FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

D.I.Y HEALTH PROSPECTUS

SALIENT FEATURES OF THE POLICY –

1. Multiple Sum Insured option from 4 Lac to 15 Lac is available under the policy.
2. Plans of Mini, Medi and Max is available with comprehensive policy with 17 base covers with 15 optional covers.
3. Exclusives covers of Air Ambulance, Accident Booster and Critical Illness Booster
4. Lifetime renewal is available for any age entry.
5. Wellness features like fitness discount on renewal policy, out-patient consultation, health check-up
6. Long term policy tenure up to 3 years
7. Option to pay premium in installments.

1 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 document.

1.1 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.

1.1.1 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 anesthetists;
(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;
(ix) Prosthetic and other devices recommended by the attending Medical Practitioner, that are implanted internally during a Surgical Procedure.

Plan Name	Mini	Medi	Max
Sum Insured	4,00,000	6,00,000	11,00,000
	5,00,000	7,00,000	12,00,000
		8,00,000	13,00,000
		9,00,000	14,00,000
		10,00,000	15,00,000

b) **Day Care Treatment Expenses**

We will pay the Reasonable and Customary Charges incurred towards Medically Necessary Treatment required by the Insured Person towards Day Care Treatments following an Illness or Injury that occurs during the Policy Year up to the Sum Insured. 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.

Lasik Surgery Limit for both eyes

Mini	Medi	Max
30,000	50,000	75,000
50,000	75,000	1,00,000

(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.

1.1.2 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 1.1.1 (Medical Expenses).

1.1.3 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 1.1.1 (Medical Expenses).

1.1.4 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 1.1.1.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.

1.1.5 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.

1.1.6 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 1.1.1.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

1.1.7 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 48 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.

1.1.8 Cumulative Bonus

Cumulative Bonus 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 1.1.10 (OPD treatment) and Section 1.1.12 (Wellness Benefits) section 1.1.14 (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 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, 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.

1.1.9 Restoration of the Sum Insured

Under this benefit a Restore Sum Insured equal to 100% of the base Sum Insured excluding Cumulative Bonus-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:

a) The Restore Sum Insured can be used for claims made for same illness/new illness in respect of Section 1.1.1 (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 to an Individual, then the restore sum insured will be available to each Insured Person.
g) If the Policy is issued on a Floater basis, then the restored sum insured will be available on Floater basis for all Insured Persons in the family.

1.1.10 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 lacs: OPD treatment expenses incurred towards consultations, diagnostic tests and medications arising due to Mental/Psychiatric Illness only.
b) For Sum insured of 5 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 2.2.13 Shall not apply to the extent of cover provided under this benefit.

OPD cover limit as specified below

Mini	Medi	Max
2,000	3,000	5,000
3,000	5,000	7,500
		10,000

1.1.11 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 schedule of benefits per Policy Year.

We will cover medical expenses incurred on the following procedures:

These sub limits are applicable for all plans under the product.

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 1.1.1.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.

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

A. Value Added Services

Under this benefit Insured Person is eligible for availing the following benefits via the 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 checkups 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.

Sum insured	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. An 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, Cyclotrons 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.	Enrolment 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 , Room no capping ,Pre 60 post 90 days		
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**	**% Of earn point**	**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 1.1.1(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.
      In case the wellness points earned post renewal of policy is not utilized within 3 months from policy expiry date, then the amount equivalent to the difference between the slab considered for wellness discount at renewal and the new slab, shall either be refunded to the Policyholder, or the policyholder shall be allowed to encash the points through vouchers under wellness programs.

1.1.13 Gender Reassignment Surgery

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

a) 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 48 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. 2.1.7 will not be applicable to the extent of cover offered under this benefit.

1.1.14 Screening and Vaccinations

We shall reimburse 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 the initial 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 the initial waiting period after completing the waiting period of 36months 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 year.

1.2 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.

1.2.1 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.

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

c) Any expenses related to Ectopic Pregnancy (abdominal operation for extra uterine pregnancy), which is proved by submission of Ultra Sonographic Report, would not be covered under this Benefit, but would be considered as a claim made under Section 1.1.1 a (In Patient Hospitalization).

