PREAMBLE

This Policy is issued to You based on Your Proposal to Us and Your payment of the Premium. You are eligible to enter this Policy if Your age is between 90 days to 70 years with lifelong renewability. This Policy records the agreement between Us and sets out the terms of insurance and the obligations of each party.

A. DEFINITIONS

1) Standard definition

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

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Any one Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/ Nursing Home where treatment was taken.
3. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
4. [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 (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.

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

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 not available for 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 expenses means:**
    a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
    b. expenses towards lawful medical termination of pregnancy during the policy period.
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 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.
32. **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
33. **Newborn baby** means baby born during the Policy Period and is aged up to 90 days.
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 policyholder (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. **Pre-Existing Disease** means any condition, ailment or injury or disease:
    a) That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement, or
    b) For which medical advice or treatment was recommended by, or received from, a Physician within 36 months prior to the effective date of the policy or its reinstatement.
39. **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.
40. **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.
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.

2) Specific definition

47. **Associated 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. In case of copayment associated with room rent higher than the entitled room rent limit, Associated Medical Expenses will not include:
    a. Cost of pharmacy and consumables.
    b. Cost of implants and medical devices.
    c. Cost of diagnostics.
48. **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.
49. **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the **primary** insured or proposer and does not have his / her independent sources of income.
50. **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.
51. **Family** means and includes You, Your Spouse / Live-in partner, Your up to 4 dependent children up to the age of 25 years and two dependent parents in the Individual Policy.
    Or You, Your Spouse / Live-in partner & Your up to 3 dependent children up to the age of 25 years in the Family Floater Policy
52. **Hazardous Activities** mean recreational or occupational activities which pose high risk of injury
53. **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.
54. **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.
55. **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
56. **Policy** means the complete documents consisting of the Proposal, Policy wording, Schedule and Endorsements and attachments if any.
57. **Policy Period** means the period commencing with the start date mentioned in the Schedule till the end date mentioned in the Schedule**.**
58. **Policy Year** means every annual period within the Policy Period starting with the commencement date.
59. **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
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. **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).

62. **We, Our, Us, Insurer, GCICL** means **Generali Central Insurance Company Limited**.
63. **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.

B. SCOPE OF COVE

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

1. **Room rent, Board & Nursing Expenses as provided by the Hospital/ Nursing Home**
   a. Gold (for Sums Insured ₹ 50000/-, ₹ 1 lakh and ₹ 1.5 lakhs) - up to 1% of the Sum Insured (excluding Cumulative Bonus) per day for non-ICU room. If admitted into Intensive Care Unit (ICU) up to 2% of the Sum Insured per day. All admissible claims under section B. (1) during the Policy year, shall be payable maximum up to 35% of the Sum Insured per claim.
   b. Gold (for Sums Insured ₹ 2 lakhs and above) – As per actuals.
   c. Platinum Plan – As per actuals.
   d. Topaz and Ruby Plans – up to 1% of the Sum Insured (excluding Cumulative Bonus) per day for non-ICU room.

i. For Topaz and Ruby Plans, in case You or insured person opts for a room with rent higher than the entitled room limit, the following co-payment will be applicable on the Associated Medical expenses (excluding pharmacy, consumables, implants, medical devices and diagnostics)

Applicable for Topaz and Ruby Plans Co-payment in case of admission in room with higher room rent is as below								
Sum insured	100000	200000	300000	400000	500000	600000	750000	1000000
Applicable limit on the sum insured (Excluding Cumulative Bonus)	1%	1%	1%	1%	1%	1%	1%	1%
Applicable room rent	1000	2000	3000	4000	5000	6000	7500	10000
Admission in higher room rent								
above 500 to 1000	0%	0%	0%	0%	0%	0%	0%	0%
above 1000 to 2000	10%	0%	0%	0%	0%	0%	0%	0%
above 2000 to 3000	15%	10%	0%	0%	0%	0%	0%	0%
above 3000 to 4000	20%	15%	10%	0%	0%	0%	0%	0%
above 4000 to 5000	20%	20%	15%	10%	0%	0%	0%	0%
above 5000 to 6000	25%	25%	20%	15%	10%	0%	0%	0%
above 6000 to 7000	25%	25%	25%	20%	15%	10%	0%	0%
above 7000 to 8000	25%	25%	25%	20%	20%	15%	0%	0%
above 8000 to 9000	25%	25%	25%	20%	20%	20%	10%	0%

above 9000 to 10000	25%	25%	25%	25%	20%	20%	15%	0%
above 10000	25%	25%	25%	25%	25%	25%	20%	10%

- Room, Boarding and Nursing Expenses as provided by the Hospital/ Nursing Home up to 1% of Sum Insured per day (Excluding Cumulative Bonus) or actual, whichever is lower
- During your hospital stay if at any time you are admitted in a Non-ICU room having room rent of more than the defined limit then the co-payment shall be applicable on the total Associated medical expenses (excluding pharmacy, consumables, implants, medical devices and diagnostics)
- If a person is admitted in ICU any time during the hospitalization and later shifted to Non-ICU room within the defined room rent limit, no co-payment shall apply and in case shifted to Non-ICU room with higher room rent limit, co-payment shall be applicable on the Associated medical expenses (excluding pharmacy, consumables, implants, medical devices and diagnostics) applicable to Non-ICU room.
- Co-payment is not applicable in case of admission in an ICU room having room rent more than the defined limit.
- If a person is admitted only in ICU during entire hospitalization, no co-payment shall apply.
- Copayment on Associated medical expenses (excluding pharmacy, consumables, implants, medical devices and diagnostics) for opting a Non –ICU room with higher room rent limit is not applicable for those hospitals where differential billing based on the room category is not adopted.

2. **Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees**
   a. Gold (for Sums Insured ₹ 50000/-, ₹ 1 lakh and ₹ 1.5 lakhs) - up to 35% of the Sum Insured (excluding Cumulative Bonus) per claim.
   b. Gold (for Sums Insured ₹ 2 lakhs and above) - As per actuals.
   c. Platinum Plan – As per actuals.

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**
   a. Gold (for Sums Insured ₹ 50000/-, ₹ 1 lakh and ₹ 1.5 lakhs) - up to 40% of the Sum Insured (excluding Cumulative Bonus) per claim.
   b. Gold (for Sums Insured ₹ 2 lakhs and above) - As per actuals.
   c. Platinum Plan – As per actuals.

