HEALTH UNLIMITED
PROSPECTUS

1. SALIENT FEATURES OF THE POLICY

Base Covers

- Hospitalization Medical Expenses
- Day Care Treatment Expenses
- Pre-Hospitalization Medical Expenses.
- Post-Hospitalization Medical Expenses
- Organ Donor Expenses
- Modern Treatments
- AYUSH Treatment
- Maternity Expenses
- Accidental Hospitalization
- Emergency Road Ambulance
- Emergency Medical Evacuation
- Home Health Care Expenses
- OPD Treatment
- Medical Second Opinion
- Medical Treatment Abroad
- Wellness Benefits
- Cumulative Bonus
- Unlimited Restoration of Sum Insured
- Bariatric Surgery
- Inflation Guard
- Premium Payback
- Unlimited Cover

Optional Covers

- Consumables/Non-medical Expenses Cover
- Voluntary Deductible
- Mandatory Co-payment Waiver

2. SCOPE OF COVER

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

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

The benefits available under this Policy are listed below. The Schedule of Benefits will specify whether the benefit in respect of which a claim arises, is in force for the Insured Person.

2.1. Base Covers

The benefits available under the Base Cover are in-built into the product. The Schedule of Benefits specifies the benefit details along with the applicable cover option / sublimit, which shall be in force for the Insured Persons during the Policy Period. The benefits available under the Base Cover in this Policy are listed below:

2.1.1 In-Patient Hospitalization

We will pay the reasonable and customary charges for Medical Expenses necessarily incurred towards one or more of the following charges, arising out of an Insured Person's Hospitalization following an Illness or Injury sustained during the Policy Year, up to the Sum Insured as specified in the Policy Schedule

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

2.1.2 Daycare Treatment Expenses

We will cover the Medical Expenses incurred in respect of the Day Care Treatment of the Insured Person during the Policy Period up to the Annual Sum Insured as specified in the Policy Schedule provided that:

a) Day Care treatment requires hospitalization as an inpatient for less than 24 hours in a hospital.
b) We will also cover Medical Expenses incurred for procedures including but not limited to intravenous chemotherapy, radiotherapy, hemodialysis or any other therapeutic procedure, which requires a period of specialized observation or medical care after completion of the procedure.
c) We will not cover any Out-Patient Treatment or diagnostic services under this Benefit.
d) Expenses associated with automation machine for peritoneal dialysis shall not be payable

2.1.3 Pre-hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Pre- Hospitalization Medical Expenses incurred immediately prior to the date of the Insured Person's hospitalization for 60 days, provided that We have accepted a claim for Hospitalization under Section 2.1.1 (In-patient Hospitalization), Section 2.1.2 (Daycare Treatment Expenses).

Pre-Hospitalization Medical Expenses towards Section 2.1.15 (Medical Treatment Abroad) shall be covered only if such expenses are incurred in India.

2.1.4 Post-hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Post- Hospitalization Medical Expenses incurred immediately following the Insured Person's discharge from Hospital for the number of days specified in the Schedule of Benefits, provided that We have accepted a claim for hospitalization under Section 2.1.1 (In-patient Hospitalization) Section 2.1.2 (Daycare Treatment Expenses) and Section 2.1.15 (Medical Treatment Abroad).

Provided that the Post-Hospitalization Medical Expenses towards Section 2.1.15 (Medical Treatment Abroad) shall be covered only if such expenses are incurred in India.

2.1.5 Organ Donor Expenses

We will pay the reasonable & customary charges for medical expenses incurred for an organ donor's treatment for the harvesting of the organ donated, up to the Sum Insured as specified in the Schedule of Benefits, provided that:

a) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act, 1994.
b) The organ donated is for the use of the Insured Person.
c) We have accepted claim under In-patient Hospitalization (Section 2.1.1) for the Insured Person.
d) The Insured Person is medically advised to undergo an organ transplant.

Special Exclusions:

(i) Any expenses other than specified above
(ii) Cost towards donor screening
(iii) Pre / Post Hospitalization expenses of the Organ Donor
(iv) Costs directly or indirectly associated with the acquisition of the donor's organ.

2.1.6 Modern Treatments Method and Advancement in Technologies:

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

We will cover medical expenses incurred on the following procedures:

a) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b) Balloon Sinuplasty
c) Deep Brain stimulation
d) Oral chemotherapy
e) Immunotherapy - Monoclonal Antibody to be given as injection.
f) Intra vitreal injections
g) Robotic surgeries
h) Stereotactic radio surgeries
i) Bronchical Thermoplasty
j) Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k) IONM - (Intra Operative Neuro Monitoring)
l) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

2.1.7 AYUSH Treatment

If the Insured Person is Hospitalized for not less than 24 hrs, in an AYUSH Hospital on the advice of a Medical Practitioner/Doctor because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period then We will pay

In-patient Treatment- Medical Expenses for AYUSH treatment

a) Room rent, boarding expenses
b) Nursing care
c) Consultation fees
d) Medicines, drugs and consumables,
e) AYUSH treatment procedures

The claim will be admissible under the policy provided that,

i. The illness/injury requires inpatient admission & the procedure performed on the insured cannot be carried out on Outpatient basis
ii. the treatment has been undergone in a government hospital

2.1.8 Maternity Expenses

We will pay reasonable and customary charges for medical expenses incurred by Insured Person towards Maternity Expenses for the Insured Persons's Delivery (Normal /Cesarean) and Miscarriage/ lawful medical termination of pregnancy during the Policy Year.

Our maximum liability under this benefit shall be up to an amount specified, in the Schedule of Benefits.

This benefit shall only be available for a female Insured Person who should be aged 18 years or above and who should be either:

a) the Policyholder insured as Self or,
b) the insured as Policyholder's Spouse or Live-in Partner.

Special Condition:

a) The cover under this benefit is available if the Female Insured person along with spouse are covered for a continuous period of 36 months before this benefit comes into effect.
b) Medical Expenses for the delivery of a child (Normal/Caesarean) or Miscarriage / lawful medical termination of pregnancy covered up to a maximum of 2 events in the lifetime of the Insured Person.
c) Any expenses related to Ectopic Pregnancy (abdominal operation for extra uterine pregnancy), which is proved by submission of Ultra Sonographic Report, would not be covered under this Benefit, but would be considered as a claim made under In-Patient Hospitalization (Section 2.1.1)
d) Clause 3.2.15 shall not apply to the extent of cover provided under this benefit.

