FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Health PowHER
Policy Wordings

1. PREAMBLE

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

2. OPERATIVE CLAUSE

If during the Policy Period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Center, following Medical Advice of a duly qualified Medical Practitioner, we shall indemnify Medically Necessary expenses towards the Coverage, as per the plan selected, as mentioned in the Schedule of Benefits.

Provided further that, any amount payable due to an admissible claim under the Policy shall be subject to the terms of coverage, exclusions, conditions, and definitions contained herein. Our maximum liability for all such claims, during the Policy Year, shall be up to the Sum Insured opted and specified in the Policy Schedule.

3. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meaning ascribed to them wherever they appear in this policy and, where, the context so requires, references to the singular include references to pleural; references to the male includes the female and other gender and references to any statutory enactment includes subsequent changes to the same.

3.1 Standard Definitions

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

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

3.1.3 **AYUSH Hospital**

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

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

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

i. Having qualified registered AYUSH *Medical Practitioner(s)* in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

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

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

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

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

b) External Congenital Anomaly - Congenital anomaly which is in the visible and accessible parts of the body.

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

3.1.9 **Critical Illness means the following disease/ illness:**

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

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

B. Myocardial Infarction (First Heart Attack of Specified Severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g., typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins, or other specific biochemical markers.

II. The following are excluded:
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris
   iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

C. Open Chest CABG (Coronary Artery Bypass Graft)

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breastbone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:
   i. Angioplasty and/or any other intra-arterial procedures

D. Open Heart Replacement or Repair of Heart Valves

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

E. Coma of Specified Severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least ninety-six (96) hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least thirty (30) days after the onset of the coma.

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

F. Kidney Failure Requiring Regular Dialysis

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted, or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

G. Stroke Resulting in Permanent Symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage, and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least three (3) months has to be produced.

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

H. Major Organ / Bone Marrow Transplant

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

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

I. Permanent Paralysis of Limbs

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than three (3) months.

J. Motor Neuron Disease with Permanent Symptoms

I. Motor neuron disease diagnosed by a specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis, or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least (three) 3 months.

K. Multiple Sclerosis with Persisting Symptoms

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

II. Neurological damage due to SLE is excluded.

L. Benign Brain Tumor

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves, or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the

relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least Ninety (90) consecutive days or
ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

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

M. Blindness

I. Total, permanent, and irreversible loss of all vision in both eyes as a result of illness or accident.
II. The Blindness is evidenced by:
i. corrected visual acuity being 3/60 or less in both eyes or;
ii. the field of vision being less than 10 degrees in both eyes.
III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

N. Deafness

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than ninety (90) decibels across all frequencies of hearing" in both ears.

O. End Stage Lung Failure

I. End stage lung disease, causing chronic respiratory failure, as confirmed, and evidenced by all of the following:
i. FEV1 test results consistently less than 1 litre measured on three (3) occasions three (3) months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
iv. Dyspnea at rest.

P. End Stage Liver Failure

I. Permanent and irreverible failure of liver function that has resulted in all three of the following:
i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.
II. Liver failure secondary to drug or alcohol abuse is excluded.

Q. Loss of Speech

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of twelve (12) months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

R. Loss of Limbs

I. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result

of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

S. Major Head Trauma

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than three (3) months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external, and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure, and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa.

iv. Mobility: the ability to move indoors from room to room on level surfaces;

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:

i. Spinal cord injury.

T. Primary (Idiopathic) Pulmonary Hypertension

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

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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

U. Third Degree Burns

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

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

3.1.11 **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner/s in charge;
iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

3.1.12 **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

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

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

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

3.1.14 **Disclosure to information norm** means 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.

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

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

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

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

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

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

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

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

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests.
2. it needs ongoing or long-term control or relief of symptoms.
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
4. it continues indefinitely.
5. it recurs or is likely to recur.

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

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

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

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

3.1.23 **Maternity expenses** means;

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

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

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

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

3.1.26 **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

Note: The Medical Practitioner should not be an insured or close member of the family.

3.1.27 **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

i. is required for the medical management of the illness or injury suffered by the insured;

ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii. must have been prescribed by a medical practitioner;

iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

3.1.30 **New-born baby** means a baby born during the Policy Period and is aged up to 90 days.

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

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

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

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

3.1.35 **Pre-existing Disease** means any condition, ailment, injury or disease:

a) That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or

b) For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy or its reinstatement.

3.1.36 **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.1.37 **Post-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

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

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

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

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

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

3.2 Specific Definitions

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

3.2.2 **Ambulance** means a motor vehicle operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

3.2.3 **Ante natal care (ANC)** means the medical care required by pregnant women during a period between conception and onset of labour. It Includes screening, medical consultations, diagnostics and medications.

3.2.4 **Assisted Reproductive Technology** with its grammatical variations and cognate expressions, means all techniques that attempt to obtain a pregnancy by handling the sperm or the oocyte outside the human body and transferring the gamete or the embryo into the reproductive system of a women.

3.2.5 **Associated Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of illness or Accident on the advice of a Medical Practitioner. In Case of copayment associated with room rent higher than the entitled room rent limit, Associated Medical Expenses will not include:

a. Cost of pharmacy and consumables
b. Cost of implants and medical devices
c. Cost of diagnostics

3.2.6 **Authority** means the Insurance Regulatory and Development Authority of India (IRDAI).

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

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

3.2.9 **Cryo-preservation** means the freezing and storing of oocytes.

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

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

3.2.12 **Domestic Help -** Domestic Help means any person employed by the Insured solely to carry out domestic duties associated with the Insured's Home but does not include any person employed in any capacity in connection with any Business, trade or profession.

3.2.13 **Emergency/Life Threatening Medical Condition** means a serious medical condition or symptom resulting from Illness/ Injury which arises suddenly and requires immediate care and treatment.

a. to avoid jeopardy to the life or
b. serious damage to the health of an Insured Person.

The emergency continues till the condition of the Insured Person stabilizes and the continuing medical condition or symptoms are not considered as an Emergency/Life Threatening medical condition anymore.

3.2.14 **Family** means Self (female), Live-in Partner/Spouse, Dependent Children (Max up to 4), Parents, Parents-in laws.

3.2.15 **Family Floater** means a Policy described as such in the Schedule where You and / or members of Your family named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents our maximum

liability for any and all claims made by You and/ or members of Your family during the Policy Year. Below family relations of the Policyholder are allowed to be covered under a Family Floater Policy:

a) Policyholder as Self
b) Legally married Spouse or Live-in Partner
c) Dependent Children up to the age of 25 years (Max up to 4),
d) Parents or Parents-in-Law.

3.2.16 **Gestational Surrogacy** means a practice whereby a surrogate mother carries a child for the intending couple through implantation of embryo in her womb and the child is not genetically related to the surrogate mother.

3.2.17 **Infertility** means the inability to conceive after one year of unprotected coitus or other proven medical condition preventing a couple from conception.

3.2.18 **Insured Person/Insured** means the person(s) named in the Policy Schedule and with respect of whom the premium has been received by Us.

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

3.2.20 **Live-in partner** shall, for the purpose herein, means either half of the two unmarried adult persons of male or female gender and irrespective of the sexual orientation, who have consensually chosen to reside jointly with the other adult person, in a long-term relationship and in the same residence. For the purpose of clarity, it is, hereby, mentioned that this definition shall be construed to include persons belonging to the LGBT community, wherein the scope of LGBT shall be in limited to gay, lesbian and bisexual.

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

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

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

3.2.23 **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental condition associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

3.2.24 **Nominee** means the person named in the Policy Schedule who is nominated to receive the Benefits in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.

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

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

3.2.27 **Policy** means the Policy Wordings, the Proposal Form, Policy Schedule and Endorsements which form part of the policy contract and shall be read together**.**

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

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

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

3.2.31 **Pre-natal Period** means period between conception and birth.

3.2.32 **Post-natal Period** means period beginning immediately after birth of child and extending for 45 days.

3.2.33 **Proposal Form** means the application (Proposal) form for insurance cover submitted to Us along with all information which has enabled Us in considering whether and on what terms to offer this insurance.

3.2.34 **Single Private Room** means a single hospital room with/without an air-conditioned facility where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such a room type shall be the most basic and the most economical of all accommodations available as a single room in that Hospital.

The room should have the provision for accommodating an attendant. This excludes a suite or higher category.

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

3.2.36 **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit. The sub-limit applicable for a specific benefit under the policy shall be as per the plan opted and as mentioned in the Schedule of Benefits,

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

3.2.38 **Survival Period** means at any point of time during the term of the Policy, any benefit shall be payable only if the Insured is alive for a period of more than or equal to 7 days from the date of the first diagnosis of the Critical illness/ Undergoing for the first time of the Surgical Procedures/ for the first time of occurrence of medical events.

3.2.39 **Surrogate Mother** means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the conditions as provided in sub-clause (b) of clause (iii) of section 4 of The Surrogacy (Regulation) Act, 2021.

3.2.40 **Voluntary Sterilization or Tubal Ligation** means the procedure of permanent contraception that a woman can choose to prevent pregnancy as a method of birth control.

3.2.41 **We, Insurer, Our, Company, FGII or Us** means Future Generali India Insurance Company Limited.

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

Please note:

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

4. SCOPE OF COVER

This Policy provides You options of 3 (three) plans namely Essential, Advance, Supreme.
Each Plan has options of Sum Insured as specified in the "Schedule of Benefits". The Policy Schedule will specify the Sum Insured and Plan which are in force for each of the Insured Persons.
For a complete description of the Benefits available as well as any specific sub-limits on the amount payable under any Benefit, please refer to the "Schedule of Benefits" attached to this Policy at **Annexure I.**

4.1 BASE COVERS

The benefits available under the Base Covers are in-built into the product and are listed below:

MEDICAL EXPENSES COVER

4.1.1 Medical Expenses

a) In-patient Hospitalization:

We will pay the reasonable & customary charges for medical expenses 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.

i) Room Rent for accommodation in Hospital room and other boarding charges, up to the limits as specified in Schedule of Benefit.
ii) Intensive Care Unit (ICU) expenses.
iii) Operation theatre charges.
iv) Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists, and anesthetists.
v) Qualified Nurses charges.
vi) Medicines, drugs, and other allowable consumables prescribed by the treating Medical Practitioner.
vii) Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized.
viii) Anesthesia, blood, oxygen and blood transfusion charges, Surgical Appliances.
ix) Prosthetic and other devices recommended by the attending Medical Practitioner are implanted internally during a Surgical Procedure.

b) Day Care Treatment:

We will pay the reasonable and customary charges incurred towards medically necessary treatment required by the Insured Person towards Day Care Treatments following an Illness or Injury that's sustained during the Policy Year.
The list of such Day Care Treatments is specified in **Annexure II** of the Policy.

c) Other Expenses:

Expenses in respect of the following specified illness will be restricted to the sublimit as detailed below:

i) LASIK Surgery – We will make payment in respect of LASIK Surgery for correction of refractive error up to an amount as specified, under the particular plan, in the Schedule of Benefits, provided that:

1) The refractive error is more than or equal to ± 7.5 diopters.
2) It shall be covered only once during the lifetime of the Insured.
3) This benefit shall come into effect only after the Insured Person has completed 24 months of continuous coverage.

ii) Bariatric Surgery - We will pay the Reasonable and Customary Charges for Medical Expenses incurred towards Surgical Procedure for Obesity, 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 Health PowHER Policy with Us), shall be restricted to an amount as specified under the particular plan, in the Schedule of Benefits.
b) The claim related to Bariatric Surgery shall be payable only for expenses related to the surgical treatment of obesity that fulfil below conditions:
   (i) Surgery to be conducted is upon the advice of the Medical Practitioner
   (ii) The surgery/ procedure conducted should be supported by clinical protocols.
   (iii) The Insured Person has to be 18 years of age or older and
   (iv) 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
c) Migration and portability shall not be applicable to this benefit.

iii) Cataract Surgery - We will make payment in respect of Cataract Surgery up to an amount as specified, under the particular plan, in the Schedule of Benefits, provided that:

1) This benefit shall come into effect only after the Insured Person has completed 24 months of continuous coverage.

