FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

D.I.Y HEALTH

POLICY WORDINGS

1 PREAMBLE

This Policy has been issued to You based on the information disclosed by you in Your Proposal to Us, the Disclosure to Information Norm which forms part of the Policy and on receipt of the Policy premium by Us.

This Policy covers Insured Persons aged between 1 day to 65 years and may continue to be renewed Lifelong**.**

This Policy document records the agreement between You and Us and sets out the terms, conditions, and exclusions applicable under this Policy as well as the obligations of You, Us, the Insured Persons, and claimants.

2 DEFINITIONS

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

2.1 STANDARD DEFINITIONS

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

2.1.2 **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.

2.1.3 **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health center 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:

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

2.1.4 **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.

2.1.5 **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.

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

2.1.7 **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.

2.1.8 **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.

2.1.9 **Critical Illness means the following disease / Illness:**

1. <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;

2. <u>Myocardial Infarction (First Heart Attack of Specified Severity)</u>

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.

3. Open Chest CABG

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

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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*;

12. <u>Kidney Failure Requiring Regular Dialysis</u>

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.

13. <u>End Stage Lung Failure</u>

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.

14. <u>End Stage Liver Failure</u>

I. Permanent and irreversible 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.

15. 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

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. Angioplasty

II. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50% of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

III. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

IV. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

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

2.1.11 **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner and must comply with all minimum criterion as under:

a) has qualified nursing staff under its employment;
b) has qualified medical practitioner(s) in charge;
c) has fully equipped operation theatre of its own where surgical procedures are carried out;
d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

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

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

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

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

Note: - Deductible shall apply on aggregate on all the admissible claims under the policy including claims related to any one illness.

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

2.1.15 **Disclosure to Information Norm:** 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.

2.1.16 **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

a) The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
b) The patient takes treatment at home on account of non- availability of room in a hospital.

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

2.1.18 **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 instalments during the policy period.

2.1.19 **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:

a) has qualified nursing staff under its employment round the clock;
b) 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;
c) has qualified medical practitioner(s) in charge round the clock;
d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

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

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

a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

(i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests.
(ii) it needs ongoing or long-term control or relief of symptoms.
(iii) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
(iv) it continues indefinitely.
(v) it recurs or is likely to recur.

2.1.22 **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.

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

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

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

2.1.26 **Maternity Expenses**

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.

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

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

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

2.1.30 **Medically Necessary Treatment** means any treatment, test, medication, or stay in hospital or part of stay in hospital which:

a) is required for the medical management of the illness or injury suffered by the insured;
b) must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity;
c) must have been prescribed by a medical practitioner;
d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.1.31 **Migration** means, the right accorded to health insurance policyholders (including all members under family

cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

2.1.32 **Network Provider** 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.

2.1.33 **Newborn Baby** means baby born during the Policy Period and is aged up to 90 days.

2.1.34 **Non-Network Provider** means any Hospital, day care center or other provider that is not part of the network.

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

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

2.1.37 **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.

2.1.38 **Pre-Existing Disease** means any condition, ailment or injury or disease:

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

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

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b) The In-Patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.1.40 **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:

a) Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required, and
b) The In-patient Hospitalization claim for such Hospitalization is admissible by the insurance company.

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

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

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

2.1.44 **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall

include associated medical expenses.

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

2.1.46 **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.

2.2 SPECIFIC DEFINITIONS

2.2.1 **Accidental Death** means death due to Accident.

2.2.2 **AIDS** means Acquired Immune Deficiency Syndrome, a condition characterized by a combination of signs and symptoms, caused by Human Immunodeficiency Virus, which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions, as may be specified from time to time.

2.2.3 [1]**Alternative Treatment/Ayush Treatment** refers to the medical and / or Hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy systems.

2.2.4 **Associate Medical Expenses** means all admissible Hospitalization Medical Expenses as mentioned under 3.1.1 with the below exceptions:

a) Cost of Pharmacy and Consumables
b) Cost of Implants and Medical Devices
c) Cost of Diagnostics

2.2.5 **Authority** means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of the IRDA Act 1999.

2.2.6 **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.

2.2.7 **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.

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

2.2.9 **Dependent Spouse** means Your legally married spouse as long as he/she continues to be married to You.

2.2.10 **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.

[1] Definition of Alternative Treatment modified to include "Yoga and Naturopathy" in accordance to AYUSH treatment

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

- To avoid jeopardy to the life or
- Serious damage to the health of an Insured Person.

2.2.12 **Family** means the Primary Insured /Proposer's legally wedded spouse / Live in partner, natural or legally adopted child/children, parents and parents in law, siblings, daughter in law, son in law, grandparents, and grandchildren whose name is mentioned in the Policy schedule as an Insured Member.

2.2.13 **Family Floater** means a Policy described as such in the Schedule where You and 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. Deductible under Family Floater will be applicable on aggregate basis for all the admissible claims made by all insured persons under the policy including claims related to any one illness.

2.2.14 **Gender reassignment surgery (GRS)** refers to all surgical procedures that a patient wishes to undergo to become like the opposite gender.

2.2.15 **HIV** means Human Immunodeficiency Virus

2.2.16 **Insured Person/ Insured** means a person named in the Schedule who is covered under this Policy, for whom the insurance is proposed and in respect of whom the applicable premium has been received in full.

2.2.17 **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.

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

2.2.19 **LGBT** will mean and include a sexual orientation / gender expression as defined below

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

2.2.20 **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands

of life, mental conditions 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.

2.2.21 **Medical practitioner** for mental illnesses 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;

2.2.22 **Mental Health Establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends;

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

2.2.24 **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.

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

2.2.26 **Policy Period** means the period commencing from the start date mentioned in the Schedule till the end date mentioned in the Schedule.

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

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

2.2.29 **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.

2.2.30 **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.

2.2.31 **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.

2.2.32 **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).

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

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

Please note:

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

3 SCOPE OF COVER

This Policy constitutes two types of covers under its scope – Basic Cover and Optional Cover. This Policy covers the Reasonable and Customary Charges incurred towards the medical treatment taken by the Insured Person following an Illness or Injury that occurs during the Policy Period, subject to the availability of the Sum Insured, any sub-limits specified in the Policy Schedule and the terms, conditions and exclusions specified in this Policy Wording.

3.1 BASIC COVER

The benefits available under the Basic Cover are in-built into the product. The Policy Schedule will specify the benefit details along with your chosen cover option / sublimit, which shall be in force for the Insured Persons during the Policy Period.
The benefits available under the Basic Cover in this Policy are listed below.

3.1.1 Medical Expenses

a) **In-Patient Hospitalization**

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

(i) Room Rent for accommodation in Hospital room and other boarding charges, up to an amount per day as specified in the Policy Schedule.
(ii) ICU charges, up to an amount per day as specified in the Policy Schedule
(iii) Operation theatre charges;
(iv) Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists, and anaesthetists;
(v) Qualified Nurse 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;
Prosthetic and other devices recommended by the attending Medical Practitioner that are implanted internally during a Surgical Procedure.

b) **Day Care Treatment Expenses**

We will pay the Reasonable and Customary Charges as specified in the Policy Schedule incurred towards Medically Necessary Treatment required by the Insured Person towards Day Care Treatments following an Illness or Injury that occurs during the Policy Year. The list of such Day Care Treatments is specified in Annexure I 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 refractory errors, up to an amount as specified in the Policy Schedule, provided that:

1) The refractive error is more than or equal to +7.5 diopters.
2) It shall be covered only once during the entire tenure of policy with Us.

(ii) Cataract Surgery – We will cover the expenses in respect of Cataract Surgery up to an amount equivalent to 20% of the Sum Insured subject to a maximum of ₹ 1 Lac.

3.1.2 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 in the policy schedule provided that we have accepted a claim for Hospitalization under Section 3.1.1 (Medical Expenses).

3.1.3 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 in the policy schedule provided that We have accepted a claim for hospitalization under Section 3.1.1 (Medical Expenses).

