FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Health PowHER
Prospectus

1. SALIENT FEATURES OF POLICY

BASE COVER

➢ MEDICAL EXPENSES COVER

- In-patient Hospitalization
- Other Expenses- LASIK Surgery, Bariatric Surgery, Cataract Surgery
- Post -hospitalization Medical Expenses
- Cosmetic/Plastic Surgery
- Emergency Air Ambulance
- Organ Donor Expenses
- Restoration of Sum Insured
- Cumulative Bonus
- Maternity Expenses
- Newborn baby Expenses Cover
- Newborn Vaccination
- Cancer Care Booster
- Day Care Treatment
- Pre-hospitalization Medical Expenses
- Modern Treatment Method and Advancement in Technologies
- Emergency Road Ambulance
- Alternative Treatment
- Home Health Care Expenses
- OPD Treatment
- Ante-Natal Care
- Miscarriage & Medical Termination of Pregnancy
- Newborn Defect
- Stem Cell Storage

➢ WOMEN CARE

- Infertility Expenses
- Senior Care
- Temporary Domestic Help
- Preventive Care
- Voluntary Sterilization
- Nursing Care Expenses
- Puberty & Menopause Disorders

➢ VALUE ADDED SERVICES

- Wellness Benefits

OPTIONAL COVER

➢ Critical Care

- Critical illness - Lumpsum Benefit
- E- Medical Second Opinion

➢ Accident Care

- Personal Accident Cover

➢ Voluntary Co-payment

2. SCOPE OF COVER

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

2.1 BASE COVERS

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

MEDICAL EXPENSES COVER

2.1.1 Medical Expenses

a) In-patient Hospitalization:

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

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

b) Day Care Treatment:

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

c) Other Expenses:

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

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

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

ii) Bariatric Surgery - We will pay the Reasonable and Customary Charges for Medical Expenses incurred towards Surgical Procedure for Obesity, subject to below conditions:

a) Our obligation to make payment in respect of Bariatric Surgery (after 36 months of continuous coverage from the first inception of the Health PowHER Policy with Us), shall be restricted to an amount as specified under the particular plan, in the Schedule of Benefits.
b) The claim related to Bariatric Surgery shall be payable only for expenses related to the surgical treatment of obesity that fulfil below conditions:

(i) Surgery to be conducted is upon the advice of the Medical Practitioner
(ii) The surgery/ procedure conducted should be supported by clinical protocols.
(iii) The Insured Person has to be 18 years of age or older and
(iv) Body Mass Index (BMI);
1) greater than or equal to 40 or
2) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

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

iii) Cataract Surgery - We will make payment in respect of Cataract Surgery up to an amount as specified, under the particular plan, in the Schedule of Benefits, provided that:
1) This benefit shall come into effect only after the Insured Person has completed 24 months of continuous coverage.

2.1.2 Pre-Hospitalization Medical Expenses:

We will pay the reasonable and customary charges for Pre-Hospitalization Medical Expenses incurred immediately prior to the date of the Insured Person's hospitalization for the number of days as specified, under the particular plan, in the Schedule of Benefits.

2.1.3 Post – Hospitalization Medical Expenses:

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

2.1.4 Modern Treatment Method and Advancement in Technologies:

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

We will cover medical expenses incurred on the following procedures:

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

2.1.5 Cosmetic/Plastic Surgery:

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

2.1.6 Emergency Road Ambulance:

We will reimburse expenses incurred towards Road Ambulance charges for transportation of an Insured person, by an ambulance of a hospital or of a registered ambulance service provider.
Our maximum liability per hospitalization under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.

Following Expenses shall be covered under this benefit:

(i) Transportation Costs towards transferring the Insured Person from the place of incident to Hospital, from one Hospital to another Hospital or to a diagnostic Centre for advanced diagnostic treatment where such facility is not available at the existing Hospital and advised by the treating medical practitioner.

(ii) When the Insured Person requires to be moved to home after discharge from the hospital and the medical condition of Insured Person is such that it requires services of Ambulance as certified by treating medical practitioner.

Special Condition:

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

2.1.7 Emergency Air Ambulance:

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

Following Expenses shall be covered under this benefit:

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

Special Condition:

a) The ambulance services of a hospital or a registered ambulance service provider is utilized.
b) The Ambulance provider is registered in India.
c) The place of occurrence of Emergency /Life Threatening medical condition and the location of hospitals, should be within the Indian Territory.

d) The original Ambulance bills and payment receipt is submitted to us.
e) We have accepted the claim under In-Patient Hospitalization (Section 2.1.1.a).
f) The severity of illness of Insured Person is such that it requires services of an Air Ambulance and is certified by treating medical practitioner.

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

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

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

2.1.9 Organ Donor Expenses:
We will pay the reasonable & customary charges for medical expenses incurred for an organ donor's treatment for the harvesting of the organ donated, up to the Sum Insured as specified in the Schedule of Benefits, provided that:
a) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act, 1994.
b) The organ donated is for the use of the Insured Person.
c) We have accepted claim under In-patient Hospitalization (Section 2.1.1.a) for the Insured Person.
d) The Insured Person is medically advised to undergo an organ transplant.

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

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

Special Condition:
a) This benefit can be availed only on cashless facility basis through Our Empaneled Home Health Care service provider.
b) The benefit is subject to pre-authorization obtained from Us.
c) Medical treatment which in the normal course requires care and treatment at a hospital, is taken while insured person is confined at home due to any of the following circumstances:
   i. The condition of the patient is such that he/she is not in a condition to be moved to a hospital, or

ii. The patient takes treatment at home on account of non-availability of bed / room in a hospital, or
iii. Non-availability of Hospital Services due to any prevailing conditions /Government Notification.
iv. Chemotherapy and dialysis at home.
v. For children up to the age of 15 years if treated at home instead of hospitalization, if certified by the Medical Practitioner that the child needs hospitalization for treatment but the same can be replicated at home with remote monitoring and nursing care.

d) The duration of Home Health Care treatment should be restricted to reasonable time and not more than the period of Hospitalization, the patient would have undergone otherwise.
e) Treatment under this benefit will be provided under the supervision of a Medical Practitioner to administer the treatment plan safely and effectively for the condition of the Insured Person.
f) In the event of medical treatment solely taken at home without any initial hospitalization, Pre and Post hospitalization expenses will be covered up to number of days specified under Section 2.1.2 & Section 2.1.3 respectively.
g) In case of post-surgical care availed through Home Health Care Services, where we have also accepted a claim under In-patient Hospitalization (Section 2.1.1.a) towards the initial hospitalization for surgical management at our empaneled network hospital on cashless basis, then Pre and Post hospitalization expenses will be covered up to number of days specified under Section 2.1.2 & Section 2.1.3 respectively.
h) Any sub limits applicable for Section 2.1.1 to Section 2.1.3 shall also be applicable under this Benefit.
i) This Benefit shall not cover any expenses incurred towards attendant/ nursing services.
j) Clause 6.2.13 shall not apply to the extent of cover provided under this benefit.

2.1.11 Restoration of Sum Insured:

Under this benefit a Restore Sum Insured equal to 100% of the base Sum Insured excluding Cumulative Bonus (if any) will automatically be available for the particular policy year for a second claim being reported during the policy year and accepted by Us.

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

a) The Restore Sum Insured can be used for claims made for same illness/ new illness in respect of Medical Expenses (Section 2.1.1).
b) The Restore Sum Insured can be used by an Insured person, once in a lifetime, for claims related to chemotherapy and dialysis under this Policy.
c) The Restoration of Sum Insured shall happen only once during a Policy Year.
d) If the Restore Sum Insured is not utilized in a policy year, it shall not be carried forward to any subsequent Policy Year.
e) If the Policy is issued on an Individual / Non-Floater basis, then the restore Sum Insured will be available to each Insured Person.
f) If the Policy is issued on a Floater basis, then the restored Sum Insured will be available on Floater basis for all Insured Persons in the family.

2.1.12 OPD Treatment:

We will reimburse the reasonable and customary charges incurred by the female Insured Person covered in the policy in relation to any illness/ injury sustained during the policy year towards medical consultations, diagnostic tests, and pharmacy expenses on an out-patient basis.