4.1.2 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 the number of days as specified, under the particular plan, in the Schedule of Benefits.

4.1.3 Post – Hospitalization Medical Expenses:

We will pay the reasonable and customary charges for Post-Hospitalization Medical Expenses incurred immediately following the Insured Person's discharge from Hospital for the number of days as specified, under the particular plan, in the Schedule of Benefits.

4.1.4 Modern Treatment 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 4.1.1.a) or Day Care Treatment (Section 4.1.1.b) 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.

4.1.5 Cosmetic/Plastic Surgery:

We will pay the reasonable & customary charges for medical expenses incurred towards cosmetic or reconstructive plastic surgery required to change appearance following an Accident, Burn(s) or Cancer or to remove a direct and immediate health risk of the insured person provided that, the requirement of such surgery should be medically necessary and must be certified by the attending Medical Practitioner. The benefit shall be available up to the Sum Insured specified in the Schedule of Benefits.

4.1.6 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, under the particular plan, 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 4.1.1.a) or Day Care Treatment (Section 4.1.1.b) for the same Illness/Injury.

4.1.7 Emergency Air Ambulance:

We will reimburse expenses incurred towards Air Ambulance charges for transportation of an Insured person, by an Air Ambulance of a Hospital or of a registered Ambulance Service Provider during the Policy Year.
Our maximum liability per policy year under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.

Following Expenses shall be covered under this benefit:

(i) The transportation Costs towards transferring the Insured Person from place of occurrence of Emergency /Life Threatening medical condition to the nearest Hospital or from one Hospital to another Hospital for providing better and adequate medical treatment, following a medical emergency where such facility is not available at the existing Hospital.

Special Condition:

a) The ambulance services of a hospital or a registered ambulance service provider is utilized.
b) The Ambulance provider is registered in India.
c) The place of occurrence of Emergency /Life Threatening medical condition and the location of hospitals, should be within the Indian Territory.
d) The original Ambulance bills and payment receipt is submitted to us.
e) We have accepted the claim under In-Patient Hospitalization (Section 4.1.1.a).
f) The severity of illness of Insured Person is such that it requires services of an Air Ambulance and is certified by treating medical practitioner.

Specific Exclusion:

i) Return transportation to Insured Person's home by air ambulance.

4.1.8 AYUSH Treatments:

We will pay reasonable and customary charges for medical expenses incurred by Insured Person towards Hospitalization for Ayurveda, Yoga and Naturopathy, Unani, Siddha, or Homeopathy treatment, provided that the treatment has been undergone in an AYUSH Hospital.
Our maximum liability under this benefit shall be up to Sum Insured as specified, in the Schedule of Benefits.

Specific Exclusion:

i) All preventive and rejuvenation treatments (non-curative in nature)

4.1.9 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 4.1.1.a) for the Insured Person.
d) The Insured Person is medically advised to undergo an organ transplant.

Special Condition:

(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.

4.1.10 Home Health Care Expenses:

We will pay reasonable and customary charges incurred towards Home Health Care Services incurred by the insured person during the Policy Year.
Our maximum liability under this benefit shall be up to a percentage of Sum Insured (excluding Cumulative Bonus, if any) as specified, under the particular plan, in the Schedule of Benefits.

Special Condition:

a) This benefit can be availed only on cashless facility basis through Our Empaneled Home Health Care service provider.
b) The benefit is subject to pre-authorization obtained from Us.
c) Medical treatment which in the normal course requires care and treatment at a hospital, is taken while insured person is confined at home due to 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.
d) 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.
e) Treatment under this benefit will be provided under the supervision of a Medical Practitioner to administer the treatment plan safely and effectively for the condition of the Insured Person.
f) In the event of medical treatment solely taken at home without any initial hospitalization, Pre and Post hospitalization expenses will be covered up to number of days specified under Section 4.1.2 & Section 4.1.3 respectively.
g) In case of post-surgical care availed through Home Health Care Services, where we have also accepted a claim under In-patient Hospitalization (Section 4.1.1.a) towards the initial hospitalization for surgical management at our empaneled network hospital on cashless basis, then Pre and Post hospitalization expenses will be covered up to number of days specified under Section 4.1.2 & Section 4.1.3 respectively.
h) Any sub limits applicable for Section 4.1.1 to Section 4.1.3 shall also be applicable under this Benefit.
i) This Benefit shall not cover any expenses incurred towards attendant/ nursing services.
j) Clause 6.2.13 shall not apply to the extent of cover provided under this benefit.

4.1.11 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 the particular policy year for a second claim being reported during the policy year and accepted by Us.
The Restoration of Sum Insured will be triggered irrespective of the Sum Insured and Cumulative Bonus (if any) being completely or partially exhausted, and is subject to following conditions:

a) The Restore Sum Insured can be used for claims made for same illness/ new illness in respect of Medical Expenses (Section 4.1.1).
b) The Restore Sum Insured can be used by an Insured person, once in a lifetime, for claims related to chemotherapy and dialysis under this Policy.

c) The Restoration of Sum Insured shall happen only once during a Policy Year.
d) If the Restore Sum Insured is not utilized in a policy year, it shall not be carried forward to any subsequent Policy Year.
e) If the Policy is issued on an Individual / Non-Floater basis, then the restore Sum Insured will be available to each Insured Person.
f) If the Policy is issued on a Floater basis, then the restored Sum Insured will be available on Floater basis for all Insured Persons in the family.

4.1.12 OPD Treatment:

We will reimburse the reasonable and customary charges incurred by the female Insured Person covered in the policy in relation to any illness/ injury sustained during the policy year towards medical consultations, diagnostic tests, and pharmacy expenses on an out-patient basis.
Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.

Special Condition:

a) Only Allopathic treatment will be covered under this Benefit.
b) Upon complete exhaustion of the OPD Sum Insured, 200% reinstatement of the limit will be done once during a policy year. This reinstated limit will be available only for expenses incurred towards Mental/ Psychiatric illness only.
c) For expenses towards Mental/ Psychiatric illness, consultation with a Psychiatrist and counselling sessions with a clinical psychologist (only when prescribed by a Psychiatrist) shall be covered.
d) All expenses individually or in aggregate cannot exceed the OPD Sum Insured.
e) OPD Treatment related to Antenatal Care and Puberty and Menopause Disorders shall not be covered under this benefit.
f) Clause 6.2.11 & 6.2.12 shall not apply to the extent of cover provided under this benefit.

4.1.13 Cumulative Bonus:

Cumulative Bonus shall be increased by 10% in respect of each claim free policy year (where no claims are reported) with an exception for any claim under Optional Cover (Critical Illness-Section 4.2.1 & Personal Accident Cover – Section 4.2.2), OPD treatment (Section 4.1.12), Wellness Benefit (Section 4.1.29), Preventive Care (Section 4.1.28), Antenatal Care (Section 4.1.14) & OPD Claim under Puberty and menopause disorders (Section 4.1.27), provided the policy is renewed with Us without a break, subject to maximum of 50% of the Sum Insured under the current policy year.
If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, Sum Insured will be maintained and will not be reduced in the policy year.

Special Condition:

a) In the case where the policy is on an individual / non-Floater basis, the Cumulative Bonus shall be added and available individually to the Insured Person if no claim has been reported. Cumulative Bonus shall reduce only in case of claim from the same Insured Person.
b) In case where the policy is on floater basis, the Cumulative Bonus shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. Cumulative Bonus shall reduce only in case of claim from any of the Insured Person.
c) Cumulative Bonus shall be available only if the Policy is renewed or renewal premium is paid within the Grace Period.

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

4.1.14 Ante-Natal Care:

We will pay reasonable and customary charges incurred by the insured person on an Out-patient Treatment basis, related to Ante-natal care after confirmation of Pregnancy during the policy year.
Our maximum liability per policy year under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.

Special Conditions:

a) This benefit shall only be available for a female Insured Person aged 18 years or above.
b) This benefit shall come into effect only after the Insured Person has completed 24 months of continuous coverage.
c) Migration and portability shall not be applicable to this benefit.

4.1.15 Maternity Expenses:

We will pay reasonable and customary charges for medical expenses incurred by Insured Person or Surrogate Mother towards maternity expenses for the Insured Persons's Delivery (Normal /Cesarean) during the Policy Year.
Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, 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 Policyholder's Insured Spouse or Live-in Partner.

Special Condition:

a) The cover under this benefit is available if Single Female Insured or Female Insured person along with spouse are covered for a continuous period of 24 months before this benefit comes into effect.
b) Medical Expenses for the delivery of a child (including caesarean section) covered up to a maximum of 2 events in the lifetime of the Insured Person & 1 event in favour of Surrogate Mother.

c) In Favour of Surrogate Mother – Benefit will become payable subject to submission of Certificate from a "District Medical Board" in favor of either or both Insured (Self & spouse) necessitating gestational surrogacy in accordance with the "Surrogacy (Regulation) Act, 2021" at the time of claim.

d) We will cover the reasonable and customary charges for Pre-natal & Post Natal hospitalization expenses, incurred during the Pre-natal and Post-natal period respectively. The Period and charges for pre-natal and post-natal hospitalization expenses shall be restricted up to the sublimit as specified in the Schedule of Benefits.
Note: In Favour of Surrogate Mother - Pre and Post natal hospitalization expenses or any medical expenses related to complications arising out of pregnancy and post-partum delivery are not covered.

e) Migration and portability shall not be applicable to this benefit.

f) 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 4.1.1.a)

g) Maternity Expenses related to Female Insured Person as a surrogate mother shall not be covered.

h) Clause 6.1.15.i shall not apply to the extent of cover provided under this benefit.

4.1.16 Miscarriage & Medical Termination of Pregnancy:

We will pay reasonable and customary charges for medical expenses incurred by the insured person towards medically necessary and lawful termination of pregnancy during the Policy Year.
Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, 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 Policyholder's Insured Spouse or Live-in Partner.

Special Conditions:

a) This benefit shall be payable only once during the lifetime of the Policy.

b) This benefit shall come into effect only after the Insured Person has completed 12 months of continuous coverage.

c) Maternity Expenses related to Female Insured Person as a surrogate mother shall not be covered.

d) Clause 6.1.15.ii shall not apply to the extent of cover provided under this benefit.

4.1.17 Newborn baby Expenses Cover:

If we have accepted a claim under Maternity Expenses (Section 4.1.15), then we will pay the reasonable and customary charges incurred by the Insured Person, during the Policy Year, towards the following:

a. In-patient Hospitalization expenses for the treatment of Newborn Baby while Insured Person (mother)/ Surrogate Mother is hospitalized for delivery.

b. This cover shall also be available for the newborn baby until the expiry date of the policy year in which the newborn baby is born without payment of any additional premium and is subject to the exclusions, terms and conditions of the Policy.

c. The cover for the newborn baby shall be up to the Sum Insured of Insured Mother. In case of a Floater Policy, the cover shall be up to the Policy Sum Insured and in case of an Individual / Non-floater Policy, the cover shall be within the Sum Insured of Insured Mother.
d. The Newborn Baby can be covered as an Insured Person subject to premium being received for subsequent Policy year immediately succeeding the Policy Year in which the Newborn Baby was born.

