
60-65	10,505	12,950	15,470	17,990	20,480	21,977
66-70	14,943	18,661	22,492	26,324	29,593	31,869
71-75	18,017	22,617	27,359	32,100	35,910	38,726
76-80	20,440	25,738	31,198	36,658	40,894	44,137
>80	21,699	27,360	33,193	39,027	43,485	46,950

Family Floater – Adults

Age Band	2 Lakhs	3 Lakhs	4 Lakhs	5 Lakhs	7.5 Lakhs	10 Lakhs
60-65	15,757	19,425	23,206	26,985	30,721	32,966
66-70	22,415	27,992	33,738	39,486	44,388	47,804
71-75	27,024	33,927	41,040	48,150	53,865	58,089
76-80	30,660	38,608	46,798	54,987	61,340	66,206
>80	32,550	41,040	49,790	58,541	65,228	70,425

**Age in completed years
*** For Family Floater, premium would be applicable as per the age of the eldest member in the family. In case the spouse /Live-in partner is of age less than 60 years, she/ he can still opt under Family Floater option, provided the age of Self is 60 years and above. In case of medical loading for spouse /Live –in partner of age less than 60 years, the loading shall be applied on the individual premium for age of 60 years.
**** The premiums above are subject to revision as and when approved by the regulator. However, such revised premiums would be applicable only from subsequent renewals and with due notice \henever implemente

Annexure 2: Schedule of Benefits

<table>
<tr><th colspan="4">Varishta Bima</th></tr>
<tr><td>A</td><td>Eligibility</td><td>Sum Insured options (in ₹)</td><td>200000, 300000, 400000, 500000, 750000, 1000000</td></tr>
<tr><td></td><td></td><td>Minimum entry age</td><td>60 years</td></tr>
<tr><td></td><td></td><td>Maximum entry age</td><td>Lifelong</td></tr>
<tr><td></td><td></td><td>Maximum Renewal Age</td><td>Lifelong</td></tr>
<tr><td></td><td></td><td>Individual/ Family Floater SI Options</td><td>Individual/ Family Floater</td></tr>
<tr><td></td><td></td><td>Policy Term</td><td>1/ 2/ 3 years</td></tr>
<tr><td></td><td></td><td>Family Definition</td><td>Insured and Insured spouse /Live-in partner

In case of Individual policy, we shall not be able to offer cover to the spouse /Live-in partner of age less than 60 years. However he/ she can still be covered under Family Floater option, provided the age of Self (primary insured) is 60 years and above.</td></tr>
<tr><td>B</td><td>Hospitalisation Benefits</td><td>Hospitalisation</td><td>Covered</td></tr>
<tr><td></td><td></td><td>Day Care Treatment</td><td>Covered</td></tr>
<tr><td></td><td></td><td>Pre- Hospitalisation for 60 days and Post-Hospitalisation for 90 days</td><td><table><tr><td>Sum Insured (₹)</td><td>2 L</td><td>3 L</td><td>4 L</td><td>5 L</td><td>7.5 L</td><td>10 L</td></tr><tr><td>Combined limits for Pre- & Post-Hospitalisation (₹)</td><td>4000</td><td>6000</td><td>8000</td><td>10000</td><td>10000</td><td>10000</td></tr></table></td></tr>
<tr><td>C</td><td>Discount</td><td colspan="2">1. Long term discount (2 and 3 years policy term) in case of single payment of premium - 5% discount for 2 year policy, 10% for 3 years policy.
2. 10% family Discount if more than 1 member is covered under single proposal with Individual sum insured.
3. 10% discount on the individual member’s premium, if the insured produces the latest medical reports within 15 days of the tests done (2 D Echo, Blood Pressure report, Glycosylated hemoglobin, blood urea & serum creatinine) along with the proposal form and the proposal is accepted. This is available for Sum Insured options of ₹ 2L, 3L, 4L and 5L. This discount will not be applicable for further renewals.</td></tr>
<tr><td>D</td><td>Instalment option (monthly, quarterly, half yearly) with Loading</td><td colspan="2">Available for policy term of 1 /2/3 years. Loadings on standard premium will be applicable in case instalment facility is opted for premium payment.<table><tr><th>Instalment frequency</th><th>Loading on standard premiums</th></tr><tr><td>Monthly</td><td>5%</td></tr><tr><td>Quarterly</td><td>4%</td></tr><tr><td>Half-yearly</td><td>3%</td></tr></table></td></tr>
<tr><td>E</td><td>Waiting Periods</td><td colspan="2">1. 12 months Waiting Period for Pre-existing Disease
2. 30 days Waiting Period, except for Accidental Hospitalization
3. 24 months Waiting Period for listed conditions irrespective whether it falls under pre-existing diseases</td></tr>
<tr><td>F</td><td>Co-payment</td><td colspan="2">a) 50% co-payment is applicable on each and every claim related to Pre-existing disease, on the admissible hospitalisation bill, excluding claim related to pre and post hospitalisation. The Insured will have no option to waive off this co-payment.
b) 25% co-payment is applicable on each and every claim for all other claims, on the admissible hospitalisation bill, excluding claim related to pre and post hospitalisation. However the Insured have an option to waive off this co-payment on payment of additional loading of 20% on the standard premium.
c) Both the above co-payments will be applicable lifelong</td></tr>
<tr><td>G</td><td>Sub limits</td><td colspan="2">1. Sub limits for listed procedures. Our maximum liability of claim payment (including</td></tr>
</table>

