FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

PROSPECTUS
FUTURE AAROGYA BIMA

I. SALIENT FEATURES OF THE POLICY

1. **In-patient treatment**
   - **a) Room rent, Board & Nursing Expenses** as provided by the Hospital/ Nursing Home.
   - **b) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees**.
   - **c) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances**
   - **d) Medicines & Drugs**
   - **e) Diagnostic Materials and X-ray**
   - **f) Cost of Pacemaker, prosthesis/internal implants and any Medical expenses** incurred which is integral part of the operation.
2. **Day Care expenses**.
3. **Pre-Hospitalisation Medical expenses**.
4. **Post-Hospitalisation Medical expenses**.

II. DEFINITIONS

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

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
   Note: Insect and mosquito bites is not included in the scope of this definition.

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

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

4. **Associated Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of **Illness** or **Accident** on the advice of a Medical Practitioner. In case of copayment associated with room rent higher than the entitled room rent limit Associated Medical Expenses will not include :
   a. Cost of pharmacy and consumables;
   b. Cost of implants and medical devices
   c. Cost of diagnostics

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

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

7. **Condition Precedent** shall mean a **Policy** term or condition upon which the **Insurer's** liability under the **Policy** is conditional upon.

8. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   a. **Internal Congenital Anomaly** -**Congenital Anomaly** which is not in the visible and accessible parts of the body.
   b. **External Congenital Anomaly** - **Congenital Anomaly** which is in the visible and accessible parts of the body.

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

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

11. **Day care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under -
    a. has qualified nursing staff under its employment;
    b. has qualified medical practitioner/s in charge;
    c. has fully equipped operation theatre of its own where surgical procedures are carried out;
    d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

12. **Day care treatment** means medical treatment, and/or surgical procedure which is:
    a. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    b. which would have otherwise required hospitalization of more than 24 hours.
    Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

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

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

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

17. **Disclosure to information norm**: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

18. **Domiciliary hospitalization** means medical treatment for an illness/ disease/ injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii) the patient takes treatment at home on account of non-availability of room in a hospital.

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

20. **Family** means and includes You, Your Spouse, Your up to 4 dependent children up to the age of 25 years and two dependent parents in the Individual Policy.
Or You, Your Spouse & Your up to 3 dependent children up to the age of 25 years in the Family Floater Policy.

21. **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents our maximum liability for any and all claims made by You and/ or all of Your Dependents during the Policy Period.

22. **Grace period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

23. **Hazardous Activities** mean recreational or occupational activities which pose high risk of injury.

24. **Hospital**: A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii. has qualified medical practitioner(s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

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

26. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
    b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        (i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        (ii) it needs ongoing or long-term control or relief of symptoms
        (iii) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        (iv) it continues indefinitely
        (v) it recurs or is likely to recur

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

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

29. **Insured Person** means the persons covered under this Policy and named in the Schedule.

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

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

32. **Maternity expense/ treatment means:**
    a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b. expenses towards lawful medical termination of pregnancy during the policy period.

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

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

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

36. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i. is required for the medical management of the illness or injury suffered by the insured;
    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. must have been prescribed by a medical practitioner;
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

39. **New Born baby** means baby born during the Policy Period and is aged upto 90 days.

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

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

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

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

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

45. **Policy Year** means every annual period within the Policy Period starting with the commencement date.

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

47. **Pre-existing Disease** means any condition, ailment or injury or disease:
    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement, or
    b) For which medical advice or treatment was recommended by, or received from, a Physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
    (Note: Reinstatement is applicable for Life Insurance policies)

48. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

49. **Post-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

51. **Prospect** means any person who is a potential customer of an insurer and likely to enter into an insurance contract either directly with the insurer or through a distribution channel.

52. **Prospectus** means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products.

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

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

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

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

57. **Schedule** means that portion of the Policy which sets out Your personal details, the type of insurance cover in force, the period and the sum insured. Any Annexure or Endorsement to the Schedule shall also be a part of the Schedule.

58. **Schedule of Benefits** means that portion of the Policy which sets out the benefits available to You/Insured Person that may be opted by You in accordance with the terms of the Policy.

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

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

61. **Unproven/ Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India.

62. **We, Our, Us, Insurer** means Future Generali India Insurance Company Limited.

63. **You, Your, Yourself** means the Insured Person shown in the Schedule.