2.1.9 Accidental Hospitalization

We will provide an additional 25% of Base Sum Insured if the Insured Person is hospitalized solely and directly due to an Accident which occurred during the Policy Year. Such Additional Sum Insured shall not exceed ₹ 10,00,000 and it will only be available for claims arising under Section 2.1.1(In-patient Hospitalization).

2.1.10 Emergency Road Ambulance

We will reimburse expenses incurred towards Road Ambulance charges for transportation of an Insured person, by an ambulance of a hospital or of a registered ambulance service provider.

Our maximum liability per hospitalization under this benefit shall be up to an amount as specified, in the Schedule of Benefits.

Following Expenses shall be covered under this benefit:

I. Transportation Costs towards transferring the Insured Person from the place of incident to Hospital, from one Hospital to another Hospital or to a diagnostic Centre for advanced diagnostic treatment where such facility is not available at the existing Hospital and advised by the treating medical practitioner.
II. When the Insured Person requires to be moved to home after discharge from the hospital and the medical condition of Insured Person is such that it requires services of Ambulance as certified by treating medical practitioner.

Special Condition:

a) The ambulance services of a hospital or a registered ambulance service provider is utilized.
b) The original Ambulance bills and payment receipt is submitted to Us.
c) We have accepted a claim under In-Patient Hospitalization (Section 2.1.1) or Day Care Treatment (Section 2.1.2) for the same Illness/Injury.

2.1.11 Emergency Medical Evacuation

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

a) Emergency Medical evacuation following an Accident/injury/illness through any mode of transportation available, during the Policy Year, from the place where the Accidental Injury/illness occurred.
b) The benefit under this cover shall only be applicable if no alternative method of transportation is available within the vicinity of occurrence of such accident/ injury/ illness leading to medical emergency.
c) For claims made under this Benefit, We will reimburse expenses for emergency evacuation/ transportation of the Insured Person and Medical Expenses incurred for treatment, during the course of evacuation, provided that such treatment is Medically Necessary and it is provided to the Insured Person en-route.

2.1.12 Home Health Care Expenses

We will cover the reasonable and customary charges up to a maximum of 25% of the Sum Insured (excluding the Cumulative Bonus, if any) towards Medical Expenses incurred for Home Health Care Services opted during the Policy Year and availed through Our empaneled Home Health Care Service Provider, on Cashless Facility basis, only if the following conditions are fulfilled:

a) The Home Health Care Expenses shall be covered only subject to Cashless authorization approved by Us.
b) Medical treatment for an Illness/ Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:
    i. The condition of the patient is such that he/she is not in a condition to be moved to a Hospital, or
    ii. The patient takes treatment at home on account of non-availability of bed / room in a Hospital, or
    iii. Non-availability of Hospital Services due to any prevailing conditions /Government Notification.
    iv. Chemotherapy and dialysis at home.
    v. For children up to the age of 15 years if treated at home instead of hospitalization, if certified by the Medical Practitioner that the child needs hospitalization for treatment but the same can be replicated at home with remote monitoring and nursing care.
c) The duration of Home Health Care treatment should be restricted to reasonable time and not more than the period of Hospitalization, the patient would have undergone otherwise.
d) Treatment under this benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
e) In case of medical treatment solely taken at home without any initial hospitalization, Pre and Post hospitalization expenses (both inclusive) are restricted up to 3% of the admissible Claim amount for each hospitalization under this Benefit.
f) In case of Post-surgical care through Home Health Care Services, where the initial hospitalization for surgical management, the condition was at our empanelled network hospital

and we have accepted an inpatient hospitalization claim on cashless basis, then Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses will be applicable as per section 2.1.3 and 2.1.4 respectively.

g) Only Allopathic treatment shall be covered under this Benefit.
h) This Benefit shall not cover any expenses incurred towards attendant/ nursing services
i) Clause 3.3.13 shall not apply to the extent of cover provided under this benefit.

2.1.13 OPD Treatment

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

Specific Conditions applicable to this benefit are:

a) Only Allopathic treatment will be covered under this Benefit.
b) 30% co-payment applicable on all expenses incurred for OPD treatments to be borne by the Insured Person
c) In case of expenses towards Mental/Psychiatric illness, only the following would be considered
   I. Consultations and counselling sessions with a Psychiatrist
   II. Diagnostics which have been prescribed by a Psychiatrist
d) All expenses individually or in aggregate cannot exceed the OPD Treatment Expenses limit specified in the Schedule of Benefits.
e) Clause 3.3.11 shall not apply to the extent of cover provided under this benefit

Specific Exclusions:

a) Initial waiting period of 30 days shall be applicable for this benefit during the first year of this Policy.
b) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until 36 months of continuous coverage after the date of inception of the first Policy
c) Coverage under the Policy after the expiry of the waiting period of 36 months, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.
d) If the cover under this benefit is not availed in the Policy year during the Policy Period, the benefit cannot be carried forward to the subsequent policy year.

2.1.14 Medical Second Opinion

If an Insured Person suffers an Illness or Injury during the Policy Year in respect of which a claim has been admitted under Section 2.1.1 (In-patient Hospitalization), then at the Insured Person's request We will arrange a maximum of two medical second opinions (in a Policy Year) from a Medical Practitioner selected by the Insured Person from Our panel.

This second opinion will be based only on the information and documentation provided to the Medical Practitioner by or on behalf of the Insured Person.

While claiming under this Benefit and deciding to obtain a second opinion, each Insured Person expressly agrees that:

i. It is entirely for the Insured Person to decide whether to obtain a second opinion, from which Medical Practitioner in Our panel to take the Second Opinion and the use (if any) to which the Second Opinion so obtained is put.
ii. We do not provide a second opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same, or the use to which the second opinion is put.

iii. We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations whatsoever made by any Medical Practitioner in Our Panel or in any second opinion or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

2.1.15 Medical Treatment Abroad

a) We shall reimburse the Charges for Medical Expenses necessarily incurred by the Insured Person, for treatment / surgical procedure of the below listed condition/diseases, outside India subject to the sum insured as specified in the policy schedule and subject to the conditions precedent as specified in the policy document and more particularly herein.

b) The benefits under this Section will be available if the Insured Person who has been continuously covered under for a period of 36 months from the inception of the Policy with Us.

c) We shall cover only those Medical Expenses that would otherwise have been payable under Section 2.1.1 (In-patient Hospitalization). For the purpose of this Benefit, Hospital (outside India) means an institution (including nursing homes) established outside India for indoor medical care and treatment of illness and injuries which has been registered and licensed with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a Medical Practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, old age home.

d) Upon the Insured Person's intimation, Our Assistance service provider will further assist the Insured Person in confirming the admissibility of the claim and co-ordinate with the Hospitals for availing the Cashless Facility for the Medically Necessary Treatment abroad within 7 working days from date of intimation.