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

<table>
<tr><th>Plan</th><th>Mini</th><th>Medi</th><th>Max</th></tr>
<tr><td rowspan="4">Sum Insured option</td><td>Normal-20,000
Caesarean- 30,000</td><td>Normal-20,000
Caesarean- 30,000</td><td>Normal-20,000
Caesarean- 30,000</td></tr>
<tr><td rowspan="3">Normal – 30,000
Caesarean – 50,000</td><td>Normal-30,000
Caesarean- 50,000</td><td>Normal-30,000
Caesarean- 50,000</td></tr>
<tr><td rowspan="2">Normal-50,000
Caesarean-75,000</td><td>Normal-50,000
Caesarean-75,000</td></tr>
<tr><td>Normal-75,000
Caesarean-10,0000</td></tr>
<tr><td>Pre-Natal Expenses</td><td>30 days</td><td>60 days</td><td>90 days</td></tr>
<tr><td>Post Natal Expenses</td><td>45 days</td><td>45 days</td><td>45 days</td></tr>
</table>

1.2.2 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 1.1.1 (Medical Expenses). This benefit is payable only once during the Policy Year.

Mini	Medi	Max
5,000	5,000	5,000
10,000	10,000	10,000

1.2.3 Critical Illness Booster

We will increase the Sum Insured by additional amount equivalent to 1.5 or 2 times of the 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 the Policy) which occurred during the Policy Year. Such increase of the Sum Insured shall be available for claims arising under Section 1.1.1.a (In Patient Hospitalization). Cumulative Bonus (if any) and Cumulative Bonus Booster (if opted) 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 is 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 1.1.1.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 and Cumulative Bonus (If any) and Cumulative Bonus Booster (If opted).

f) The insured should cover 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 –

I. Basic Sum Insured

II. Cumulative Bonus
III. Cumulative Bonus Booster (if opted)
IV. Critical Illness Booster
V. Restoration Sum Insured

1.2.4 Cumulative Bonus Booster

a. The Insured Person would 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 (1.1.14), Wellness Benefits (1.1.12), OPD treatment (1.1.10) 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 (1.1.9) 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.

Illustration –

Year of policy	SI**	CB *	CB Booster	Total SI	Claims status
1 year	500,000	-	-	500,000	No
2 years	500,000	125,000	500,000	1,125,000	No
3 years	500,000	250,000	1,000,000	1,750,000	No
4 years	500,000	375,000	1,500,000	2,375,000	Yes
5 years	500,000	250,000	1,500,000	2,250,000	No
6 years	500,000	375,000	2,000,000	2,875,000	No
7 years	500,000	500,000	2,500,000	3,500,000	No
8 years	500,000	500,000	2,500,000	3,500,000	No
9 years	500,000	500,000	2,500,000	3,500,000	Yes
10 years	500,000	375,000	2,500,000	3,375,000	No
CB* = Cumulative bonus , SI = Sum Insured**					

1.2.5 Accident Booster

We will increase the Sum Insured by an additional amount equivalent to the 1.5 or 2 times of the 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 1.1.1.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 1.1.1.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 and 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

1.2.6 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 1.1.1.a (In Patient Hospitalization).

Mini	Medi	Max
250	500	1,500
500	750	2,000
	1,000	

1.2.7 Alternative Treatment

[1]We will Pay Reasonable and Customary Charges for Medical Expenses up to the Sum Insured, 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)
b) [2]Outpatient Medical Expenses.
[3]

1.2.8 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 1.1.1 (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.

Mini	Medi	Max
250	500	1,500

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

500	1,000	2,000
1,000	1,500	2,500
-	2,000	-

1.2.9 Road Ambulance

We will reimburse expenses incurred towards Road Ambulance charges for transportation of an Insured person, by an ambulance of a Hospital or of a registered ambulance service provider. Our 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 have accepted the claim under Section 1.1.1 a (In Patient Hospitalization) and Section 1.1.1b (Day care Treatment Expenses).

Mini	Medi	Max
1,000	1,500	2,000
1,500	2,000	3,00/0
2,000	3,000	5,000

1.2.10 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 is 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 are submitted to Us.

e) We have accepted the claim under Section 1.1.1.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.

Limit of Emergency Air Ambulance

Mini	Medi	Max
1,00,000	3,00,000	5,00,000

1.2.11 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 would 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 1.1.2 & 1.1.3 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 1.1.2 and 1.1.3 respectively.
g) Only Allopathic treatment shall be covered under this Benefit.
h) Any sub limits applicable for Section 1.1.1 to Section 1.1.3 shall also be applicable under this Benefit.
i) This Benefit shall not cover any expenses incurred towards attendant/ nursing services
j) Section 1.2.6 (Accompanying Person) are not applicable for claims admissible under this Benefit.
k) Clause 1.2.14 (Voluntary Co-Payment) shall not apply to the extent of cover provided under this benefit.