4. **Pre-Hospitalization 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- Hospitalization Expenses
   a. Gold and Platinum Plans – As per actuals
   b. Topaz and Ruby Plans – up to 1% of the Sum Insured (excluding Cumulative Bonus)

5. **Post-Hospitalization 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- Hospitalization Expenses
   a. Gold and Platinum Plans – As per actuals
   b. Topaz and Ruby Plans – up to 1% of the Sum Insured (excluding Cumulative Bonus)

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

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

8. **Free medical check-up** - At the end of every continuous period of 4 years during which You have

held Our Health Suraksha Policy without making a claim, You may apply to Us for a free medical check-up (Physician's Consultation, ECG, Complete Blood Count, Urine Routine, Fasting blood Sugar, Post Prandial Blood Sugar, Lipid Profile, Sr. Creatinine, SGOT, SGPT, GGTP) at Our Diagnostic Center, the location of which We will specify at the time of Your application. 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).

i. In case of Individual policy, the benefit will be available for all insured persons who were already covered under the Policy.
ii. In case of family floater policy, the benefit will be available for two of the insured persons covered under the Policy.

9. **Patient Care –** Available for persons above 60 years, We shall provide payment for the nursing charges by a qualified nurse if necessary and recommended by the treating physician immediately after discharge from the Hospital, up to the amount specified in the Schedule of Benefits, up to a maximum of 10 days per Hospitalization subject to maximum of 30 days during the Policy Year. This cover is over and above the Hospitalization sum insured.

10. **Accidental Hospitalization** – In case of Hospitalization following an Accident, the limits under the Policy shall increase by 25% of the balance Sum Insured available subject to maximum of ₹ 1 Lakh irrespective of number of claims in a Policy Year.

11. **Hospital Cash** – We shall make payments of ₹ 500/- for each completed day of Hospitalization subject to maximum of 60 days during the Policy Year. This benefit is applicable for Platinum plan and Ruby plan with Sum Insured ₹ 6 lakhs and above. This benefit is over and above the Hospitalization sum insured.

12. **Accompanying Person** - We shall make payment of ₹ 500/- for each completed day of Hospitalization for the Accompanying Person of an Insured Person provided that the Insured Person is a Dependent Child of age up to 10 years and is undergoing Medically Necessary Hospitalization due to an Injury or Illness that occurred during the Policy Period. We will not make payment under this Benefit in respect of an Insured Person for more than 30 days in any Policy Year.
    Accompanying person means and includes mother, father, grandfather, grandmother and any immediate Family member. This benefit is over and above the Hospitalization sum insured.

13. **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 (AMENDMENT) BILL, 2011 and the organ donated is for the use of the Insured Person, and
    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 hospitalization 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.
    e. These expenses shall be covered under the recipient's Policy.

14. **Recharge of Sum Insured**
    Recharge benefit is applicable for all plans, where the basic Sum Insured opted is 3 Lakhs and above. If the Basic Sum Insured and Cumulative Bonus (if any) is exhausted due to claims made and paid during the Policy Year, then We are in agreement to automatically re-instate the Sum Insured up to 100%, once in a policy year which is valid for that Policy Year only, subject to conditions specified below:
    a) A claim will be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization or Day Care Treatment.

b) The recharge shall be utilized only after the Sum Insured, Cumulative Bonus has been completely exhausted in that Policy Year.
c) The recharge shall be available only for all future claims for that Insured Person during that Policy Year. (Irrespective of whether the claim is for the same ailment for which he/she has claimed).
d) Cumulative Bonus shall not be considered while calculating the Recharge.
e) Any unutilized recharge cannot be carried forward to any subsequent Policy Year.
f) If the Policy is issued on Individual basis, then the recharge will be available to each insured person and can be utilized by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.
g) If the Policy is issued on Floater basis, then the recharged sum insured will be available on Floater basis for all Insured Persons in the family.
h) The waiting periods, the standard exclusions and the standard limits shall be applicable for the recharged sum Insured.

C. EXCLUSIONS

1. Waiting Periods

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

a) Pre-Existing Disease- Excl 01

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

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

i. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12/24/36 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
vi. List of specific diseases/procedures:

i. Waiting period of 36 months:

a. Organ transplant
b. Joint replacement Surgery due to Degenerative condition, Age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is necessitated by accidental Bodily Injury

ii. Waiting period of 24 months:

a. Cataracts
b. Benign Prostatic Hypertrophy

c. Hernia of all types, Hydrocele
d. Para nasal sinuses
e. Deviated Nasal Septum
f. Fistulae, Hemorrhoids
g. Fissure in ano, Dysfunctional Uterine Bleeding
h. Fibromyoma
i. Endometriosis
j. Hysterectomy
k. All internal or external tumors/ cysts/ nodules/ polyps of any kind including breast lumps with exception of malignant tumor or growth
l. Surgery for prolapsed inter vertebral disc unless arising from Accident.
m. Surgery of Varicose Veins, Varicose Ulcers

iii. **Waiting period of 12 months**:
a. Any types of gastric or duodenal Ulcers
b. Stones in the Urinary and Biliary systems
c. Surgery on ears/ tonsils/ adenoids.

iv. **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) Investigation & Evaluation- Code- Excl04
i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

b) Rest Cure, rehabilitation and respite care- Code- Excl05
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
(i) Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
(ii) Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs.

c) Obesity/ Weight Control: Code- Excl06
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease

iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

d) Change-of-Gender treatments: Code- Excl07
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

e) Cosmetic or Plastic Surgery: Code- Excl08
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medically necessity, it must be certified by the attending Medical Practitioner.

f) Hazardous or Adventure sports: Code- Excl09
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc. unless specifically agreed by the Insurance Company.

g) Breach of law: Code- Excl10
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

h) Excluded Providers: Code- Excl11
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by 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.

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

j) Code- Excl13
Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or 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.

k) 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 hospitalization claim or day care procedures.