4.1.18 Newborn Defect:

We will pay a fixed lump sum benefit amount as specified, under the particular plan, in Schedule of Benefits in case Newborn is diagnosed with respect to any of the below listed condition during policy year in which the newborn baby is born.

1. Down Syndrome
2. Cerebral Palsy
3. Spina Bifida

Special Condition

a) This benefit shall be payable only if we have accepted the claim under Maternity Expenses (Section 4.1.15).
b) This benefit shall be payable only once during the lifetime of the Policy.
c) Clause 6.2.6 shall not apply to the extent of cover provided under this benefit.

4.1.19 Newborn Vaccination:

We will pay reasonable and customary charges incurred by the Insured Person towards vaccination of Newborn until the Newborn Baby completes one year of age.
Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.

Special Condition:

a) This benefit shall be payable only if we have accepted the claim under Maternity Expenses (Section 4.1.15).
b) If the Policy ends before the Newborn Baby has completed one year, then we will cover such vaccinations until the Newborn Baby completes one year, only if We have received the Newborn Baby premium as an Insured Person at the time of Renewal of the Policy.
c) Clause 6.2.3 shall not apply to the extent of cover provided under this benefit.

4.1.20 Stem Cell Storage:

We will pay one-time expenses incurred by the insured Person towards the harvesting and storage of stem cells of the Newborn Baby which is carried out as a preventive measure against possible future Illnesses.
Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.

Special Condition:

a) The stem cells of the Newborn Baby are preserved in an Indian based Stem Cell Bank only.
b) The payment under this Benefit is subject to a valid claim being accepted by Us under Maternity Expenses (Section 4.1.15).
c) This benefit shall be payable only once during the lifetime of the Policy.
d) Clause 6.2.8 shall not apply to the extent of cover provided under this benefit.

4.1.21 Cancer Care Booster:

We will increase the Sum Insured by additional amount up to a percentage of Sum Insured (excluding Cumulative Bonus, if any) as specified, under the particular plan, in the Schedule of Benefits towards medical expenses incurred by the female Insured Person, who is hospitalized for the treatment of cancer during policy year.

Special Conditions:

a) Cover under this benefit is payable only if the symptoms of the condition are first diagnosed or manifest itself during the Policy Year.
b) In case of an admissible claim, the sequence of Sum Insured applicability shall be:
   1) Policy Sum Insured
   2) Cumulative Bonus
   3) Cance Care Booster
   4) Restoration of Sum Insured
c) This benefit shall come into effect only after the Insured Person has completed 12 months of continuous coverage.
d) We have accepted a claim for Medical Expenses (Section 4.1.1)
e) This benefit can be triggered only once during the lifetime of the Policy.
f) This benefit shall be available only in the Policy Year in which a claim, under this benefit, is triggered and utilized. This benefit shall not be available in any subsequent Policy Years.

WOMEN CARE

4.1.22 Infertility Expenses:

We will pay reasonable and customary charges incurred by the insured person towards medically necessary treatment for Infertility & cryopreservation, during Policy Year, on in-Patient Hospitalization / Day Care / OPD basis.

This benefit shall only be available for Insured Person aged above 18 years, who should be either:

i. the Policyholder insured as Self or,
ii. the Policyholder's Insured Spouse or Live-in Partner.

Following Expenses shall be covered under this benefit:

(i) Surgical procedures related to correction of pathological abnormalities in reproductive organs.
(ii) Assisted Reproductive Technology procedures including but not limited to IVF (in vitro fertilization), ZIFT (Zygote Intrafallopian Transfer), GIFT (Gamete Intrafallopian Transfer), ICSI (Intracytoplasmic Sperm Injection) and pronuclear stage transfer.

Special Condition:

a) The treatment is undertaken on written advice of a specialist Medical Practitioner at a healthcare facility/ center duly registered in accordance with applicable law.
b) Our maximum and lifetime liability under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.
c) This benefit shall come into effect only after the Insured Person has completed 36 months of continuous coverage.
d) Cryo- preservation is covered up to 36 months from the day of first retrieval of Oocyte subject to policy being continuously renewed with Us.
e) Migration and portability shall not be applicable to this benefit.
f) Clause 6.1.14 shall not apply to the extent of cover provided under this benefit.

Specific Exclusion

i) Any expenses with respect to the Insured Person's use of third-party surrogate or gestational carrier in pregnancy.
ii) Any expenses for consultation, diagnostic tests, or procedure or any such other expenses for diagnosis of infertility.
iii) Any expenses incurred towards complications, arising out of the Infertility treatment.

4.1.23 Voluntary Sterilization:

We will pay reasonable and customary charges incurred by the Female Insured person towards Voluntary Sterilization (Tubal Ligation) during Policy Year.
Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.

Special Condition:

a) This benefit shall only be available for married female and age between 23 to 48 years (both age inclusive), should be either:
   i. the Policyholder Insured as Self or,
   ii. the Policyholder's Insured Spouse or Live-in Partner.
b) The benefit shall come into effect only after the Insured Person has completed 36 months of continuous coverage.
c) Migration and portability shall not be applicable to this benefit.
d) Available once in the Lifetime of the Policy.
e) Expenses incurred for Reversal of Sterilization are not payable.
f) Clause 6.1.14 shall not apply to the extent of cover provided under this benefit.

4.1.24 Senior Care:

We will pay reasonable and customary charges incurred by the female Insured age 60 Years & above towards Curative Care Treatments as recommended by the treating medical practitioner during Policy Year.
Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.

Following Expenses shall be covered under this benefit:

(i) Intra articular joint injections (Injections given in between joints for treatment of joint related disorders)
(ii) Intravitreal injections (Injections given in the eye for treatment of eye related disorders)
(iii) Bone strengthening Injections.

Special Condition:

a) The benefit shall come into effect only after the Insured Person has completed 24 months of continuous coverage.

4.1.25 Nursing Care Expenses:

We will pay a fixed benefit amount as specified in the Schedule of Benefit, incurred towards the nursing care taken by the female insured person from a Qualified Nurse, immediately following the Insured Person's discharge from Hospital during the Policy Year.

Special Condition:

a) We have accepted claims under In-patient Hospitalization (Section 4.1.1.a) or Day care treatment (Section 4.1.1.b).
b) Our maximum liability under this benefit shall be a fixed amount per day for the number of days as specified, under the particular plan, in the Schedule of Benefits.
c) The treating Medical Practitioner has recommended that nursing care is Medically Necessary.
d) Clause 6.2.13 shall not apply to the extent of cover provided under this benefit.

4.1.26 Temporary Domestic Help:

We will pay fixed benefit amount as specified in Schedule of Benefits, for engaging services of temporary domestic help at Insured person residential address for the duration while female Insured is hospitalized following an Illness or Injury sustained during the Policy Year.

Special Condition:

a) We have accepted a claim under In-Patient Hospitalization (Section 4.1.1.a) against any female Insured aged 18 Years & above covered in the Policy during the Policy Year.
b) Our maximum liability under this benefit shall be a fixed amount per day for the number of days as specified, under the particular plan, in the Schedule of Benefits.

4.1.27 Puberty & Menopause Disorders:

We will pay the reasonable & customary charges for medical expenses incurred towards Female Insured Person's Hospitalization or OPD treatment, during the Policy Year, due to treatment for symptoms, illness, complications arising due to physiological conditions associated with Puberty & Menopause such as menopausal bleeding, flushing etc.

Special Condition:

a) In- Patient Hospitalization- This benefit shall come into effect only after the insured Person has completed 24 months of continuous coverage.
b) Waiting period shall not be applicable for OPD treatments.
c) Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.

4.1.28 Preventive Care:

We will pay reasonable and customary charges incurred by female Insured towards Preventive Care as recommended by the treating medical practitioner.
The cover under this benefit will be part of the Base Sum Insured.

Following Expenses shall be covered under this benefit:

(i) Dexa Scan **-** Covered up to ₹2,500/- once in the block of 4 consecutive Policy year and applicable for Female Insured 50 years & above.
(ii) HPV vaccination - Covered up to ₹2000/- payable, once in lifetime of the Policy.

VALUE ADDED SERVICES

4.1.29 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 FGII mobile App.

"Wellness Benefits" - All Insured Persons above 18 years are eligible to avail the "Wellness Reward Points" under the Wellness Benefits.
"Value Added Services" - Only Female Insured Persons above the age of 18 years can avail all the Value-Added Services except for "Health Check -Up" which can be availed by both male and female insured persons above the age of 18 years.
The Insured Person would have to register into the FGII 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 benefits 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 the eligible Insured Person is eligible for availing the following benefits via the FGII mobile App: -

Sr No.	Wellness Program	Limit each policy year
1.	**Psychological Consultation** for discussion on general mental health issues with a mental health expert (clinical psychologist).	4 Tele consultation sessions
2.	**Gynecologist Consultation** with a clinical gynecologist during the Policy Year. This will include clinical support related to menstrual issues, Sexual health issues, fertility, contraception, and menopause, to maintain and improve the quality of Your healthy life.	4 consultation sessions (Online / In-Clinic) In-clinic Consultation available Only at network providers. In case network provider is not available, then opt for online consultation.
3.	**Home Diagnostic Services** Wherein the Network Provider shall be assigned to arrive at the doorstep of the Insured Person to collect samples required for prescribed diagnostic tests. Refer Health Checkup (point no. 11) for list of Diagnostic Test against home diagnostic services can be availed except for PAP smear and Mammography.	2 times in a policy year.
4.	**Women Fitness Program** (Gym) available to improve Your overall well-being. We	12 fitness sessions

	will arrange a platform to book physical gym/training sessions at nearby network Gyms/Fitness studios.	
5.	**Diet & Nutritional Session** with professional Dietitian & Nutrition Coach to guide on General nutrition, diet, Wellness, and lifestyle.	4 Online consultation Sessions
6.	**Spa Wellness Session** for releasing toxic or unhealthy substances that can affect different aspects of health.	2 Spa Sessions
7.	**Face Yoga Sessions** to guide on a series of facial exercises which help to tone and tighten the muscles of the face.	1 Online Session
8.	**Fitness /Yoga Membership** which includes sessions on fitness workout, yoga, and meditation.	Online Annual Membership
9.	**Access to Health Content & Webinars** which provide information on Physical and Mental wellness related topics.	Available
10.	**Discount on Wellness Products**	Available as per partner offering
11.	***Health Check Up** Hemogram, Thyroid function tests (T3, T4 & TSH), Glycosylated Hemoglobin (HbA1c), Lipid Profile, Fasting Blood Sugar Level, Anti Mullerian Hormone (AMH), Serum Calcium, Liver Function Test, Serum Phosphorus, Renal Profile, PAP smear, Mammography, Blood Pressure and Body Mass Index (BMI)	Once in a Policy Year

**Every Insured Person from 18 years onwards is eligible for availing the Health Checkup. The health checkup can be conducted from 1st year of the Health PowHER with Us except for mammography and PAP smear which shall be covered for the Insured Person only after completion of 12 months of continuous coverage with Us. Health checkup will be provided at Our Wellness partner empaneled Diagnostic Centres only. Lipid profile -Low Density Lipoproteins (LDL), Serum Triglycerides, High Density Lipoproteins (HDL), Serum Cholesterol; Liver Function Test - Serum Glutamic Oxaloacetic Transaminase (SGOT), Serum Glutamic Pyruvic Transaminase (SGPT), Bilirubin, Total Protein; Renal Function Test – Serum Creatinine, Uric Acid, Urea, Urine Routine / Microscopy. PAP smear and Mammography shall be available once in a block of 2 years.*

B. Wellness Rewards points

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

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 FGII 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 FGII 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 FGII organized events**
Insured Person has an option to participate in FGII organized events and view wellness content through FGII 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 11) 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 FGII mobile App.