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

Special Condition:

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

2.1.13 Cumulative Bonus:

Cumulative Bonus shall be increased by 10% in respect of each claim free policy year (where no claims are reported) with an exception for any claim under Optional Cover (Critical Illness-Section 2.2.1 & Personal Accident Cover – Section 2.2.2), OPD treatment (Section 2.1.12), Wellness Benefit (Section 2.1.29), Preventive Care (Section 2.1.28), Antenatal Care (Section 2.1.14) & OPD Claim under Puberty and menopause disorders (Section 2.1.27), provided the policy is renewed with Us without a break, subject to maximum of 50% of the Sum Insured under the current policy year.

If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, Sum Insured will be maintained and will not be reduced in the policy year.

Special Condition:

a) In the case where the policy is on an individual / non-Floater basis, the Cumulative Bonus shall be added and available individually to the Insured Person if no claim has been reported. Cumulative Bonus shall reduce only in case of claim from the same Insured Person.
b) In case where the policy is on floater basis, the Cumulative Bonus shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. Cumulative Bonus shall reduce only in case of claim from any of the Insured Person.
c) Cumulative Bonus shall be available only if the Policy is renewed or renewal premium is paid within the Grace Period.
d) If the Insured Persons on the expiring policy are covered on an individual / Non Floater basis as specified in the Policy Schedule and there is an accumulated Cumulative Bonus for such Insured Person under the expiring policy and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
e) In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/ individual policies, or in cases where the policy is split due to the child attaining the age of 25 years, the Cumulative Bonus of the expiring policy shall be apportioned to such Renewed Policies in the proportion to the Sum Insured of each Renewed Policy.

f) If the Sum insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured in current Policy.
g) If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
h) If a claim is made in the expiring Policy Year and is notified to Us after the acceptance of renewal premium, any awarded Cumulative Bonus shall be withdrawn.

2.1.14 Ante-Natal Care:

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

Special Conditions:

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

2.1.15 Maternity Expenses:

We will pay reasonable and customary charges for medical expenses incurred by Insured Person or Surrogate Mother towards maternity expenses for the Insured Persons's Delivery (Normal /Cesarean) during the Policy Year.
Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.
This benefit shall only be available for a female Insured Person who should be aged 18 years or above and who should be either:

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

Special Condition:

a) The cover under this benefit is available if Single Female Insured or Female Insured person along with spouse are covered for a continuous period of 24 months before this benefit comes into effect.
b) Medical Expenses for the delivery of a child (including caesarean section) covered up to a maximum of 2 events in the lifetime of the Insured Person & 1 event in favour of Surrogate Mother.
c) In Favour of Surrogate Mother – Benefit will become payable subject to submission of Certificate from a "District Medical Board" in favor of either or both Insured (Self & spouse) necessitating gestational surrogacy in accordance with the "Surrogacy (Regulation) Act, 2021" at the time of claim.
d) We will cover the reasonable and customary charges for Pre-natal & Post Natal hospitalization expenses. The Period and charges for pre-natal and post-natal hospitalization expenses shall be restricted up to the sublimit as specified in the Schedule of Benefits.
   Note: In Favour of Surrogate Mother - Pre and Post natal hospitalization expenses or any medical expenses related to complications arising out of pregnancy and post-partum delivery are not covered.
e) Migration and portability shall not be applicable to this benefit.

f) Any expenses related to Ectopic Pregnancy (abdominal operation for extra uterine pregnancy), which is proved by submission of Ultra Sonographic Report, would not be covered under this Benefit, but would be considered as a claim made under In-Patient Hospitalization (Section 2.1.1.a)
g) Maternity Expenses related to Female Insured Person as a surrogate mother shall not be covered.
h) Clause 6.1.15.i shall not apply to the extent of cover provided under this benefit.

2.1.16 Miscarriage & Medical Termination of Pregnancy:

We will pay reasonable and customary charges for medical expenses incurred by the insured person towards medically necessary and lawful termination of pregnancy during the Policy Year.
Our maximum liability under this benefit shall be up to an amount as specified, under the particular plan, in the Schedule of Benefits.
This benefit shall only be available for a female Insured Person who should be aged 18 years or above and who should be either:
a) the Policyholder insured as Self or,
b) the Policyholder's Insured Spouse or Live-in Partner.

Special Conditions:
a) This benefit shall be payable only once during the lifetime of the Policy.
b) This benefit shall come into effect only after the Insured Person has completed 12 months of continuous coverage.
c) Maternity Expenses related to Female Insured Person as a surrogate mother shall not be covered.
d) Clause 6.1.15.ii shall not apply to the extent of cover provided under this benefit.

2.1.17 Newborn baby Expenses Cover:

If we have accepted a claim under Maternity Expenses (Section 2.1.15), then we will pay the reasonable and customary charges incurred by the Insured Person, during the Policy Year, towards the following:
a. In-patient Hospitalization expenses for the treatment of Newborn Baby while Insured Person (mother)/ Surrogate Mother is hospitalized for delivery.
b. This cover shall also be available for the newborn baby until the expiry date of the policy year in which the newborn baby is born without payment of any additional premium and is subject to the exclusions, terms and conditions of the Policy.
c. The cover for the new born baby shall be up to the Sum Insured of Insured Mother. In case of a Floater Policy, the cover shall be up to the Policy Sum Insured and in case of an Individual / Non-floater Policy, the cover shall be within the Sum Insured of Insured Mother.
d. The Newborn Baby can be covered as an Insured Person subject to premium being received for subsequent Policy year immediately succeeding the Policy Year in which the Newborn Baby was born.

2.1.18 Newborn Defect:

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

3. Spina Bifida

Special Condition

a) This benefit shall be payable only if we have accepted the claim under Maternity Expenses (Section 2.1.15).
b) This benefit shall be payable only once during the lifetime of the Policy.
c) Clause 6.2.6 shall not apply to the extent of cover provided under this benefit.

2.1.19 Newborn Vaccination:

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

Special Condition:

a) This benefit shall be payable only if we have accepted the claim under Maternity Expenses (Section 2.1.15).
b) If the Policy ends before the Newborn Baby has completed one year, then we will cover such vaccinations until the Newborn Baby completes one year, only if We have received the Newborn Baby premium as an Insured Person at the time of Renewal of the Policy.
c) Clause 6.2.3 shall not apply to the extent of cover provided under this benefit.

2.1.20 Stem Cell Storage:

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

Special Condition:

a) The stem cells of the Newborn Baby are preserved in an Indian based Stem Cell Bank only.
b) The payment under this Benefit is subject to a valid claim being accepted by Us under Maternity Expenses (Section 2.1.15).
c) This benefit shall be payable only once during the lifetime of the Policy.
d) Clause 6.2.8 shall not apply to the extent of cover provided under this benefit.

2.1.21 Cancer Care Booster:

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

Special Conditions:

a) Cover under this benefit is payable only if the symptoms of the condition are first diagnosed or manifest itself during the Policy Year.
b) In case of an admissible claim, the sequence of Sum Insured applicability shall be:
   1) Policy Sum Insured
   2) Cumulative Bonus

3) Cance Care Booster
4) Restoration of Sum Insured

c) This benefit shall come into effect only after the Insured Person has completed 12 months of continuous coverage.
d) We have accepted a claim for Medical Expenses (Section 2.1.1)
e) This benefit can be triggered only once during the lifetime of the Policy.
f) This benefit shall be available only in the Policy Year in which a claim, under this benefit, is triggered and utilized. This benefit shall not be available in any subsequent Policy Years.

WOMEN CARE

2.1.22 Infertility Expenses:

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

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

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

Following Expenses shall be covered under this benefit:

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

Special Condition:

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

Specific Exclusion

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

2.1.23 Voluntary Sterilization:

We will pay reasonable and customary charges incurred by the Female Insured person towards Voluntary Sterilization (Tubal Ligation) during Policy Year.

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

Special Condition:

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

2.1.24 Senior Care:

We will pay reasonable and customary charges incurred by the female Insured age 60 Years & above towards Curative Care Treatments as recommended by the treating medical practitioner during Policy Year.