3.1.4 Organ Donor Expenses

We will pay the Reasonable and Customary Charges up to the Sum Insured incurred for an organ donor's treatment for the harvesting of the organ donated provided that:

a) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act, 1994
b) The organ donated is for the use of the Insured Person;
c) We have accepted claim under Section 3.1.1.a (In patient Hospitalization) for the Insured Person
d) The Insured Person has been Medically Advised to undergo an organ transplant;

Following shall not be covered under this benefit –

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

3.1.5 Mental / Psychiatric Conditions

We will pay the Reasonable and Customary charges up to the Sum Insured as specified in the Policy Schedule, if Insured Person is hospitalized for any Mental Illness contracted during the Policy period in accordance with The Mental Health Care Act, 2017, subsequent amendments and other applicable laws and Rules Provided that;

i. The Hospitalization is prescribed by a Medical Practitioner for Mental Illness

ii. Treatment is taken by Insured Person in Mental Health Establishment

What is not covered:

- Treatment related to intentional self-inflicted Injury or attempted suicide by any means.
- Treatment and complications related to disorders of intoxication, dependence, abuse, and withdrawal caused by drugs and other substances such as alcohol, opioids, or nicotine.

3.1.6 HIV/AIDS Cover

We will pay the Reasonable and Customary charges up to the Sum Insured as specified in the Policy Schedule, if the Insured Person is hospitalized in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 and amendments thereafter.

i. Medical Expenses which are arise from or are in way related to Human Immunodeficiency Virus (HIV) and/ or HIV related illness and including Acquired Immune Deficiency Syndrome (AIDS) being maintained throughout or AIDS Related Complex (ARC) and/or any mutant the period, derivative or variations thereof.
ii. Medical Expenses as listed in 3.1.1.a (In patient Hospitalization)

We will pay expenses subject to below conditions:

- Any Expenses related to OPD treatment on HIV/AIDS shall be excluded.
- HIV /AIDS shall be examined and confirmed by Medical Practitioner.
- The first incidence of HIV/AIDS experienced by the insured during the Policy Period

3.1.7 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 D.I.Y Health Policy with Us), shall be restricted to 50% of the Sum Insured subject to a maximum of ₹ 5 Lac per policy Year.
b) The claim related to Bariatric Surgery shall be payable only for expenses related to the surgical treatment of obesity that fulfil below conditions:
   (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.

3.1.8 Cumulative Bonus

Cumulative Bonus (CB) shall be increased by 25% in respect of each claim free policy year where no claims are reported, with the exception of any claim under Section 3.1.10 (OPD treatment) and Section 3.1.12 (Wellness Benefits), section 3.1.14 (Screening and vaccination) provided the policy is renewed with Us without a break subject to maximum of 100% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has been accrued. However, Sum Insured will be maintained and will not be reduced in the policy year.

Notes:

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

3.1.9 Restoration of the Sum Insured

Under this benefit a Restore Sum Insured equal to 100% of the base Sum Insured excluding Cumulative Bonus and Cumulative Bonus Booster-if any, will automatically be available for the particular Policy year for a second claim being reported during the Policy Year and accepted as payable by Us.

The Restoration of Sum insured will be triggered irrespective of the Sum Insured and Cumulative Bonus and Cumulative Bonus Booster (if any) is completely or partially exhausted due to the claim incurred, and is subject to following conditions:

a) The Restore Sum Insured can be used for claims made for same illness/new illness in respect of Section 3.1.1 (Medical Expenses)
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 Restore Sum Insured cannot be used for claims based on Maternity Expenses.
d) The Restore Sum Insured will happen only once during a Policy Year.
e) If the Restore Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
f) If the Policy is issued on Individual basis, then the restore sum insured will be available to each Insured Person.
g) If the Policy is issued on a Floater basis, then the restore sum insured will be available on Floater basis for all Insured Persons in the family.

3.1.10 OPD Treatment

We will reimburse the Reasonable and Customary Charges, up to the limit as specified in the Policy Schedule, arising from Medical Expenses incurred towards OPD (outpatient) treatment of the Insured Person as specified below:

a) For Sum insured of 4 Lac: OPD treatment expenses incurred towards consultations, diagnostic tests and medications arising due to Mental/Psychiatric Illness only.
b) For Sum insured 5 Lac and above: OPD treatment expenses incurred towards consultations, diagnostic tests and medications arising due to any illness (Physical or Mental/Psychiatric) and Injury.

The Specific Conditions applicable to this benefit are:

a) Only Allopathic treatment will be covered under this Benefit.
b) In case of expenses towards Mental/Psychiatric illness, only the following would be considered -
   - Consultations with a Psychiatrist
   - Medications and diagnostics which have been prescribed by a Psychiatrist.
   - Counselling sessions with a Clinical Psychologist which have been prescribed by a Psychiatrist.
   - Upon complete exhaustion of the OPD Treatment Expenses limit, 100% reinstatement of the OPD limit will be done once during a policy year. This reinstated limit will be available for expenses incurred towards Mental/ Psychiatric illness only.
c) All expenses individually or in aggregate cannot exceed the OPD Treatment Expenses limit specified in the Policy Schedule.
d) Clause 4.2.13 Shall not apply to the extent of cover provided under this benefit.

3.1.11 Modern Treatment Methods and Advancement in Technologies

Our obligation to make payment in respect of the Medical Expenses incurred for the below listed treatments or procedures, as inpatient or as day care treatment (inclusive of pre and post hospitalization), is restricted to 50% of the sum insured opted maximum up to the amount specified in the Policy Schedule per Policy Year. These sub limits are applicable for all plans under the product.

We will cover medical expenses incurred on the following procedures:

a) Uterine Artery Embolization and HIFU
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 haematological conditions to be covered.

Provided that:

a) We have accepted the claim under Section 3.1.1.a (In Patient Hospitalization)
b) Our liability to make payment shall be restricted to 50% of the Sum Insured subject to a maximum of ₹ 5 Lac per policy year.

3.1.12 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.

All Insured Persons above 18 years are eligible to avail themselves of Wellness benefits. 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 Insured Person is eligible for availing the following benefits via the FGII mobile App: -

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

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

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

4) Vouchers (Fitness / Sports Memberships, Wellness centers, Diagnostic centers)

Under this benefit Insured Person will have access to discount vouchers as per partner tie-ups which can be utilized for aspects pertaining to a healthy lifestyle, diagnostics, medicines etc. The voucher details will be displayed on the FGII mobile App.

5) Health checkup

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

Plan	Tests
Mini	Complete Blood Count (CBC), Glycosylated Hemoglobin(HbA1C), Electrocardiogram (ECG reported by an MD Physician),Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index), Uric Acid, Total Protein, Pulmonary Function Test.
Medi	Complete Blood Count (CBC), Glycosylated Hemoglobin(HbA1C), Electrocardiogram (ECG reported by an MD Physician),Serum Creatinine, Low Density Lipoproteins(LDL), Serum Triglycerides, High Density Lipoproteins(HDL), Serum Cholesterol, Medical examination report including Blood Pressure and BMI(Body Mass Index), Serum Glutamic Oxaloacetic Transaminase(SGOT), Serum Glutamic Pyruvic Transaminase(SGPT), Serum Calcium, Uric Acid, Total Protein,

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

B. Wellness Rewards points

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

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 information on health and wellness training, health related applications etc.

4) Lifestyle disease monitor

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

	Condition	**Health parameters**	**Points Allotted**
1	Blood Pressure	Blood pressure Systolic Up to 140/ Diastolic up to 90 mm Hg	10

2	Glycosylated Hemoglobin	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) Enrollment 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 an 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 on the basis of 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 in, however the 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 the plan opted for.