6) **Fitness / Healthy lifestyle tracking** – We aim at encouraging a healthy fitness regime for all age groups.
Insured Person can earn wellness points every month by completing any one of the following

activities.

a) Daily Step tracking (monthly average of 10000 steps/day). The step count can be tracked either through our FGII mobile App. or insured can sync his/her fitness device with our App.
b) Participation in Marathon, Cyclathons etc.: Insured can upload the completion certificate of the event on the FGII mobile App.
c) Burning average of 300 calories per day in a month. The calorie burning count can be tracked either through the FGII mobile App. or insured can sync his/her fitness device with our App.
d) Submission of monthly Gym/Yoga membership detail - Insured can upload the monthly membership receipts on the FGII mobile App.
e) Wellness points will be allotted basis the activity details submitted by the insured at the end of 30 days.

Conditions applicable for 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 FGII organized events (as and when organized) and viewing of FGII Content around wellness	As planned by FGII	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) • Burning average of 300 calories per day in a month • Submission of monthly Gym /yoga membership detail • Participation in Marathon, Cyclathon etc.	Monthly	60
6.	Enrolment to Wellness	Once/year	15
	Total points		**200**

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

Points earned per member per year	Value of points earned
185- 200	5%
150-184	4%
100-149	3%
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-2024 to 31 Dec 2024		
Relation	Self (Female)	Spouse	Child (Female)
Sum insured (₹)	20L	20L	20L
Age Band	26	31	0-17
Individual premium (₹)	28,189	21,902	13,252
Family discounted premium (₹)	25,370	19,712	11,927
Points Earned	200	180	NA
% value of points earned	5%	4%	0%
Monetary value of reward points (₹)	1269	788	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) (₹)
21/03/2024	40	2%	507	30	2%	394	902		100
31/08/2024	100	3%	761	60	2%	394	1155	1055	200
15/10/2024	170	4%	1015	150	4%	788	1803	1503	
31/12/2024	200	5%	1269	180	4%	788	2057	1757	
Balance monetary value of reward points (₹) 1757 would be applied as discount at renewal									

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

Relation	Self (Female)	Spouse	Child (Female)	
Sum insured (₹)	20L			
Age Band	26	31	0-17	Premium total of eligible members
Floater Discounted premium (₹)	28,189	12,046	5,301	40,235
Points Earned	200	180	NA	Average of Points
				190
% value of points earned				5%
Monetary value of reward points (₹)				2,012

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					
21/03/2024	40	30	35	2%	805		100
31/08/2024	100	60	80	2%	805	705	
15/10/2024	170	150	160	4%	1,609	1,509	200
31/12/2024	200	180	190	5%	2,012	1,712	Applied as discount at renewal
Balance monetary value of reward points (₹) 1712 would be applied as discount at renewal							

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 the first year can be carried forward to the 2nd or 3rd year in case of long-term policies.
3) The points can be burned for utilization of the 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 4.1.1 (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.

4.2 OPTIONAL COVER

The benefits mentioned under the optional covers are to be selected by the Insured Person based on his/ her requirement & available on payment of additional premium.

The Policy schedule shall specify such selected benefits which shall be in force for the Insured Persons during the Policy Period.

CRITICAL CARE

4.2.1 Critical illness:

A. Lumpsum Benefit

If the Insured Person suffers from a Critical Illness of the nature as specified below during the Policy Period and while the Policy is in force, then we will pay 100% of Sum Insured as specified in the Policy Schedule provided that the Critical Illness is first diagnosed or manifests itself during the Policy Period after completion of 90 days from the inception of the First Policy with Us.

Sr No	List of Critical Illness covered	Sr No	List of Critical Illness covered
1	Cancer of Specified Severity	2	Myocardial Infarction (First Heart Attack of Specified Severity)
3	Open Chest CABG (Coronary Artery Bypass Graft)	4	Open Heart Replacement or Repair of Heart Valves
5	Coma of Specified Severity	6	Kidney Failure Requiring Regular Dialysis

7	Stroke Resulting in Permanent Symptoms	8	Major Organ / Bone Marrow Transplant
9	Permanent Paralysis of Limbs	10	Motor Neuron Disease with Permanent Symptoms
11	Multiple Sclerosis with Persisting Symptoms	12	Benign Brain Tumor
13	Blindness	14	Deafness
15	End Stage Lung Failure	16	End Stage Liver Failure
17	Loss of Speech	18	Loss of Limbs
19	Major Head Trauma	20	Primary (Idiopathic) Pulmonary Hypertension
21	Third Degree Burns		

Special Condition:

a) Our total, cumulative, maximum liability during the lifetime of the Insured Person is up to 100% of the Sum Insured.

b) Once a claim for a listed condition is admissible in respect of an Insured Person, no further Renewals shall be allowed for that Insured Person under this Benefit.

c) The payment of a Benefit under Section shall be subject to survival of the Insured Person for 7 days following the first diagnosis of the Critical Illness/undergoing the Surgical Procedure for the first time.

d) All claims under Section must be made in accordance with the procedure set out in Section 8.

B. E- Medical Second Opinion –

a) If an Insured Person is diagnosed with Critical Illnesses as listed under Section 4.2.1.A, then on the Insured Person's request, We will arrange a maximum of two e-opinions (in a Policy Year) form a Medical Practitioner selected by the Insured Person from Our panel. The e-opinion will be based only on the information and documentation provided to the Medical Practitioner by or on behalf of the Insured Person.:

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

1) It is entirely for the Insured Person to decide whether to obtain an E-opinion, from which Medical Practitioner in Our panel to take the e-opinion and the use (if any) to which the e-opinion so obtained is put.

2) We do not provide an e-opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other persons' reliance on the same, or the use to which the E-opinion is put.

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

ACCIDENT CARE

4.2.2 Personal Accident Cover:

If an Insured Person suffers an Injury due to an Accident during the Policy Year, and that Injury solely results in Death, Permanent Total Disablement OR Permanent Partial Disability of Insured Person within 365 days from the date of the Accident, we will pay the Sum Insured as specified in the table below:

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

Special Conditions:

a) Our maximum liability is restricted to 100% of the Sum Insured irrespective of permanent loss of one or more body parts and / or death.
b) Once a claim is admissible in respect of an Insured Person, no further Renewals shall be allowed for that Insured Person under this Benefit.
c) For the purpose of Permanent Total Disablement:
   i. Limb means a hand at or above the wrist or a foot above the ankle.
   ii. Physical separation of one hand or foot means separation at or above wrist and/or at or above ankle, respectively.
d) The benefit will be paid to the Insured Person or legal representative of the Insured Person.
e) On Insured Person's death, the benefit will be paid to the nominee appointed by the Insured Person or the Insured Person's legal heir.

4.2.3 Voluntary Co-payment

The Voluntary Co-Payment as opted for by the Policy Holder and specified in the Policy Schedule, shall be applicable for all the Insured Persons under this Policy.
This benefit is subject to the following:

a) The Insured Person will bear a percentage share of the admissible claim amount.
b) Co-Pay will be applied to the admissible claim amount on each claim.
c) Co-Pay shall not be applicable to the following benefits:
   i. LASIK Surgery
   ii. Cataract Surgery
   iii. Home Health Care Expenses
   iv. OPD Treatment
   v. Ante-Natal Care
   vi. Maternity Expenses
   vii. Miscarriage & Medical Termination of Pregnancy
   viii. Newborn Defect
   ix. Newborn Vaccination
   x. Stem Cell Storage
   xi. Senior Care
   xii. Nursing Care Expenses
   xiii. Temporary Domestic Help
   xiv. Puberty & Menopause Disorders (only OPD Treatment, co-pay will be applicable to IPD treatment)
   xv. Preventive Care
   xvi. Wellness Benefits
   xvii. Critical Illness
   xviii. Personal Accident Cover

5. WAITING PERIOD

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

5.1 Pre-Existing Diseases (Code- Excl01)

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 (Applicable as per plan opted) of continuous coverage after the date of inception of the first policy with us.

b) In case of the enhancement of the 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 the 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.

5.2 Specific Waiting Period (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 Months and 36 Months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of the enhancement of the 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 the waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures:

A. 24 Months waiting period:

1) Benign ENT disorders
2) Tonsillectomy
3) Adenoidectomy
4) Mastoidectomy
5) Tympanoplasty
6) Hysterectomy
7) All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps.
8) Benign prostate hypertrophy
9) Cataract and age-related eye ailments
10) Gastric/ Duodenal Ulcer
11) Gout and Rheumatism
12) Hernia of all types
13) Hydrocele
14) Non-Infective Arthritis
15) Piles, Fissures and Fistula in anus
16) Pilonidal sinus, Sinusitis and related disorders
17) Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident.
18) Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19) Varicose Veins and Varicose Ulcers
20) LASIK Surgery

B. 36 Months waiting period:

1) Treatment for joint replacement unless arising from accident.
2) Age-related Osteoarthritis & Osteoporosis

5.3 First Thirty Days Waiting Period (Code- Excl03)

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.

6. 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:

6.1 Standard Exclusions

6.1.1 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.

6.1.2 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 physical, social, emotional, and spiritual needs.

6.1.3 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

6.1.4 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.

6.1.5 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.

6.1.6 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.

6.1.7 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.

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

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

6.1.10 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons**. (Code- Excl13)**

6.1.11 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 **(Code- Excl14)**

6.1.12 Refractive Error (Code- Excl15)
Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

6.1.13 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.

6.1.14 Sterility and Infertility (Code- Excl17)
Expenses related to sterility and infertility. This includes:
(i) Any type of sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy
(iv) Reversal of sterilization

6.1.15 Maternity (Code Excl18)

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

6.2 Specific Exclusions

6.2.1 Illness or Injury 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).
6.2.2 Circumcision, unless necessary for treatment of an Illness or necessitated due to an Accident.
6.2.3 Vaccination/ inoculation (except as post bite treatment)
6.2.4 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.
6.2.5 Venereal /Sexually Transmitted disease other than HIV/AIDS.
6.2.6 External Congenital Anomaly and related Illness/ defect.
6.2.7 Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.
6.2.8 Stem cell storage.
6.2.9 Non-prescribed drugs and medical supplies, hormone replacement therapy.
6.2.10 Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
6.2.11 Outpatient diagnostic, medical and Surgical Procedures or treatments.
6.2.12 Dental Treatment or Surgery of any kind unless requiring Hospitalization as a result of Injury.
6.2.13 A Medical Practitioner's home visit charges during pre and post Hospitalization period and attendant nursing charges.
6.2.14 Commercial Surrogacy / Traditional surrogacy
6.2.15 Treatment outside India.
6.2.16 Intentional self-Injury.
6.2.17 Non –Payable items: The expenses that are not covered in this policy are placed under List-I of Annexure III.
6.2.18 Any specific exclusion(s) applied by Us, specified in the Schedule, and accepted by the insured.

7. GENERAL TERMS AND CONDITIONS

7.1 Standard General Terms and Clauses

7.1.1 Disclosure of Information

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

7.1.2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for

claim(s) arising under the policy.

7.1.3 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.

7.1.4 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.

7.1.5 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.

7.1.6 Notice & Communication

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

7.1.7 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

7.1.8 Multiple Policies

i. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer, if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
iv. Where an insured has policies from more than one insurer to cover the same risk on an indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

7.1.9 Fraud

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

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy: —

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

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

7.1.10 Automatic change in Coverage under the policy

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

i. 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 guardian 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.
ii. 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.

7.1.11 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.

7.1.12 Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are affected.