e) In case the cashless facility is not available or the hospital is not available within the Network of Our Assistance Service Provider the claim can be addressed on reimbursement basis.

f) Any payments under this Benefit shall always be, in Indian rupees only. The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of Hospitalization, shall be used for conversion of foreign currency amounts into Indian rupees for payment of any claim under this Benefit. If on the date of Hospitalization the RBI rates are not published, the rates next published by the RBI shall be considered for conversion.

g) Clause 3.3.14 shall not apply to the extent of cover provided under this benefit.

h) The benefits under Inflation Guard (Section No.2.1.20) and Unlimited Restoration of Sum Insured (Section No. 2.2.18) shall not be available for Medical Treatment Abroad. In-Patient Hospitalization/Daycare treatment expenses incurred under this benefit will be covered only up to Base Sum Insured and Cumulative Bonus under the Policy.

i) For the purposes of this Benefit and the determination of the Company's liability under it, Listed treatment / surgical procedure in relation to the Insured, shall mean any Illness, medical event or Surgical Procedure as specifically defined below, for which the insured opts to take treatment abroad. The cover is offered during the Policy Year, subject to terms and conditions as given below:

1) **Craniotomy & Craniectomy: only as a treatment for cancers-**
   The actual undergoing of surgery to the brain as a result of Cancerous growth, under general anaesthesia during which a Craniotomy or Craniectomy is been performed.
   This requirement of surgery must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques and certified by a specialist medical practitioner.

2) **Lung Lobectomy that involves complete removal of one of the five lobes of the lungs for lung cancer:**
   We will cover the Medical expenses incurred towards the actual undergoing of a complete Lung Lobectomy due to cancerous growth in any of the lung characterized by the

uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues.
The diagnosis has to be confirmed and evidenced by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques and certified by qualified medical doctor of relevant specialty and histological evidence of malignancy.

3) **Liver Lobectomy that involves removal of 70% of liver mass in case of liver failure:**
We will cover the Medical expenses incurred towards the actual undergoing of liver lobectomy involving removal of 70% of liver mass due to failure of liver functions.
The diagnosis and the surgical procedure has to be confirmed by a specialist Medical Practitioner.
Liver Lobectomy as a result of liver failure due to consumption of alcohol or drug abuse is excluded.

4) **Major organ transplant**
The actual undergoing of a transplant of one of the following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ.
The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
The following are excluded:
a) Where only islets of Langerhans are transplanted
b) Other Stem-Cell Transplant

5) **Bone marrow transplant:**
The actual undergoing of a transplant for Human bone marrow using hematopoietic stem cells.
The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

6) **Repair of Aortic Aneurysm**
We will cover the Medical expenses incurred towards the actual undergoing of major Surgery to repair or correct aneurysm. For the purpose of this cover the definition of “Aorta” shall mean the thoracic and abdominal aorta but not its branches.
The diagnosis to be evidenced by any two of the following:
1) Computerized tomography (CT) scan
2) Magnetic Resonance Imaging (MRI) scan
3) Echocardiography (an ultrasound of the heart)
4) Angiography (Injecting X ray dye)
5) Abdominal ultrasound

7) **Heart valve replacement:**
We will cover the Medical expenses incurred towards the actual undergoing of surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s).
The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

8) **Coronary Artery Bypass Graft.**
We will cover the Medical expenses incurred towards the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breastbone) or minimally invasive keyhole coronary artery bypass procedures.
The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
a) Angioplasty and/or any other intra-arterial procedures are excluded.

2.1.16 Wellness Benefits

The Insured Person will be eligible for "Wellness Benefits" as per the Plan in force under the Policy. These wellness benefits will include Value added services and Wellness reward points. These services would be conducted through Our Wellness partner and can be availed from our GCI mobile App.

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

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

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

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

A. Value Added Services

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

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

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

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

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

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

Sum Insured	Tests
7.5, 10L	Complete Blood Count (CBC), Glycosylated Haemoglobin (HbA1C), Electrocardiogram (ECG reported by an MD Physician), Serum Creatinine, Low Density Lipoproteins (LDL), Serum Triglycerides, High Density Lipoproteins (HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI (Body Mass Index), Uric Acid, Total Protein, Pulmonary Function Test.

15, 25L	Complete Blood Count (CBC) , Glycosylated Haemoglobin (HbA1C), Electrocardiogram (ECG reported by an MD Physician),Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index), Serum Glutamic Oxaloacetic Transaminase(SGOT), Serum Glutamic Pyruvic Transaminase(SGPT), Serum Calcium, Uric Acid, Total Protein, Pulmonary Function Test, USG (abdomen)
50,100,200L	Complete Blood Count (CBC) , Glycosylated Haemoglobin (HbA1C), Electrocardiogram (ECG reported by an MD Physician),Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index), Serum Glutamic Oxaloacetic Transaminase(SGOT), Serum Glutamic Pyruvic Transaminase(SGPT),Vitamin D, Thyroid function (T3,T4,TSH), Serum Calcium, Uric Acid, Total Protein, Pulmonary Function Test, USG (abdomen)

B. Wellness Rewards points

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

Conditions applicable for earning the reward points

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

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

Sr. No.	Criteria	Frequency allowed	Max. Points
1.	Stress & Happiness Index score	2 times /year	20
2.	Expert Wellness Assessment	Once/year	40
3.	Participation in GCI organized events (as and when organized) and viewing of GCI Content around wellness	As planned by GCI	20
4.	Lifestyle disease monitor • Hypertension – Blood pressure • Obesity -BMI • Diabetes – Hb A1C • Cardiac Health- Sr. Cholesterol, Triglycerides	Once/year	45
5.	Fitness/ Healthy Lifestyle tracking- (Any one activity) • Daily Step tracking (monthly average of 10000 steps/day)	Monthly	60

	• Burning average of 300 calories per day in a month • Submission of monthly Gym /yoga membership detail • Participation in Marathon, Cyclathon etc.		
6.	**Enrolment to Wellness**	Once/year	15
	Total points		**200**

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

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

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

Family Type	2 Adult+1 child		
Policy period	01-Jan-2025 to 31 Dec 2025		
Relation	Self	Spouse	Child
Sum insured (₹)	10L	10L	10L
Age Band	26	31	0-25
Individual premium (₹)	13,006	13,895	11,631
Family discounted premium (₹)	11,705	12,506	10,468
Points Earned	200	180	NA
% value of points earned	20%	15%	0%
Monetary value of reward points (₹)	2341	1876	0

Detail breakup of reward point calculation (Earning and burning)