1.2.12 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 1.1.1 (Medical Expenses)
c) Will be covered up to sublimit of 15 % of admissible claim amount.
d) Pre and post hospitalization expenses will be excluded from this cover.
e) Exclusion 2.2.18 will not be applicable.

1.2.13 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.

Limit of Accidental Death Cover

Mini	Medi	Max
1,00,000	2,00,000	3,00,000
2,00,000	3,00,000	4,00,000
	4,00,000	5,00,000

1.2.14 Voluntary Co-Payment

The Co-Payment as opted by the Policyholder from 10% / 20% / 30% 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 Cover
   (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

1.2.15 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 1.2.14 above and Section 5.2.1.b(ix), the same would be applied on 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

Plan	Mini	Medi	Max
Deductible option	10,000	10,000	50,000
	25,000	25,000	75,000

	50,000	50,000	1,00,000

2 EXCLUSIONS

We shall not be liable to 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.

2.1 STANDARD EXCLUSIONS

2.1.1 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 of 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 case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then 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.

2.1.2 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 case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

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

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

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then 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) Benign Prostatic Hypertrophy
3) Lasik Surgery
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

2.1.3 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.

2.1.4 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.

2.1.5 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.

2.1.6 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

2.1.7 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.

2.1.8 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 medically necessity, it must be certified by the attending Medical Practitioner.

2.1.9 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.

2.1.10 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.

2.1.11 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.

2.1.12 Code - Excl12

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

2.1.13 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.

2.1.14 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.

2.1.15 Refractive Error: Code - Excl15

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

2.1.16 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.

2.1.17 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

2.2 SPECIFIC EXCLUSIONS

2.2.1 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.

2.2.2 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.

2.2.3 Any expenses incurred on Domiciliary Hospitalization.

2.2.4 Treatment taken outside the Geographical limits of India

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

2.2.6 Vaccination/ inoculation (except as post bite treatment)

2.2.7 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.

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

2.2.9 External Congenital Anomaly and related Illness/ defect.

2.2.10 Stem cell storage.

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

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

2.2.13 Outpatient diagnostic, medical and Surgical Procedures or treatments.

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

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

2.2.16 Intentional self-Injury.

2.2.17 Yoga and Naturopathy

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

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

3 Eligibility:

3.1 **Policy Options:** Individual and Family Floater

3.2 **Age Eligibility:**

Minimum Age At Entry Adult	18 days
Maximum Age At Entry Adult	65 years
Minimum Age At Entry child	1 day
Maximum Age At Entry child	25 years
Maximum Renewal Age	Life Long
Minimum policy term	1 year
Maximum Policy term	3 years

3.3 **Family Definition:**

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 Maxi plan** - Self, Spouse/Live - in partner, Children (up to 25 years of age) , parents and parents- in-law .

Family means the Primary Insured /Proposer's legally wedded spouse, natural or legally adopted child, parents and parents in law, siblings, daughter in law, son in law, parents in law, grandparents.

The maximum number of members that can be covered is up to 15 members.

3.4 Optional benefit criteria -

- If you opt for the optional covers, you should pick at least 3 optional covers.
- If you have chosen the sum insured for a particular section, then you are eligible to choose the sublimit, waiting period, and optional benefits for that section only.

3.5 Change In Sum Insured/ optional benefits:

1. Change in sum insured or plan allowed only at renewal.
2. Fresh proposal form/ Change Request Form is required all change in request.
3. No increase/decrease in Sum Insured/Plan during the currency of the policy.
4. Increase in Sum Insured can be allowed up to five slabs higher.
5. For sum insured up to ₹ 10 Lacs
   For age group up to 50 years increase in sum insured can be allowed without medical examination (Subject to no claim/ no health declaration).
   For the age group above 50 years an increase in the sum insured can be allowed only with medical examination.
6. Sum insured above 10 lakhs; medical examination is required irrespective of age.
   In case of claims under expiring policies and fresh declaration, the guidelines mentioned under Medical Underwriting Guidelines shall be applicable.
7. For basic coverage, there is an option to modify the Sum Insured at renewal. The appropriate sublimit offered under the new plan must be chosen.
   There is no option to modify sublimit under the same plan.
   Even if the Sum Insured plan is modified at renewal, there is no opportunity to alter the Waiting periods.
8. Under the Optional covers, there is option to change only benefits at renewal and
9. It is mandatory to opt for at least three optional benefits at any given time.