III. Scope of Cover

We shall pay the following **Medical expenses** for medically necessary treatment, **Reasonable and Customary Charges** incurred for **Hospitalisation**:

1. **Room rent, Board & Nursing Expenses as provided by the Hospital/ Nursing Home**
   Up to 1% of the **Sum Insured** per day for non-ICU room
   In case **You** or insured person opts for a room with rent higher than the entitled room limit, the following co-payment will be applicable on the Associate Medical expenses (excluding pharmacy, consumables, implants, medical devices and diagnostics)

Co-payment in case of admission in room with higher room rent is as below			
Sum insured (in ₹)	**200000**	**300000**	**500000**
Applicable limit on the sum insured	1%	1%	1%
Applicable room rent	2000	3000	5000
above 2000 to 3000	15%	0%	0%
above 3000 to 5000	15%	15%	0%
above 5000 to 10000	15%	15%	15%
above 10000	15%	15%	15%

- Room, Boarding and Nursing Expenses as provided by the Hospital/ Nursing Home up to 1% of Sum Insured per day or actual, whichever is lower.
- During your hospital stay if at any time you are admitted in a Non-ICU room having room rent of more than the defined limit then the co-payment shall be applicable on the total Associated Medical expenses (excluding pharmacy, consumables, implants, medical devices and diagnostics).
- If a person is admitted in ICU any time during the hospitalisation and later shifted to Non-ICU room within the defined room rent limit, no co-payment shall apply and in case shifted to Non-ICU room with higher room rent limit, co-payment shall applicable on the Associated Medical expenses (excluding pharmacy, consumables, implants, medical devices and diagnostics) applicable to Non ICU-Room.
- Co-payment is not applicable in case of admission in an ICU room having room rent more than the defined limit.
- If a person is admitted only in ICU during entire hospitalisation, we will pay up to actual expenses and no co-payment shall apply.
- Co-payment on Associated Medical expenses (excluding pharmacy, consumables, implants, medical devices and diagnostics) for opting a Non –ICU room with higher room rent limit is not applicable for those hospitals where differential billing based on the room category is not adopted.
- Reasonable and Customary charges would be applicable only in cases where the services (like Professional Fees, OT charges etc), applied are higher as compared to standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/ injury involved.

2. **Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees**

3. **Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Cost of Pacemaker, prosthesis/internal implants and any Medical expenses incurred which is integral part of the operation**

4. **Pre-Hospitalisation Medical Expenses – We** shall pay for **Medical expenses** incurred with respect to the **Insured Person** for up to 60 days immediately prior to date of admission of **Insured Person** into the **Hospital**, provided that We have accepted a claim for Inpatient-Hospitalisation Expenses

5. **Post-Hospitalisation Medical expenses – We** shall pay for **Medical expenses** incurred with respect to the **Insured Person** for up to 90 days after the date of discharge of **Insured Person** from the **Hospital**, provided that We have accepted a claim for Inpatient- Hospitalisation Expenses

   Pre and Post hospitalisation combined expenses are limited up to 2% of Sum Insured opted for each hospitalisation.

6. **Day Care expenses** – **We** shall pay for expenses incurred under **Day Care Treatment** requiring less than 24 hours of **Hospitalisation**.

IV. Exclusions

i. **Waiting Periods**
All **Illnesses** and treatments shall be covered subject to the waiting periods specified below:

a) Pre-Existing Disease- Excl 01

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

b) **Specified disease/procedure waiting period- Code- Excl02**

i. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. 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.

I. **Waiting period of 48 months**:

a. Any **medical expenses** in connection with treatment for any mental **Illness** or psychiatric **Illness**
b. Any **hospitalisation expenses** in connection with treatment for AIDS (Acquired Immune Deficiency Syndrome) and/ or infection with HIV (Human Immunodeficiency Virus)
c. Behavioural and Neuro developmental disorders
    i. Disorders of adult personality
    ii. Disorders of speech and language including stammering, dyslexia