Date	**Self**			**Spouse**			**Total**		
	Points earned as on date	**% value of points earned**	**Monetary value (₹)**	**Points earned as on date**	**% value of points earned**	**Monetary value (₹)**	**Monetary value (₹)**	**Balance available for utilization (₹)**	**Burn/Utilised on date (OPD/ Pharmacy/ NME) (₹)**
21/03/2025	40	2%	234	30	2%	250	484		100
31/08/2025	100	5%	585	60	2%	250	835	735	200
15/10/2025	170	15%	1756	150	15%	1876	3632	3332	
31/12/2025	200	20%	2341	180	15%	1876	4217	3917	
Balance monetary value of reward points (₹) 3,917 would be applied as discount at renewal									

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

Relation	Self	Spouse	Child	
Sum insured (₹)	10L			
Age Band	26	31	0-17	Premium total of eligible members
Floater Discounted premium (₹)	13,006	7,642	4,652	20,648
Points Earned	200	180	NA	190 (Average of Points)
% value of points earned				20%
Monetary value of reward points (₹)				4,130

Detail breakup of reward point calculation (Earning and burning)

Date	Self	Spouse	Average of points earned	% value of points earned	Monetary value (₹)	Balance available for utilization (₹)	Burn/Utilised (OPD/ Pharmacy/ NME) (₹)
	Points earned as on date	Points earned as on date					
21/03/2025	40	30	35	2%	413		100
31/08/2025	100	60	80	2%	413	313	
15/10/2025	170	150	160	15%	3,097	2,997	200
31/12/2025	200	180	190	20%	4,130	3,830	Applied as discount at renewal
Balance monetary value of reward points (₹) 3,830 would be applied as discount at renewal							

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

2) **Expert Wellness Assessment**
   Insured Person has an option to take a telephonic Expert Wellness Assessment, with a Clinical psychologist. This will help the Insured Person to understand his/ her mental health. Insured Person can log into the account on GCI mobile App and ask for Expert Wellness Assessment. This can be undertaken once per policy year per insured person.
   The reward points will be allotted only for taking the expert wellness assessment. Confidentiality of the assessment will be maintained.

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

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

	Condition	Health parameters	Points Allotted
1	Blood Pressure	Blood pressure Systolic Up to 140/ Diastolic up to 90 mm Hg	10
2	Glycosylated Haemoglobin	HbA1C Up to 6.5 mg/dl	15
3	Lipids	Serum Triglycerides Less than 175 (mg/dL), or less than 1.7 (mmol/L)	5
		Serum Cholesterol - Desirable - < 200	5
4	BMI	BMI between 18 – 32	10

5) **Enrolment to Wellness**
Insured Person can earn reward points by enrolling into the Wellness Program. To enroll into the Wellness program, the Insured Person shall need to complete the registration in the GCI mobile App.

6) **Fitness / Healthy lifestyle tracking** – We aim at encouraging a healthy fitness regime for all age groups. Insured Person can earn wellness points every month by completing any one of the following activities.
Daily Step tracking (monthly average of 10000 steps/day). The step count can be tracked either through our GCI mobile App. or insured can sync his/her fitness device with our App.
Participation in Marathon, Cyclathons etc.: Insured can upload the completion certificate of the event on the GCI mobile App.
Burning average of 300 calories per day in a month. The calorie burning count can be tracked either through the GCI mobile App. or insured can sync his/her fitness device with our App.
Submission of monthly Gym/Yoga membership detail - Insured can upload the monthly membership receipts on the GCI mobile App.
Wellness points will be allotted basis the activity details submitted by the insured at the end of 30 days.

Conditions applicable for burning of points:

1. The points earned will float among all members of the family irrespective of the persons who have contributed for earning the points.
2. Points earned in first year can be carried forward to 2nd or 3rd year in case of long term policies.
3. The points can be burned for utilization of following benefits
   i. Availing Out-patient Consultations through the Wellness Partner network clinics
   ii. Diagnostic tests, preventive tests through the Wellness Partner network clinics
   iii. Purchase of Prescribed medicines through online pharmacy having tie up with Our Wellness Partner
   iv. Reimbursement of Non-medical expenses in case of claim under Section 2.1.1 (In-Patient Hospitalization)
   v. Renewal Discount –
      a) Insured Person /Policy holder has an option to utilize the balance reward points as discount in premium at the time of renewal of the Policy.
      b) If the insured does not opt for Renewal discount, then the insured has an option to redeem the wellness reward points for availing the services as mentioned in point no. i, ii & iii above. The accrued wellness points can be utilized up to a period of 3 months from the policy expiry date

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

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

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

4. In case of cancellation of the policy or if the policy is not renewed with Us, any wellness reward points earned by the Insured can be utilized up to 3 months from the policy cancellation date or policy end date for the following benefits only.
   i. Availing Out-patient Consultations through Our Wellness Partner network clinics
   ii. Diagnostic tests, preventive tests through Our Wellness Partner network clinics
   iii. Purchase of Prescribed medicines through online pharmacy having tie up with Our Wellness Partner

2.1.17 Cumulative Bonus

Cumulative Bonus shall be increased by 50% in respect of each claim free policy year (where no claims are reported) with the exception of any claim under Section 2.1.13 (OPD Expenses Cover) and Section 2.1.16 (Wellness Benefits), provided the policy is renewed with Us without a break subject to accumulation up to a maximum of 100% of the expiring Sum Insured or the renewal Policy Sum Insured, whichever is lower.

Notes:

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

2.1.18 Unlimited Restoration of Sum Insured

Under this benefit a Restore Sum Insured (equal to 100% of the Base Sum Insured excluding Cumulative Bonus, if any) will automatically be available for unlimited times during the Policy Year, subject to the below conditions:

a) The Restoration of Sum insured will be triggered for any illness/injury only after the Sum Insured, Cumulative Bonus (if any) and Inflation Guard (if any) is completely exhausted, in the policy year due to the claim incurred.
b) This benefit will not be triggered for the first claim made during the Policy Year. The benefit shall be applicable from the second claim onwards.
c) The Restore Sum Insured for a single claim event shall be limited to an amount equal to the Base Sum Insured of the Policy.
d) The restore Sum Insured can be triggered only once for a single claim event.
e) The Restore Sum Insured can be used for claims made for same illness/new illness in respect of Section 2.1.1 to Section 2.1.4;
f) If the Restore Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
g) If the Policy is issued on Individual / Non-Floater basis, then the Restore Sum Insured will be available to each Insured Person.
h) If the Policy is issued on Floater basis, then the Restore Sum Insured will be available on Floater basis for all Insured Persons in the family.
i) The cover under this benefit shall not be applicable to “Medical Treatment Abroad” (Section 2.1.15).