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

m) Unproven Treatments: **Code- Excl16**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

n) 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

o) **Maternity: Code Excl 18**
   i. Medical treatment expenses traceable to childbirth (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 exclusion: -

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:

p) **Circumcision**, unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an Accident.
q) **Vaccination**/ inoculation (except as post bite treatment).
r) **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.
s) **Dental** treatment or Surgery of any kind unless requiring Hospitalization as a result of accidental Bodily Injury.
t) **Venereal** /Sexually Transmitted disease other than HIV/AIDS, intentional self-Injury.
u) **Congenital** External Illness/ disease/ defect anomaly.
v) [3]**Cost incurred** on all methods of treatment except AYUSH and Allopathic treatments.
w) **Stem** cell storage.
x) **Expenses** related to donor screening, treatment, excluding Surgery to remove organs from the donor in case of a transplant Surgery. We will also not pay donor's pre and post Hospitalization expenses or any other medical treatment for the donor consequent to Surgery.
y) **Outpatient** Diagnostic, Medical and Surgical Procedures or OPD treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy.
z) **Doctor's** home visit charges during pre and post Hospitalization period, Attendant Nursing charges unless more than 60 years as specified in the Patient Care benefit Section B. (9).
aa) **Domiciliary** hospitalization/treatment
bb) **Treatment** outside India.
cc) **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).
dd) **Injury** or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.
ee) **Personal** comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
ff) **Standard** list of excluded items as mentioned in Annexure 2 and on our website https://generalicentralinsurance.com
gg) **Any** specific exclusion(s) applied by Us, specified in the Schedule and accepted by the insured.

D. GENERAL TERMS & 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, misdescription or non-disclosure of any material fact by the

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

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. Portability

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 the Policyholder (including all members under family cover) is presently covered and has been continuously covered without any lapses under the health insurance policy with existing Indian General/Health Insurer, then the credit gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy, shall be transferred from the existing Insurer to Our Company.

4. Migration

The Policyholder shall have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy, preferably 30 days before the policy renewal date.
If the Policyholder (including all members under family cover and group insurance policies) is presently covered and has been continuously covered without any lapses under the previous health insurance policy, then the credit gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy, shall be transferred to the migrated Policy.

5. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.
The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

6. 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.

v. This section is not applicable to the Hospital Cash benefit payable in case of Platinum Plan and Ruby Plan.

7. 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.

8. 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.

9. 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.

10. 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.

11. Redressal of Grievance

In case of any grievance the insured person may contact the company through
Website: https://generalicentralinsurance.com
Toll Free: 1800-220-233 / 1860-500-3333 / 022-67837800
Email: GCIcare@generalicentral.com

Courier: Grievance Redressal Cell, Generali Central Insurance Company Limited.
Unit No. 301, 3rd Floor Part, Building No. 8, Mindspace IT/ITES SEZ, MIDC Industrial Area, Airavali, Navi Mumbai, Thane District – 400 708.

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/

12. 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.

13. 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.
- 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.

II. SPECIFIC GENERAL TERMS AND CLAUSES

1. Condition Precedent to the contract

I. **Zone wise Premium payment**

a) Premium will be calculated based on the Sum Insured opted, Age and Zone.
b) Default Zone of Cover will be based on location of your residence.
c) All Premiums are age based and will vary as per the change in age group.
d) Zone Classification:

Zone Classification	Areas covered
Zone 1	Mumbai, Navi Mumbai, Thane, Panvel, Pune, Delhi & NCR, Surat, Vadodara, Ahmedabad, Anand, Gandhinagar, Indore and Bangalore.
Zone 2	Kolkata, Chennai, Hyderabad, Trivandrum, Cochin, Rest of Gujarat.

Zone 3	Rest of India

*Please note the Cities/Towns that fall under respective Zones shall be identified as per the updated/ latest Jurisdiction defined by Government.

e) Zonal Co-payment-
If the treatment is in higher zone than the policyholder's selected zone (for which policy holder has paid the premium), co-payment will be applicable as per below:
If you select Zone 1, then no co-payment will apply for treatment in Zone 1, Zone 2, or Zone 3.
If You select Zone 2, then 10% Co-payment will apply for treatment in Zone 1.
If You select Zone 3, then 20% Co-payment will apply for treatment in Zone 1 and Zone 2.

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

Only those persons named, as the Insured in the Schedule shall be covered under this Policy. The details of the Insured are as provided by You. A person may be added as an insured during the Policy Period after his application has been accepted by Us, an additional premium has been paid and Our agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person as an Insured.

III. Cost of pre-insurance medical examination

We will reimburse 100% 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. 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.

VI. Policy Period

The Policy can be issued for tenure of 1 year, 2 years and 3 years.

VII. 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.

VIII. Special Conditions applicable for Policies issued with Premium Payment on Instalment Basis: -

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 instalments 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.

IX. [4]AYUSH Coverage:

Expenses incurred on hospitalization due to accident and illnesses under AYUSH system 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 center and a request for pre-authorization 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 authorization letter. The authorization 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-authorization letter at the time of the Insured Person's admission to the Hospital.

(iii) 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-authorization 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-authorization as above is denied by Us or if treatment is taken in a Hospital which is Non-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.

[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.

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

c) Claims 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 D. II 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.

B. Basis of claims payment

a) Claims related to Any One Illness

All claims relating to Any One Illness shall be deemed to be part of the same original claim.

b) 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.

c) Claims related to Surgery for cataract

For Gold and Platinum plans, Our obligation to make payment in respect of Surgery for cataracts (after the expiry of the 2-year period referred to in Exclusion C.1 b) iii. above, shall be restricted to 10% of the Sum Insured for each eye, subject to a minimum of Rs 15000 (or the actual incurred amount whichever is lower) and maximum of Rs 50,000/- per eye. This will be Our maximum liability irrespective of the number of Health Suraksha policies You hold.

For Topaz and Ruby plans, Our obligation to make payment in respect of Surgery for cataracts (after the expiry of the 2-year period referred to in Exclusion C. 1 b) iii. above, shall be restricted to the sub-limits table, mentioned in Annexure 1 (Sub-limits table).

d) Disease wise sub-limits applicable under the policy

For Topaz and Ruby Plans, Sub limits will be applicable for listed diseases as mentioned in Annexure 1 (Sub-limits table).

e) 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.

In case of Topaz and Ruby Plans, the proportionate deduction for room rent shall also be applicable. Our maximum liability shall be subject to 50% of the Sum Insured opted, per policy period.