4 Discounts/ Other Loadings Applicable Under the Product

a) **Family discount** – 10% Family discount in the case of more than one insured covered under the same policy on an individual sum insured basis.

b) **Long-term discount** (applicable in case of single payment for policy term of more than one year)

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

c) **Voluntary deductible discount –** In case a deductible is opted under the policy, a corresponding discount will be applicable as per table below. The deductible is applicable on an aggregate basis.

Up to 10 lakhs		11 lakhs-15 lakhs	
Deductible	**Discount**	**Deductible**	**Discount**
Rs.10,000	8%	Rs.50,000	15%
Rs.25,000	15%	Rs.75,000	20%
Rs.50,000	20%	Rs.1,00,000	25%

d) **Web sales / Tele sales discount:** A discount of 15% in lieu of intermediary commissions if policy is sourced directly from the Company's website or through leads generated via Tele sales channel.

e) **Employee discount:** we shall accord a discount of 15 %, on the premium amount, against proposals received from the following categories of individuals, provided that the respective individual, at least till the date of issuance of the policy cover, continues to be in/of such capacity:

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

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

f) **Floater discount:**
Applicable discount is as per following table:

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

Premium applicable for the primary insured will be the standard individual premiums from the premium table. For remaining dependent members, floater discounts applicable on their respective premium are as per table above.

For example – In case of a family of Self, spouse and 1 child, the premium for floater for Sum Insured ₹ 10,00,000 would be charged in the following manner –

Sum insured is 1000000, OPD- 5K, Lasik Surgery-75K, Waiting Period- 2 Years			
	Self	Spouse	Child
Age band (in years)	36-40	31-35	0-17
Premium as per Individual rate table (in ₹)	12401	11746	7911
Applicable premium (in ₹)	12401	6460	3164

		(45% discount applied on the respective person's premium)	(60% discount applied on the respective person's premium)
Total Premium to be charged (in ₹)	12401+6460+3164		
	22025		

g) **Instalment Loading:**
Premium Payment facility on instalment basis is available. Given below are the loadings applicable on Standard premiums in case of instalments:

Instalment frequency	Loading on standard premiums
Monthly	5%
Quarterly	4%
Half-Yearly	3%
Yearly (for 2,3-year policies	0%

Pre-Existing Diseases Waiting Period	
Waiting Period	Loadings
1 Year	4%
2 Years	0%
3 Years	-1.5%
4 Years	-2.50%

h) **Loading On Claim Experience**: There will be no loading on premium for adverse claims experience.

i) **Underwriting Loading:**

Taking into account the proposal form and /or the medical reports following decisions & loadings are applicable.

	Condition	Underwriting Decision
1	**Diabetes**	
A	Pre-Diabetic/ Not a known case of Diabetes (HbA1c 5.9 - 6.49%)	Exclusion[#]
B	Known case of Diabetes (HbA1c up to 5.9 - 6.49%)	10% loading with Exclusion for pre-existing
C	Diabetic (HbA1c level 6.5% - up to 8%)	15% loading with Exclusion for pre-existing
D	Diabetic (HbA1c level >8%)	Decline
2	**Hypertension**	
a	Known / not known Hypertensive (140mm HG Systolic /90 mmHg diastolic)	10% loading with Exclusion for pre-existing
b	Known / not known Hypertension (141 to 150 mmHg Systolic / 91 to 100 mm Hg diastolic)	15% loading with Exclusion
c	Known / not known Hypertension (Above 150 mmHg Systolic / Above 100 mm Hg diastolic)	Decline
3	**Serum Cholesterol**	
a	Above +25 mg/dl to +50 mg/dl above the maximum *Normal range	10% loading
b	+51 mg/dl to +100 mg/dl above the maximum *Normal range	15% loading
4	**Serum Triglycerides**	
a	Above +20 mg/dl to + 45 mg/dl above the maximum *Normal range	10% loading

b	Above+46 mg/dl to 75 mg/dl of the maximum* Normal range	15% loading
5	**Serum creatinine**	
a	up to 0.3 mg/dL above the maximum *Normal range	10% loading
b	Above 0.3 up to 0.8 mg/dl of the maximum*Normal range	15% loading
6	**Asthma**	10% loading
7	Smoking and or Tobacco chewing/ Ghutka	10% loading
9	**BMI**	
a	(BMI from 32.1 to 34)	10% loading
b	(BMI from 34.1 to 36)	15% loading
c	36.1 and above	Decline
10	**Combination of any two or more conditions**	To be Reviewed for Acceptance/ Declinature
11	**Positive history of any other ailment(s)/ disease(s)**	To be Reviewed for Acceptance/ Declinature