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

Following Expenses shall be covered under this benefit:

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

Special Condition:

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

2.1.25 Nursing Care Expenses:

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

Special Condition:

a) We have accepted claims under In-patient Hospitalization (Section 2.1.1.a) or Day care treatment (Section 2.1.1.b).
b) Our maximum liability under this benefit shall be a fixed amount per day for the number of days as specified, under the particular plan, in the Schedule of Benefits.
c) The treating Medical Practitioner has recommended that nursing care is Medically Necessary.
d) Clause 6.2.13 shall not apply to the extent of cover provided under this benefit.

2.1.26 Temporary Domestic Help:

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

Special Condition:

a) We have accepted a claim under In-Patient Hospitalization (Section 2.1.1.a) against any female Insured aged 18 Years & above covered in the Policy during the Policy Year.
b) Our maximum liability under this benefit shall be a fixed amount per day for the number of days as specified, under the particular plan, in the Schedule of Benefits.

2.1.27 Puberty & Menopause Disorders:

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

Special Condition:

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

2.1.28 Preventive Care:

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

Following Expenses shall be covered under this benefit:

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

VALUE ADDED SERVICES

2.1.29 Wellness Benefits

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

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

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

a) All decisions regarding availing the wellness benefits are to be solely made by the Insured Person.
b) We do not provide/assume responsibility for the wellness benefits or make any representation as

to the adequacy or accuracy or quality of the same; any actual or alleged errors, omissions or representations whatsoever made by any of Our wellness service provider or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

A. Value Added Services

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

Sr No.	Wellness Program	Limit each policy year
1.	**Psychological Consultation** for discussion on general mental health issues with a mental health expert (clinical psychologist).	4 Tele consultation sessions
2.	**Gynecologist Consultation** with a clinical gynecologist during the Policy Year. This will include clinical support related to menstrual issues, Sexual health issues, fertility, contraception, and menopause, to maintain and improve the quality of Your healthy life.	4 consultation sessions (Online / In-Clinic) In-clinic Consultation available Only at network providers. In case network provider is not available, then opt for online consultation.
3.	**Home Diagnostic Services** Wherein the Network Provider shall be assigned to arrive at the doorstep of the Insured Person to collect samples required for prescribed diagnostic tests. Refer Health Checkup (point no. 11) for list of Diagnostic Test against home diagnostic services can be availed except for PAP smear and Mammography.	2 times in a policy year.
4.	**Women Fitness Program** (Gym) available to improve Your overall well-being. We will arrange a platform to book physical gym/training sessions at nearby network Gyms/Fitness studios.	12 fitness sessions
5.	**Diet & Nutritional Session** with professional Dietitian & Nutrition Coach to guide on General nutrition, diet, Wellness, and lifestyle.	4 Online consultation Session
6.	**Spa Wellness Session** for releasing toxic or unhealthy substances that can affect different aspects of health.	2 Spa Sessions
7.	**Face Yoga Sessions** to guide on a series of facial exercises which help to tone and tighten the muscles of the face.	1 Online Session
8.	**Yoga Membership** which includes sessions on fitness workout, yoga, and meditation.	Online Annual Membership
9.	**Access to Health Content & Webinars** which provide information on Physical and Mental wellness related topics.	Available
10.	**Discount on Wellness Products**	Available as per partner offering

11.	***Health Check Up** Hemogram, Thyroid function tests (T3, T4 & TSH), Glycosylated Hemoglobin (HbA1c), Lipid Profile, Fasting Blood Sugar Level, Anti Mullerian Hormone (AMH), Serum Calcium, Liver Function Test, Serum Phosphorus, Renal Profile, PAP smear, Mammography, Blood Pressure and Body Mass Index (BMI)	Once in a Policy Year

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

B. Wellness Rewards points

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

1) Stress & Happiness Index score

Stress & Happiness Index score is an online questionnaire for evaluation of health and quality of life. It helps the Insured Person to review the personal lifestyle practices which may impact his/ her health status. Insured Person can log into his/her account on FGII mobile App and take Stress & Happiness Index score. This can be undertaken twice per policy year at an interval of 6 months.

The reward points will be allotted only for participating in the online Stress & Happiness Index score Assessment.

2) Expert Wellness Assessment

Insured Person has an option to take a telephonic Expert Wellness Assessment, with a Clinical psychologist. This will help the Insured Person to understand his/ her mental health. Insured Person can log into the account on FGII mobile App and ask for Expert Wellness Assessment. This can be undertaken once per policy year per insured person.

The reward points will be allotted only for taking the expert wellness assessment. Confidentiality of the assessment will be maintained.

3) Participation in FGII organized events

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

4) Lifestyle disease monitor

Insured Person can earn wellness reward points on undergoing the Health Checkup included in Value Added Services (Point 11) under Wellness Benefit. Reward points will be allotted basis the below parameters falling within normal limits.

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

5) Enrolment to Wellness

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

6) Fitness / Healthy lifestyle tracking – We aim at encouraging a healthy fitness regime for all age groups.

Insured Person can earn wellness points every month by completing any one of the following activities.

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

Conditions applicable for earning the reward points:

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

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

Sr. No.	Criteria	Frequency allowed	Max. Points
1.	Stress & Happiness Index score	2 times /year	20
2.	Expert Wellness Assessment	Once/year	40
3.	Participation in FGII organized events (as and when organized) and viewing of FGII Content around wellness	As planned by FGII	20
4.	Lifestyle disease monitor • Hypertension – Blood pressure • Obesity -BMI • Diabetes – Hb A1C • Cardiac Health- Sr. Cholesterol, Triglycerides	Once/year	45
5.	Fitness/ Healthy Lifestyle tracking- (Any one activity) • Daily Step tracking (monthly average of 10000 steps/day) • Burning average of 300 calories per day in a month • Submission of monthly Gym /yoga membership detail • Participation in Marathon, Cyclathon etc.	Monthly	60
6.	Enrolment to Wellness	Once/year	15
	Total points		**200**

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

Points earned per member per year	Value of points earned
185- 200	5%
150-184	4%
100-149	3%
15-99	2%

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

Family Type	2 Adult+1 child		
Policy period	01-Jan-2024 to 31 Dec 2024		
Relation	Self (Female)	Spouse	Child (Female)
Sum insured (₹)	20L	20L	20L
Age Band	26	31	0-17
Individual premium (₹)	28,189	21,902	13,252
Family discounted premium (₹)	25,370	19,712	11,927

Points Earned	200	180	NA
% value of points earned	5%	4%	0%
Monetary value of reward points (₹)	1269	788	0

Detail breakup of reward point calculation (Earning and burning)

Date	Self			Spouse			Total		
	Points earned as on date	% value of points earned	Monetary value (₹)	Points earned as on date	% value of points earned	Monetary value (₹)	Monetary value (₹)	Balance available for utilization (₹)	Burn/Utilised on date (OPD/ Pharmacy/ NME) (₹)
21/03/2024	40	2%	507	30	2%	394	902		100
31/08/2024	100	3%	761	60	2%	394	1155	1055	200
15/10/2024	170	4%	1015	150	4%	788	1803	1503	
31/12/2024	200	5%	1269	180	4%	788	2057	1757	
Balance monetary value of reward points (₹) 1757 would be applied as discount at renewal									

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

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

Detail breakup of reward point calculation (Earning and burning)

Date	Self	Spouse	Average of points earned	% value of points earned	Monetary value (₹)	Balance available for utilization (₹)	Burn/Utilised (OPD/ Pharmacy/ NME) (₹)
	Points earned as on date	Points earned as on date					
21/03/2024	40	30	35	2%	805		100

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

Conditions applicable for burning of points:

1) The points earned will float among all members of the family irrespective of the persons who have contributed for earning the points.
2) Points earned in the first year can be carried forward to the 2nd or 3rd year in case of long-term policies.
3) The points can be burned for utilization of the following benefits.
   i. Availing Out-patient Consultations through the Wellness Partner network clinics
   ii. Diagnostic tests, preventive tests through the Wellness Partner network clinics
   iii. Purchase of Prescribed medicines through online pharmacy having tie up with Our Wellness Partner
   iv. Reimbursement of non-medical expenses in case of claim under Section 2.1.1.a (In-patient Hospitalization)
   v. Renewal Discount –
      a) Insured Person /Policy holder has an option to utilize the balance reward points as discount in premium at the time of renewal of the Policy.
      b) If the insured does not opt for Renewal discount, then the insured has an option to redeem the wellness reward points for availing the services as mentioned in point no. i, ii & iii above. The accrued wellness points can be utilized up to a period of 3 months from the policy expiry date.
      In case the wellness points earned are not utilized within 3 months from policy expiry date, then the amount equivalent to the total accrued wellness points, shall either be refunded to the policyholder, or the policyholder shall be allowed to encash the points through vouchers under wellness programs.
      c) After the renewal of the Policy with applicable wellness discount, the insured can continue to earn and accrue wellness reward points till the policy expiry date. The wellness points earned post renewal, that results in change of slab with respect to “Value of points earned”, can be utilized for availing the services as mentioned in point no. i, ii & iii above. Such wellness points can be utilized up to a period of 3 months from the policy expiry date.
      In case the wellness points earned post renewal of policy is not utilized within 3 months from policy expiry date, then the amount equivalent to the difference between the slab considered for wellness discount at renewal and the new slab, shall either be refunded to the policyholder, or the policyholder shall be allowed to encash the points through vouchers under wellness programs.
4) In case of cancellation of the policy or if the policy is not renewed with Us, any wellness reward points earned by the Insured can be utilized up to 3 months from the policy cancellation date or policy end date for the following benefits only.
   i. Availing Out-patient Consultations through Our Wellness Partner network clinics
   ii. Diagnostic tests, preventive tests through Our Wellness Partner network clinics
   iii. Purchase of Prescribed medicines through online pharmacy having tie up with Our Wellness Partner.

2.2 OPTIONAL COVER

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

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

CRITICAL CARE

2.2.1 Critical illness:

A. Lumpsum Benefit

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

Sr No	List of Critical Illness covered	Sr No	List of Critical Illness covered
1	Cancer of Specified Severity	2	Myocardial Infarction (First Heart Attack of Specified Severity)
3	Open Chest CABG (Coronary Artery Bypass Graft)	4	Open Heart Replacement or Repair of Heart Valves
5	Coma of Specified Severity	6	Kidney Failure Requiring Regular Dialysis
7	Stroke Resulting in Permanent Symptoms	8	Major Organ / Bone Marrow Transplant
9	Permanent Paralysis of Limbs	10	Motor Neuron Disease with Permanent Symptoms
11	Multiple Sclerosis with Persisting Symptoms	12	Benign Brain Tumor
13	Blindness	14	Deafness
15	End Stage Lung Failure	16	End Stage Liver Failure
17	Loss of Speech	18	Loss of Limbs
19	Major Head Trauma	20	Primary (Idiopathic) Pulmonary Hypertension
21	Third Degree Burns		

Special Condition:

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

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

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

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

B. E- Medical Second Opinion –

a) If an Insured Person is diagnosed with Critical Illnesses as listed under Section 2.2.1.A, then on the Insured Person's request, We will arrange a maximum of two e-opinions (in a Policy Year) form a Medical Practitioner selected by the Insured Person from Our panel. The e-opinion will be based only on the information and documentation provided to the Medical Practitioner by or on behalf of the Insured Person.:

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

1) It is entirely for the Insured Person to decide whether to obtain an E-opinion, from which Medical Practitioner in Our panel to take the e-opinion and the use (if any) to which the e-opinion so obtained is put.
2) We do not provide an e-opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other persons' reliance on the same, or the use to which the E-opinion is put.
3) We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations whatsoever made by any Medical Practitioner in Our Panel or in any e-opinion or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

ACCIDENT CARE

2.2.2 Personal Accident Cover:

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

	Lumpsum benefit	
Sr no	**Event**	**Percentage of Sum Insured**
1	**Accidental Death**	100%
2	**Permanent Total Disablement**	
	Permanent total loss of sight of both Eyes	100%
	Permanent total loss of sight of one eye and physical separation of or the loss of ability to use either one hand or foot	100%
	Permanent total loss or physical separation of or the loss of ability to use both hands or both feet	100%
	Permanent total loss or physical separation of or the loss of ability to use one hand and foot	100%
3	**Permanent Partial Disability**	
	An arm at the shoulder joint	75%
	An arm above the elbow joint	70%
	A hand at the wrist	50%
	An arm beneath the elbow joint	60%

	A thumb	25%
	An index Finger	10%
	Any other Finger	5%
	A leg above mid-thigh	75%
	A leg up to mid-thigh	60%
	A leg up to beneath the knee	50%
	A leg up to mid-calf	45%
	A foot at the ankle	40%
	A large Toe	5%
	Any other Toe	2%
	Sight of one eye	50%
	Hearing of one ear	25%
	Hearing of both ears	75%
	Sense of smell	10%
	Sense of taste	5%
	Shortening of leg by at least 5%	7%
	Any other Permanent Partial Disablement	Percentage as certified by Government Civil Surgeon in India

Special Conditions:

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

2.2.3 Voluntary Co-payment

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

a) The Insured Person will bear a percentage share of the admissible claim amount.
b) Co-Pay will be applied to the admissible claim amount on each claim.
c) Co-Pay shall not be applicable to the following benefits:
   i. LASIK Surgery
   ii. Cataract Surgery
   iii. Home Health Care Expenses
   iv. OPD Treatment
   v. Ante-Natal Care

vi. Maternity Expenses
vii. Miscarriage & Medical Termination of Pregnancy
viii. Newborn Defect
ix. Newborn Vaccination
x. Stem Cell Storage
xi. Senior Care
xii. Nursing Care Expenses
xiii. Temporary Domestic Help
xiv. Puberty & Menopause Disorders (only OPD Treatment, co-pay will be applicable to IPD treatment)
xv. Preventive Care
xvi. Wellness Benefits
xvii. Critical Illness
xviii. Personal Accident Cover

3. WAITING PERIOD

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

3.1 Pre-Existing Diseases (Code- Excl01)

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

3.2 Specific Waiting Period (Code- Excl02)

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

A. 24 Months waiting period:

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

B. 36 Months waiting period:

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

3.3 First Thirty Days Waiting Period (Code- Excl03)

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

4. EXCLUSIONS

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

4.1 Standard Exclusions

4.1.1 Investigation & Evaluation (Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.1.2 Rest Cure, rehabilitation, and respite care (Code- Excl05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving

treatment. This also includes:

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

4.1.3 Obesity/ Weight Control (Code- Excl06)

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

a) Surgery to be conducted is upon the advice of the Doctor.
b) The surgery/Procedure conducted should be supported by clinical protocols.
c) The member has to be 18 years of age or older and
d) Body Mass Index (BMI);
    1) greater than or equal to 40 or
    2) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        i. Obesity-related cardiomyopathy
        ii. Coronary heart disease
        iii. Severe Sleep Apnea
        iv. Uncontrolled Type2 Diabetes

4.1.4 Change-of-Gender treatments (Code- Excl07)

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

4.1.5 Cosmetic or Plastic Surgery (Code- Excl08)

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

4.1.6 Hazardous or Adventure sports (Code- Excl09)

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

4.1.7 Breach of law (Code- Excl10)

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

4.1.8 Excluded Providers (Code-Excl11)

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

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

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

4.1.11 **Dietary supplements** and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code- Excl14)**

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

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

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

4.1.15 **Maternity (Code Excl18)**
(i) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except for ectopic pregnancy.
(ii) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

4.2 Specific Exclusions

4.2.1 Illness or Injury directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not).
4.2.2 Circumcision, unless necessary for treatment of an Illness or necessitated due to an Accident.
4.2.3 Vaccination/ inoculation (except as post bite treatment)
4.2.4 Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, durable medical equipment (including but not limited to cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and oxygen concentrator for asthmatic condition, wheel chair, crutches, artificial limbs, belts, braces, stocking, Glucometer and the like), namely that equipment used externally for the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose, such cost of all appliances/devices whether for diagnosis or treatment after discharge from the Hospital.
4.2.5 Venereal /Sexually Transmitted disease other than HIV/AIDS.
4.2.6 External Congenital Anomaly and related Illness/ defect.
4.2.7 Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.
4.2.8 Stem cell storage.