Illustration of Unlimited Restoration of Sum Insured

Policy Year	Claim Event	Base Sum Insured	Cumulative Bonus	Unlimited Restoration SI	Admissible Claim Amount	Claim paid	Balance BSI	Balance CB
1st year	**1**	10L	Nil	NA	20L	10L (10 Lac from Base Sum Insured , Restoration SI doesn’t get triggered in the first claim during the policy year)	Nil	Nil
	2	Nil	Nil	10L	19L	10L (10 Lac from Restore Sum Insured)	Nil	Nil

2nd year	**No Claim**	10L	Nil	10 Lac (Available form 2nd claim onward)	NA	NA	10L	Nil
3rd year	**1**	10L	5L	NA	11L	11L (10 Lac from Base Sum Insured and 1 Lac from Cumulative Bonus)	Nil	4L
	2	Nil	4L	10L	18L	14L (4 Lac from Cumulative Bonus and 10 Lac from Retore Sum Insured)	Nil	Nil

2.1.19 Bariatric Surgery

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

a) Our obligation to make payment in respect of Bariatric Surgery (after 36 months of continuous coverage from the first inception of the policy with Us), shall be restricted to the sublimit specified in the Schedule of Benefits per policy Year.

b) The claim related to Bariatric Surgery shall be payable only for expenses related to the surgical treatment of obesity that fulfil below conditions:
   1) Surgery to be conducted is upon the advice of the Medical Practitioner
   2) The surgery/ Procedure conducted should be supported by clinical protocols
   3) The Insured Person has to be 18 years of age or older and
   4) Body Mass Index (BMI);
      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

2.1.20 Inflation Guard

Under this benefit, an additional Sum Insured of 6% shall be made available in the renewed Policy after completion of each policy year.

a) Such additional Sum Insured can be accumulated up to a maximum of 100% of the expiring Sum Insured or the renewal Policy Sum Insured, whichever is lower, provided that the policy being continuously renewed with Us without a break.
b) The increase in Sum Insured under the Inflation Guard shall apply regardless of any claims made under the policy.
c) In case where the policy is on an individual / Non-Floater basis, the Inflation Guard shall be added and available individually to the Insured Person.
d) In case where the policy is on a floater basis, the Inflation Guard shall be added and available to the family on a floater basis.
e) The % increase will be applicable only on Base Sum Insured under the Policy and not on Cumulative Bonus or any other Covers which leads to increase in Sum Insured.
f) The cover under this benefit shall not be applicable to "Medical Treatment Abroad" (Section 2.1.15).

Illustration-

Policy Year	Base Sum Insured	Inflation Guard every Policy Year	Accumulated Inflation Guard
1	₹ 10,00,000	Not Applicable	Not Applicable
2	₹ 10,00,000	10,00,000*6% = 60,000	₹ 60,000/-
3	₹ 15,00,000	10,00,000*6% = 60,000	₹ 60,000 + ₹ 60,000 = ₹1,20,000/-
4	₹ 15,00,000	15,00,000*6% = 90,000	₹ 1,20,000 + ₹ 90,000 = ₹ 2,10,000/-

2.1.21 Premium Payback

If there is no OPD / Hospitalization / Day Care claim in the preceding 4 consecutive Policy Years, then an amount equivalent to the 1st Policy year base premium shall be utilized for discount of subsequent renewal premium in the 5th Policy year. Such benefit shall be applicable only once in every block of 4 Policy years.

2.1.22 Unlimited Cover

The cover under this benefit can be triggered for any one claim on the choice of the Policyholder, in respect of a single event of in-patient Hospitalization/ Daycare treatment, after the exhaustion of Base Sum Insured, Cumulative Bonus, Inflation Guard and Unlimited Restoration of Sum Insured, in sequential order.

Special Conditions:

1. This benefit can be utilized once in the lifetime of the Policy, irrespective of Policy Tenure or Policy Type (individual or Floater), and without any limits on the Policy Sum Insured.
2. Once a claim has been made under this benefit, this cover will cease to exist thereafter.
3. This benefit shall be applicable in India only.
4. This benefit would be subject to all the limits, sub-limits, co-payments and deductibles as applicable in the policy.

2.2. Optional Covers

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

2.2.1 Consumables / Non-medical Expenses Cover

We will cover for expenses incurred towards consumables and non-medical expenses which are listed in "List I – Items for which coverage is not available in the Policy" under Annexure I, provided that;

a) Such consumables are utilized or expended during the in-patient treatment associated with the related to Insured Person's medical or surgical care and
b) We have accepted the claim under section 2.1.1 (In-patient Hospitalization) or Section 2.1.2 (Daycare Treatment Expenses)
c) Pre and post hospitalization expenses will be excluded from this cover.

2.2.2 Voluntary Deductible

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

The deductible shall not be applicable to the following benefits:

a) Maternity Benefit
b) Accidental Hospitalization
c) Emergency Road Ambulance
d) Emergency Medical Evacuation
e) Home Health Care
f) OPD Treatment
g) Medical Treatment Abroad
h) Wellness Benefit
i) Bariatric Surgery

2.2.3 Mandatory Co-payment Waiver

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

Specific Conditions:

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

3. EXCLUSIONS

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

3.1 Waiting Periods

3.1.1 Pre-Existing Disease- Excl 01

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

3.1.2 Specified disease/procedure waiting period- Code- Excl02

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

A. Waiting period of 36 months:
i) Rheumatoid Arthritis
ii) Gout
iii) Joint replacement Surgery due to degenerative condition
iv) Age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is Medically Necessary due to Injury.

B. Waiting period of 24 months:
i) Cataracts
ii) Benign Prostatic Hypertrophy
iii) Hernia of all types
iv) Deviated Nasal Septum
v) Hypertrophied Turbinate
vi) All types of nasal and para nasal sinus related disorders
vii) Hydrocele
viii) Fistulae, hemorrhoids, fissure in ano
ix) Dysfunctional uterine bleeding, Fibromyoma, Endometriosis, Hysterectomy,
x) All internal or external tumors/cysts/nodules/polyps of any kind including breast lumps with exception of malignant tumor or growth
xi) Surgery for prolapsed inter vertebral disc unless arising from Accident
xii) Surgery of varicose veins and varicose ulcers
xiii) Any types of gastric or duodenal ulcers
xiv) Stones in the urinary and biliary systems
xv) Surgery on ears and tonsils.
xvi) LASIK surgery for eyes

3.1.3 30 days waiting period Excl-03

(a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

(b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

(c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

3.2 Standard Exclusions

3.2.1 Investigation & Evaluation- Code- Excl04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

a. 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.