Medical loading shall be applicable on the respective individual member premium in individual as well as on floater policy.
* Normal range of values of the respective Laboratory where tests were conducted.
Insured is eligible for 100% reimbursement of pre-acceptance medical tests charges subject to policy issuance and 64 VB compliance.
Pre-acceptance medical tests need to be done in the empaneled diagnostic centers only.
The tests would be considered valid for a period of one month from the date the tests were conducted.

j) **Medical Tests**

Plans	**Mini**		**Midi**		**Max**	
	4 lakhs, 5 lakhs		6 lakhs, 7 lakhs, 8 lakhs, 9 lakhs, 10 lakhs		11 lakhs, 12 lakhs, 13 lakhs, 14 lakhs, 15 lakhs	
Age band	Up to 50 years	Above 50 years	From 18 years to 50 years	Above 50 years	From 18 years to 50 years	Above 50 Years
Medical tests	Not required	Required	Not required	Required	Required	Required
Series details	Not Applicable	Series 9	Not Applicable	Series 9	Series 10	Series 10

*No tests required for children below 18 years for any plan
** Age in completed years
Nil Medical tests mentioned above shall be subject clean proposal form.
FMR: Full Medical Report by an MD Physician
ECG: Electrocardiogram reported by an MD Physician

*** Normal range** of values of the respective Laboratory where tests were conducted.

[#] Insured is eligible for 100% reimbursement of pre-acceptance medical tests charges subject to policy issuance and 64 VB compliance.

- Pre-acceptance medical tests need to be done in the empaneled diagnostic centers only.
- The tests would be considered valid for a period of one month from the date the tests have been conducted.
- Decision will be based on underwriter's discretion with respect to the specific conditions as per the provisions of Chapter IV of 'Guidelines on Standardization of Exclusions in Health Insurance Contracts'

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 fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

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 eight continuous years under the policy no look back to be applied. This period of eight years is called the moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

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 an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

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

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

5.1.12 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.

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

For updated details of grievance officer, kindly refer the link https://general.futuregenerali.in/general-insurance/pdf/Grievance_Redressal_Procedures.pdf

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

Kindly refer to the annexure on Grievance Redressal Procedures.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/igms.irda.gov.in/

5.1.13 Nomination

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

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 2.2.12 (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 2.2.10 (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) 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 6.2.1.a.ii and 6.2.1.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 1 day's 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
Yearly	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 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 Yearly 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 the instalment premium due for the policy.
b) During such a grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
c) The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
d) No interest will be charged if the instalment premium is not paid on due date
e) In case the instalment premium due, is not received within the grace period, the policy will get cancelled.
f) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
g) The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
h) The payment will be accepted through E-NACH / ACH/ ECS / any other mode approved by Government of India.
i) On successful registration for the mandate/ E-NACH/ any other mode approved by Government of India; the premium shall be auto debited as per the frequency opted.
j) In case of withdrawal of E-NACH/ ACH/ ECS / any other mode approved by Government of India; a written communication will be required from policyholder.
k) In case there is failure in transaction in E-NACH/ ACH/ ECS mode/ any other mode approved by Government of India, or the instalment premiums are not received within the grace period, the Policy will get cancelled. A fresh policy with all waiting periods would be issued.
l) If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered. This provision will not apply to claims arising under Section 1.1.10 (OPD Treatment Expenses) and Section 1.1.12 (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 the 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 – Premium rates in INR exclusive of Goods & Services Tax (age in completed years)