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

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

4.2.11 Outpatient diagnostic, medical and Surgical Procedures or treatments.

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

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

4.2.14 Commercial Surrogacy / Traditional surrogacy

4.2.15 Treatment outside India.

4.2.16 Intentional self-Injury.

4.2.17 Non –Payable items: The expenses that are not covered in this policy are placed under List-I of Annexure III.

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

5. GENERAL TERMS AND CONDITIONS

5.1 Standard General Terms and Clauses

5.1.1 Disclosure of Information

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

5.1.2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

5.1.3 Material Change

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

5.1.4 Records to be Maintained.

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

5.1.5 Complete Discharge

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

5.1.6 Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

5.1.7 Territorial Limit

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

5.1.8 Multiple Policies

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

5.1.9 Fraud

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

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

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

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

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

5.1.10 Automatic change in Coverage under the policy

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

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

ii. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

5.1.11 Territorial Jurisdiction

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

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

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

5.1.13 Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

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

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or

ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

5.1.14 Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such a change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

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

5.1.15 Withdrawal of Policy

a) In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

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

5.1.16 Moratorium Period

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

5.1.17 Nomination:

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

5.1.18 Redressal of Grievance

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

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

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

Kindly refer the annexure on Grievance Redressal Procedures.

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

5.2 Specific General Terms and Clauses

5.2.1 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

5.2.2 Terms and conditions of the Policy

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

5.2.3 Migration

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

i. The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

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

5.2.4 Portability

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

i. The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

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

25-Mar-2020.pdf

5.2.5 **Cancellation**

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

1) Single Premium Payment

i. 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 date of Policy Inception	**Rate of premium refunded**
Up to 1 month	75% of annual rate
Above 1 month to 3 months	50% of annual rate
Above 3 months to 6 months	25% of annual rate
Above 6 months	No Refund

ii. 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%.

2) **Premium paid in** Multiple Instalments

i. 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

ii. 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 in the ongoing Policy Year	No Refund

Quarterly	Up to 3 months in the ongoing Policy Year	12.5% of the respective quarterly instalment premium
	Above 3 months to 6 months in the ongoing Policy Year	12.5% of the respective quarterly instalment premium
	Above 6 months in the ongoing Policy Year	No Refund
Half-Yearly	Up to 3 months in the ongoing Policy Year	25% of the half-yearly instalment premium
	Above 3 months to 6 months in the ongoing Policy Year	12.5% of the half-yearly instalment premium
	Above 6 months in the ongoing Policy Year	No refund
Annually	Up to 1 month in the ongoing Policy Year	75% of the annual instalment premium
	Above 1 month to 3 months in the ongoing Policy Year	50% of the annual instalment premium
	Above 3 months to 6 months in the ongoing Policy Year	25% of the annual instalment premium
	Above 6 months in the ongoing Policy Year	No refund

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

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

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

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

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

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

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

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

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

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

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

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

1) Non-Floater Policy

i. Claims incurred by the deceased Insured Person in the current Policy Year, The premium pertaining to the deceased Insured Person for the unutilized current Policy Year shall not be refunded.

ii. Claims incurred by any other Insured Person but no claims incurred by deceased Insured Person in the current Policy Year- The premium pertaining to the deceased shall be refunded on pro-rata basis.

2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Policy Year, The premium for the deceased Insured Person for the unutilized subsequent Policy Period, will not be refunded.

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

1) Non-Floater Policy

i. Claims incurred by the deceased Insured Person in the current Policy Year –The premium pertaining to the deceased Insured Person for the unutilized current Policy Year shall not be refunded. However, premium pertaining to the deceased Insured Person for the unutilized subsequent Policy Years (if any), shall be refunded.

ii. Claims incurred by any other Insured Person but no claims incurred by deceased Insured Person in the current Policy Year- The premium pertaining to the deceased Insured Person for the unutilized Policy Period, shall be refunded on pro-rata basis.

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

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

1) Non-Floater Policy

i. Claims incurred by the deceased Insured Person in the current Instalment Period, the instalment premium pertaining to the deceased Insured Person for the unutilized current instalment period shall not be refunded.

ii. Claims incurred by any other Insured Person but no claims incurred

by deceased Insured Person in the current Instalment Period –The premium pertaining to the deceased Insured Person for the unutilized instalment Period, shall be refunded on pro-rata basis.

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

5.2.6 Renewal of Policy

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

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

5.2.7 Premium Payment in Instalment

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

a) Grace Period of 15 days would be given to pay in case of monthly instalment premium and grace period of 30 days shall be given to pay in case of quarterly / Half Yearly installment premiums, due for the policy..
b) The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
c) No interest will be charged lf the instalment premium is not paid on the due date.
d) In case the instalment premium due, is not received within the grace period, the policy will

get cancelled.

e) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
f) The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
g) The payment will be accepted through E-NACH / ACH/ ECS / any other mode approved by Government of India.
h) On successful registration for the mandate/ E-NACH/ any other mode approved by Government of India; the premium shall be auto debited as per the frequency opted.
i) In case of withdrawal of E-NACH/ ACH/ ECS / any other mode approved by Government of India; a written communication will be required from policyholder.
j) In case there is failure in transaction in E-NACH/ ACH/ ECS mode/ any other mode approved by Government of India, or the instalment premiums are not received within the grace period, the Policy will get cancelled. A fresh policy with all waiting periods would be issued.
k) If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered. This provision will not apply to claims arising under Wellness Benefits (Section 2.1.29).

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 Revision of Premium due to Inflation

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

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

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

5.2.10 Cost of Pre-Policy Medical Examination

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

5.2.11 Discounts & Loadings:

a) Family Discount

10% family discount in case of more than 1 insured member is covered under the same policy on 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) 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.

d) 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.

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

e) Floater discount:

Age Band	Floater Discount
0-17	60%
18-25	55%
26-30	50%
31-35	45%
36-40	45%
41-45	40%
46-50	40%
51-55	40%
56-60	35%
61-65	35%

66-70	35%
71-75	35%
76-80	25%
>=81	25%

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

For example – In case of a family of Self, 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			
	Self (Male)	Spouse (Female)	Child (Female)
Age (in years)	36	31	0-17
Premium as per Individual rate table (in ₹)	17,549	21,768	10,728
Applicable premium (in ₹)	17549	11,972 (45% discount applied on the respective person's premium)	4291 (60% discount applied on the respective person's premium)
Total Premium to be charged (in ₹)	17549+11972+4291		
	33813		

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

Instalment Frequency	**Loading on standard premiums**
Monthly	5%
Quarterly	4%
Semi-Annually	3%

g) **Voluntary Copayment:** Insured has an option to opt for Voluntary co-payment, Given below are the discounts applicable on standard premium in case opted Voluntary Co-payment.

Co-Pay %	**Discount**
10%	8%
20%	15%
30%	25%

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

i) **Underwriting** Loading:

Medical Underwriting Criteria without optional CI cover

	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 preexisting
c	Diabetic (HbA1c level 6.5% - up to 8%)	15% loading with Exclusion for preexisting
d	Diabetic (HbA1c level >8%)	Decline
2	**Hypertension**	
a	Known / not known Hypertensive (140mm HG Systolic /90 mmHg diastolic)	10% loading with Exclusion for preexisting
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	20% 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	20% 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**	
a	Asthma (not on steroids)	10% loading
b	Asthma (on steroids)	20% loading
7	**Smoking**	5% loading
8	**Tobacco chewing/ Ghutka**	5% loading
9	**BMI**	
a	(BMI from 32.1 to 34)	15% loading
b	(BMI from 34.1 to 36)	25% loading
c	36.1 and above	Decline
10	**Combination of any two or more conditions**	To be Reviewed for Acceptance/ Declinature

13	**Positive history of any other ailment(s)/ disease(s)**	To be Reviewed for Acceptance/ Declinature

Additional Medical Underwriting Criteria if optional CI cover opted.