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

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. Coverage is not available during the grace period.
e) No loading shall apply on renewals based on individual claims experience
f) Your Health Suraksha Policy shall be renewable lifelong
g) 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.
h) For Renewal Proposal received after completion of Grace Period of 30 days, all waiting periods would apply afresh.
i) 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.
j) If any Dependent Child has completed 25 years at the time of Renewal, then such person can

be covered under a separate Policy. The Cumulative Bonus will be passed on to the separate policy taken by such person

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

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

II. Cumulative Bonus

a) We will provide cumulative bonus for every claim free year. We shall increase in the Sum Insured by 10% towards Cumulative Bonus for every claim free year on the basic Sum Insured up to the maximum of 50% of the sum insured.

b) In case of a claim in the Policy, the Cumulative Bonus will get reduced by 10% for each claim year. Increase/ Reduction in cumulative bonus will depend on the claims in the previous year, but the base Sum Insured (excluding cumulative bonus amount if any) of the Policy issued by Us shall be preserved.

c) In case You have opted for the 'Family Floater' option as specified in the Schedule, the Cumulative Bonus so applied will only be available to those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

d) The Cumulative Bonus is provisional and is subject to revision if a claim is made in respect of the expiring Policy Year, which is notified after the acceptance of Renewal premium, such awarded Cumulative Bonus shall be withdrawn.

E. SCHEDULE OF BENEFITS

			Plans Options						
			Gold Plan			**Platinum Plan**	**Topaz Plan**		**Ruby Plan**
A	Eligibility	**Sum Insured options (in ₹)**	**50,000* 1,00,000* 1,50,000***	**2,00,000 2,50,000**	**3,00,000 3,50,000 4,00,000 4,50,000 5,00,000**	**6,00,000 7,50,000 8,00,000 9,00,000 10,00,000**	**1,00,000***	**2,00,000 3,00,000 4,00,000 5,00,000**	**6,00,000 7,50,000 10,00,000**
		Entry age of Proposer	18 years – 70 years	18 years – 70 years	18 years – 70 years	18 years – 70 years	18 years – 70 years	18 years – 70 years	18 years – 70 years
		Entry age of Child	90 days – 25 years	90 days – 25 years	90 days – 25 years	90 days – 25 years	90 days – 25 years	90 days – 25 years	90 days – 25 years
		Maximum Renewal Age	Lifelong	Lifelong	Lifelong	Lifelong	Lifelong	Lifelong	Lifelong
		Individual/ Family Floater SI Options	Individual	Both	Both	Both	Individual	Both	Both
		Policy Term	1/ 2/ 3 years	1/ 2/ 3 years	1/ 2/ 3 years	1/ 2/ 3 years	1/ 2/ 3 years	1/ 2/ 3 years	1/ 2/ 3 years
		Family Definition – Individual SI	S+Sp/Lp+4C +2P	S+Sp/Lp+ 4C+2P	S+Sp/Lp+4 C+2P	S+Sp/Lp+4C +2P	S+Sp/Lp+4C +2P	S+Sp/Lp+4 C+2P	S+Sp/Lp+4C +2P
		Family Definition – Family Floater SI	Not Applicable	S+Sp/Lp+ 3C	S+Sp/Lp+3 C	S+Sp/Lp+3C	Not Applicable	S+Sp/Lp+3 C	S+Sp/Lp+3C
B	Hospitalisation Benefits	Hospitalisation	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI
		Room Rent Limit	1% of SI per day for non-ICU and 2% of SI per day for ICU up to 35% of the SI per claim	As per actuals	As per actuals	As per actuals	1% of the SI per day for non-ICU room	1% of the SI per day for non-ICU room	1% of the SI per day for non-ICU room
		Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	up to 35% of the SI per claim	As per actuals	As per actuals	As per actuals	As per the co-payment clause for room rent	As per the co-payment clause for room rent	As per the co-payment clause for room rent

		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	up to 40% of the SI per claim	As per actuals	As per actuals	As per actuals	As per the co-payment clause for room rent	As per the co-payment clause for room rent	As per the co-payment clause for room rent
		Day Care Treatment	Covered	Covered	Covered	Covered	Covered	Covered	Covered
		Pre-Hospitalisation	60 days, as actuals	60 days, as actuals	60 days, as actuals	60 days, as actuals	Medical Expenses up to 1% of Sum Insured up to maximum 60 days	Medical Expenses up to 1% of Sum Insured up to maximum 60 days	Medical Expenses up to 1% of Sum Insured up to maximum 60 days
		Post-Hospitalisation	90 days, as actuals	90 days, as actuals	90 days, as actuals	90 days, as actuals	Medical Expenses up to 1% of Sum Insured up to maximum 90 days	Medical Expenses up to 1% of Sum Insured up to maximum 90 days	Medical Expenses up to 1% of Sum Insured up to maximum 90 days
		Cumulative Bonus - 10% for every claim free year to Max 50%	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
		Hospital cash benefit	Not Applicable	Not Applicable	Not Applicable	₹ 500/- per day, up to 60 days	Not Applicable	Not Applicable	₹ 500/- per day, up to 60 days
		Patient Care (Above 60 years) - Per day Benefit	₹ 500/- per day, maximum up to 10 days and 30 days in a policy period	₹ 500/- per day, maximum up to 10 days and 30 days in a policy period	₹ 500/- per day, maximum up to 10 days and 30 days in a policy period	₹ 500/- per day, maximum up to 10 days and 30 days in a policy period	₹ 350/- per day, maximum up to 10 days and 30 days in a policy period	₹ 350/- per day, maximum up to 10 days and 30 days in a policy period	₹ 350/- per day, maximum up to 10 days and 30 days in a policy period
		Accidental Hospitalisation – 25% increase subject to Maximum of ₹ 1 lacs irrespective of number of claims in a Policy period	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
		Accompanying Person - ₹ 500/- per day for child up to 10 years, maximum up to 30 days in a Policy Year	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
		Organ donor expenses	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable

C	Sublimit for Specified procedure's	Mandatory Sub limits for Modern Treatment Methods and Advancement in Technologies	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
D	Recharge Benefit	Recharge Benefit	Not Applicable	Not Applicable	Applicable	Applicable	Not Applicable	Applicable for Sum Insured 3 L and above	Applicable
E	Ambulance	Ambulance charges	₹ 2000 per hospitalization	₹ 2000 per hospitalization	₹ 2000 per hospitalization	₹ 2000 per hospitalization	₹ 750/- per hospitalization and overall limit of ₹ 1500/- per policy period	₹ 750/- per hospitalization and overall limit of ₹ 1500/- per policy period	₹ 750/- per hospitalization and overall limit of ₹ 1500/- per policy period
F	Discount	Family discount of 10% is applicable in case more than one family member is covered on individual sum insured basis in the same policy, except for the policy with coverage for one adult with one or more children, the family discount shall be on basis of age of the Adult as per below table: **Age Bands** / **Discount** <=65 / 10.0% 66-70 / 7.5% 71-75 / 5.0% 76 & above / 4.0%	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
		Long term Discount (on single premium payment) – 5% for 2-year policy and 10% for 3 year policy	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
		Loyalty Discount – 2.5% discount if the client already has a separate Retail Health insurance policy (other than Health Suraksha/ Personal Accident /Travel) from Generali Central Insurance Company Limited The loyalty	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable

		discount shall continue only if the insured maintains the separate health insurance policy with us							
G	Premium instalment option (monthly, quarterly, half yearly) with Loading	Option of paying premium on instalment basis. Available for 1 year, 2 years and 3 years policy terms	Available	Available	Available	Available	Available	Available	Available
H	Waiting Periods	Pre-existing Disease- 36 months	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
		30 day - fresh proposals excluding Accidental Hospitalization	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
		1 year Waiting Period for listed conditions	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
		2 years Waiting Period for listed conditions	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
		3 years Waiting Period - Joint Replacement and Organ Transplant	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
I	Zone wise pricing	Zone wise pricing	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable
J	Disease wise Sublimits	Applicable for specific ailments	Not Applicable except for Cataract	Not Applicable except for Cataract	Not Applicable except for Cataract	Not Applicable except for Cataract	Applicable as per sub-limits table	Applicable as per sub-limits table	Applicable as per sub-limits table
K	Free Medical Check up	Medical Check-up - At the end of every continuous period of 4 claim free years	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable	Applicable

* Note –
Sum insured of ₹ 50000, 100000, 150000 will be applicable only for Children up to age of 25 years.

SI: Sum insured, S: Self, Sp: Spouse, Lp: Live-in partner, C: Child, P: Parent

Annexure 1: Sub-limits table

Sub-limits table applicable for Topaz and Ruby Plans

The Medical Expenses incurred during hospitalization (inclusive of pre and post hospitalization) due to the below listed treatments shall be limited to actual expenses or up to sub-limits mentioned below or up to the sub-limits mentioned in section 4 B e) (modern treatment methods), whichever is less.
No other co-payments/ deductibles will be applicable in case there is a claim for the listed procedures.
All values are in INR.

Procedure/ Treatment	**Topaz Plan**	**Topaz Plan**	**Topaz Plan**	**Ruby Plan**
	1,00,000	**2,00,000** **3,00,000**	**4,00,000** **5,00,000**	**6,00,000** **7,50,000** **10,00,000**
Cataract surgery (per eye)	10000	20000	30000	40000
Hysterectomy	20000	35000	45000	55000

Gall Bladder removal	20000	35000	45000	55000
Surgery on piles	15000	20000	30000	40000
Surgery Fissure, Fistula, Sinus	15000	20000	30000	40000
Surgery of Deviated Nasal Septum correction	15000	20000	30000	40000
Angiography invasive	10000	15000	20000	30000
Percutaneous Transluminal Coronary Angioplasty (PTCA)	40000	80000	120000	150000
Appendectomy	20000	30000	40000	50000
Hernia	20000	30000	40000	50000
Surgery of renal stone/ Lithotripsy	20000	30000	40000	50000
Prostate Surgery TURP	30000	75000	100000	120000
Coronary Artery Bypass Grafting (CABG)	80000	100000	150000	200000
Total Knee Replacement (per knee)	40000	80000	120000	150000
Total Hip Replacement (per hip)	40000	80000	120000	150000
Tonsillectomy/ Adenoidectomy	15000	25000	35000	45000
Transplant surgery (this includes total cost of organ donor surgery, recipient surgery and hospitalisation)	80000	100000	150000	200000
Dialysis (policy limit)	10000	15000	20000	30000

F. DAY CARE LIST

Day Care

In addition to Day Care list, We would also cover any other surgeries/ procedures agreed by Us in a Hospital or a Day care centre which require less than 24 hours Hospitalisation for inpatient care due to subsequent advancement in technology.

I. Cardiology Related:

1. Coronary Angiography

II. ENT Related:

2. Myringotomy With Grommet Insertion
3. Tympanoplasty (closure Of An Eardrum Perforation reconstruction Of The Auditory Ossicles)
4. Removal Of A Tympanic Drain
5. Operations On The Turbinates (nasal Concha)
6. Stapedotomy To Treat Various Lesions In Middle Ear
7. Revision Of A Stapedectomy
8. Other Operations On The Auditory Ossicles
9. Myringoplasty (post-aura/endaural Approach As Well As Simple Type-I Tympanoplasty)
10. Fenestration Of The Inner Ear
11. Revision Of A Fenestration Of The Inner Ear
12. Palatoplasty
13. Transoral Incision And Drainage Of A Pharyngeal Abscess
14. Tonsillectomy Without Adenoidectomy
15. Tonsillectomy With Adenoidectomy
16. Excision And Destruction Of A Lingual Tonsil
17. Revision Of A Tympanoplasty
18. Other Microsurgical Operations On The Middle Ear
19. Incision Of The Mastoid Process And Middle Ear
20. Mastoidectomy
21. Reconstruction Of The Middle Ear
22. Other Excisions Of The Middle And Inner Ear
23. Other Operations On The Middle And Inner Ear
24. Excision And Destruction Of Diseased Tissue Of The Nose
25. Nasal Sinus Aspiration
26. Foreign Body Removal From Nose