Individual premium for base cover Excluding OPD and Lasik benefit

Age Band	400,000	500,000	600,000	700,000	800,000	900,000	1,000,000	1,100,000	1,200,000	1,300,000	1,400,000	1,500,000
0-17	4,849	5,380	5,864	6,149	6,433	6,717	7,001	7,212	7,290	7,369	7,447	7,526
18-25	6,716	7,467	8,069	8,470	8,872	9,274	9,675	11,172	11,282	11,392	11,502	11,612
26-30	7,325	8,156	8,800	9,244	9,689	10,133	10,577	12,085	12,207	12,328	12,450	12,571
31-35	7,629	8,530	9,152	9,573	9,994	10,415	10,836	12,349	12,475	12,601	12,727	12,852
36-40	8,071	9,030	9,683	10,135	10,587	11,039	11,491	13,012	13,146	13,281	13,415	13,549
41-45	8,757	9,804	10,503	11,002	11,500	11,999	12,498	14,031	14,178	14,325	14,471	14,618
46-50	11,881	13,338	14,256	14,973	15,691	16,408	17,126	18,718	18,924	19,129	19,335	19,541
51-55	18,374	20,536	21,830	22,924	24,017	25,111	26,205	26,820	27,127	27,434	27,741	28,048
56-60	24,138	27,056	28,754	30,252	31,749	33,246	34,744	35,468	35,884	36,299	36,715	37,130
61-65	40,856	45,970	48,839	51,507	54,175	56,843	59,511	60,551	61,282	62,013	62,743	63,474
66-70	57,578	64,888	68,928	72,767	76,606	80,446	84,285	85,640	86,686	87,732	88,778	89,824
71-75	72,963	82,293	87,410	92,327	97,244	102,161	107,077	108,722	110,059	111,395	112,731	114,067
76-80	86,700	97,834	103,913	109,792	115,671	121,549	127,428	129,332	130,927	132,523	134,118	135,713
>=81	90,097	101,677	107,995	114,111	120,228	126,345	132,462	134,430	136,089	137,748	139,408	141,067

OPD Premium	(Comprehensive Cover including mental illness and mental illness restoration Applicable for SI 4 lacs and above)			
2000	3000	5000	7500	10000
240	360	600	900	1,200

only mental illness and mental illness restoration-Applicable for SI 4 lacs	
2000	3000
48	72

Lasik Premium	30000	50000	75000	100000
	124	207	310	414

Optional Covers:

Maternity Expenses				
Option	**Age-Group**	**Caesarians Limit**	**Normal delivery limit**	**Office Premium**
A	18-25	30,000	20,000	140
	26-30	30,000	20,000	302
	31-35	30,000	20,000	186
	>35	30,000	20,000	186
B	18-25	50,000	30,000	228
	26-30	50,000	30,000	492
	31-35	50,000	30,000	305
	>35	50,000	30,000	305
C	18-25	75,000	50,000	351
	26-30	75,000	50,000	755
	31-35	75,000	50,000	466
	>35	75,000	50,000	466
D	18-25	100,000	75,000	481
	26-30	100,000	75,000	1,034
	31-35	100,000	75,000	634
	>35	100,000	75,000	634

Hospital Daily Cash		
Hospital Daily Cash-Non-ICU	**Hospital Daily Cash-ICU**	**Office Premium**
250	500	108
500	1000	215
1000	2000	430
1500	3000	645
2000	4000	860
2500	5000	1075

Accompanying Person	
Amount per day	**Office Premium**
250	78
500	156
750	235
1000	313
1500	469
2000	626

Convalescence Benefit	
Convalescence Benefit	**Office Premium**
5000	15
10000	30

Road Ambulance Charges					
Age Band	**1,000**	**1,500**	**2,000**	**3,000**	**5,000**
0-17	10	15	20	29	49
18-25	10	15	20	29	49

26-30	10	15	20	30	50
31-35	10	15	20	31	51
36-40	11	16	21	32	53
41-45	11	17	22	33	56
46-50	15	23	30	45	76
51-55	19	29	38	58	96
56-60	22	33	44	66	111
61-65	33	49	65	98	163
66-70	39	58	78	116	194
71-75	46	70	93	139	232
76-80	55	83	111	166	277
>=81	58	86	115	173	288

Air Ambulance			
Sub-limit	**100000**	**300000**	**500000**
Office Premium	94	187	187

Non-Medical & Consumables expenses Cover	
Office Premium	646

Home Health Care	
Office Premium	329

AYUSHTreatments	
Office Premium	247

Accidental Death Benefit					
SI	**100000**	**200000**	**300000**	**400000**	**500000**
Office Rates	59	118	178	237	296

Voluntarily Deductible			
Up to 10 lakhs		**11 lakhs-15 lakhs**	
Deductible	**Discount**	**Deductible**	**Discount**
Rs.10,000	8%	Rs.50,000	15%
Rs.25,000	15%	Rs.75,000	20%
Rs.50,000	20%	Rs.1,00,000	25%