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.	Enrollment to wellness	Once/year	15

	Total points		**200**

The points earned in a year will be equal to a 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 Sum Insured policy

Family Type – Individual	2 Adult+1 child		
Cover type	Basic cover - OPD -10 K , lasik 1 LAC , Waiting of 2 year		
Policy period	01-Jan-2023 to 31 Dec 2023		
Relation	Self	Spouse	Child
Sum insured (₹)	5L	5L	5L
Age Band	26-30	31-35	0-17
Individual premium (₹)	9,769	10,144	6,993
Family discounted premium (₹)	8,792	9,129	6,294
Points Earned	200	180	NA
% Value of points earned	5%	4%	0%
Monetary value of reward points (₹)	440	365	0

Detail breakup of reward point calculation (Earning and burning)

Date	**Self**			**Spouse**			**Total**		
	Points earned as on date	**% of earn point**	**Monetary value (₹)**	**Points earned as on date**	**%**	**Monetary value (₹)**	**Monetary value (₹)**	**Balance available for utilization (₹)**	**Burn/Utilised on date (OPD/ Pharmacy/ NME) (₹)**
21-03-2023	40	2%	176	30	2%	183	358		100
31-08-2023	100	3%	264	60	2%	183	446	346	200
15-10-2023	170	4%	352	150	4%	365	717	517	
31-12-2023	200	5%	440	180	4%	365	805	505	
Balance monetary value of reward points (₹) 505 would be applied as discount at renewal									

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

Relation	Self	Spouse	Child	
Sum insured	5 L			
Age Band	26-30	31-35	0-17	Premium total of eligible members
Floater Discounted premium	9,769	5,579	2,797	15,348
Points Earned	200	180	NA	Average of Points

				190
% value of points earned				5%
Monetary value of reward points				767

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					
21/03/2023	40	30	35	2%	307		100
31/08/2023	100	60	80	2%	307	207	
15/10/2023	170	150	160	4%	614	514	200
31/12/2023	200	180	190	5%	767	467	Applied as discount at renewal
Balance monetary value of reward points (₹) 467 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 3.1.1(Medical expenses)
   v. Renewal Discount –
      a) Insured Person /Policy holder has an option to utilize the balance reward points as discount in premium at the time of renewal of the Policy.
      b) If the insured does not opt for Renewal discount, then the insured has an option to redeem the wellness reward points for availing the services as mentioned in point no. i, ii & iii above. The accrued wellness points can be utilized up to a period of 3 months from the policy expiry date.
      In case the wellness points earned are not utilized within 3 months from policy expiry date, then the amount equivalent to the total accrued wellness points, shall either be refunded to the Policyholder, or the Policyholder shall be allowed to encash the points through vouchers under wellness programs.
      c) After the renewal of the Policy with applicable wellness discount, the insured can continue to earn and accrue wellness reward points till the policy expiry date. The wellness points earned post renewal, that results in change of slab with respect to "Value of points earned", can be utilized for availing the services as mentioned in point no. i, ii & iii above. Such wellness points can be utilized up to a period of 3 months from the policy expiry date.
      The difference 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.

3.1.13 Gender Reassignment Surgery

We will pay the reasonable and customary charges incurred toward the below surgeries / benefits up to the lifetime limit as specified in the Policy Schedule.

a) Gender reassignment surgery (GRS) for Female to Male.

i. Urethroplasty (urethral lengthening),
ii. Vaginectomy (removal of vagina) including hysterectomy and oophorosalpingectomy.
iii. Scrotoplasty (creation of scrotum)
iv. Metoidioplasty or Phalloplasty (create a penis),
v. Mastectomy.
vi. Hormonal Therapy as prescribed by medical practitioner, limited to 15% of the Gender Reassignment Surgery Sum Insured
vii. Facial hair implant surgeries
viii. Voice modulation surgery

b) Gender reassignment surgery (GRS) for Male to Female
i. Vaginoplasty,
ii. clitoroplasty
iii. labioplasty,
iv. orchiectomy and penectomy / scrotectomy
v. Mammoplasty (breast augmentation)
vi. Facial feminizing surgeries
vii. Hormonal Therapy as prescribed by medical practitioner, limited to 15% of the Gender Reassignment Surgery Sum Insured under this benefit.
viii. Facial hair removal or facial hair implant surgeries
ix. Voice modulation surgery

Special conditions applicable for benefits under this section:
1) Insured has completed at least 36 months of continuous coverage from the first inception of the D.I.Y Health Policy with Us.
2) Any expenses incurred towards complications arising out of the Gender Reassignment Surgery shall be excluded.
3) Any reversal surgery post the past Gender Reassignment Surgery shall be excluded.
4) Insured must be of age 18 years and above to avail benefits under this section.
5) Clause no. 4.1.7 will not be applicable to the extent of cover offered under this benefit.

3.1.14 Screening and Vaccinations

We shall reimburse reasonable and customary charges for diagnostic tests and vaccinations, for below listed components -

a) Screening for breast cancer
b) Hepatitis-B vaccination
c) HPV vaccination
d) Screening for cervical cancer – PAP Smear
e) HIV Test - (ELISA)

Special conditions applicable for benefits under this section:
1. Insured has completed at least 36 months of continuous coverage from the first inception of the D.I.Y Health Policy with Us.
2. Screening for breast cancer – Mammography – we will pay once in 3 years after completing the waiting period of 36 months from the first inception of the D.I.Y Health Policy with Us.
3. Hepatitis-B vaccination course will be payable once in lifetime.
4. HPV vaccination course will be payable once in lifetime.
5. Screening for cervical cancer- we will pay once in 3 years after completing the waiting period of 36 months from the first inception of the D.I.Y Health Policy with Us.
6. HIV Test (ELISA)-we will pay once in 3 years after completing the waiting period of 36 months from the first inception of the D.I.Y Health Policy with Us.

7. The maximum sublimit for benefit is Rs 20,000 per policy period.

3.2 OPTIONAL COVER

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

If you opt for the optional covers, you should pick at least 3 optional covers.

3.2.1 Maternity Expenses

We will pay the Reasonable and Customary Charges incurred towards Maternity Expenses for the Insured Person's delivery, subject to the following:

a) The female Insured Person along with spouse/ live in partner should have been covered under this policy with Maternity Expenses benefit included, for a continuous period of 36 months, before this benefit comes into effect.
b) Our Maximum liability per policy year towards delivery (Normal /Cesarean), Lawful Medical termination of Pregnancy, Pre-natal hospitalization and Post-natal Hospitalization will be subject to the sub-limit specified in the Policy Schedule.
c) We will cover Reasonable and Customary Charges, for Pre-natal Medical Expenses incurred towards hospitalization immediately prior to the date of delivery and Post-natal Medical Expenses incurred towards Hospitalization immediately following the date of delivery. The period and charges for pre- and post-natal medical expenses under the applicable Plan will be restricted up to the sub limit specified in the Schedule of Benefits
d) 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 Section 3.1.1.a (In patient Hospitalization).
e) Migration and portability shall not be applicable to this benefit.

3.2.2 Convalescence Benefit

In the event the Insured Person is hospitalized, for the treatment of disease / illness / injury, for a continuous period exceeding 10 days, We will pay a fixed amount as specified in the Policy Schedule. This benefit will be triggered provided that the hospitalization claim is accepted under section 3.1.1 (Medical Expenses). This benefit is payable only once during the Policy Year.

3.2.3 Critical Illness Booster

We will increase the Sum Insured by additional amount equivalent to the percentage of current year Sum Insured as mentioned in the Policy Schedule, in case the Insured Person is hospitalized due to any of the listed critical illness (as mentioned and defined under clause 2.1.9) which occurred during the Policy Year. Such increase of the Sum Insured shall be available for claims arising under Section 3.1.1.a (Inpatient Hospitalization). Cumulative Bonus and Cumulative Bonus Booster (if any) will not be considered for assessing the Sum Insured increase under this Benefit.