		pre and post hospitalisation), shall be limited to amount mentioned in the sublimit table. 2. **Mandatory Sub limits for Modern Treatment Methods and Advancement in Technologies** The Medical Expenses incurred for the listed treatments or procedures, as inpatient or as day care treatment (inclusive of pre and post hospitalization), shall be restricted to 50% of the sum insured opted, per policy period. Claims related to conditions for which sub limits are already included, any expense towards Modern Treatment Methods and Advancement in Technologies are restricted to the applicable sublimit or 50% of Sum Insured whichever is lower. Above co-payments will not be applicable in case of a claim for the listed procedures mentioned in the Sub-limits Section.
H	Road Ambulance charges	Up to ₹ 1000/- per hospitalization
I	Free Annual Medical Check-up from second year onwards	Free Medical Check-up after every continuous period of 1 year (Physician's Consultation, ECG, Complete Blood Count, Fasting blood Sugar, Post Prandial Blood Sugar, Sr. Creatinine), irrespective of claim free years. This option will be available to the policy holder once during the respective policy period from the second year onwards.
J	Pre-insurance medical examination	a) Applicable for proposal form with any medical declaration for any sum insured b) Mandatory Pre-insurance medical examination for sum insured ₹ 7.5 L and ₹ 10 L

Annexure 3: Sub-limits table on listed procedures:

Sub-limits on listed procedures (All values are in INR.)						
Procedure/ Treatment	**200,000**	**300,000**	**400,000**	**500,000**	**750000**	**1,000,000**
Coronary Artery Bypass Grafting (CABG)	150000	200000	225000	275000	300000	350000
Percutaneous Transluminal Coronary Angioplasty (PTCA)	150000	200000	225000	275000	300000	350000
Cataract surgery (per eye)	15000	18000	20000	21500	23000	25000
Total Knee Replacement (per knee)	150000	200000	225000	275000	300000	350000
Total Hip Replacement (per hip)	150000	200000	225000	275000	300000	350000

Annexure 4

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

Sl No.	**Item**
1.	BABY FOOD
2.	BABY UTILITES CHARGES
3.	BEAUTY SERVICES

4.	BELTS/ BRACES
5.	BUDS
6.	COLD PACK/HOT PACK
7.	CARRY BAGS
8.	EMAIL / INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVENYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG/ SHORT/ HINGED)
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53.	SUGAR FREE TABLETS
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)

55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	VASOFIX SAFETY

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

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

32.	ENTRANCE PASS / VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES
35.	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36.	PATIENT IDENTIFICATION BAND / NAME TAG
37.	PULSEOXYMETER CHARGES

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

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

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

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