Voluntarily Copay*	
Copay %	**Discount**
10%	8%
20%	15%
30%	25%

Cumulative Bonus Booster	
Loading	12%

Critical Illness Booster												
For booster 1.5 X												
Age-Band	**400,000**	**500,000**	**600,000**	**700,000**	**800,000**	**900,000**	**1,000,000**	**1,100,000**	**1,200,000**	**1,300,000**	**1,400,000**	**1,500,000**

0-17	291	346	394	437	474	507	535	559	580	596	610	621
18-25	381	452	516	571	620	663	700	731	758	780	798	812
26-30	448	532	606	672	730	780	823	860	892	918	939	956
31-35	560	665	758	840	912	975	1,029	1,075	1,115	1,147	1,174	1,194
36-40	829	984	1,122	1,244	1,350	1,443	1,523	1,592	1,650	1,698	1,737	1,768
41-45	1,411	1,676	1,910	2,117	2,299	2,457	2,593	2,710	2,809	2,891	2,957	3,010
46-50	2,285	2,713	3,093	3,428	3,722	3,978	4,199	4,388	4,547	4,680	4,788	4,873
51-55	3,494	4,150	4,731	5,243	5,692	6,084	6,422	6,711	6,955	7,158	7,323	7,454
56-60	5,152	6,118	6,975	7,730	8,393	8,970	9,468	9,894	10,254	10,553	10,796	10,989
61-65	7,370	8,751	9,977	11,057	12,005	12,831	13,543	14,153	14,667	15,095	15,444	15,719
66-70	10,259	12,183	13,888	15,393	16,712	17,861	18,854	19,702	20,418	21,014	21,499	21,883
71-75	13,955	16,572	18,892	20,938	22,733	24,296	25,646	26,800	27,774	28,585	29,244	29,766
76-80	18,570	22,051	25,139	27,862	30,250	32,330	34,126	35,662	36,958	38,036	38,914	39,609
81-85	24,304	28,861	32,902	36,466	39,592	42,313	44,664	46,674	48,371	49,782	50,931	51,840
>85	31,293	37,160	42,363	46,952	50,976	54,481	57,508	60,096	62,281	64,097	65,577	66,748

For booster For booster 2 X

Age-Band	400,000	500,000	600,000	700,000	800,000	900,000	1,000,000	1,100,000	1,200,000	1,300,000	1,400,000	1,500,000
0-17	374	445	507	562	610	652	688	719	745	767	785	799
18-25	490	581	663	735	798	852	900	940	974	1,003	1,026	1,044
26-30	576	684	780	864	938	1,003	1,059	1,106	1,146	1,180	1,207	1,229
31-35	720	855	975	1,080	1,173	1,254	1,323	1,383	1,433	1,475	1,509	1,536
36-40	1,066	1,265	1,443	1,599	1,736	1,855	1,958	2,046	2,121	2,183	2,233	2,273
41-45	1,814	2,155	2,456	2,722	2,956	3,159	3,334	3,484	3,611	3,716	3,802	3,870
46-50	2,938	3,488	3,977	4,408	4,785	5,114	5,399	5,641	5,847	6,017	6,156	6,266
51-55	4,493	5,335	6,082	6,741	7,319	7,822	8,257	8,628	8,942	9,203	9,415	9,583
56-60	6,624	7,866	8,967	9,939	10,791	11,532	12,173	12,721	13,183	13,568	13,881	14,129
61-65	9,475	11,252	12,827	14,217	15,435	16,496	17,413	18,196	18,858	19,408	19,856	20,211
66-70	13,190	15,664	17,857	19,791	21,487	22,965	24,240	25,331	26,252	27,018	27,642	28,135
71-75	17,942	21,307	24,290	26,921	29,228	31,238	32,973	34,457	35,710	36,752	37,600	38,271
76-80	23,875	28,352	32,321	35,822	38,893	41,567	43,876	45,851	47,518	48,904	50,032	50,926
81-85	31,248	37,107	42,302	46,885	50,903	54,403	57,425	60,010	62,192	64,006	65,483	66,652
>85	40,234	47,777	54,466	60,367	65,541	70,047	73,938	77,266	80,075	82,411	84,313	85,818

Accident Booster

SI	400,000	500,000	600,000	700,000	800,000	900,000	1,000,000	1,100,000	1,200,000	1,300,000	1,400,000	1,500,000
1.5 times booster	54	64	73	81	88	94	99	103	107	110	113	115
2 times booster	69	82	94	104	113	120	127	133	138	142	145	147