This benefit is subject to the following conditions:

a) The benefit can be utilized by the Insured Person diagnosed with a Critical Illness during the Policy Year and such diagnosed Critical Illness occurs or manifests itself as a first incidence.

b) The Insured Person diagnosed with a particular Critical Illness during any Policy Year shall not be allowed to claim under this benefit for the same Critical Illness in any subsequent Policy Year. However, the cover shall be continued & shall be available for other Critical Illnesses.
c) We have accepted the claim under Section 3.1.1.a (Inpatient Hospitalization).
d) The unutilized amount cannot be carried forward to the next Policy Year.
e) The additional Sum Insured shall be available on exhaustion of the Policy Sum Insured Cumulative Bonus (If any) and Cumulative Bonus Booster (If opted).
f) The insured should be covered under this policy along with this benefit included, for a continuous period of 12 months, before this benefit comes into effect.
g) In case of an admissible claim, the sequence of Sum Insured applicability shall be –
    1) Basic Sum Insured
    2) Cumulative Bonus
    3) Cumulative Bonus Booster (if opted)
    4) Critical Illness Booster
    5) Restoration of the Sum Insured

3.2.4 Cumulative Bonus Booster

a) The Insured Person will receive a flat 100% increase in the Sum Insured on a cumulative basis as a Cumulative Bonus Booster (which is over & above the Sum Insured accrued as Cumulative Bonus), for each completed and continuous Policy Year.
b) In any Policy Year, the accrued Cumulative Bonus Booster shall not exceed 500% of the Sum Insured available in the expiring Policy or renewed Policy, wherever Sum Insured is lower.
c) In the event of a Claim there is no impact on the accrued Cumulative Bonus Booster but there will be no increase of “Cumulative bonus Booster “in the subsequent year.
(Claims under Screening and Vaccinations (3.1.14), Wellness Benefits (3.1.12), OPD treatment (3.1.10) shall not be considered)
d) At the time of Policy renewal if the Policyholder chooses not to renew this Optional Benefit, then the Cumulative Bonus Booster under the expiring Policy shall be forfeited.
e) Restoration of the sum Insured (3.1.9) shall not be considered while calculating 'Cumulative Bonus Booster'.
f) If the Policy is issued on Individual basis, then the Cumulative Bonus Booster will be available to each Insured Person.
g) If the Policy is issued on Floater basis, then the Cumulative Bonus Booster will be available on Floater basis for all Insured Persons in the family.

3.2.5 Accident Booster

We will increase the Sum Insured by an additional amount equivalent to the percentage of current year Sum Insured as mentioned in the Policy Schedule, in case the Insured Person is hospitalized due to an accident which occurred during the Policy Year. Such increase of the Sum Insured shall be available for claims arising under Section 3.1.1.a (In Patient Hospitalization). Cumulative Bonus and Cumulative Bonus Booster (if any) will not be considered for assessing the Sum Insured increase under this Benefit.
This benefit is subject to the following conditions:

a) This benefit is payable once in a Policy Year.
b) The benefit shall be applicable only once during a Policy Year and can be utilized by the Insured Person only for the particular Hospitalization due to Accidental Injury.
c) We have accepted the claim under Section 3.1.1.a (In Patient Hospitalization).
d) The unutilized amount cannot be carried forward to the next Policy Year.

e) The additional Sum Insured shall be available on exhaustion of the Policy Sum Insured, Cumulative Bonus (If any) and Cumulative Bonus Booster (If opted).
f) In case of an admissible claim, the sequence of Sum Insured applicability shall be –
    1. Basic Sum Insured
    2. Cumulative Bonus
    3. Cumulative Bonus Booster (if opted)
    4. Accident Booster
    5. Restoration of the Sum Insured

3.2.6 Accompanying Person

We will make payment of the fixed amount as specified in the Policy Schedule, for each completed day of Hospitalization of an Insured, towards the expenses of an Accompanying Person to take care of the Insured, provided that:

a) the Insured is a child less than 12 years of age.
b) the child is undergoing Hospitalization due to an Injury or Illness that occurred during the Policy Year.
c) We will not make payment under this Benefit in respect of an Insured Person for more than 30 days during a Policy Year.
d) We have accepted the claim under Section 3.1.1.a (In Patient Hospitalization).

3.2.7 Alternative Treatment

[2]We will pay Reasonable and Customary Charges for Medical Expenses incurred towards Hospitalization for Ayurveda, Yoga and Naturopathy, Unani, Siddha, or Homeopathy treatment, provided that the treatment has been undergone in an AYUSH Hospital.

The Specific Exclusions applicable to this Benefit are:

a) All preventive and rejuvenation treatments (non-curative in nature)
[3]Outpatient Medical Expenses.[4]

3.2.8 Hospital Daily Cash

We will pay an amount as specified in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalization, during the Policy year for treatment of an Illness /disease/ Injury provided that:

a) We have accepted a claim under section 3.1.1 (Medical Expenses)
b) The Insured Person has been hospitalized for a minimum continuous period of 24 hours.
c) In case the Insured Person is hospitalized in an ICU, then We will pay twice the daily cash amount for each continuous and completed day of such hospitalization in ICU.
d) Our maximum liability per Policy Year is limited to 30 days. However, the maximum liability per hospitalization shall be limited to 5 consecutive days.
e) The sum insured available under this benefit shall be in addition to the Policy Sum Insured.

3.2.9 Road Ambulance

[2] Alternative Treatment modified to include “Yoga and Naturopathy”
[3] Specific exclusions b) is modified to extend the scope of benefit to cover tPre-Hospitalization, Post-Hospitalization, and AYUSH Day Care Treatments.
[4] Specific exclusions c). is deleted.

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 Liability per hospitalization under this benefit shall be up to a maximum of the amount as specified in the Policy Schedule.

Following Expenses shall be covered under this benefit:

a) Transportation Costs towards transferring the Insured Person from the place of incident to Hospital or 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.
b) When the Insured Person requires to be moved to home after discharge from the hospital. The medical condition of Insured Person is such that it requires services of Ambulance and is certified by treating medical practitioner.

We will reimburse payments under this Benefit provided that:

a) The ambulance services of a Hospital or a registered ambulance service provider are utilized.
b) The original Ambulance bills and payment receipt are submitted to Us.
c) We will accept the claim under Section 3.1.1 a (In Patient Hospitalization) or Section 3.1.1b (Day care Treatment Expenses).

3.2.10 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. Our Liability per hospitalization under this benefit shall be up to a maximum of the amount as specified in the Policy Schedule.

Following Expenses shall be covered under this benefit:

a) 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.

We will reimburse payments under this Benefit provided that:

a) The ambulance services of a Hospital or a registered ambulance service provider are 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 Section 3.1.1.a (In Patient Hospitalization).
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.

3.2.11 Home Health Care Expenses

We will cover the reasonable and customary charges up to a maximum of 20% of the Sum Insured (excluding the Cumulative Bonus, if any) towards Medical Expenses incurred for Home Health Care Services during the Policy Year and availed through Our empaneled Home Health Care Service Provider, on Cashless Facility basis, only if the following conditions are fulfilled:

a) The Home Health Care Expenses shall be covered only subject to Cashless authorization approved by Us.
b) Medical treatment for an Illness/ Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:
   (i) The condition of the patient is such that he/she is not in a condition to be moved to a Hospital, or
   (ii) The patient takes treatment at home on account of non-availability of bed / room in a Hospital, or
   (iii) Non-availability of Hospital Services due to any prevailing conditions /Government Notification.
   (iv) Chemotherapy and dialysis at home.
   (v) For children up to the age of 15 years if treated at home instead of hospitalization, if certified by the Medical Practitioner that the child needs hospitalization for treatment but the same can be replicated at home with remote monitoring and nursing care.
c) The duration of Home Health Care treatment should be restricted to reasonable time and not more than the period of Hospitalization, the patient would have undergone otherwise.
d) Treatment under this benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
e) In the case of medical treatment solely taken at home without any initial hospitalization, Pre and Post hospitalization expenses will be covered up to the overall limit of the cover under this benefit. The number of days for pre and post hospitalization cover will be applicable as per section 3.1.2 & 3.1.3 respectively.
f) In case of post-surgical care through Home Health Care Services, where the initial hospitalization for surgical management, the condition was at our empaneled network hospital and we have accepted an inpatient hospitalization claim on cashless basis, then Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses will be applicable as per section 3.1.2 and 3.1.3 respectively.
g) Only Allopathic treatment shall be covered under this Benefit.
h) Any sub limits applicable for Section 3.1.1 to Section 3.1.3 shall also be applicable under this Benefit.
i) This Benefit shall not cover any expenses incurred towards attendant/ nursing services.
j) Section 3.2.6 (Accompanying Person) is not applicable for claims admissible under this Benefit.
k) Clause 3.2.14 (Voluntary Co-Payment) shall not apply to the extent of cover provided under this benefit.