27. Adenoidectomy
28. Stapedectomy Under GA
29. Stapedectomy Under LA
30. Tympanoplasty (type IV)
31. Turbinectomy
32. Endoscopic Stapedectomy
33. Incision And Drainage Of Perichondritis
34. Septoplasty
35. Thyroplasty Type I
36. Pseudocyst Of The Pinna - Excision
37. Incision And Drainage - Haematoma Auricle
38. Reduction Of Fracture Of Nasal Bone
39. Excision Of Angioma Septum
40. Turbinoplasty
41. Incision & Drainage Of Retro Pharyngeal Abscess
42. Uvulo Palato Pharyngo Plasty
43. Adenoidectomy With Grommet Insertion
44. Adenoidectomy Without Grommet Insertion
45. Incision & Drainage Of Para Pharyngeal Abscess

III. Gastroenterology Related:

46. Pancreatic Pseudocyst EUS & Drainage
47. RF Ablation For Barrett's Oesophagus
48. EUS + Aspiration Pancreatic Cyst
49. Small Bowel Endoscopy (therapeutic)
50. Colonoscopy, Lesion Removal
51. ERCP
52. Colonoscopy Stenting Of Stricture
53. Percutaneous Endoscopic Gastrostomy
54. EUS And Pancreatic Pseudo Cyst Drainage
55. ERCP And Choledochoscopy
56. Proctosigmoidoscopy Volvulus Detorsion
57. ERCP And Sphincterotomy
58. Esophageal Stent Placement
59. ERCP + Placement Of Biliary Stents
60. Sigmoidoscopy W / Stent
61. EUS + Coeliac Node Biopsy

IV. General Surgery Related:

62. Incision Of A Pilonidal Sinus / Abscess
63. Fissure In Ano Sphincterotomy
64. Piles Banding
65. Surgery for Hernia
66. Surgical Treatment Of Anal Fistulas
67. Division Of The Anal Sphincter (sphincterotomy)
68. Epididymectomy
69. Incision Of The Breast Abscess
70. Operations On The Nipple
71. Excision Of Single Breast Lump
72. Incision And Excision Of Tissue In The Perianal Region
73. Surgical Treatment Of Hemorrhoids
74. Sclerotherapy
75. Wound Debridement And Cover
76. Abscess-decompression
77. Infected Sebaceous Cyst
78. Incision And Drainage Of Abscess
79. Suturing Of Lacerations

80. Scalp Suturing
81. Infected Lipoma Excision
82. Maximal Anal Dilatation
83. Piles Injection Sclerotherapy
84. Liver Abscess- Catheter Drainage
85. Fissure In Ano-Fissurectomy
86. Fibroadenoma Breast Excision
87. Oesophageal Varices Sclerotherapy
88. ERCP - Pancreatic Duct Stone Removal
89. Perianal Abscess I & D
90. Perianal Hematoma Evacuation
91. UGI Scopy And Polypectomy Oesophagus
92. Breast Abscess I & D
93. Oesophagoscopy And Biopsy Of Growth Oesophagus
94. ERCP - Bile Duct Stone Removal
95. Splenic Abscesses Laparoscopic Drainage
96. UGI Scopy And Polypectomy Stomach
97. Feeding Jejunostomy
98. Varicose Veins Legs - Injection Sclerotherapy
99. Pancreatic Pseudocysts Endoscopic Drainage
100. Zadek's Nail Bed Excision
101. Rigid Oesophagoscopy For Dilation Of Benign Strictures
102. Lord's Plication
103. Jaboulay's Procedure
104. Scrotoplasty
105. Circumcision For Trauma
106. Meatoplasty
107. Intersphincteric Abscess Incision And Drainage
108. PSOAS Abscess Incision And Drainage
109. Thyroid Abscess Incision And Drainage
110. Tips Procedure For Portal Hypertension
111. Esophageal Growth Stent
112. Pair Procedure Of Hydatid Cyst Liver
113. Tru Cut Liver Biopsy
114. Laparoscopic Reduction Of Intussusception
115. Microdochectomy Breast
116. Sentinel Node Biopsy
117. Testicular Biopsy
118. Sentinel Node Biopsy Malignant Melanoma
119. TURBT
120. URS + LL

V. Gynecology Related:

121. Conization Of The Uterine Cervix
122. Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas
123. Incision Of Vulva
124. Salpingo-oophorectomy Via Laparotomy
125. Endoscopic Polypectomy
126. Hysteroscopic Removal Of Myoma
127. D & C
128. Hysteroscopic Resection Of Septum
129. Thermal Cauterisation Of Cervix
130. Mirena Insertion
131. Laparoscopic Hysterectomy
132. LEEP (Loop Electrosurgical Excision Procedure)
133. Cryocauterisation Of Cervix
134. Polypectomy Endometrium

135. Hysteroscopic Resection Of Fibroid
136. LLETZ (large loop excision of the transformation zone)
137. Conization
138. Polypectomy Cervix
139. Hysteroscopic Resection Of Endometrial Polyp
140. Vulval Wart Excision
141. Laparoscopic Paraovarian Cyst Excision
142. Uterine Artery Embolization
143. Laparoscopic Cystectomy
144. Hymenectomy (Imperforate Hymen)
145. Vaginal Wall Cyst Excision
146. Vulval Cyst Excision
147. Laparoscopic Paratubal Cyst Excision
148. Vaginal Mesh For POP
149. Laparoscopic Myomectomy
150. Repair Recto- Vagina Fistula
151. Pelvic Floor Repair (Excluding Fistula Repair)
152. Laparoscopic Oophorectomy

VI. Neurology Related:

153. Facial Nerve Glycerol Rhizotomy
154. Stereotactic Radiosurgery
155. Percutaneous Cordotomy
156. Diagnostic Cerebral Angiography
157. VP Shunt
158. Ventriculoatrial Shunt