	Condition	**Underwriting Decision**
1	**Diabetes**	
a	Known case of Diabetes/Not known Diabetes (HbA1c up to 5.9 - 6.49%)	25%
b	Diabetic (HbA1c level 6.5% - up to 8%)	35%
c	Diabetic (HbA1c level >8%)	Decline
2	**Hypertension**	
a	Known / not known Hypertension (140mm HG Systolic /90 mmHg) with Optional CI Cover	25%
b	Known / not known Hypertension (Above 150 mmHg Systolic / Above 100 mm Hg diastolic) with Optional CI Cover	Decline
3	**Serum Cholesterol**	
a	Above +25 mg/dl to +50 mg/dl above the maximum *Normal range	25% loading
b	Above +51 mg/dl *Normal range	Decline
4	**Serum Triglycerides**	
	Above +20 mg/dl to + 75 mg/dl above the maximum *Normal range	25% Loading
	Above + 75 mg/dl of the maximum* Normal range	Decline
5	**Serum creatinine**	
	Above * Normal range	Decline
6	**Asthma**	25% Loading
7	**Smoking**	10% loading
8	**Tobacco chewing of any kind**	10% loading
9	**BMI**	
a	BMI from 32.1 to 35	25% loading
b	35.1 and above	Decline
10	**Positive family history of any other family member/(s)**	To be Reviewed for Acceptance/ Declinature
11	**Combination of any two or more conditions with optional CI cover**	Decline
12	**Positive history of any other ailment(s)/ disease(s)**	To be Reviewed for Acceptance/ Declinature

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

6. CLAIM PROCEDURES

6.1 Procedure for Cashless Claims

Cashless Facility is only available at a Network Provider. To avail Cashless Facility, the following procedure

must be followed:

1) We must be called at Our call center and a request for pre-authorization must be made by way of the written form prescribed by Us.
2) After considering the request and obtaining any further information or documentation that We have sought, We may, if satisfied, send the Network Provider an authorization letter. The authorization letter, the ID card issued to the Insured Person along with this Policy and any other information or documentation that We have specified must be produced to the Network Provider identified in the pre-authorization letter at the time of the Insured Person's admission to the Hospital.
3) If the above procedure is followed, the Insured Person will not be required to directly pay for those Medical Expenses to the Network Provider that We are liable to indemnify under this Policy. The original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-authorization does not guarantee that all costs and expenses that are incurred will be covered. We reserve the right to review each claim for Medical Expenses incurred and accordingly coverage will be determined according to the terms, conditions and exclusions of this Policy. All other costs and expenses that are not covered under this Policy must be settled directly with the Network Provider and We shall have no liability in this regard.

6.2 Procedure for Reimbursement Claims

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

1) We must be given Notification of Claim immediately and in any event within 48 hours of admission to the Hospital.
2) The Insured Person must take reasonable steps or measures in good faith to minimize the quantum of any claim that may be made under this Policy.
3) The Insured Person must submit to examination by Our medical advisors if We ask, the cost for which will be borne by Us.

6.3 Notification of Claim

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

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

6.4 Documents to be submitted:

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

1) The claim form specified by Us duly completed and signed by the claimant or a family member;
2) First consultation letter;
3) First prescription from the Medical Practitioner;
4) Original vouchers/ invoice of original bill ;
5) Original Hospital bills giving a detailed break up of all expense heads mentioned in the bill;
6) Money receipt duly signed with a revenue stamp;
7) Birth/Death certificate (as applicable);
8) The original Hospital discharge card/ summary;
9) All original laboratory and diagnostic test reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram,

etc

10) If medicines have been purchased in cash and if this has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner and the supporting medicine bill from the chemist;
11) If diagnostic or radiology tests have been paid for in cash and it has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner advising the tests, the actual test reports and the bill from the diagnostic centre for the tests.
12) Copy of proposer`s photo ID proof & address proof
13) NEFT Form with photocopy of cancelled cheque with printed name of proposer
14) Copy of Operation theatre Notes, if applicable
15) Copy of the Claim Intimation, if any
16) Copies of health insurance policies held with any other insurer covering the insured persons.
17) If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that original claim documents are retained at their end.
18) It is a condition precedent to Our liability under this Benefit that the following information and documentation shall be submitted to Us immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
19) Additional documents for Air ambulance
    (a) Medical reports and transportation details issued by the air ambulance service provider, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirming the necessity of air ambulance services.
    (b) Original Bills for expenses incurred towards availing Air Ambulance services.
20) Additional documents for Infertility and Surrogacy related claims
    (a) Infertility related treatment details including consultation papers and investigation reports.
    (b) Copy or Registration certificate towards registration of “Surrogacy Clinic” under Surrogacy regulation Act.
    (c) Certificate issued to Surrogate Mother from appropriate authority for carrying surrogacy according to Surrogacy regulation act.
    (d) Certificate of essentiality issued to insured person / intended couple/ intended women by the appropriate authority under Surrogacy regulation Act.
    (e) Copy of an order concerning the parentage and custody of the child to be born through surrogacy, passed by a court of the Magistrate Regulation of surrogacy and surrogacy procedures of the first class or above on an application made by the intending couple or the intending woman and the surrogate mother, which shall be the birth affidavit after the surrogate child is born.
21) Additional Documents for Home Health Care Expenses (Section 2.1.10) - A certificate from the attending doctor confirming that the condition of the patient is such that he/she cannot be moved to a hospital.
22) In the event of Your/Insured Person’s death, You/Insured Person’s nominee/legal heir claiming on his/her behalf must inform Us immediately and send Us a copy of the postmortem report (if any).

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

6.5 Payment of Claim

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

6.6 Sequence of Sum Insured Applicability

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

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

6.7 Claim Settlement

1) The Company shall settle or reject a claim within 30 days of the date of receipt of last necessary document.
2) In the case of a delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
3) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
4) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
5) Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified Section 6.4 above.
6) In case of 'pending' claims, we will ask for submission of incomplete documents.
7) 'Rejected' claims will be informed to the Insured Person in writing with reasons for rejection.

Annexure to Prospectus -

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

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

PREMIUM TABLE: Exclusive of Goods & Services Tax (age in completed years)

A. Premium Table for Female:

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Age/ SI	Essential		Advance		Supreme			
	500,000	1,000,000	1,500,000	2,000,000	2,500,000	5,000,000	7,500,000	10,000,000
0-17	8,436	10,728	12,404	13,252	15,019	18,058	20,797	22,454
18	9,185	11,634	13,639	14,546	16,658	19,918	22,852	24,626
19	10,002	12,617	14,996	15,968	18,477	21,969	25,111	27,008
20	10,891	13,683	16,488	17,528	20,493	24,232	27,592	29,620
21	11,858	14,838	18,129	19,240	22,730	26,728	30,319	32,485
22	12,912	16,092	19,933	21,120	25,211	29,480	33,315	35,627
23	14,060	17,451	21,916	23,183	27,963	32,516	36,607	39,073
24	15,309	18,925	24,097	25,449	31,015	35,865	40,224	42,852
25	16,670	20,524	26,495	27,935	34,400	39,559	44,199	46,997
26	16,837	20,733	26,726	28,189	34,691	39,932	44,647	47,489
27	17,005	20,944	26,959	28,445	34,984	40,309	45,098	47,986
28	17,175	21,157	27,194	28,703	35,280	40,689	45,555	48,488
29	17,346	21,373	27,430	28,964	35,579	41,073	46,016	48,995
30	17,519	21,591	27,669	29,227	35,879	41,461	46,481	49,507
31	17,677	21,768	27,857	29,434	36,118	41,766	46,848	49,911
32	17,836	21,946	28,046	29,642	36,357	42,074	47,218	50,317
33	17,996	22,125	28,237	29,852	36,599	42,385	47,590	50,727
34	18,158	22,306	28,429	30,063	36,842	42,697	47,965	51,140
35	18,321	22,489	28,622	30,276	37,086	43,012	48,344	51,556
36	18,476	22,697	28,830	30,504	37,346	43,342	48,736	51,986
37	18,639	22,891	29,031	30,724	37,599	43,666	49,124	52,412
38	18,803	23,086	29,233	30,946	37,853	43,992	49,515	52,842
39	19,151	23,603	29,713	31,491	38,410	44,778	50,506	53,957
40	19,506	24,131	30,201	32,044	38,976	45,578	51,518	55,094
41	19,867	24,671	30,697	32,608	39,549	46,393	52,549	56,256
42	20,235	25,222	31,201	33,181	40,131	47,222	53,601	57,442
43	20,610	25,787	31,714	33,765	40,722	48,066	54,674	58,653
44	20,838	26,197	31,979	34,093	40,959	48,529	55,339	59,439
45	21,069	26,614	32,247	34,425	41,198	48,996	56,013	60,235
46	21,303	27,037	32,517	34,760	41,438	49,468	56,694	61,042
47	21,539	27,468	32,789	35,098	41,679	49,945	57,383	61,860
48	21,777	27,905	33,064	35,440	41,922	50,426	58,081	62,688
49	22,789	29,373	34,239	36,759	43,069	52,095	60,212	65,094
50	23,848	30,918	35,456	38,127	44,247	53,821	62,420	67,592
51	24,956	32,545	36,716	39,546	45,457	55,603	64,710	70,186
52	26,115	34,257	38,021	41,018	46,701	57,444	67,083	72,879
53	27,328	36,059	39,372	42,544	47,978	59,346	69,544	75,676
54	28,370	37,630	41,068	44,274	49,945	61,860	72,548	78,974
55	29,451	39,268	42,838	46,074	51,993	64,481	75,681	82,415