3.2.12 Non-Medical and Consumable Expenses Cover

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

a) Such consumables are utilized or consumed during the treatment related to Insured Person's medical or surgical treatment and
b) We have accepted the claim under section 3.1.1 (Medical Expenses)
c) Will be covered up to sublimit of 15 % of admissible claims amount.
d) Pre and post hospitalization expenses will be excluded from this cover.
e) Exclusion 4.2.18 will not be applicable.

3.2.13 Accidental Death Cover

In the unfortunate event of death of the Policyholder (who is also insured under this Policy) or his / her insured spouse, directly due to an injury which is sustained in an Accident during the Policy Year, We will pay fixed benefit equal to an amount as specified in the Policy Schedule, provided that:

a) The insured person's death occurs within twelve months from the date of Accident.
b) This benefit is applicable to the Policyholder and his / her Spouse provided that they are insured under this Policy. In the event of death of both the members (Policyholder and his or her spouse) insured under this policy, We will pay the fixed amount against both the members separately, on individual basis.
c) The benefit will be paid to the nominee or legal heir of the insured member.
d) The sum insured available under this benefit shall be in addition to the Policy Sum Insured.
e) In case of a claim under this benefit, Policy Sum Insured, the Cumulative Bonus (if any) and the Cumulative Bonus Booster (if opted) will not be impacted.

Specific Exclusions:

We shall not be liable to make payment for a claim under this benefit, arising out of or attributable to any of the following:

i) Any Pre-existing Condition(s) / disability, any complication arising from it; or
ii) Intentional self-Injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) or attempted suicide.
iii) Accident while under the influence of alcohol or drugs or other intoxicants except where the Insured Person is not directly responsible for the injury / accident through under the influence of intoxication.
iv) Participation in an actual or attempted felony, riot, crime, misdemeanor, or civil commotion
v) Operating or learning to operate any aircraft or performing duties as a member of the crew on any aircraft.
vi) Loss resulting due to Insured person flying in an aircraft other than as a fare paying passenger in a Scheduled Airline / Licensed Aircraft.
vii) Insured Person committing or attempting to commit a breach of law with criminal intent.
viii) War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints, and detainment of all kinds.
ix) Participating in motor racing or trial run as a driver, co-driver, or passenger.
x) Nuclear, chemical, or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
    1) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement, or death.
    2) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid, or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
    3) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
xi) The Insured Person engaging in or taking part in armed forces service or operations.

xii) Bodily Injury caused by or arising from terrorism, except in case where the Policyholder is a victim of terrorist act and not abetting terrorism.

xiii) Any loss resulting due to Pregnancy or childbirth or in consequences thereof.

xiv) Any loss resulting due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

3.2.14 Voluntary Co-Payment

The Co-Payment as opted for by the Policyholder 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) Voluntary Co-Pay will apply in conjunction with mandatory Co-Pay (section 5.2.1.b (ix))

d) Co-Pay shall not be applicable to the following benefits:

(i) Cataract Surgery (Per Eye)
(ii) Wellness Benefits
(iii) OPD treatment
(iv) LASIK Surgery
(v) Maternity Benefit
(vi) Daily Hospital Cash
(vii) Convalescence Benefit
(viii) Accompanying Person
(ix) Accidental Death
(x) Home Health Care
(xi) Gender Reassignment Surgery
(xii) Screening and Vaccinations

3.2.15 Voluntary Deductible

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

b) Wherever Co-payments are applicable, as per Section 3.2.14 above and Section 5.2.1.b(ix), the same would be applied to the admissible claim amount after the application of Voluntary Deductible, if any.

c) The deductible shall not be applicable to the following benefits:

I. Cataract Surgery (Per Eye)
II. Restoration of S.I
III. Wellness Benefits
IV. OPD Cover
V. LASIK Surgery
VI. Maternity Benefit
VII. Daily Hospital Cash
VIII. Convalescence Benefit
IX. Accompanying Person
X. Accidental Death
XI. Accident Booster
XII. Home Health Care
XIII. Gender Reassignment Surgery
XIV. Screening and Vaccinations

4 WAITING PERIOD AND EXCLUSIONS

We shall not be liable make payment for a claim in respect of any Insured Person under all Sections of the Policy, arising out of or attributable to any of the following unless specifically covered elsewhere in this Policy:

4.1. Standard Exclusion

4.1.1 Pre-Existing Disease: Code - Excl 01

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry number of months of continuous coverage as mentioned in the Policy Schedule, after the date of inception of the first policy with Us.

b) In the event of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then the waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of a number of months, as mentioned in the Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

4.1.2 Specified disease/procedure waiting period: Code - Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months of continuous coverage as mentioned in the Policy Schedule, after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b) In the event of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then the waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures:

(i) **Waiting period of 36 months**:

1) Joint replacement Surgery due to degenerative condition
2) Age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is Medically Necessary due to Injury.

(ii) **Waiting period of 12/24 months**:

1) Cataracts
2) Lasik Surgery.
3) Benign Prostatic Hypertrophy
4) Hernia of all types
5) Deviated Nasal Septum
6) Hypertrophied Turbinate

7) All types of nasal and para nasal sinus related disorders
8) Hydrocele
9) Fistulae, hemorrhoids, fissure in ano
10) Dysfunctional uterine bleeding, Fibromyoma, Endometriosis, Hysterectomy,
11) All internal or external tumors/cysts/nodules/polyps of any kind including breast lumps with exception of malignant tumor or growth.
12) Surgery for prolapsed inter vertebral disc unless arising from Accident.
13) Surgery of varicose veins and varicose ulcers
14) Any types of gastric or duodenal ulcers
15) Stones in the urinary and biliary systems
16) Surgery on ears and tonsils.
17) Rheumatoid Arthritis
18) Gout

4.1.3 30 days waiting period: Code - Excl - 03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.1.4 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.

4.1.5 Rest Cure, rehabilitation, and respite care: Code - Excl05

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a) Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b) Any services for people who are terminally ill to address medical, physical, social, emotional, and spiritual needs.

4.1.6 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);
   (i) greater than or equal to 40 or
   (ii) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      1) Obesity-related cardiomyopathy
      2) Coronary heart disease
      3) Severe Sleep Apnea
      4) Uncontrolled Type2 Diabetes

4.1.7 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.

4.1.8 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 medical necessity, it must be certified by the attending Medical Practitioner.

4.1.9 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.

4.1.10 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.

4.1.11 Excluded Providers: Code - Excl11

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

4.1.12 Code - Excl12

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

4.1.13 Code - Excl 13

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.

4.1.14 Code - Excl14

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

4.1.15 Refractive Error: Code - Excl15

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

4.1.16 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.

4.1.17 Sterility and Infertility: Code - Excl17

Expenses related to sterility and infertility. This includes:

a) Any type of contraception, sterilization

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

4.2 SPECIFIC EXCLUSIONS

4.2.1 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints, and detainment of all kinds.

4.2.2 Nuclear, chemical, or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement, or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid, or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.2.3 Any expenses incurred on Domiciliary Hospitalization.

4.2.4 Treatment taken outside the Geographical limits of India.

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

4.2.6 Vaccination/ inoculation (except as post bite treatment)

4.2.7 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.

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

4.2.9 External Congenital Anomaly and related Illness/ defect.

4.2.10 Stem cell storage.

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

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

4.2.13 Outpatient diagnostic, medical and Surgical Procedures or treatments.

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

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

4.2.16 Intentional self-Injury.

4.2.17 Yoga and Naturopathy

4.2.18 Standard list of excluded items as mentioned in Annexure III and on our website https://general.futuregenerali.in.

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

5 GENERAL TERMS AND CLAUSES

5.1 Standard General Terms and Clauses

5.1.1 Disclosure to Information Norm

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.