3.2.3 Obesity/ Weight Control: Code- Excl06

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

a) Surgery to be conducted is upon the advice of the Doctor

b) The surgery/Procedure conducted should be supported by clinical protocols

c) The member has to be 18 years of age or older and

d) Body Mass Index (BMI);

1) greater than or equal to 40 or

2) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

3.2.4 Change-of-Gender treatments: Code- Excl07

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

3.2.5 Cosmetic or Plastic Surgery: Code- Excl08

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

3.2.6 Hazardous or Adventure sports: Code- Excl09

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

3.2.7 Breach of law: Code- Excl10

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

3.2.8 Excluded Providers: Code- Excl11

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

3.2.9 Code- Excl12

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

3.2.10 Code –Excl 13

Treatments received in health hydros, nature-cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

3.2.11 Code- Excl14

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

3.2.12 Refractive Error: Code- Excl15

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

3.2.13 Unproven Treatments: Code- Excl16

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

3.2.14 Sterility and Infertility: Code- Excl17

Expenses related to, sterility and infertility. This includes:

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

3.2.15 Maternity (Code Excl18)

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except for ectopic pregnancy.
b) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of

pregnancy during the policy period.

3.3 Specific Exclusions

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

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

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

3.3.3 Vaccination/ inoculation (except as post bite treatment)

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

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

3.3.6 External Congenital Anomaly and related Illness/ defect.

3.3.7 Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.

3.3.8 Stem cell storage.

3.3.9 Non-prescribed drugs and medical supplies, hormone replacement therapy.

3.3.10 Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

3.3.11 Outpatient diagnostic, medical and Surgical Procedures or treatments.

3.3.12 Dental Treatment or Surgery of any kind unless requiring Hospitalization as a result of Injury.

3.3.13 A Medical Practitioner's home visit charges during pre and post Hospitalization period and attendant nursing charges.

3.3.14 Treatment outside India.

3.3.15 Intentional self-Injury.

3.3.16 Any complications arising out of the Infertility treatment.

3.3.17 Any specific exclusion(s) applied by Us, specified in the Schedule and accepted by the insured.

3.3.18 Specific Exclusions for OPD Treatment claims- We will not pay for any expenses incurred in respect of any claims made under Benefit 15(OPD Treatment), arising out of or howsoever related to any of the following:

a) Cost of an Annual Health Check-up.

b) Any expenses for consultation and diagnostics which are not duly supported with medical documents from the Medical Practitioner mentioning:

1) Diagnosis;

2) Referral for diagnostic test;

4. General Terms and conditions

4.1 Standard General Terms and Clauses

4.1.1 Disclosure to Information Norm

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

4.1.2 Condition Precedent to Admission of Liability

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

4.1.3 Material Change:

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

4.1.4 Records to be Maintained:

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

4.1.5 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim

4.1.6 Notice and Communications

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

4.1.7 Territorial Limits and Law

a. Except as provided in Section 2.1.15 (Medical Treatment Abroad), We shall cover only treatment and investigations covered in terms of this Policy that is taken during the Policy Period and takes place anywhere in the territory of India.
b. The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law.
c. The Policy constitutes the complete contract of insurance between Us and You/Insured Person. No change or alteration shall be valid or effective unless approved in writing by Us, where approval shall be evidenced by an endorsement on the Schedule.

4.1.8 Multiple Policies

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

claim amount, the Primary Insurer shall co-ordinate with other Insurer to ensure settlement of the balance amount as per the policy contract.

4.1.9 Fraud

a. 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.
b. Any amount already paid against claims which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who shall be jointly and severally liable for such repayment.
c. 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 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:
    I. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
    II. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
    III. any other act fitted to deceive; and
    IV. any such act or omission as the law specially declares to be fraudulent
d. The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

4.1.10 Automatic change in Coverage under the policy:

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

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

4.1.11 Territorial Jurisdiction:

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

4.1.12 Possibility of Revision of Terms of the Policy including the Premium Rates

The Company, with the 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 affected.

4.1.13 Free Look Period

a. The Free Look Period shall be applicable at the inception of the policy and not on renewals or at the time of porting the policy.
b. The Insured Person shall be allowed free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
c. 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.
d. A request received by insurer for cancellation of the Policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request.
e. In the case of delay in the refund, the Company shall refund such amounts along with interest at the bank rate plus 2% on the refundable amount, from the date of receipt of the request for free look cancellation till the date of refund.

4.1.14 Endorsements (Changes in Policy)

a. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
b. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.
c. The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

4.1.15 Withdrawal of Policy

a. 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.
b. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

4.1.16 Moratorium Period

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

4.1.17 Nomination

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

4.1.18 Redressal of Grievance

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

Courier: Grievance Redressal Cell, Generali Central Insurance Company Ltd.
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 Integrated Grievance Management System - https://bimabharosa.irdai.gov.in/

4.2 Specific General Terms and Clauses

4.2.1 Change of Sum Insured:

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

4.2.2 Terms and conditions of the Policy:

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

4.2.3 Migration

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.

4.2.4 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.

4.2.5 Cancellation

a. The policyholder may cancel this policy at any time 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 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
   I. Claims incurred by the deceased Insured Person or any other Insured Person in the current Policy Year, The premium for the deceased Insured Person for the unutilized Policy Period, will not be refunded.

B. Policy Term – 2 / 3 Years; Payment Mode – Single Premium Payment

1) Non-Floater Policy
   I. Claims incurred by the deceased Insured Person in the current Policy Year –The premium pertaining to the deceased Insured Person for the unutilized current Policy Year shall not be refunded. However, premium pertaining to the deceased Insured Person for the unutilized subsequent Policy Years (if any), shall be refunded.
   II. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Policy Year- The premium pertaining to the deceased Insured Person for the unutilized Policy Period, shall be refunded on pro-rata basis.
2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Policy Year – The premium for the deceased Insured Person for the unutilized current Policy Year, will not be refunded. Premium pertaining to the deceased Insured Person for the unutilized subsequent Policy Years (if any), shall be refunded.

C. Policy Term – 1 / 2 / 3 Years; Payment Mode – Multiple Instalments

1) Non-Floater Policy
   I. Claims incurred by the deceased Insured Person in the current Instalment Period, the instalment premium pertaining to the deceased Insured Person for the unutilized current instalment period shall not be refunded.
   II. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Instalment Period –The

premium pertaining to the deceased Insured Person for the unutilized instalment Period, shall be refunded on pro-rata basis.