7.1.13 Free look period

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.

The insured shall be allowed a period of thirty days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, 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.

7.1.14 Endorsements (Changes in Policy)

i. 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.
ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such a 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.

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

7.1.15 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.

7.1.16 Moratorium Period

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

7.1.17 Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement,

the Company will pay the policyholder. 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.

7.1.18 Redressal of Grievance

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

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

lf lnsured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at fggro@futuregenerali.in or call at: 7900197777

For updated details of grievance officer, kindly refer the link
https://general.futuregenerali.in/customer-service/grievance-redressal
lf lnsured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of lnsurance Ombudsman of the respective area/region for redressal of grievance as per lnsurance Ombudsman Rules 2017.

Kindly refer the annexure on Grievance Redressal Procedures.

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

7.2 Specific General Terms and Clauses

7.2.1 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.

7.2.2 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.

7.2.3 Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the

proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link- https://general.futuregenerali.in/generalinsurance/pdf/Guide_to_Portability_and_Migration_25-Mar-2020.pdf

7.2.4 Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link- https://general.futuregenerali.in/generalinsurance/pdf/Guide_to_Portability_and_Migration_25-Mar-2020.pdf

7.2.5 **Cancellation**

a) The policyholder may cancel this policy by giving 7 days written notice.
b) In case the Policyholder requests for cancellation of the Policy, where no claims are reported under the Policy, the Company shall refund premium for the unexpired policy/ instalment period as detailed below:
   i. **Single Premium Payment (1/2/3 years Policy Term)** – There shall be refund of proportionate premium for the unexpired policy period on prorate basis.
   ii. **Premium paid in multiple instalments (1/2/3 years Policy Term)** - There shall be refund of proportionate premium for the unexpired instalment period on prorate basis.
c) In case the Policyholder requests for cancellation of the Policy, where there are claims reported under the Policy, then the Company shall refund premium for the unexpired/ instalment policy period as detailed below:
   i. Single Premium Payment
      1) 1 year Policy Term - There shall be no refund of premium for the unexpired policy period.
      2) 2/3 years Policy Term – There shall be no refund of premium for the current Policy Year in which the claim got reported. However, the premium for the unutilized subsequent Policy Years (if any), shall be refunded.
   ii. Premium paid in multiple instalments –

1) 1/2/3 years Policy Term - There shall be no refund of premium for the unexpired instalment period.

d) The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud or non-cooperation by the insured person by giving 15 days' written notice. There would be no refund of premium upon cancellation on the abovementioned grounds.

e) In the event of death of an Insured Person, We shall refund the premium for the unutilized Policy / Instalment period based on the guidelines for various scenarios as mentioned below:

Scenario 1 – In case of no claim reported under the policy-

A. Policy Term – 1 / 2 / 3 Years; Payment Mode – Single Premium Payment

1) Non-Floater Policy - the corresponding premium pertaining to the deceased insured person for the unutilized Policy period shall be refunded on pro rata basis.
2) Floater policy - the premium for pertaining to the deceased Insured person for the unutilized Policy Period shall be refunded on pro rata basis.

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

1) Floater / Non-Floater Policy - the instalment premium pertaining to the deceased Insured Person for the unutilized instalment period shall be refunded on pro-rata basis.

Scenario 2 – In case of claim reported under the policy –

A. Policy Term – 1 Year; Payment Mode – Single Premium Payment

1) Non-Floater Policy
   i. Claims incurred by the deceased Insured Person in the current Policy Year, The premium pertaining to the deceased Insured Person for the unutilized current Policy Year shall not be refunded.
   ii. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Policy Year- The premium pertaining to the deceased shall be refunded on pro-rata basis.
2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Policy Year, The premium for the deceased Insured Person for the unutilized Policy Period, will not be refunded.

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

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

other Insured Person in the current Policy Year – The premium for the deceased Insured Person for the unutilized current Policy Year, will not be refunded. Premium pertaining to the deceased Insured Person for the unutilized subsequent Policy Years (if any), shall be refunded.

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

1) Non-Floater Policy
   i. Claims incurred by the deceased Insured Person in the current Instalment Period, the instalment premium pertaining to the deceased Insured Person for the unutilized current instalment period shall not be refunded.
   ii. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Instalment Period –The premium pertaining to the deceased Insured Person for the unutilized instalment Period, shall be refunded on pro-rata basis.
2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Instalment Period, the instalment premium pertaining to the deceased Insured Person for the unutilized current instalment period shall not be refunded.

7.2.6 Renewal of Policy

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

a) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
b) Renewal shall not be denied on the grounds that the insured person had made a claim or claims in the preceding policy years.
c) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
e) No loading shall apply on renewals based on individual claims experience.
f) Health PowHER Policy shall be renewable lifelong.
g) The brochure/ prospectus mentions the premiums as per the age slabs/ Sum Insured and the same would be charged as per the completed age at every Renewal.
h) The premiums as shown in the brochure/ prospectus are subject to revision as and when approved by the IRDAI. However, such revised premiums would be applicable only from subsequent Renewals and with due notice whenever implemented.
i) Any Change (increase/ decrease) in Sum Insured is not allowed during the currency of the Policy. However, increase/decrease in Sum Insured or change in cover, will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling in the Proposal before the expiry of the Policy.
j) In the case of enhancement of sum insured, the waiting periods shall apply afresh to the extent of sum insured increase.

7.2.7 Premium Payment in Instalment

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

a) Grace Period of 15 days would be given to pay in case of monthly instalment premium and grace period of 30 days shall be given to pay in case of quarterly / Half Yearly installment premiums, due for the policy.
b) .
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 lf the instalment premium is not paid on the due date.
e) ln case the instalment premium due, is not received within the grace period, the policy will get cancelled.
f) ln 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. This provision will not apply to claims arising under Wellness Benefits (Section 4.1.29).

7.2.8 Proportionate Deduction

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

Proportionate Deductions shall not be applied to the following:

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

7.2.9 Revision of Premium due to Inflation

The premium rates of the product shall be subject to revision after 3 years of its first launch. Such revision in rates shall be:

a) based on the inflation index prevalent during that period.
b) implemented after prior approval from the IRDAI.

All the extant regulations/guidelines/circulars prescribed by IRDAI shall be followed to implement the premium rate revision.

8. CLAIM PROCEDURES

8.1 Procedure for Cashless Claims

Cashless Facility is only available at a Network Provider. 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.

8.2 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.

8.3 Notification of Claim

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

1) Within 24hours 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.

8.4 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) Additional documents for Air ambulance
    (a) Medical reports and transportation details issued by the air ambulance service provider, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirming the necessity of air ambulance services.
    (b) Original Bills for expenses incurred towards availing Air Ambulance services.
20) Additional documents for Infertility and Surrogacy related claims
    (a) Infertility related treatment details including consultation papers and investigation reports.
    (b) Copy or Registration certificate towards registration of “Surrogacy Clinic” under Surrogacy regulation Act.
    (c) Certificate issued to Surrogate Mother from appropriate authority for carrying surrogacy according to Surrogacy regulation act.
    (d) Certificate of essentiality issued to insured person / intended couple/ intended women by the appropriate authority under Surrogacy regulation Act.
    (e) Copy of an order concerning the parentage and custody of the child to be born through surrogacy, passed by a court of the Magistrate Regulation of surrogacy and surrogacy procedures of the first class or above on an application made by the intending couple or the intending woman and the surrogate mother, which shall be the birth affidavit after the surrogate child is born.
21) Additional Documents for Home Health Care Expenses (Section 4.1.10) - A certificate from the attending doctor confirming that the condition of the patient is such that he/she cannot be moved to a hospital.
22) 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.

8.5 Payment of Claim

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

8.6 Sequence of Sum Insured Applicability

In case of an admissible claim, the sequence of Sum Insured applicability shall be:

i. Basic Sum Insured
ii. Cumulative Bonus
iii. Cancer Care Booster
iv. Restoration of the Sum Insured

8.7 Claim Settlement

1) The Company shall settle or reject a claim within 30 days of the date of receipt of the last necessary document.
2) In the case of a 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) Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified Section 8.4 above.
6) In case of 'pending' claims, we will ask for submission of incomplete documents.
7) 'Rejected' claims will be informed to the Insured Person in writing with reasons for rejection.

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Annexure I: Schedule of Benefit

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Plans			Essential	Advance	Supreme
Eligibility	Sum Insured (In ₹)		₹ 5L, 10L	₹ 15L, 20L	₹ 25L, 50L, 75L,100L
	Proposer		Adult – 18 Years & Above		
	Minimum Entry Age		Child - 1 Day	Child - 1 Day	Child - 1 Day
			Adult - 18 years	Adult - 18 years	Adult - 18 years
	Maximum Entry Age		Child - 25 years	Child - 25 years	Child - 25 years
			Adult – 65 years	Adult – 65 years	Adult – 65 years
	Maximum Renewal Age		Life Long	Life Long	Life Long
	Cover Type		Individual / non-floater - Family Floater	Individual / non-floater - Family Floater	Individual / non-Floater - Family Floater
	Family Definition (Transgender will not be covered under this product.)		**Individual / non-floater** Self, Live-in Partner / Spouse, Dependent Children (max. 4), Parents, Parents in Law	**Individual / non-floater** Self, Live-in Partner / Spouse, Dependent Children (max. 4), Parents, Parents in Law	**Individual / non-floater** Self, Live-in Partner / Spouse, Dependent Children (max. 4), Parents, Parents in Law
			Family Floater Self, Live-in Partner / Spouse, Dependent Children (max. 4), Parents / Parents in Law	**Family Floater** Self, Live-in Partner / Spouse, Dependent Children (max. 4), Parents / Parents in Law	**Family Floater** Self, Live-in Partner / Spouse, Dependent Children (max. 4), Parents / Parents in Law
Base Cover					
Medical Expense Cover	In-patient Hospitalization		Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
	Room Rent Limit	Normal Room	Single Private Room	Single Private Room	Actuals
		ICU	Actuals	Actuals	Actuals
	Day Care Treatment	530 Listed Day Care procedures	Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
	Other Expenses	LASIK Surgery	Up to ₹50,000 each policy year (One or both the eyes)	Up to ₹75,000 each policy year (One or both the eyes)	Up to ₹1,00,000 each policy year (One or both the eyes)
			- Only Once during the lifetime of the Policy. - Covered After Waiting Period of 24 months.		
		Bariatric Surgery	Up to 50% of SI, Max up to ₹5,00,000 each policy year	Up to ₹5,00,000 each policy year	Up to ₹5,00,000 each policy year
			- Covered After Waiting Period of 36 months.		
		Cataract Surgery	Up to ₹1,00,000 per eye each policy year	Up to ₹1,00,000 per eye each policy year	Up to ₹1,00,000 per eye each policy year
			- Covered After Waiting Period of 24 months.		