5.1.2 Condition Precedent to Admission of Liability

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

5.1.3 Free Look Period

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

The Insured Person shall be allowed a free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

a) a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or
b) Where the risk has already commenced and the option of return of the policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or
c) Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

5.1.4 Complete Discharge

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

5.1.5 Multiple Policies

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

5.1.6 Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited. Any amount already paid against claims made under this policy, but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s),

who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

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

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

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

5.1.7 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.

5.1.8 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.

5.1.9 Migration

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

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

5.1.10 Portability

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

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

5.1.11 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 the policy contract.

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

The Company, with prior approval of lRDAI, 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.

5.1.13 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 Insured 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 Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Kindly refer the annexure on Grievance Redressal Procedures.

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

5.1.14 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 of the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

5.2 Specific Terms and Clauses

5.2.1 Claims Procedure

a) **Accidental Death Claim**

(i) Upon the occurrence of covered event that may give rise to a claim under section 3.2.12 (Accidental Death Cover), the Policyholder / Insured Person or Nominee, must intimate Us either at the call center or in writing, immediately or within 15 days of occurrence of such Insured Event.

(ii) The indicative list of documents as mentioned below shall be submitted by the Policy Holder/Insured Person, immediately but not later than 15 days of date of occurrence of an accident, at own expense to avail the Claim.

1) Duly filled and signed Claim Form
2) Photo Identity Proof - Voter ID, Passport, PAN Card, Driving License, Ration Card, or any other proof accepted by the KYC norms as approved by Us and which is admissible in court of law.
3) Copy of FIR/ Panchnama /Police Inquest Report (if conducted) duly attested by the concerned Police Station;
4) Copy of Medico Legal Certificate duly attested by the concerned Hospital.
5) NEFT details of the Insured (NEFT details of Nominee in case of death)
6) Copy of Death Certificate (issued by the office of Registrar of Births and Deaths)
7) Copy of Postmortem report if conducted.
8) In absence of post-mortem report, documents related to accidental hospitalization / consultation papers for treatment taken immediately the accident / investigation report / case papers.
9) Copy of viscera report wherever applicable.
10) Copy of histopathology report, if conducted
11) Any other relevant document required by Us for assessment of the claim.

b) **Hospitalization Claim**

If the Insured Person meets with any Injury or contracts an Illness that may result in a claim under the Policy, then as a Condition Precedent to Our liability, the following must be complied with:

(i) Cashless Facility is available for hospitalization only at Our Network Provider. In order to avail Cashless Facility, the following procedure must be followed:

1) We must be called at Our call center and a request for pre-authorization must be made by way of the written form prescribed by Us.
2) After considering the request and obtaining any further information or documentation that We have sought, We may, if satisfied, issue an authorization letter to the Network Provider. 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.

(ii) 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.

(iii) 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 center 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) For:
    i. maternity claims - Discharge Summary mentioning LMP, EDD & Gravida
    ii. Cataract claims -IOL sticker
17) Copies of health insurance policies held with any other insurer covering the insured persons.
18) 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.
19) For claims made under Section 3.2.10 (Home Health Care Expenses), a certificate from the attending doctor confirming that the condition of the patient is such that he/she cannot be moved to a hospital.
20) Any other relevant document required by Us for assessment of the claim.

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

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

(vi) **Reimbursement Claims**

For reimbursement claims, the payment will be made to You/ Insured Person. In the event of Your/Insured Person's death, We will pay the nominee (as named in the Schedule) and in case the nominee is deceased or untraceable, payment to Your/Insured Person's legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and where discharge shall be treated as full and final discharge of Our liability under the Policy.

(vii) **Pre & Post Hospitalization Claim**

1) Claim documents for Pre-Hospitalization expenses should be sent to Us within 30 days of date of discharge from the Hospital.
2) Claim documents for Post-Hospitalization expenses should be sent to Us within 15 days of completion of treatment.

(viii) **Basis Of Claims Payment**

1) Claims related to Any One Illness: All claims relating to Any One Illness shall be deemed to be part of the same original claim.
2) Claims for Day Care Treatment: The Day Care Treatments listed are subject to the exclusions, terms and conditions of the Policy and will not be treated as independent coverage under the Policy.

(ix) **Mandatory Co-Payment**

The mandatory Co-Payment of 20% shall be applicable subject to the following:

1) The mandatory Co-Payment will be applicable for all the Insured Persons who are aged 61 years and above at the time of issuance of the first Policy with Us.
2) The mandatory Co-Payment applicable to the Insured Person at the inception of the first policy will also be applicable on all subsequent renewals.
3) The mandatory Co-Payment shall not be applicable to the following benefits:
   I. Cataract Surgery (Per Eye)
   II. Wellness Benefits
   III. OPD treatment
   IV. LASIK Surgery
   V. Maternity Benefit
   VI. Daily Hospital Cash
   VII. Convalescence Benefit
   VIII. Accompanying Person
   IX. Accidental Death
   X. Home Health Care
   XI. Gender Reassignment Surgery
   XII. Screening and Vaccinations

c) **Policy Currency**

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

d) **Claim Settlement**

(i) The Company shall settle or reject a claim, as the case may be, within 30 days of the date of receipt of the last necessary document.

(ii) 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.

(iii) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company

shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

(iv) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(v) Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified Clause 5.2.1.a.ii and 5.2.1.b.iii above.

(vi) In case of 'pending' claims, We will ask for submission of incomplete documents.

(vii) 'Rejected' claims will be informed to the Insured Person in writing with reasons for rejection.

5.2.2 Insured Persons

The following relations of the Primary Insured/Proposer shall be eligible to be Insured Persons under the Policy:

Individual Sum Insured Policy - Self, Spouse/Live-in partner, Children (up to 25 years of age), Parents, Siblings, Daughter-in-law, Son-in-law, Parents-in-law, Grandparents and Grandchildren.
Floater Sum Insured for Mini plan - Self, Spouse/Live- in- partner, Children (up to 25 years of age)

Floater Sum Insured for Medi and Max plan - Self, Spouse/Live - in partner, Children (up to 25 years of age), parents and parents- in- law.

A person may be added as an Insured Person during the Policy Period after his/her application has been accepted by us, an additional premium has been received and Our agreement to extend cover has been indicated by Us issuing an endorsement confirming the addition of such person as an Insured Person.

5.2.3 Cost Of Pre-Insurance Medical Examination

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

5.2.4 Communications

a) Any communications, notifications or declarations meant for Us must be in writing and delivered to Our address specified in the Schedule.

b) Any communication meant for You will be sent by Us to Your address shown in the Schedule. You must notify Us immediately of any change in Your address.

c) Our agents are not authorized to receive communications, notices, or declarations on Our behalf.

5.2.5 Territorial Limit

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

5.2.6 Cancellation

a) The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

(i) **Single Premium Payment**

1) In case the Policy Period is one year, and the cancellation happens during the risk period on the Policyholders request, the Company shall refund premium for the unexpired policy period as detailed below.

Cancellation Request Received from the date of Policy Inception	**Rate of premium refunded**
Up to one month	75% of annual rate
Up to three months	50% of annual rate

Up to six months	25% of annual rate
Exceeding six months	No Refund

2) In case the Policy Period exceeds one year, We shall refund premium on a pro-rata basis by reference to the time period for which cover is provided, subject to a minimum retention of premium of 25%.