2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Instalment Period, the instalment premium pertaining to the deceased Insured Person for the unutilized current instalment period shall not be refunded.

4.2.6 Renewal of Policy

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

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

4.2.7 Premium Payment in Instalment

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

a) Grace Period of 15 days would be given to pay in case of monthly instalment premium and grace period of 30 days shall be given to pay in case of Half Yearly, Quarterly due for the policy.
b) If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
c) The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
d) No interest will be charged If the instalment premium is not paid on due date
e) In case the instalment premium due, is not received within the grace period, the policy will get cancelled.
f) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
g) The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
h) The payment will be accepted through E-NACH / ACH/ ECS / any other mode approved by Government of India.
i) On successful registration for the mandate/ E-NACH/ any other mode approved by Government of India, the premium shall be auto debited as per the frequency opted.
j) In case of withdrawal of E-NACH/ ACH/ ECS / any other mode approved by Government of India, a written communication will be required from policyholder.
k) In case there is failure in transaction in E-NACH/ ACH/ ECS mode/ any other mode approved by Government of India or the instalment premiums are not received within the grace period, the Policy will get cancelled. A fresh policy with all waiting periods would be issued.
l) If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered.

4.2.8 Proportionate Deduction

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

Proportionate Deductions shall not be applied to the following:

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

4.2.9 Zone wise Premium payment

a) Premium will be calculated based on the Sum Insured opted, Age and Zone.
b) The 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	Pune, Mumbai, Bangalore, New Delhi, Chennai, Hyderabad, Gurgaon, Kolkata, Thane, Ahmedabad, Indore, Vadodara, Noida, Secunderabad, Panvel, Navi Mumbai, Surat, Gandhi Nagar.
Zone 2	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
If You select Zone 2, then 15% Co-payment will apply for treatment in Zone 1

4.2.10 Cost of Pre-Policy Medical Examination

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

4.2.11 Discounts & Loadings:

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

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

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

c) Web sales / Tele sales discount -

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

d) Employee discount -

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

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

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

e) Floater discount -

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

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

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

Sum insured is 1000000			
	Self (Male)	Spouse (Female)	Child (Female)
Age (in years)	36	31	0-17

Premium as per Individual rate table (in ₹)	14,921	13,895	11,631
Applicable premium (in ₹)	14921	7,642 (45% discount applied on the respective person's premium)	4652.4 (60% discount applied on the respective person's premium)
Total Premium to be charged (in ₹)	14921+7642+4652		
	27,216		

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

Instalment Frequency	Loading on standard premiums
Monthly	5%
Quarterly	4%
Half Yearly	3%

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

h) Underwriting Loading –

	Condition	Underwriting loading
1	**Diabetes**	
A	Pre-Diabetic/ Not a known case of Diabetes (HbA1c 5.9 - 6.49%)	Not applicable
B	Known case of Diabetes (HbA1c up to up to 6.5 %)	No loading with Exclusion
C	Known case of Diabetes (HbA1c 6.6 up to 7%)	up to 10% loading with Exclusion
D	Diabetic level (HbA1c 7.1% - up to 8%)	up to 20% loading with Exclusion
E	Diabetic level (HbA1c 8.1% - up to 8.5%)	up to 20% loading with Exclusion
F	Diabetic level (HbA1c >8.5%)	Decline
2	**Hypertension**	
A	Known / not known Hypertensive (140mm HG Systolic /90 mmHg diastolic)	up to 10% loading with Exclusion
B	Known / not known Hypertension (141 to 160 mmHg Systolic / 91 to 100 mm Hg diastolic)	up to 20% loading with Exclusion

C	Known / not known Hypertension (Above 150 mmHg Systolic / Above 100 mm Hg diastolic)	Decline
3	**Serum Cholesterol**	
A	Above +40 mg/dl to +100 mg/dl above the maximum *Normal range	upto 10% loading with Exclusion (Either Cholesterol loading or Triglycerides loading shall be applied)
B	Above 100 mg/dl above the maximum *Normal range	Decline
4	**Serum Triglycerides**	
A	Above +20 mg/dl to + 45 mg/dl above the maximum *Normal range up to 100 mg/dl	up to 10% loading with Exclusion (Either Cholesterol loading or Triglycerides loading shall be applied in case of both parameters are in acceptance range)
B	Above+46 mg/dl to 75 mg/dl of the maximum* Normal range	Decline
5	**Serum creatinine**	
A	up to 0.3 mg/dL above the maximum *Normal range	Up to 10% (UW Discretion for acceptance)
B	From 0.3 up to 0.8 mg/dL above the maximum*Normal range	Up to 15% (UW Discretion for acceptance)
6	**Asthma**	
A	Asthma (not on steroids)	Up to 10% loading
B	Asthma (on steroids)	Up to 10% loading
7	**Smoking**	Up to 5% loading
8	**Tobacco chewing/ Ghutka**	Up to 5% loading
9	**BMI**	
A	(BMI from 34 to 36)	Up to 10% loading
B	(BMI from 36.1 to 37)	Up to 15% loading
C	above 37	Decline
10	**Positive history of any other ailment(s)/ disease(s)**	To be Reviewed for Acceptance/ Acceptance up to 100%/Declinature
11	**Combination of any two or more conditions**	To be Reviewed for Acceptance/ Acceptance up to 100%/Declinature

4.2.12 Eligibility

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

b) Policy Tenure: 1,2 & 3 Years

c) Age Eligibility:

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

d) Family Definition:

Individual/Non-Floater - Self, Legally married spouse/Live-in Partner, dependent children, parents and parents in law (Either of one set can be covered)

Individual/Non-Floater – Max 4 adults and any number of children can be covered under single policy.

Family Floater - Self, Legally married spouse/Live-in Partner, up to 3 dependent children. For Parents separate floater policy can be take.

Family Floater – Max 5 members can be covered under single policy.

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

Sum Insured (In ₹)	₹ 7.5L, ₹10L, ₹15L, ₹25L, ₹50L, ₹100L, ₹200L

5. CLAIM PROCEDURES

5.1 Procedure for cashless claim

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

1. We must be called at Our call center and a request for pre-authorization must be made by way of the written form prescribed by Us.
2. After considering the request and obtaining any further information or documentation that We have sought, We may, if satisfied, send the Network Provider an authorization letter. The authorization letter, the ID card issued to the Insured Person along with this Policy and any other information or documentation that We have specified must be produced to the Network Provider identified in the pre-authorization letter at the time of the Insured Person's admission to the Hospital.
3. If the above procedure is followed, the Insured Person will not be required to directly pay for those Medical Expenses to the Network Provider that We are liable to indemnify under this Policy. The original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-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.