	Pre-Hospitalization Medical Expenses	Up to 30 Days	Up to 60 Days	Up to 60 Days
	Post Hospitalization Medical Expenses	Up to 60 Days	Up to 90 Days	Up to 90 Days
	Modern Treatment Method and Advancement in Technologies	Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
	Cosmetic/Plastic Surgery	Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
	Emergency Road Ambulance (per hospitalization event)	Up to ₹2000	Up to ₹3000	Up to ₹4000
	Emergency Air Ambulance (Per policy year)	Not Available	Up to ₹2,00,000	Up to ₹3,00,000
	Alternative Treatments	Up to Sum Insured	Up to Sum Insured	Up to Sum Insured
		- Covers Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy only.		
	Organ Donor Expenses	Up To Sum Insured	Up To Sum Insured	Up To Sum Insured
	Home Health Care Expenses	Not Available	Up to 20% of Sum Insured	Up to 20% of Sum Insured
	Restoration of Sum Insured	Not Available	Available	Available
		- Equal to 100% of the base Sum Insured excluding Cumulative Bonus, if any. - Available for the Policy year for a second claim irrespective of the Sum Insured and Cumulative Bonus (if any) is completely or partially exhausted.		
	OPD Treatment (Each policy year irrespective of Policy Type)	Up to ₹ 2500	Up to ₹ 3500	Up to ₹ 5000
		- Restoration of the OPD Sum Insured available up to 200% of SI, once in a Policy Year, in case the available OPD SI is insufficient for covering a claim incurred towards Mental/ Psychiatric illness.		
	Cumulative Bonus	10% of SI per annum	10% of SI per annum	10% of SI per annum
		- Max up to 50% of Base Sum Insured, for each claim free policy year. - Claiming under Optional Cover (Critical illness & Personal Accident Cover, OPD treatment and Wellness Benefits, Preventive care, Antenatal Care, OPD Claim under Puberty and Menopause disorder will not impact cumulative Bonus.		
	Ante-Natal Care (Each policy year)	Up to ₹7,500	Up to ₹10,000	Up to ₹15,000
		- Applicable for female Insured Person 18 Years & Above - Covered After Waiting Period of 24 months.		
	Maternity Expenses (Normal/Cesarean Delivery)	Normal Delivery - Up to ₹ 50,000 Cesarean – Up to ₹ 75,000	Normal Delivery - Up to ₹ 75,000 Cesarean – Up to ₹ 1,25,000	Normal Delivery - Up to ₹1,25,000 Cesarean – Up to ₹ 2,00,000
		- Waiting period of 24 months is applicable if Single Female Insured or Female Insured person along with spouse are covered.		
		45 Days	45 Days	45 Days

	Pre-Natal Hospitalization (Within Maternity Limits)	- Pre Natal-Hospitalization expense not covered for Surrogate Mother.		
	Post Natal Hospitalization (Within Maternity Limits)	45 Days	45 Days	45 Days
		- Post Natal Hospitalization expense not covered for Surrogate Mother.		
	Miscarriage & Medical Termination of Pregnancy	Up to ₹25,000	Up to ₹35,000	Up to ₹50,000
		- Covered After Waiting Period of 12 months. - Not available for Surrogate Mother.		
	Newborn Baby Expenses Cover	Automatic Cover Within Mother's / Floater Sum Insured Up to Expiry Date of Policy Year	Automatic Cover Within Mother's / Floater Sum Insured Up to Expiry Date of Policy Year	Automatic Cover Within Mother's / Floater Sum Insured Up to Expiry Date of Policy Year
	Newborn Defect	₹50,000	₹75,000	₹1,00,000
	Newborn Vaccination (Up to One year of age)	₹5,000	₹7,500	₹10,000
	Stem Cell Storage	₹ 15,000	₹ 20,000	₹ 20,000
		- Only Once during the lifetime of the policy.		
	Cancer Care Booster	- Additional 100% of SI for Female Cancers. - Other Cancers Additional 50% of SI.	- Additional 200% of SI for - Female Cancers. - Other Cancers Additional 100% of SI	- Additional 200% of SI for - Female Cancers. - Other Cancers Additional 100% of SI
		- Covered After Waiting Period of 12 months. - Only Once during the lifetime of the policy. - Female Cancers- Breast, Cervix, Uterus, Fallopian Tube, Ovary, Vagina/ Vulva cancers.		
Women Care	Infertility Expenses	Not Available	Infertility - Up to ₹2,00,000 Cryopreservation - Up to ₹15,000	Infertility - Up to ₹3,00,000 Cryopreservation - Up to ₹20,000
		- Only Once during the lifetime of the policy. - Covered After Waiting Period of 36 months. - Cryo- preservation for up to 36 months from day of first retrieval of Oocyte, subject to policy being continuously renewed with Us.		
	Voluntary Sterilization (Tubal Ligation)	Not Available	₹50,000	₹50,000
		- Only Once during the lifetime of the policy. - Covered After Waiting Period of 36 months.		
	Senior Care (For Female Insured 60 Years & above - Each Policy year)	Up to ₹15,000	Up to ₹20,000	Up to ₹20,000
		- Covered After Waiting Period of 24 months.		
	Nursing Care Expenses	Not Available	₹500 per day	₹750 per day
		- Maximum up to 10 days for each claim, max up to 30 days per policy year.		
		₹500 per day	₹750 per day	₹1,000 per day

	Temporary Domestic Help	- Maximum up to 10 days per event, 30 days each policy year.		
	Puberty & Menopause Disorders (each policy year)	- OPD Limit - Up to ₹7,500 - IPD – Covered up to Sum Insured	- OPD Limit - Up to ₹10,000 - IPD – Covered up to Sum Insured	- OPD Limit Up to ₹15,000 - IPD – Covered up to Sum Insured
		- Covered After Waiting Period of 24 months for IPD, No Waiting period for OPD		
	Preventive Care	Available	Available	Available
		- Dexa Scan - Covered up to ₹2500, once in the block of 4 consecutive Policy year (Applicable for Insured 50 years & above.) - HPV vaccination - Covered up to ₹2000, once in lifetime of the Policy.		
Value Added Services	Wellness Benefits (VAS and Wellness Reward Points)	Available	Available	Available
Optional Cover				
Critical Care	Critical Illness	₹ 5L, 10L	₹5L,10L, 15L, 20L	₹5L,10L, 15L, 20L
		- Covered After Waiting Period 90 Days & Survival period 7 Days. - Entry age -Min 18 Years & Max 65 Years. (Not applicable for child)		
	E- Medical Second Opinion	Available	Available	Available
Accident Care	Personal Accident Cover- (AD, PTD, PPD)	₹, 5L, 10L	₹5L,10L, 15L, 20L	₹5L,10L, 15L, 20L
		- Entry age - Adult Min 18 Years & Max 65 Years. Child Min 3 Years & Max 25 Years.		
Voluntary Co-payment	Co-pay applicable on each admissible claim Option to choose co-payment - 10% or 20% or 30%	√	√	√
Waiting Period				
Initial Waiting Period		30 Days	30 Days	30 Days
Specific Waiting Period		24 Months and 36 Months	24 Months and 36 Months	24 Months and 36 Months
Pre-existing Waiting Period		36 Months	36 Months	36 Months

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Annexure II: Day Care List

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

I.	**Cardiology Related:**
1	Coronary Angiography
2	Insert Non - Tunnel Cv Cath
3	Insert Picc Cath (Peripherally Inserted Central Catheter)
4	Replace Picc Cath (Peripherally Inserted Central Catheter)
5	Insertion Catheter, Intra Anterior
6	Insertion Of Portacath
7	RF Ablation Heart
II.	**ENT Related:**
8	Myringotomy With Grommet Insertion
9	Tympanoplasty (closure Of An Eardrum Perforation reconstruction Of The Auditory Ossicles)
10	Removal Of A Tympanic Drain
11	Operations On The Turbinates (nasal Concha)
12	Stapedotomy To Treat Various Lesions In Middle Ear
13	Revision Of A Stapedectomy
14	Other Operations On The Auditory Ossicles
15	Myringoplasty (post-aura/endaural Approach As Well As Simple Type-I Tympanoplasty)
16	Fenestration Of The Inner Ear
17	Revision Of A Fenestration Of The Inner Ear
18	Palatoplasty
19	Transoral Incision And Drainage Of A Pharyngeal Abscess
20	Tonsillectomy Without Adenoidectomy
21	Tonsillectomy With Adenoidectomy
22	Excision And Destruction Of A Lingual Tonsil
23	Revision Of A Tympanoplasty
24	Other Microsurgical Operations On The Middle Ear
25	Incision Of The Mastoid Process And Middle Ear
26	Mastoidectomy
27	Reconstruction Of The Middle Ear
28	Other Excisions Of The Middle And Inner Ear
29	Other Operations On The Middle And Inner Ear
30	Excision And Destruction Of Diseased Tissue Of The Nose
31	Nasal Sinus Aspiration
32	Foreign Body Removal From Nose
33	Adenoidectomy
34	Stapedectomy Under GA
35	Stapedectomy Under LA
36	Tympanoplasty (type IV)
37	Turbinectomy
38	Endoscopic Stapedectomy
39	Incision And Drainage Of Perichondritis

40	Septoplasty
41	Thyroplasty Type I
42	Pseudocyst Of The Pinna – Excision
43	Incision And Drainage - Haematoma Auricle
44	Reduction Of Fracture Of Nasal Bone
45	Excision Of Angioma Septum
46	Turbinoplasty
47	Incision & Drainage Of Retro Pharyngeal Abscess
48	Uvulo Palato Pharyngo Plasty
49	Adenoidectomy With Grommet Insertion
50	Adenoidectomy Without Grommet Insertion
51	Incision & Drainage Of Para Pharyngeal Abscess
52	Operations On The Turbinates (nasal Concha)
53	Removal Of Keratosis Obturans
54	Stapedotomy To Treat Various Lesions In Middle Ear
55	Other Operations On The Tonsils And Adenoids
56	Labyrinthectomy For Severe Vertigo
57	Endolymphatic Sac Surgery For Meniere's Disease
58	Vestibular Nerve Section
59	Thyroplasty (Type II)
60	Tracheostomy
61	Turbinoplasty
62	Vocal Cord Lateralisation Procedure
63	Tracheoplasty
III.	**Gastroenterology Related:**
64	Pancreatic Pseudocyst Eus & Drainage
65	RF Ablation For Barrett's Oesophagus
66	EUS + Aspiration Pancreatic Cyst
67	Small Bowel Endoscopy (therapeutic)
68	Colonoscopy, Lesion Removal
69	ERCP
70	Colonscopy Stenting Of Stricture
71	Percutaneous Endoscopic Gastrostomy
72	EUS And Pancreatic Pseudo Cyst Drainage
73	ERCP And Choledochoscopy
74	Proctosigmoidoscopy Volvulus Detorsion
75	ERCP And Sphincterotomy
76	Esophageal Stent Placement
77	ERCP + Placement Of Biliary Stents
78	Sigmoidoscopy W / Stent
79	EUS + Coeliac Node Biopsy
80	Cholecystectomy
81	Choledocho-jejunostomy
82	Duodenostomy
83	Gastrostomy
84	Exploration Common Bile Duct

85	Duodenoscopy with Polypectomy
86	Diathery Of Bleeding Lesions
87	Construction Of Gastrostomy Tube
88	UGI Scopy And Injection Of Adrenaline, Sclerosants Bleeding Ulcers
89	Surgical Treatment Of A Varicocele And A Hydrocele Of the Spermatic Cord
90	Laparotomy For Grading Lymphoma With Splenectomy.
91	Laparotomy For Grading Lymphoma with Liver Biopsy
92	Laparotomy For Grading Lymphoma with Lymph Node Biopsy
93	Therapeutic Laparoscopy With Laser
94	Appendicectomy With Drainage
95	Appendicectomy without Drainage
96	Colonoscopy
IV.	**General Surgery Related:**
97	Incision Of A Pilonidal Sinus / Abscess
98	Fissure In Ano Sphincterotomy
99	Piles Banding
100	Surgery for Hernia
101	Surgical Treatment Of Anal Fistulas
102	Division Of The Anal Sphincter (sphincterotomy)
103	Epididymectomy
104	Incision Of The Breast Abscess
105	Operations On The Nipple
106	Excision Of Single Breast Lump
107	Incision And Excision Of Tissue In The Perianal Region
108	Surgical Treatment Of Hemorrhoids
109	Sclerotherapy
110	Wound Debridement And Cover
111	Abscess-decompression
112	Infected Sebaceous Cyst
113	Incision And Drainage Of Abscess
114	Suturing Of Lacerations
115	Scalp Suturing
116	Infected Lipoma Excision
117	Maximal Anal Dilatation
118	Piles Injection Sclerotherapy
119	Liver Abscess- Catheter Drainage
120	Fissure In Ano- Fissurectomy
121	Fibroadenoma Breast Excision
122	Oesophageal Varices Sclerotherapy
123	ERCP - Pancreatic Duct Stone Removal
124	Perianal Abscess I & D
125	Perianal Hematoma Evacuation
126	UGI Scopy And Polypectomy Oesophagus
127	Breast Abscess I & D
128	Oesophagoscopy And Biopsy Of Growth Oesophagus
129	ERCP - Bile Duct Stone Removal