VII. Oncology Related:

159. Radiotherapy For Cancer
160. Cancer Chemotherapy
161. IV Push Chemotherapy
162. HBI-hemibody Radiotherapy
163. Infusional Targeted Therapy
164. SRT-stereotactic ARC Therapy
165. SC Administration Of Growth Factors
166. Continuous Infusional Chemotherapy
167. Infusional Chemotherapy
168. CCRT-concurrent Chemo + RT
169. 2D Radiotherapy
170. 3D Conformal Radiotherapy
171. IGRT- Image Guided Radiotherapy
172. IMRT- Step & Shoot
173. Infusional Bisphosphonates
174. IMRT- DMLC
175. Rotational Arc Therapy
176. Tele Gamma Therapy
177. FSRT-fractionated SRT
178. VMAT-volumetric Modulated Arc Therapy
179. SBRT-stereotactic Body Radiotherapy
180. Helical Tomotherapy
181. SRS-stereotactic Radiosurgery
182. X-knife SRS
183. Gammaknife SRS
184. TBI- Total Body Radiotherapy
185. Intraluminal Brachytherapy
186. Electron Therapy
187. TSET-total Electron Skin Therapy

188. Extracorporeal Irradiation Of Blood Products
189. Telecobalt Therapy
190. Telecesium Therapy
191. External Mould Brachytherapy
192. Interstitial Brachytherapy
193. Intracavity Brachytherapy
194. 3D Brachytherapy
195. Implant Brachytherapy
196. Intravesical Brachytherapy
197. Adjuvant Radiotherapy
198. Afterloading Catheter Brachytherapy
199. Conditioning Radiothearpy For BMT
200. Nerve Biopsy
201. Muscle Biopsy
202. Epidural Steroid Injection
203. Extracorporeal Irradiation To The Homologous Bone Grafts
204. Radical Chemotherapy
205. Neoadjuvant Radiotherapy
206. LDR Brachytherapy
207. Palliative Radiotherapy
208. Radical Radiotherapy
209. Palliative Chemotherapy
210. Template Brachytherapy
211. Neoadjuvant Chemotherapy
212. Adjuvant Chemotherapy
213. Induction Chemotherapy
214. Consolidation Chemotherapy
215. Maintenance Chemotherapy
216. HDR Brachytherapy

VIII. Operations On The Salivary Glands & Salivary Ducts:

217. Incision And Lancing Of A Salivary Gland And A Salivary Duct
218. Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct
219. Resection Of A Salivary Gland
220. Reconstruction Of A Salivary Gland And A Salivary Duct

IX. Operations On The Skin & Subcutaneous Tissues:

221. Surgical Wound Toilet (wound Debridement) And Removal Of Diseased Tissue Of The Skin And Subcutaneous Tissues
222. Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues
223. Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues
224. Free Skin Transplantation, Donor Site
225. Free Skin Transplantation, Recipient Site
226. Revision Of Skin Plasty
227. Chemosurgery To The Skin.
228. Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues
229. Reconstruction Of Deformity/defect In Nail Bed
230. Excision Of Bursirtis
231. Tennis Elbow Release

X. Operations On The Tongue:

232. Incision, Excision And Destruction of Diseased Tissue Of The Tongue
233. Partial Glossectomy
234. Glossectomy
235. Reconstruction Of The Tongue

XI. Ophthalmology Related

236. Surgery For Cataract
237. Incision Of Tear Glands
238. Incision Of Diseased Eyelids
239. Excision And Destruction Of Diseased Tissue Of The Eyelid
240. Operations On The Canthus And Epicanthus
241. Corrective Surgery For Entropion And Ectropion
242. Corrective Surgery For Blepharoptosis
243. Removal Of A Foreign Body From The Conjunctiva
244. Removal Of A Foreign Body From The Cornea
245. Incision Of The Cornea
246. Operations For Pterygium
247. Removal Of A Foreign Body From The Lens Of The Eye
248. Removal Of A Foreign Body From The Posterior Chamber Of The Eye
249. Removal Of A Foreign Body From The Orbit And Eyeball
250. Correction Of Eyelid Ptosis By Levator Palpebrae Superioris Resection (bilateral)
251. Correction Of Eyelid Ptosis By Fascia Lata Graft (bilateral)
252. Diathermy/cryotherapy To Treat Retinal Tear
253. Anterior Chamber Paracentesis/ Cyclodiathermy/ Cyclocryotherapy/ Goniotomy Trabeculotomy And Filtering And Allied Operations To Treat Glaucoma
254. Enucleation Of Eye Without Implant
255. Dacryocystorhinostomy For Various Lesions Of Lacrimal Gland
256. Laser Photocoagulation To Treat Retinal Tear
257. Biopsy Of Tear Gland

XII. Orthopedics Related:

258. Incision On Bone, Septic And Aseptic
259. Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
260. Suture And Other Operations On Tendons And Tendon Sheath
261. Reduction Of Dislocation Under GA
262. Arthroscopic Knee Aspiration
263. Surgery For Ligament Tear
264. Surgery For Hemoarthrosis/ pyoarthrosis
265. Removal Of Fracture Pins/nails
266. Removal Of Metal Wire
267. Closed Reduction On Fracture, Luxation
268. Reduction Of Dislocation Under GA
269. Epiphyseolysis With Osteosynthesis
270. Excision Of Various Lesions In Coccyx
271. Arthroscopic Repair Of ACL Tear Knee
272. Closed Reduction Of Minor Fractures
273. Arthroscopic Repair Of PCL Tear Knee
274. Tendon Shortening
275. Arthroscopic Meniscectomy - Knee
276. Treatment Of Clavicle Dislocation
277. Haemarthrosis Knee- Lavage
278. Abscess Knee Joint Drainage
279. Carpal Tunnel Release
280. Closed Reduction Of Minor Dislocation
281. Repair Of Kneecap Tendon
282. ORIF With K Wire Fixation- Small Bones
283. Release Of Midfoot Joint
284. ORIF With Plating- Small Long Bones
285. Implant Removal Minor
286. K Wire Removal
287. Closed Reduction And External Fixation
288. Arthrotomy Hip Joint
289. Syme's Amputation