Specified Illness waiting Period	
Waiting Period	Loadings
1 Year	4%
2 Years	0%

Pre-Existing Diseases Waiting Period	
Waiting Period	Loadings
1 Year	4%
2 Years	0%
3 Years	-1.5%
4 Years	-2.50%

Pre/Post Hospitalization options		
	Days	Loading
Pre-hospitalization	30	-1.0%
	60	0.0%
	90	3.5%
Post Hospitalization	60	-1.0%
	90	0.0%
	120	3.5%

Room Rent Capping Options	
Discount if capping is chosen-	
Sum Insured	Selected discount at 1% of Sum Insured
400000	10.00%
500000	8.5%
600000	8.00%
700000	7.5%
800000	7.25%
900000	7.00%
1000000	6.50%
1100000	6.25%
1200000	6.00%
1300000	5.70%
1400000	5.25%
1500000	5%

Premium Illustration:

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (in ₹)	Sum insured (in ₹)	Premium (in ₹)	Discount, if any	Premium after discount (in ₹)	Sum insured (in ₹)	Premium or consolidated premium for all members of family (in ₹)	Floater discount, if any	Premium after discount (in ₹)	Sum insured (in ₹)
50 years	13,822	500,000	13,822	1382	12,440	500,000	13,822	5529	8,293	500,000
42 years	10,288	500,000	10,288	1029	9,259	500,000	10,288	4115	6,173	
17 years	5,864	500,000	5,864	586	5,278	500,000	5,864	3518	2,346	
20 years	7,951	500,000	7,951	795	7,156	500,000	7,951	4373	3,578	
27 years	8,640	500,000	8,640	864	7,776	500,000	8,640	4320	4,320	
27 years	8,640	500,000	8,640	864	7,776	500,000	8,640	4320	4,320	
32 years	9,014	500,000	9,014	901	8,113	500,000	9,014	4056	4,958	
35 years	9,014	500,000	9,014	901	8,113	500,000	9,014	4056	4,958	
36 years	9,514	500,000	9,514	951	8,563	500,000	9,514	4281	5,233	
40 years	9,514	500,000	9,514	951	8,563	500,000	9,514	4281	5,233	
52 years	21,020	500,000	21,020	2102	18,918	500,000	21,020	8408	12,612	
57 years	27,541	500,000	27,541	2754	24,787	500,000	27,541	9639	17,901	
65 years	46,454	500,000	46,454	4645	41,809	500,000	46,454	16259	30,195	
65 years	46,454	500,000	46,454	4645	41,809	500,000	46,454	16259	30,195	
70 years	65,372	500,000	65,372	6537	58,835	500,000	65,372	0	65,372	
Total Premium for all members of the family is ₹299101/-, when each member is covered separately.			Total Premium for all members of the family is ₹269191/-, when they are covered under a single policy.				Total Premium when policy is opted on floater basis is ₹205686/-			
Sum insured available for each individual is ₹500000			Sum insured available for each family member is ₹500000				Sum insured of ₹500000 is available for the entire family.			

Note - Premium illustration is based on S.I of ₹ 500,000, OPD limit of ₹ 3000 and Lasik limit ₹ 30,000 with waiting period of 2 year for PED and listed illness, no capping for room rent and pre & post hospitalization of 30 and 90 days respectively.

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

Section 41 of Insurance Act 1938 (Prohibition of Rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.
2. Any person making default in complying with the provision of this section shall be punishable with fine which may extend to Ten Lakh Rupees

Disclaimer: THE ABOVE IS DESCRIPTIVE ONLY. THE ACTUAL TERMS AND CONDITIONS CAN BE FOUND IN THE POLICY DOCUMENT. INSUREDS ARE ADVISED TO READ THE POLICY DOCUMENT COMPLETELY FOR A FULL DESCRIPTION OF THE TERMS AND CONDITIONS OF COVERAGE AND THE EXCLUSIONS RELATING TO THERETO.

In case of any claims please contact:

Claims Department Future Generali Health (FGH) Future Generali
India Insurance Co. Ltd. Office No. 3, 3rd Floor, ³$´ Building,
G - O - Square S. No. 249 & 250, Aundh Hinjewadi Link Road,
Wakad, Pune - 411 057.

Toll Free Number: 1800 103 8889
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