130	Splenic Abscesses Laparoscopic Drainage
131	UGI Scopy And Polypectomy Stomach
132	Feeding Jejunostomy
133	Varicose Veins Legs - Injection Sclerotherapy
134	Pancreatic Pseudocysts Endoscopic Drainage
135	Zadek's Nail Bed Excision
136	Rigid Oesophagoscopy For Dilation Of Benign Strictures
137	Lord's Plication
138	Jaboulay's Procedure
139	Scrotoplasty
140	Circumcision For Trauma
141	Meatoplasty
142	Intersphincteric Abscess Incision And Drainage
143	PSOAS Abscess Incision And Drainage
144	Thyroid Abscess Incision And Drainage
145	Tips Procedure For Portal Hypertension
146	Esophageal Growth Stent
147	Pair Procedure Of Hydatid Cyst Liver
148	Tru Cut Liver Biopsy
149	Laparoscopic Reduction Of Intussusception
150	Microdochectomy Breast
151	Sentinel Node Biopsy
152	Testicular Biopsy
153	Sentinel Node Biopsy Malignant Melanoma
154	TURBT
155	URS + LL
156	Suturing Lacerated Lip
157	Suturing Oral Mucosa
158	Oral Biopsy In Case Of Abnormal Tissue Presentation
159	Abdominal Exploration In Cryptorchidism
160	Ultrasound Guided Aspirations
161	Infected Keloid Excision
162	Axillary Lymphadenectomy
163	Cervical Lymphadenectomy
164	Ileostomy Closure
165	Polypectomy Colon
166	Rigid Oesophagoscopy For Fb Removal
167	Colostomy
168	Ileostomy
169	Colostomy Closure
170	Submandibular Salivary Duct Stone Removal
171	Pneumatic Reduction Of Intussusception
172	Rigid Oesophagoscopy For Plummer Vinson Syndrome
173	Subcutaneous Mastectomy
174	Excision Of Ranula Under GA
175	Eversion Of Sac Unilateral/Bilateral

176	Photodynamic Therapy Or Esophageal Tumour And Lung Tumour
177	Excision Of Cervical Rib
178	Surgery For Fracture Penis
179	Parastomal Hernia
180	Revision Colostomy
181	Prolapsed Colostomy- Correction
182	Laparoscopic Cardiomyotomy(Hellers)
183	Laparoscopic Pyloromyotomy(Ramstedt)
184	Eua + Biopsy Multiple Fistula In Ano
185	Construction Skin Pedicle Flap
186	Gluteal Pressure Ulcer-excision
187	Muscle-skin Graft, Leg
188	Removal Of Bone For Graft
189	Muscle-skin Graft Duct Fistula
190	Removal Cartilage Graft
191	Myocutaneous Flap
192	Fibro Myocutaneous Flap
193	Breast Reconstruction Surgery After Mastectomy
194	Sling Operation For Facial Palsy
195	Split Skin Grafting Under RA
196	Wolfe Skin Graft
197	External Incision And Drainage In The Region Of The Mouth.
198	External Incision And Drainage in the Region Of the Jaw.
199	External Incision And Drainage in the Region Of the Face.
200	Incision Of The Hard And Soft Palate
201	Excision And Destruction Of Diseased Hard Palate
202	Excision And Destruction of Diseased Soft Palate
203	Incision, Excision And Destruction In The Mouth
204	Other Operations In The Mouth
205	Removal of Foreign Body
V.	**Gynecology Related:**
206	Conization Of The Uterine Cervix
207	Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas
208	Incision Of Vulva
209	Salpingo-oophorectomy Via Laparotomy
210	Endoscopic Polypectomy
211	Hysteroscopic Removal Of Myoma
212	D & C
213	Hysteroscopic Resection Of Septum
214	Thermal Cauterisation Of Cervix
215	Mirena Insertion
216	Laparoscopic Hysterectomy
217	LEEP (Loop Electrosurgical Excision Procedure)
218	Cryocauterisation Of Cervix
219	Polypectomy Endometrium
220	Hysteroscopic Resection Of Fibroid

221	LLETZ (large loop excision of the transformation zone)
222	Conization
223	Polypectomy Cervix
224	Hysteroscopic Resection Of Endometrial Polyp
225	Vulval Wart Excision
226	Laparoscopic Paraovarian Cyst Excision
227	Uterine Artery Embolization
228	Laparoscopic Cystectomy
229	Hymenectomy (Imperforate Hymen)
230	Vaginal Wall Cyst Excision
231	Vulval Cyst Excision
232	Laparoscopic Paratubal Cyst Excision
233	Vaginal Mesh For POP
234	Laparoscopic Myomectomy
235	Repair Recto- Vagina Fistula
236	Pelvic Floor Repair (Excluding Fistula Repair)
237	Laparoscopic Oophorectomy
238	Operations On Bartholin's Glands (cyst)
239	Leep (Loop electrosurgical excision procedure)
240	Lletz (large loop excision of the transformation zone)
241	Vulval Cyst Excision
242	Ureterocoele Repair - Congenital Internal
243	Laparoscopic Myomectomy
244	Surgery For Sui (stress incontinence - "sling" surgery)
245	Repair Recto- Vagina Fistula
VI.	**Neurology Related:**
246	Facial Nerve Glycerol Rhizotomy
247	Stereotactic Radiosurgery
248	Percutaneous Cordotomy
249	Diagnostic Cerebral Angiography
250	VP Shunt
251	Ventriculoatrial Shunt
252	Spinal Cord Stimulation
253	Motor Cortex Stimulation
254	Intrathecal Baclofen Therapy
255	Entrapment Neuropathy Release
VII.	**Oncology Related:**
256	Radiotherapy For Cancer
257	Cancer Chemotherapy
258	IV Push Chemotherapy
259	HBI-hemibody Radiotherapy
260	Infusional Targeted Therapy
261	SRT-stereotactic ARC Therapy
262	SC Administration Of Growth Factors
263	Continuous Infusional Chemotherapy
264	Infusional Chemotherapy

265	CCRT-concurrent Chemo + RT
266	2D Radiotherapy
267	3D Conformal Radiotherapy
268	IGRT- Image Guided Radiotherapy
269	IMRT- Step & Shoot
270	Infusional Bisphosphonates
271	IMRT- DMLC
272	Rotational Arc Therapy
273	Tele Gamma Therapy
274	FSRT-fractionated SRT
275	VMAT-volumetric Modulated Arc Therapy
276	SBRT-stereotactic Body Radiotherapy
277	Helical Tomotherapy
278	SRS-stereotactic Radiosurgery
279	X-knife SRS
280	Gammaknife SRS
281	TBI- Total Body Radiotherapy
282	Intraluminal Brachytherapy
283	Electron Therapy
284	TSET-total Electron Skin Therapy
285	Extracorporeal Irradiation Of Blood Products
286	Telecobalt Therapy
287	Telecesium Therapy
288	External Mould Brachytherapy
289	Interstitial Brachytherapy
290	Intracavity Brachytherapy
291	3D Brachytherapy
292	Implant Brachytherapy
293	Intravesical Brachytherapy
294	Adjuvant Radiotherapy
295	Afterloading Catheter Brachytherapy
296	Conditioning Radiothearpy For BMT
297	Nerve Biopsy
298	Muscle Biopsy
299	Epidural Steroid Injection
300	Extracorporeal Irradiation To The Homologous Bone Grafts
301	Radical Chemotherapy
302	Neoadjuvant Radiotherapy
303	LDR Brachytherapy
304	Palliative Radiotherapy
305	Radical Radiotherapy
306	Palliative Chemotherapy
307	Template Brachytherapy
308	Neoadjuvant Chemotherapy
309	Adjuvant Chemotherapy
310	Induction Chemotherapy

311	Consolidation Chemotherapy
312	Maintenance Chemotherapy
313	HDR Brachytherapy
VIII.	**Operations On The Salivary Glands & Salivary Ducts:**
314	Incision And Lancing Of A Salivary Gland And A Salivary Duct
315	Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct
316	Resection Of A Salivary Gland
317	Reconstruction Of A Salivary Gland And A Salivary Duct
IX.	**Operations On The Skin & Subcutaneous Tissues:**
318	Surgical Wound Toilet (wound Debridement) And Removal Of Diseased Tissue Of The Skin And Subcutaneous Tissues
319	Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues
320	Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues
321	Free Skin Transplantation, Donor Site
322	Free Skin Transplantation, Recipient Site
323	Revision Of Skin Plasty
324	Chemosurgery To The Skin.
325	Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues
326	Reconstruction Of Deformity/defect In Nail Bed
327	Excision Of Bursirtis
328	Tennis Elbow Release
329	Other Incisions Of The Skin And Subcutaneous Tissues
330	Keratosis Removal Under Ga
X.	**Operations On The Tongue:**
331	Incision, Excision And Destruction Of Diseased Tissue Of The Tongue
332	Partial Glossectomy
333	Glossectomy
334	Reconstruction Of The Tongue
335	Other Operations On The Tongue
XI.	**Ophthalmology Related**
336	Surgery For Cataract
337	Incision Of Tear Glands
338	Incision Of Diseased Eyelids
339	Excision And Destruction Of Diseased Tissue Of The Eyelid
340	Operations On The Canthus And Epicanthus
341	Corrective Surgery For Entropion And Ectropion
342	Corrective Surgery For Blepharoptosis
343	Removal Of A Foreign Body From The Conjunctiva
344	Removal Of A Foreign Body From The Cornea
345	Incision Of The Cornea
346	Operations For Pterygium
347	Removal Of A Foreign Body From The Lens Of The Eye
348	Removal Of A Foreign Body From The Posterior Chamber Of The Eye
349	Removal Of A Foreign Body From The Orbit And Eyeball
350	Correction Of Eyelid Ptosis By Levator Palpebrae Superioris Resection (bilateral)
351	Correction Of Eyelid Ptosis By Fascia Lata Graft (bilateral)