(ii) **Premium paid in Multiple Instalments**

1) In case the Policy Period is one year, with instalment premium, the cancellation shall be as follows:

Instalment Frequency	**Cancellation Request received**	**Rate of Premium refunded**
Monthly	Anytime during the Policy Year	No Refund
Quarterly	Up to 3 months	12.5% of the respective quarterly instalment premium
	Above 3 months to 6 months	12.5% of the respective quarterly instalment premium
	Above 6 months	No Refund
Half yearly	Up to 3 months	25% of the half-yearly instalment premium
	Above 3 months to 6 months	12.5% of the half-yearly instalment premium
	Above 6 months	No refund

2) In case of Policy Period more than one year, with instalment premium, the cancellation shall be as follows:

Instalment Frequency	**Cancellation Request received**	**Rate of Premium refunded**
Monthly	Anytime within the Policy Period	No refund
Quarterly	1st Quarter of 1st Policy Year	12.5% of the respective quarter premium
	2nd Quarter of 1st Policy Year	12.5% of the respective quarter premium
	3rd Quarter of 1st Policy Year	No refund
Half yearly	Up to first 3 months of the 1st Policy Year	25% of the half-yearly instalment premium
	Above first 3 months to 6 months of the 1st Policy Year	12.5% of the half-yearly instalment premium
	Above first 6 months of the 1st Policy Year and thereafter	No refund
Annually	Up to 1 month in the ongoing Policy Year	75% of the annual instalment premium

	Above 1 month to 3 months in the ongoing Policy Year	50% of the annual instalment premium
	Above 3 months to 6 months in the ongoing Policy Year	25% of the annual instalment premium
	Above 6 months in the ongoing Policy Year	No refund

b) Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

c) 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.

d) No refund of premium shall be due on cancellation if the Insured Person has made a claim under this Policy.

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) Individual Policy - the corresponding premium pertaining to the deceased insured person for the unutilized Policy period shall be refunded on a 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 / individual 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) Individual 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 subsequent Policy Period, will not be refunded.

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

1) Individual 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) Individual 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.

5.2.7 Premium Payment in Instalment

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

a) Grace Period of 15 days would be given to pay in case of monthly instalment premium and grace period of 30 days shall be given to pay in case of quarterly / Half Yearly installment premiums, due for the
b) policy.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.
c) No interest will be charged if the instalment premium is not paid on the due date.
d) In case the instalment premium due, is not received within the grace period, the policy will get cancelled.
e) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
f) The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
g) The payment will be accepted through E-NACH / ACH/ ECS / any other mode approved by Government of India.
h) 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.
i) 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.

j) 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.

k) 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 Section 3.1.10 (OPD Treatment Expenses) and Section 3.1.12 (Wellness Benefits).

5.2.8 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.

5.2.9 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud or 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) D.I.Y Health 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 and optional benefit is not allowed during the currency of the Policy. However, increase/decrease in Sum Insured or change in optional benefit, 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 case of enhancement of sum insured, the waiting periods shall apply afresh to the extent of sum insured increase.

5.2.10 Dispute Resolution

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

Annexure I: Plan Details

Basic Covers			
Plan Name	Mini	Medi	Max
Sum Insured	4L, 5 L	6L, 7L, 8L, 9L, 10L	11L, 12L, 13L, 14L, 15L
1. A. Hospitalization	Covered up to the Sum Insured		
i. Room Rent (Normal Room) – Proportional Deductions will be applicable (discount for 1% capping)	1% / No capping	1% / No capping	1% / No capping
ii. ICU Charges	2 times of the Room Rent selected / "No Capping" will be applicable, in case Room Rent is selected with "No Capping"	2 times of the Room Rent selected / "No Capping" will be applicable, in case Room Rent is selected with "No Capping"	2 times of the Room Rent selected / "No Capping" will be applicable, in case Room Rent is selected with "No Capping"
1. B. Day Care	530 no. of procedures covered; up to the Sum Insured		
1. C. i) LASIK Surgery (1/2 years waiting period) Will be part of Named Ailments list	₹30,000 / ₹50,000 for both eyes	₹50,000 / ₹75,000 for both eyes	₹75000 / ₹1,00,000 for both eyes
1. C. ii) Cataract Surgery (Per Eye)	Covered up to 20% of Sum Insured subject to maximum of ₹ 1,00,000		
2. Pre-Hospitalization	30 / 60 / 90 Days		
3. Post Hospitalization	60 / 90 / 120 Days		
4. Modern Methods of Treatment (Restricted to 50% of the S.I, up to a maximum of ₹ 5 Lac)	- Uterine Artery Embolization and HIFU - Balloon Sinuplasty - Deep Brain stimulation - Oral chemotherapy - Immunotherapy- Monoclonal Antibody to be given as injection. - Intravitreal injections - Robotic surgeries - Stereotactic radio surgeries - Bronchial Thermoplasty - Vaporisation of the prostrate (Green laser treatment or holmium laser treatment) - IONM - (Intra Operative Neuro Monitoring) - Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.		
5. Organ Donor Expenses	Covered up to Sum Insured		
6. Bariatric Surgery (3 years waiting period; Portability and Migration not applicable)	Covered up to 50% of Sum Insured subject to maximum of ₹ 5,00,000		
7. HIV / AIDS	Covered up to Sum Insured		
8. Mental / Psychiatric Conditions and Neurodevelopmental Disorders	Covered up to Sum Insured		
9. Cumulative Bonus	Additional Sum Insured of 25% on every claim free year; up to a max of 100%		
10. 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 as payable by us. The Restoration of Sum insured will be triggered irrespective of the Sum Insured and Cumulative Bonus (if any) is completely or partially exhausted due to the claim incurred, and is subject to following conditions: The Restore Sum Insured can be used for claims made for same illness/new illness. 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		
11. Wellness Benefits	Covered		
12. OPD Cover (Diagnostics, Medications, Consultations covered) Restoration for Mental illness	₹2000 / ₹3000 Mental illness OPD for 4 L and comprehensive cover from 5 L	₹3000 / ₹5000 Comprehensive cover	₹5000 / ₹7500 / ₹10000 Comprehensive cover
13. Gender Reassignment Surgery (Lifetime sublimit) Waiting of 3 years applicable for portability and migration policies also	Covered up to 1 Lac		
14. Screening and Vaccinations (Reimbursement Basis) Waiting of 3 year applicable including portability and migration policies. Overall Sub-limit ₹ 20,000 per policy period	Screening for breast cancer – Mammography every 3 years Hepatitis-B vaccination complete course as required (once in lifetime) HPV vaccination complete course as required (once in lifetime) Screening for cervical cancer – PAP Smear test every 3 years. HIV Test Elisa every 3 years.		
Mandatory Co-Pay (condition)	20% co-pay will be applicable for insured persons, aged 61 – 65 years entering the Policy the first time. This co-pay will be applicable for all subsequent renewals.		
OPTIONAL COVERS			
1. Maternity Benefit (Pre & Post natal expenses covered within maternity limits) – Portability and Migration is not applicable (pre post Natal OPD will not covered MTP up to normal limit)	A-Normal-₹20000/Caesarean-₹30,000 B- Normal-₹30000/Caesarean-₹50,000 C- Normal-₹50000/Caesarean-₹75,000 D- Normal-₹75000 /Caesarean-₹10,0000		
	Waiting Period – Cover is only applicable if the female insured person along with spouse is covered with Us for a continuous period of 3 years		
	A / B	A / B / C	A / B / C / D
Pre Natal-Expenses (OPD not covered)	30 days	60 days	90 days
Post Natal Expenses (OPD not covered)	45 days	45 days	45 days
2. Road Ambulance (Home to Hospital, Hospital to Hospital, Hospital to Home)	₹1000/ ₹1500/₹2000	₹1500/ ₹2000/₹3000	₹2000/ ₹3000/₹5000