5.2 Procedure for Reimbursement Claims

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

1. We must be given Notification of Claim immediately and in any event within 48 hours of admission to the Hospital.
2. The Insured Person must take reasonable steps or measures in good faith to minimize the quantum of any claim that may be made under this Policy.

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

5.3 Notification of Claim

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

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

5.4 Documents to be submitted:

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

1) The claim form specified by Us duly completed and signed by the claimant or a family member.
2) First consultation letter.
3) First prescription from the Medical Practitioner.
4) Original vouchers/ invoice of original bill.
5) Original Hospital bills giving a detailed break up of all expense heads mentioned in the bill.
6) Money receipt duly signed with a revenue stamp.
7) Birth/Death certificate (as applicable).
8) The original Hospital discharge card/ summary.
9) All original laboratory and diagnostic test reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram, etc.
10) If medicines have been purchased in cash and if this has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner and the supporting medicine bill from the chemist.
11) If diagnostic or radiology tests have been paid for in cash and it has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner advising the tests, the actual test reports and the bill from the diagnostic centre for the tests.
12) Copy of proposer's photo ID proof & address proof
13) NEFT Form with photocopy of cancelled cheque with printed name of proposer
14) Copy of Operation theatre Notes, if applicable
15) Copy of the Claim Intimation, if any
16) Copies of health insurance policies held with any other insurer covering the insured persons.
17) If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that original claim documents are retained at their end.
18) It is a condition precedent to Our liability under this Benefit that the following information and documentation shall be submitted to Us immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
19) In the event of Your/Insured Person's death, You/Insured Person's nominee/legal heir claiming on his/her behalf must inform Us immediately and send Us a copy of the postmortem report (if any).

If We are not given notice/documentation within the time frames set out above, then We may accept the claim notice/ documentation if it is demonstrated to Us that the delay was for reasons beyond the control of the claimant.

5.5 Payment of Claim

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

5.6 Claim Settlement (provision for Penal Interest)

1. 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.
2. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
3. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
4. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
5. In case of 'pending' claims, we will ask for submission of incomplete documents.
6. 'Rejected' claims will be informed to the Insured Person in writing with reasons for rejection.

5.7 Co-Payments Applicable under the Policy

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

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

5.8 Voluntary Deductible Applicable under the Policy

If a Voluntary Deductible has been opted and is in force under the Policy, Our liability would be over and above the Voluntary Deductible amount on aggregate basis for all the admissible claims under the policy other than Section 2.1.13 (OPD Treatment) and Section 2.1.16 (Wellness Benefits) including claims related to any one illness

Wherever Co-payments are applicable, as per Clause 5.7 above, the same would be applied on the admissible claim amount after the application of Voluntary Deductible, if any.

Annexure to Prospectus –

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

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

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

6.1 Zone 1

Age Band	750,000	1,000,000	1,500,000	2,500,000	5,000,000	10,000,000	20,000,000

0-25	10,731	11,631	13,865	16,071	19,059	23,702	33,183
26-30	11,999	13,006	15,503	17,970	21,311	26,504	37,105
31-35	12,819	13,895	16,563	19,198	22,768	28,314	39,640
36-40	13,729	14,921	17,845	20,624	24,537	30,557	42,780
41-45	16,234	17,673	21,181	24,351	29,025	36,172	50,640
46-50	20,521	22,388	26,901	31,029	37,076	46,258	64,762
51-55	27,952	30,553	36,801	42,585	51,004	63,699	89,179
56-60	37,460	41,027	49,532	56,813	68,211	85,263	1,19,368
61-65	50,522	55,430	67,066	76,876	92,525	1,15,737	1,62,032
66-70	66,926	73,434	88,845	1,03,566	1,24,787	1,55,913	2,18,278
71-75	85,510	93,996	1,13,966	1,33,262	1,61,003	2,01,307	2,81,829
76-80	1,06,726	1,17,495	1,42,695	1,67,314	2,02,658	2,53,469	3,54,857
>81	1,25,914	1,38,644	1,68,432	1,97,487	2,39,125	2,99,130	4,18,782

6.2 Zone 2 – Discount of 5% on Zone 1 premium.

6.3 Optional Covers:

(a) Voluntary Deductible-

SI	**Deductible**						
	10,000	**25,000**	**50,000**	**75,000**	**100,000**	**300,000**	**500,000**
750,000	8%	15%	20%	NA	NA	NA	NA
1,000,000	8%	15%	20%	NA	NA	NA	NA
1,500,000	NA	NA	15%	20%	25%	NA	NA
2,500,000	NA	NA	15%	20%	25%	NA	NA
5,000,000	NA	NA	NA	NA	15%	20%	25%
10,000,000	NA	NA	NA	NA	15%	20%	25%
20,000,000	NA	NA	NA	NA	15%	20%	25%

(b) Consumables / Non-Medical Expenses Cover-

SI	**Premium**
750,000	927
1,000,000	1,071
1,500,000	1,433
2,500,000	1,813
5,000,000	2,659
10,000,000	4,487
20,000,000	5,000

(c) Waiver of Mandatory co-pay for age above 60 years- Loading of 20% of Base Premium

Note:

- *Premiums exclusive of Goods & Services Tax.*
- *Age in completed years*
- *For Family Floater, the premium applicable for the primary insured will be the standard individual premiums. For the remaining dependent members, floater discounts will be applicable on their respective premium.*
- *Insured has an option to change Sum Insured at the time of renewal of the policy, subject to underwriting.*
- *The premiums above are subject to revision as and when approved by the regulator. However, such revised premiums would be applicable only from subsequent renewals and with due notice whenever implemented*

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

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

Signature	Place
Name	Date

In case of any claims, contact:
Claims Department:
Generali Central Health (GCH)
Generali Central Insurance Co. Ltd.
Qubix Business Park, Building No. Block IT – 1, Ground Floor, Plot No. 2,

Blueridge Township, Near Rajiv Gandhi Infotech Park, Phase – 1,
Village Hinjewadi, Taluka Mulshi, Pune, Maharashtra - 411057.
Toll Free Number: 1800 103 8889,
Toll Free Fax: 1800 103 9998
Email: GCH@generalicentral.com

Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | IRDAI Regn. No.: 132 |
CIN: U66030MH2006PLC165287 | Website: www.generalicentralinsurance.com |
Email ID: gcicare@generalicentral.com |Toll-free Phone: 1800 220 233 / 1860 500 3333/ 022 6783 7800
ISO No.: GCH/HP/HUL/PRS/002