352	Diathermy/cryotherapy To Treat Retinal Tear
353	Anterior Chamber Paracentesis/ Cyclodiathermy/ Cyclocryotherapy/ Goniotomy Trabeculotomy And Filtering And Allied Operations To Treat Glaucoma
354	Enucleation Of Eye Without Implant
355	Dacryocystorhinostomy For Various Lesions Of Lacrimal Gland
356	Laser Photocoagulation To Treat Retinal Tear
357	Biopsy Of Tear Gland
358	Treatment Of Retinal Lesion
359	Chalazion Surgery
XII.	**Orthopedics Related:**
360	Incision On Bone, Septic And Aseptic
361	Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
362	Suture And Other Operations On Tendons And Tendon Sheath
363	Reduction Of Dislocation Under GA
364	Arthroscopic Knee Aspiration
365	Surgery For Ligament Tear
366	Surgery For Hemoarthrosis/pyoarthrosis
367	Removal Of Fracture Pins/nails
368	Removal Of Metal Wire
369	Closed Reduction On Fracture, Luxation
370	Reduction Of Dislocation Under GA
371	Epiphyseolysis With Osteosynthesis
372	Excision Of Various Lesions In Coccyx
373	Arthroscopic Repair Of Acl Tear Knee
374	Closed Reduction Of Minor Fractures
375	Arthroscopic Repair Of PCL Tear Knee
376	Tendon Shortening
377	Arthroscopic Meniscectomy - Knee
378	Treatment Of Clavicle Dislocation
379	Haemarthrosis Knee- Lavage
380	Abscess Knee Joint Drainage
381	Carpal Tunnel Release
382	Closed Reduction Of Minor Dislocation
383	Repair Of Knee Cap Tendon
384	ORIF With K Wire Fixation- Small Bones
385	Release Of Midfoot Joint
386	ORIF With Plating- Small Long Bones
387	Implant Removal Minor
388	K Wire Removal
389	Closed Reduction And External Fixation
390	Arthrotomy Hip Joint
391	Syme's Amputation
392	Arthroplasty
393	Partial Removal Of Rib
394	Treatment Of Sesamoid Bone Fracture
395	Shoulder Arthroscopy / Surgery

396	Elbow Arthroscopy
397	Amputation Of Metacarpal Bone
398	Release Of Thumb Contracture
399	Incision Of Foot Fascia
400	Partial Removal Of Metatarsal
401	Repair / Graft Of Foot Tendon
402	Amputation Follow-up Surgery
403	Exploration Of Ankle Joint
404	Remove/graft Leg Bone Lesion
405	Repair/graft Achilles Tendon
406	Remove Of Tissue Expander
407	Biopsy Elbow Joint Lining
408	Removal Of Wrist Prosthesis
409	Biopsy Finger Joint Lining
410	Tendon Lengthening
411	Treatment Of Shoulder Dislocation
412	Lengthening Of Hand Tendon
413	Removal Of Elbow Bursa
414	Fixation Of Knee Joint
415	Treatment Of Foot Dislocation
416	Surgery Of Bunion
417	Tendon Transfer Procedure
418	Removal Of Knee Cap Bursa
419	Treatment Of Fracture Of Ulna
420	Treatment Of Scapula Fracture
421	Removal Of Tumor Of Arm/ Elbow Under RA/GA
422	Repair Of Ruptured Tendon
423	Decompress Forearm Space
424	Revision Of Neck Muscle (torticollis Release)
425	Lengthening Of Thigh Tendons
426	Treatment Fracture Of Radius & Ulna
427	Surgery For Meniscus Tear
428	Repair Of Knee Joint
XIII.	**Other Operations On The Mouth & Face:**
429	External Incision And Drainage In The Region Of The Mouth, Jaw And Face
430	Incision Of The Hard And Soft Palate
431	Excision And Destruction Of Diseased Hard And Soft Palate
XIV.	**Pediatric Surgery Related:**
432	Excision Of Fistula-in-ano
433	Excision Juvenile Polyps Rectum
434	Vaginoplasty
435	Dilatation Of Accidental Caustic Stricture Oesophageal
436	Presacral Teratomas Excision
437	Removal Of Vesical Stone
438	Excision Sigmoid Polyp
439	Sternomastoid Tenotomy

440	Infantile Hypertrophic Pyloric Stenosis Pyloromyotomy
441	Excision Of Soft Tissue Rhabdomyosarcoma
442	Mediastinal Lymph Node Biopsy
443	High Orchidectomy For Testis Tumours
444	Excision Of Cervical Teratoma
445	Rectal-myomectomy
446	Rectal Prolapse (delorme's Procedure)
447	Detorsion Of Torsion Testis
448	Infantile Hypertrophic Pyloric Stenosis Pyloromyotomy
XV.	**Thoracic Surgery Related:**
449	Thoracoscopy And Lung Biopsy
450	Excision Of Cervical Sympathetic Chain Thoracoscopic
451	Laser Ablation Of Barrett's Oesophagus
452	Pleurodesis
453	Thoracoscopy And Pleural Biopsy
454	EBUS + Biopsy
455	Thoracoscopy Ligation Thoracic Duct
456	Thoracoscopy Assisted Empyema Drainage
457	Thoracoscopy And Lung Biopsy
XVI.	**Urology Related:**
458	Haemodialysis
459	Lithotripsy/nephrolithotomy For Renal Calculus
460	Excision Of Renal Cyst
461	Drainage Of Pyonephrosis/perinephric Abscess
462	Incision Of The Prostate
463	Transurethral Excision And Destruction Of Prostate Tissue
464	Transurethral And Percutaneous Destruction Of Prostate Tissue
465	Open Surgical Excision And Destruction Of Prostate Tissue
466	Operations On The Seminal Vesicles
467	Other Operations On The Prostate
468	Incision Of The Scrotum And Tunica Vaginalis Testis
469	Operation On A Testicular Hydrocele
470	Other Operations On The Scrotum And Tunica Vaginalis Testis
471	Incision Of The Testes
472	Excision And Destruction Of Diseased Tissue Of The Testes
473	Unilateral Orchidectomy
474	Bilateral Orchidectomy
475	Surgical Repositioning Of An Abdominal Testis
476	Reconstruction Of The Testis
477	Other Operations On The Testis
478	Excision In The Area Of The Epididymis
479	Operations On The Foreskin
480	Local Excision And Destruction Of Diseased Tissue Of The Penis
481	Other Operations On The Penis
482	Cystoscopical Removal Of Stones
483	Lithotripsy

484	Biopsy Oftemporal Artery For Various Lesions
485	External Arterio-venous Shunt
486	AV Fistula – Wrist
487	URSL With Stenting
488	URSL With Lithotripsy
489	Cystoscopic Litholapaxy
490	ESWL
491	Cystoscopy & Biopsy
492	Cystoscopy And Removal Of Polyp
493	Suprapubic Cystostomy
494	Percutaneous Nephrostomy
495	Cystoscopy And "SLING" Procedure
496	TUNA- Prostate
497	Excision Of Urethral Diverticulum
498	Excision Of Urethral Prolapse
499	Mega-ureter Reconstruction
500	Kidney Renoscopy And Biopsy
501	Ureter Endoscopy And Treatment
502	Surgery For Pelvi Ureteric Junction Obstruction
503	Anderson Hynes Operation
504	Kidney Endoscopy And Biopsy
505	Paraphimosis Surgery
506	Surgery For Stress Urinary Incontinence
507	Injury Prepuce- Circumcision
508	Frenular Tear Repair
509	Meatotomy For Meatal Stenosis
510	Surgery For Fournier's Gangrene Scrotum
511	Surgery Filarial Scrotum
512	Surgery For Watering Can Perineum
513	Repair Of Penile Torsion
514	Drainage Of Prostate Abscess
515	Orchiectomy
516	Radical Prostatovesiculectomy
517	Incision And Excision Of Periprostatic Tissue
518	Bladder Neck Incision
519	Removal Of Urethral Stone
520	Cystoscopy And Removal Of Fb
521	Renal Angiography
522	Peripheral Angiography
523	Percutaneous nephrolithotomy (PCNL)
524	Laryngoscopy Direct Operative with Biopsy
525	RF Ablation Varicose Veins
526	RF Ablation Uterus
527	Amputation Of The Penis
528	Implantation, Exchange And Removal Of A Testicular Prosthesis
529	Excision And Destruction Of Diseased Scrotal Tissue

530	Orchidopexy

Annexure III

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

S. No.	Item
1.	BABY FOOD
2.	BABY UTILITES CHARGES
3.	BEAUTY SERVICES
4.	BELTS/ BRACES
5.	BUDS
6.	COLD PACK/HOT PACK
7.	CARRY BAGS
8.	EMAIL / INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVENYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING

41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG/ SHORT/ HINGED)
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53.	SUGAR FREE TABLETS
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	VASOFIX SAFETY

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

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

14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP
19.	DISINFECTANT LOTIONS
20.	LUXURY TAX
21.	HVAC
22.	HOUSE KEEPING CHARGES
23.	AIR CONDITIONER CHARGES
24.	IM IV INJECTION CHARGES
25.	CLEAN SHEET
26.	BLANKET/WARMER BLANKET
27.	ADMISSION KIT
28.	DIABETIC CHART CHARGES
29.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30.	DISCHARGE PROCEDURE CHARGES
31.	DAILY CHART CHARGES
32.	ENTRANCE PASS / VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES
35.	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36.	PATIENT IDENTIFICATION BAND / NAME TAG
37.	PULSEOXYMETER CHARGES

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

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

19.	COTTON BANDAGE
20.	SURGICAL TAPE
21.	APRON
22.	TORNIQUET
23.	ORTHOBUNDLE, GYNAEC BUNDLE

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

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

In case of any claims, contact:

Claims Department
Future Generali Health (FGH)
Future Generali India Insurance Co. Ltd.
Office No. 3, 3rd Floor, "A" Building, G - O - Square
S. No. 249 & 250, Aundh Hinjewadi Link Road, Wakad, Pune - 411 057.
Toll Free Number: 1800 103 8889
Toll Free Fax: 1800 103 9998 Email: fgh@futuregenerali.in

ISO No: FGH/UW/RET/300/02

Future Generali India Insurance Company Limited. IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287. Regd. and Corp. Office: 801 and 802, 8th floor, Tower C, Embassy 247 Park, L.B.S. Marg, Vikhroli (W), Mumbai – 400083. Call us at: 1800-220-233 / 1860-500-3333 / 022-67837800 | Fax No: 022 4097 6900 | Website: https://general.futuregenerali.in | Email: fgcare@futuregenerali.in. Trade Logo displayed above belongs to M/S Assicurazioni Generali - Societa Per Azioni and used by Future Generali India Insurance Co Ltd. under License.

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Grievance Redressal Procedures

Dear Customer,

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

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

What is a Grievance?

"Complaint" or "Grievance" means expression (includes communication in the form of electronic mail or other electronic scripts, Inbound Call, SMS, Letter), of dissatisfaction by a complainant with insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities.

- Explanation: An inquiry/ query or request does not fall within the definition of the 'complaint' or 'grievance'.

- Complainant' means a policyholder or prospect or any beneficiary of an insurance policy who has filed a complaint or grievance against an insurer or a distribution channel.

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

Helpline	Website	Email	Branch GRO	Complaint form
Call us on 1800 220 233/ 1860 500 3333/ 022-67837800	**Click here** to know more	Write to us at fgcare@futuregenerali.in	**Click here** to know your nearest branch.	**Click here** to raise a complaint

By when will my grievance be resolved?

- You will receive grievance acknowledgement from us within 3 business days for your complaint.
- Final resolution will be shared with you within 2 weeks of receiving your complaint.
- Your complaint will be considered as closed if we do not receive any reply from you within 8 weeks from the date of receipt of response.

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

- You may write to our Grievance Redressal Office at fggro@futuregenerali.in
- You may send a physical letter to our Grievance Redressal Cell, Head Office at the below address-

Future Generali India Insurance Company Ltd.
Lodha I – Think Techno Campus, B Wing – 2nd Floor, Pokhran Road – 2,
Off Eastern Express Highway Behind TCS, Thane West – 400607

What if I am not able to register my grievance?

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

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

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

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

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

Insurance Ombudsman:

If you are still dissatisfied with the resolution provided, you may opt to approach the Office of the Insurance Ombudsman, provided the same is under their purview.
Click here to know the guidelines for taking up a complaint with the Insurance Ombudsman.

In case you wish to send your complaint to the Insurance Ombudsman.
Click here to access the list of insurance ombudsman offices.