56	30,573	40,978	44,684	47,947	54,125	67,212	78,949	86,006
57	31,738	42,763	46,609	49,896	56,345	70,059	82,359	89,753
58	32,948	44,625	48,618	51,925	58,655	73,026	85,916	93,664
59	34,527	46,885	51,242	54,521	61,573	76,689	90,246	98,394
60	36,181	49,260	54,007	57,248	64,637	80,535	94,795	103,364
61	37,915	51,754	56,922	60,110	67,852	84,574	99,572	108,585
62	39,732	54,376	59,994	63,116	71,228	88,816	104,590	114,069
63	41,636	57,130	63,232	66,272	74,771	93,270	109,862	119,830
64	43,448	59,864	66,380	69,622	78,203	97,662	115,113	125,598
65	45,339	62,728	69,684	73,141	81,793	102,260	120,616	131,644
66	47,312	65,730	73,153	76,838	85,547	107,075	126,382	137,980
67	49,371	68,875	76,795	80,722	89,473	112,117	132,424	144,622
68	51,520	72,171	80,618	84,803	93,580	117,396	138,755	151,584
69	54,037	75,999	85,184	89,499	98,565	123,034	145,501	158,995
70	56,677	80,031	90,009	94,455	103,815	128,944	152,575	166,768
71	59,445	84,277	95,108	99,685	109,344	135,137	159,993	174,921
72	62,349	88,747	100,495	105,206	115,169	141,627	167,772	183,473
73	65,395	93,455	106,187	111,031	121,303	148,430	175,929	192,443
74	68,222	97,515	111,382	116,716	127,715	155,673	184,599	201,968
75	71,171	101,752	116,832	122,691	134,465	163,269	193,695	211,965
76	74,248	106,172	122,548	128,972	141,572	171,236	203,240	222,456
77	77,457	110,784	128,544	135,575	149,055	179,592	213,256	233,467
78	80,806	115,597	134,833	142,515	156,933	188,356	223,764	245,023
79	85,835	122,820	143,720	152,257	167,955	201,307	239,270	262,062
80	91,178	130,494	153,192	162,665	179,752	215,148	255,850	280,285
>81	96,853	138,648	163,288	173,784	192,377	229,941	273,580	299,776

B. Premium Table for Male:

Age/ SI	Essential		Advance		Supreme			
	500,000	**1,000,000**	**1,500,000**	**2,000,000**	**2,500,000**	**5,000,000**	**7,500,000**	**10,000,000**
0-17	6,867	9,436	10,654	11,598	12,993	16,381	19,422	21,261
18	7,285	10,017	11,429	12,432	13,971	17,574	20,808	22,762
19	7,727	10,633	12,259	13,327	15,022	18,854	22,292	24,369
20	8,197	11,287	13,151	14,286	16,152	20,227	23,883	26,090
21	8,695	11,981	14,107	15,314	17,368	21,700	25,587	27,933
22	9,223	12,718	15,132	16,415	18,675	23,280	27,412	29,905
23	9,784	13,501	16,232	17,597	20,080	24,975	29,368	32,017
24	10,378	14,331	17,412	18,863	21,591	26,794	31,463	34,278
25	11,009	15,213	18,678	20,220	23,215	28,745	33,708	36,699
26	11,181	15,442	18,935	20,502	23,535	29,157	34,201	37,241
27	11,355	15,674	19,195	20,788	23,860	29,574	34,702	37,792

28	11,533	15,910	19,458	21,078	24,189	29,998	35,210	38,351
29	11,713	16,149	19,726	21,372	24,522	30,427	35,726	38,918
30	11,896	16,393	19,997	21,671	24,860	30,863	36,249	39,494
31	12,047	16,581	20,208	21,902	25,123	31,201	36,654	39,940
32	12,201	16,771	20,421	22,137	25,389	31,543	37,065	40,391
33	12,356	16,964	20,636	22,374	25,658	31,889	37,479	40,847
34	12,514	17,159	20,854	22,613	25,929	32,238	37,899	41,309
35	12,673	17,356	21,074	22,855	26,204	32,591	38,323	41,775
36	12,789	17,549	21,290	23,093	26,473	32,938	38,739	42,233
37	12,936	17,748	21,513	23,338	26,751	33,296	39,168	42,705
38	13,085	17,950	21,738	23,586	27,032	33,657	39,602	43,183
39	13,536	18,596	22,464	24,384	27,938	34,821	40,996	44,715
40	14,002	19,265	23,215	25,210	28,874	36,024	42,439	46,302
41	14,484	19,959	23,991	26,063	29,842	37,270	43,933	47,945
42	14,982	20,677	24,793	26,945	30,842	38,558	45,480	49,647
43	15,498	21,422	25,622	27,857	31,876	39,891	47,081	51,408
44	15,951	22,072	26,352	28,661	32,788	41,062	48,484	52,952
45	16,417	22,743	27,104	29,487	33,725	42,267	49,930	54,541
46	16,897	23,434	27,877	30,338	34,690	43,508	51,419	56,179
47	17,392	24,146	28,672	31,212	35,681	44,785	52,952	57,865
48	17,900	24,880	29,490	32,112	36,702	46,100	54,531	59,603
49	18,788	26,046	30,638	33,362	37,989	47,751	56,508	61,776
50	19,719	27,266	31,831	34,660	39,321	49,462	58,558	64,030
51	20,697	28,544	33,070	36,009	40,701	51,234	60,682	66,365
52	21,724	29,881	34,357	37,410	42,128	53,069	62,883	68,785
53	22,801	31,281	35,694	38,866	43,606	54,970	65,164	71,294
54	23,759	32,656	37,234	40,558	45,523	57,434	68,117	74,541
55	24,758	34,091	38,840	42,324	47,525	60,007	71,204	77,935
56	25,799	35,589	40,516	44,167	49,615	62,696	74,430	81,484
57	26,883	37,153	42,264	46,090	51,797	65,506	77,803	85,194
58	28,013	38,785	44,087	48,097	54,075	68,442	81,328	89,074
59	29,319	40,658	46,186	50,404	56,688	71,799	85,353	93,500
60	30,685	42,622	48,383	52,820	59,427	75,322	89,578	98,145
61	32,115	44,681	50,686	55,353	62,299	79,017	94,012	103,022
62	33,612	46,838	53,098	58,007	65,309	82,893	98,665	108,141
63	35,178	49,101	55,625	60,788	68,465	86,960	103,548	113,515
64	36,856	51,509	58,322	63,753	71,826	91,279	108,727	119,209
65	38,614	54,036	61,150	66,863	75,351	95,813	114,165	125,190
66	40,455	56,687	64,115	70,124	79,049	100,572	119,875	131,471
67	42,385	59,469	67,224	73,545	82,929	105,567	125,871	138,066
68	44,406	62,386	70,484	77,132	86,999	110,810	132,166	144,993