3. Emergency Air Ambulance only in India	₹1,00,000	₹3,00,000	₹5,00,000
4. Daily Hospital Cash (Max. up to 5 days per hospitalization & Min. 24 hrs hospitalization Required; Max. 30 days per policy period); For ICU the benefit will be doubled.	₹250/ ₹500/₹1000	₹500 /₹ 1000 / ₹1500/₹2000	₹1500/₹2000/₹2500
5. Convalescence Benefit (Hospitalization for 10 consecutive days or more; Once in a policy year)	₹5000 / ₹10000	₹5000 / ₹10000	₹5000 / ₹10000
6. Accompanying Person (For insured patient less than 12 years)	₹250/ ₹500	₹500 / ₹750 / ₹1000	₹1500/₹2000
7. Accidental Death (Primary Member & Spouse)	₹1,00,000/ ₹2,00,000	₹2,00,000/₹3,00,000/₹4,00,000	₹3,00,000/ ₹4,00,000/ ₹5,00,000
8. Critical Illness Booster not applicable for same illness in subsequent policies (In case diagnosed with listed C.I, additional S.I will be offered)	1.5 times / 2 times the Sum Insured	1.6 times / 2 times the Sum Insured	1.5 times / 2 times the Sum Insured
9. Accident Booster (In case of hospitalization due to accident, additional S.I will be offered)	1.5 times / 2 times the Sum Insured	1.5 times / 2 times the Sum Insured	1.5 times / 2 times the Sum Insured
10. Non-Medical & Consumables expenses Cover	Cover for non-medical and consumable expenses as indicated in List-I Up to 15 % of admissible claims	Cover for non-medical and consumable expenses as indicated in List-I Up to 15 % admissible claims.	Cover for non-medical and consumable expenses as indicated in List-I Up to 15 % admissible claims.
11. Home Health Care	Covered up to 20% of the Sum Insured	Covered up to 20% of the Sum Insured	Covered up to 20% of the Sum Insured
12. AYUSH Treatments	Covered Up to the Sum Insured	Covered Up to the Sum Insured	Covered Up to the Sum Insured
13. Cumulative Bonus Booster	CB increases 100% every year upto 500% of the Sum Insured The bonus will not decrease in case of a claim	CB increases 100% every year upto 500% of the Sum Insured The bonus will not decrease in case of a claim	CB increases 100% every year upto 500% of the Sum Insured The bonus will not decrease in case of a claim
14. #Voluntary Co-Pay	10%/20%/30%	10%/20%/30%	10%/20%/30%
15. # Deductible (on aggregate basis)	₹10,000/ ₹25,000/₹50,000	₹10,000/₹25,000/₹50,000	₹50,000 /₹75,000/₹100,000
[#] Voluntary Co pays, and Deductible can be opted on mutually exclusive basis. Note - Organ transplant is covered as part of base plan			
For Portability and Migration policies only **two-year** waiting period option for pre –existing diseases and Specified disease/procedure waiting period is available.			

General Terms	
Entry Age	Adult – 18 years to 65 years Child – 1 day to 25 years
Exit Age	Lifelong
Tenure	1 / 2 / 3 Years
Instalment option	Monthly 5% Quarterly 4% Semi- annually 3% Annually (for 2,3 year policies 0%
Family Definition	Individual Sum Insured Policy - Self, Spouse/Live-in partner, Children (up to 25 years of age), Parents, Siblings, Daughter-in-law, Son-in-law, Parents-in-law, Grandparents and Grandchildren. Floater Sum Insured for Mini plan- Self, Spouse/Live- in- partner, Children (up to 25 years of age) Floater Sum Insured for Medi and Max plan - Self, Spouse/Live - in partner, Children (up to 25 years of age) , parents and parents- in- law .
Specified disease/procedure waiting period	1 / 2 years
Pre-Existing Waiting Period	1/ 2 / 3 years
Discounts/ Other Loadings Applicable Under the Product	
Family discount	10% Family discount in case of more than one insured covered under the same policy on individual sum insured basis.
Long-term discount	1 year Nil 2 years 7.5% 3 years 10%
Voluntary deductible discount	In case a deductible is opted the deductible is applicable on aggregate basis
Web sales / Tele sales discount / Employee discount	we shall accord a discount of 15 %, on the premium amount
Note: - Either Website/Employee discount would apply in a single policy.	

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 center 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 FOOTWEAR
45.	KNEE BRACES (LONG/ SHORT/ HINGED)
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53.	SUGAR FREE TABLETS
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY

60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	VASOFIX SAFETY

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

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

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

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 Number: FGH/UW/RET/273/04

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

HEALTH INSURANCE CLAIM FORM

ALL FIELDS IN THIS FORM ARE MANDATORY AND THE CLAIM WILL NOT BE PROCESSED IF ANY OF THE DETAILS ARE MISSING

Claim Number (For FGH Use Only)

POLICY / INSURED DETAILS

Policy No.:			**Health Card No. Of Patient:**		
Policy Start Date	DD / MM / YYYY	**Policy End Date**	DD / MM / YYYY	**Date Of Joining Policy**	DD / MM / YYYY
Corporate Name	*(Only for group policies)*			**Employee ID:**	

PERSONAL DETAILS OF EMPLOYEE / PROPOSER

1. Name of the Employee / Individual	
2. E-Mail address of the Employee/Individual	
3. Mobile No.	
4. Permanent Account Number (PAN)	

CLAIMANT / PATIENT DETAILS

1. Name of the Patient		
2. Relationship with the Employee / Proposer	□ Self □ Spouse □ Child □ Parent □ Others _____	
3. Date of Birth of Claimant: DD / MM / YYYY	Age: _____ (years)	Gender: □ Male □ Female
4. Residential Address:		

CLAIM DETAILS

Total Claimed Amount:

Claimed Amount in Words: Rupees _____

Diagnosis		Enclosure Check List:
Admission Date: DD / MM / YYYY	Discharge Date: DD / MM / YYYY	
Name of Treating Doctor:		i. Original Discharge Summary containing all relevant details
Mobile No. of Treating Doctor:		

Name of Family Physician: Mobile No. of Family Physician:	ii. All Original Bills and their Receipts iii. Copies of all Reports & prescriptions iv. First Prescription / Consultation Letter from your Doctor. v. Original Money Receipt duly signed with a Revenue Stamp. vi. Copy of Proposer/Employee Photo ID Proof & Address Proof

CONSENT REQUIREMENT FOR ACCESS TO TREATMENT PAPERS / INDOOR CASE SHEETS / MEDICAL RECORDS / INVESTIGATOR VISIT

I hereby authorize Future Generali India Insurance, or any agency / individual authorized by them to obtain copies or review in person all my medical records including but not limited to admission notes, treatment sheets, indoor case papers, investigation reports, prescriptions and all other documents present in the hospital case file. Details related to my past Hospitalizations in your hospital can also be provided / shown to Future Generali or its authorized representatives. I agree that all information provided above by me in the claim documents is true and that if I have provided any false or untrue information, my right to claim reimbursement of expenses shall be absolutely forfeited.

Name of Patient / Relative: _____

_____

Relationship with Patient: _____

Signature of Patient / Relative

Date: DD / MM / YYYY

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Please attach this form in Original to the hospital bill and other claim documents. Separate claim form required for each claim. PLEASE ENCLOSE A PHOTOCOPY OF THE FUTURE GENERALI HEALTH ID CARD.

Authorization for Transfer of Claim Amount by National Electronic Fund Transfer

Name as per Bank Account												
Bank Name												
Branch Name & Address												
Branch Phone No.												
Branch MICR Code												
Branch IFSC Code for NEFT												
(Please attach a Photocopy of a cheque or a blank cheque of your bank duly cancelled for ensuring accuracy of the bank name, branch name, account number & name of account holder printed)												
Account Type (Please Tick)	□ Savings □ Current □ Cash / Credit											
Account No. (As appearing in Cheque Book)												
HR Authorization & Stamp					Bank Authorization & Stamp							

Date from which the mandate should be effective: _____

I hereby declare that the particulars given above are correct and complete and request you to remit any amount due to me, if any to the aforesaid bank account. I herewith further declare that if any transaction is delayed or not effected at all or is wrongly credited to any other account for reasons of incomplete or incorrect information as provided above, I shall not hold Future Generali India Insurance Company Ltd ("Company ") or any of its directors, employees or agents responsible for the same. I also declare that the remittance of any dues to the aforesaid bank account shall be considered as full and valid discharge of its obligations by the company. I also undertake to advise any change in the particulars of my bank account to facilitate updating of records for the purpose of credit of any amount due, through NEFT.

Name of Employee / Proposer: _____

Policy No.: _____ Signature of Employee / Proposer

Claimant Name: _____ Date: DD / MM / YYYY

FEEDBACK AND SUGGESTIONS

We thank you for choosing Future Generali as your Insurance provider. We always strive to ensure that our service levels exceed our customers' expectations. In the spirit of this endeavour, we will greatly appreciate your valuable input and feedback. Kindly provide your feedback on your experience with Future Generali and any suggestions for improving our services. We value your time and promise to evaluate your suggestions for the improvement of our service.

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.