290. Arthroplasty
291. Partial Removal Of Rib
292. Treatment Of Sesamoid Bone Fracture
293. Shoulder Arthroscopy / Surgery
294. Elbow Arthroscopy
295. Amputation Of Metacarpal Bone
296. Release Of Thumb Contracture
297. Incision Of Foot Fascia
298. Partial Removal Of Metatarsal
299. Repair / Graft Of Foot Tendon
300. Amputation Follow-up Surgery
301. Exploration Of Ankle Joint
302. Remove/graft Leg Bone Lesion
303. Repair/graft Achilles Tendon
304. Remove Of Tissue Expander
305. Biopsy Elbow Joint Lining
306. Removal Of Wrist Prosthesis
307. Biopsy Finger Joint Lining
308. Tendon Lengthening
309. Treatment Of Shoulder Dislocation
310. Lengthening Of Hand Tendon
311. Removal Of Elbow Bursa
312. Fixation Of Knee Joint
313. Treatment Of Foot Dislocation
314. Surgery Of Bunion
315. Tendon Transfer Procedure
316. Removal Of Kneecap Bursa
317. Treatment Of Fracture Of Ulna
318. Treatment Of Scapula Fracture
319. Removal Of Tumor Of Arm/ Elbow Under RA/GA
320. Repair Of Ruptured Tendon
321. Decompress Forearm Space
322. Revision Of Neck Muscle (torticollis Release)
323. Lengthening Of Thigh Tendons
324. Treatment Fracture Of Radius & Ulna

XIII. Other Operations On The Mouth & Face:

325. External Incision And Drainage In The Region Of The Mouth, Jaw And Face
326. Incision Of The Hard And Soft Palate
327. Excision And Destruction Of Diseased Hard And Soft Palate

XIV. Pediatric Surgery Related:

328. Excision Of Fistula-in-ano
329. Excision Juvenile Polyps Rectum
330. Vaginoplasty
331. Dilatation Of Accidental Caustic Stricture Oesophageal
332. Presacral Teratomas Excision
333. Removal Of Vesical Stone
334. Excision Sigmoid Polyp
335. Sternomastoid Tenotomy
336. Infantile Hypertrophic Pyloric Stenosis Pyloromyotomy
337. Excision Of Soft Tissue Rhabdomyosarcoma
338. Mediastinal Lymph Node Biopsy
339. High Orchidectomy For Testis Tumours
340. Excision Of Cervical Teratoma
341. Rectal myomectomy
342. Rectal Prolapse (Delorme's Procedure)

343. Detorsion Of Torsion Testis

XV. Thoracic Surgery Related:

344. Thoracoscopy And Lung Biopsy
345. Excision Of Cervical Sympathetic Chain Thoracoscopic
346. Laser Ablation Of Barrett's Oesophagus
347. Pleurodesis
348. Thoracoscopy And Pleural Biopsy
349. EBUS + Biopsy
350. Thoracoscopy Ligation Thoracic Duct
351. Thoracoscopy Assisted Empyema Drainage

XVI. Urology Related:

352. Haemodialysis
353. Lithotripsy/nephrolithotomy For Renal Calculus
354. Excision Of Renal Cyst
355. Drainage Of Pyonephrosis/perinephric Abscess
356. Incision Of The Prostate
357. Transurethral Excision And Destruction Of Prostate Tissue
358. Transurethral And Percutaneous Destruction Of Prostate Tissue
359. Open Surgical Excision And Destruction Of Prostate Tissue
360. Operations On The Seminal Vesicles
361. Other Operations On The Prostate
362. Incision Of The Scrotum And Tunica Vaginalis Testis
363. Operation On A Testicular Hydrocele
364. Other Operations On The Scrotum And Tunica Vaginalis Testis
365. Incision Of The Testes
366. Excision And Destruction Of Diseased Tissue Of The Testes
367. Unilateral Orchidectomy
368. Bilateral Orchidectomy
369. Surgical Repositioning Of An Abdominal Testis
370. Reconstruction Of The Testis
371. Other Operations On The Testis
372. Excision In The Area Of The Epididymis
373. Operations On The Foreskin
374. Local Excision And Destruction Of Diseased Tissue Of The Penis
375. Other Operations On The Penis
376. Cystoscopical Removal Of Stones
377. Lithotripsy
378. Biopsy Of temporal Artery For Various Lesions
379. External Arterio-venous Shunt
380. AV Fistula - Wrist
381. URSL With Stenting
382. URSL With Lithotripsy
383. Cystoscopic Litholapaxy
384. ESWL
385. Cystoscopy & Biopsy
386. Cystoscopy And Removal Of Polyp
387. Suprapubic Cystostomy
388. Percutaneous Nephrostomy
389. Cystoscopy And "SLING" Procedure
390. TUNA- Prostate
391. Excision Of Urethral Diverticulum
392. Excision Of Urethral Prolapse
393. Mega-ureter Reconstruction
394. Kidney Renoscopy And Biopsy
395. Ureter Endoscopy And Treatment

396. Surgery For Pelvi Ureteric Junction Obstruction
397. Anderson Hynes Operation
398. Kidney Endoscopy And Biopsy
399. Paraphimosis Surgery
400. Surgery For Stress Urinary Incontinence
401. Injury Prepuce- Circumcision
402. Frenular Tear Repair
403. Meatotomy For Meatal Stenosis
404. Surgery For Fournier's Gangrene Scrotum
405. Surgery Filarial Scrotum
406. Surgery For Watering Can Perineum
407. Repair Of Penile Torsion
408. Drainage Of Prostate Abscess
409. Orchiectomy

Note: *The standard exclusions and waiting periods are applicable to all of the above procedures depending on the medical condition/ disease under treatment. Only 24 hours Hospitalisation is not mandatory.*

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

Annexure 2

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 FOOTWEAR
45.	KNEE BRACES (LONG/ SHORT/ HINGED)
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR

50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53.	SUGAR FREE TABLETS
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	VASOFIX SAFETY

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

Sl No.	Item
1.	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU-DE-COLOGNE / ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTHPASTE
13.	TOOTHBRUSH
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

GRIEVANCE REDRESSAL PROCEDURE

Dear Customer,

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

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

What is a grievance?

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

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

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

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

By when will my grievance be resolved?

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

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

- You may write to our Grievance Redressal Officer at **GCIGRO@generalicentral.com**
- You may send a physical letter to our Grievance Redressal Cell, Head Office at the below address:

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

  Unit No. 301, 3rd Floor Part, Building No. 8, Mindspace IT/ITES SEZ, MIDC Industrial Area, Airavali, Navi Mumbai, Thane District – 400 708.

GRIEVANCE REDRESSAL PROCEDURE

What if I am not able to register my grievance?

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

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

Call on toll-free number: **155255**

Click here to register complaint online

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

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

Insurance Ombudsman:

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

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