69	46,563	65,485	73,953	80,946	91,321	116,368	138,831	152,322
70	48,825	68,737	77,592	84,948	95,859	122,204	145,831	160,022
71	51,197	72,151	81,411	89,148	100,621	128,333	153,185	168,110
72	53,683	75,735	85,417	93,556	105,621	134,769	160,910	176,608
73	56,291	79,497	89,621	98,182	110,868	141,528	169,024	185,535
74	59,065	83,484	94,084	103,088	116,430	148,680	177,602	194,969
75	61,976	87,671	98,768	108,240	122,271	156,193	186,616	204,883
76	65,030	92,068	103,686	113,649	128,404	164,087	196,087	215,300
77	68,235	96,685	108,849	119,329	134,846	172,379	206,038	226,248
78	71,597	101,534	114,268	125,292	141,610	181,090	216,495	237,752
79	76,555	108,666	122,247	134,067	151,558	193,887	231,846	254,636
80	81,857	116,298	130,784	143,456	162,205	207,587	248,286	272,719
>81	87,525	124,466	139,916	153,503	173,600	222,257	265,891	292,086

C. Premium Table for Critical Care:

Age /SI	Essential Plan		Advance Plan				Supreme Plan			
	500,000	**1,000,000**	**500,000**	**1,000,000**	**1,500,000**	**2,000,000**	**500,000**	**1,000,000**	**1,500,000**	**2,000,000**
18	1,175	2,341	1,242	2,414	3,582	4,749	1,192	2,358	3,524	4,690
19	1,227	2,445	1,370	2,600	3,822	5,042	1,264	2,482	3,700	4,918
20	1,282	2,554	1,513	2,801	4,079	5,354	1,340	2,613	3,885	5,157
21	1,340	2,668	1,670	3,017	4,353	5,685	1,420	2,750	4,079	5,408
22	1,399	2,788	1,843	3,250	4,645	6,037	1,505	2,895	4,283	5,672
23	1,462	2,912	2,035	3,501	4,957	6,410	1,595	3,047	4,497	5,948
24	1,527	3,042	2,246	3,771	5,290	6,807	1,691	3,207	4,722	6,237
25	1,595	3,178	2,479	4,062	5,645	7,228	1,793	3,375	4,958	6,541
26	1,651	3,288	2,536	4,174	5,812	7,450	1,848	3,486	5,124	6,761
27	1,708	3,402	2,594	4,289	5,984	7,679	1,906	3,600	5,295	6,989
28	1,767	3,520	2,654	4,408	6,162	7,915	1,965	3,719	5,472	7,225
29	1,829	3,643	2,715	4,530	6,344	8,158	2,027	3,841	5,655	7,469
30	1,892	3,769	2,777	4,655	6,532	8,409	2,090	3,967	5,844	7,721
31	2,005	3,995	2,896	4,887	6,877	8,866	2,204	4,194	6,183	8,173
32	2,125	4,234	3,020	5,130	7,239	9,348	2,326	4,434	6,543	8,651
33	2,252	4,487	3,149	5,386	7,621	9,856	2,453	4,688	6,923	9,157
34	2,387	4,756	3,283	5,654	8,023	10,392	2,588	4,957	7,325	9,693
35	2,530	5,040	3,424	5,936	8,447	10,957	2,730	5,240	7,751	10,261
36	2,781	5,541	3,680	6,442	9,202	11,962	2,983	5,742	8,502	11,261
37	2,984	5,944	3,876	6,838	9,799	12,760	3,184	6,144	9,104	12,064
38	3,201	6,377	4,083	7,259	10,435	13,610	3,398	6,574	9,750	12,925
39	3,561	7,093	4,457	7,991	11,524	15,057	3,761	7,294	10,826	14,359

40	3,961	7,890	4,866	8,798	12,728	16,658	4,164	8,093	12,022	15,952
41	4,406	8,776	5,313	9,686	14,058	18,429	4,609	8,980	13,350	17,721
42	4,900	9,762	5,800	10,664	15,526	20,388	5,102	9,963	14,825	19,686
43	5,451	10,858	6,332	11,740	17,147	22,555	5,647	11,055	16,462	21,870
44	6,286	12,254	6,897	12,852	18,807	24,762	6,202	12,157	18,111	24,066
45	7,250	13,829	7,512	14,070	20,628	27,185	6,811	13,368	19,925	26,482
46	8,362	15,607	8,182	15,404	22,625	29,845	7,480	14,701	21,921	29,141
47	9,644	17,614	8,912	16,864	24,815	32,766	8,215	16,166	24,116	32,067
48	11,123	19,878	9,707	18,462	27,217	35,972	9,022	17,777	26,532	35,287
49	11,709	21,252	10,388	19,922	29,455	38,987	9,797	19,328	28,860	38,391
50	12,326	22,722	11,116	21,498	31,876	42,254	10,639	21,016	31,393	41,769
51	12,975	24,293	11,896	23,198	34,497	45,795	11,553	22,850	34,147	45,445
52	13,659	25,973	12,731	25,033	37,334	49,634	12,546	24,845	37,144	49,443
53	14,379	27,769	13,624	27,014	40,404	53,794	13,624	27,014	40,404	53,794
54	15,478	29,949	14,715	29,186	43,657	58,128	14,715	29,186	43,657	58,128
55	16,661	32,301	15,893	31,533	47,172	62,812	15,893	31,533	47,172	62,812
56	17,935	34,837	17,166	34,068	50,970	67,873	17,166	34,068	50,970	67,873
57	19,306	37,573	18,541	36,808	55,075	73,341	18,541	36,808	55,075	73,341
58	20,781	40,523	20,026	39,768	59,509	79,251	20,026	39,768	59,509	79,251
59	22,266	43,473	21,504	42,711	63,918	85,125	21,504	42,711	63,918	85,125
60	23,858	46,639	23,091	45,872	68,653	91,434	23,091	45,872	68,653	91,434
61	25,563	50,035	24,796	49,268	73,739	98,211	24,796	49,268	73,739	98,211
62	27,389	53,678	26,626	52,914	79,202	105,490	26,626	52,914	79,202	105,490
63	29,347	57,586	28,591	56,831	85,070	113,309	28,591	56,831	85,070	113,309
64	31,301	61,472	30,540	60,710	90,881	121,052	30,540	60,710	90,881	121,052
65	33,385	65,620	32,620	64,855	97,089	129,324	32,620	64,855	97,089	129,324
66	35,608	70,047	34,843	69,282	103,721	138,161	34,843	69,282	103,721	138,161
67	37,979	74,774	37,217	74,012	110,807	147,602	37,217	74,012	110,807	147,602
68	40,508	79,819	39,753	79,064	118,376	157,688	39,753	79,064	118,376	157,688
69	43,029	84,836	42,268	84,075	125,882	167,689	42,268	84,075	125,882	167,689
70	45,707	90,167	44,944	89,404	133,864	178,324	44,944	89,404	133,864	178,324
71	48,552	95,834	47,788	95,070	142,352	189,634	47,788	95,070	142,352	189,634
72	51,574	101,857	50,812	101,095	151,378	201,661	50,812	101,095	151,378	201,661
73	54,784	108,258	54,028	107,503	160,977	214,451	54,028	107,503	160,977	214,451
74	57,958	114,577	57,198	113,817	170,435	227,054	57,198	113,817	170,435	227,054
75	61,317	121,265	60,555	120,502	180,449	240,397	60,555	120,502	180,449	240,397
76	64,870	128,343	64,108	127,580	191,052	254,524	64,108	127,580	191,052	254,524
77	68,630	135,834	67,869	135,074	202,278	269,482	67,869	135,074	202,278	269,482
78	72,607	143,763	71,851	143,007	214,163	285,319	71,851	143,007	214,163	285,319
79	79,345	157,179	78,584	156,418	234,252	312,086	78,584	156,418	234,252	312,086
80	86,709	171,848	85,947	171,086	256,225	341,364	85,947	171,086	256,225	341,364

>81	94,756	187,885	94,001	187,130	280,259	373,388	94,001	187,130	280,259	373,388

D. Premium for Accident Care

Premium per mille	2.2

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

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

Signature	Place
Name	Date

In case of any claims, contact:

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

ISO No: FGH/UW/RET/301/02