II. **Waiting period of 24 months**:

(i) Cataract
(ii) Para nasal sinuses
(iii) **Surgery** on ears/ tonsils/ adenoids
(iv) Deviated Nasal Septum
(v) Hernia
(vi) Hydrocele
(vii) Fistula/ Fissure in Ano and Hemorrhoids
(viii) Benign Prostatic Hypertrophy
(ix) Congenital Internal **Illness**/ disease/ defect anomaly
(x) stones in the Urinary and Biliary systems
(xi) All treatments for Uterine Prolapse, Dysfunctional Uterine Bleeding, Fibromyoma, Endometriosis, Hysterectomy
(xii) Arthroscopic repair/ removal [other than caused by an accident],
(xiii) Joint replacement **Surgery** due to Degenerative condition
(xiv) Age related Osteoarthritis and Osteoporosis unless such joint replacement **Surgery** is necessitated by accidental Bodily **Injury**
(xv) All internal or external Tumors/ Cysts/ Nodules/ Polyps of any kind including breast lumps with exception of malignant tumour or growth
(xvi) Degenerative disc of vertebral diseases and prolapse of intervertebral disc (other than caused by accident)
(xvii) Varicose Veins and Varicose Ulcers.

III. 30 days waiting period Excl -03

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

ii. **Standard Exclusions**

We will not pay for any expenses incurred by **You** in respect of claims arising out of or howsoever related to any of the following:

a) **Investigation & Evaluation- Code- Excl04**

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

b) **Rest Cure, rehabilitation and respite care- Code- Excl05**

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

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

c) **Obesity/ Weight Control: Code- Excl06**

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

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

d) **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.

e) **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.

f) **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 scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc. unless specifically agreed by the Insurance

Company.

g) **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.

h) **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.

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

j) **Code- Excl13**
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 a Hospital where the Hospital has effectively become the Insured Person's home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

k) **Code- Excl14**
Dietary supplements and substances which are available naturally and 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 hospitalisation claim or day care procedures.

l) **Refractive Error: Code- Excl15**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

m) **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.

n) **Birth control, Sterility and Infertility: Code- Excl17**
Expenses related to Birth Control, sterility and infertility. This includes:
(i) Any type of contraception, 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

o) **Maternity : Code Excl 18**
i. Medical treatment expenses traceable to child birth (including complicated deliveries and caesarean section incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during policy period.

p) Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an Accident.
q) Vaccination/ inoculation (except as post bite treatment)
r) 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), 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.
s) Dental treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental Bodily Injury.
t) Convalescence, general debility or rest cure, intentional self-Injury, venereal/ Sexually Transmitted disease other than HIV/AIDS.
u) Congenital External Illness/ disease/ defect anomaly.
v) Costs incurred on all methods of treatment including AYUSH treatments except Allopathic.
w) Stem cell storage.
x) Expenses related to donor screening, treatment, including Surgery to remove organs from the donor in case of a transplant Surgery. We will also not pay donor's pre and post Hospitalisation expenses or any other medical treatment for the donor consequent to Surgery.
y) Outpatient Diagnostic, Medical and Surgical Procedures or OPD treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.
z) Medical Practitioner's home visit charges during pre and post Hospitalisation period, Attendant Nursing charges.
aa) Domiciliary hospitalisation, treatment received outside India.
bb) Injury or Disease 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).
cc) Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.
dd) Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
ee) Standard list of excluded items as mentioned in Annexure 4and on our website https://general.futuregenerali.in
ff) Any specific exclusion(s) applied by Us, specified in the Schedule and accepted by the insured.

V. Eligibility

Age limit

- Minimum age at entry – 1 day.
- Maximum age at entry – 70 years.
- Children will be covered as dependents up to the age of 25 years.

Minimum Policy Term	1 year
Maximum Policy Term	3 years
Minimum Age at entry	1 day
Maximum Age at entry	70 years
Renewal	Lifelong

Pre-insurance medical examination, for any insured, will be conducted on the basis of age of the Insured and Sum Insured opted.

In case the policy is issued for that particular client, the client is eligible for 50% of reimbursement of pre-insurance medical tests charges.

All pre-acceptance medical tests will have to be done in Future Generali empanelled diagnostic centers only. The reports would be valid for a period of 30 days from the date of test conducted.

We shall maintain a list of, and the fees chargeable by, institutions where such pre-insurance medical examination may be conducted, the reports from which will be accepted by **Us**. Such list shall be furnished to the prospective policyholder at the time of pre-insurance medical examination.

VI. Sum Insured

The sum insured that can be offered is ₹ 200000/-, ₹ 300000/-, ₹ 500000/-.

VII. Conditions

1. **Condition Precedent to the contract**

(i) **Co-Payments Applicable under the policy**

a) **Mandatory co-payment** – 10% co-payment is applicable on each and every claim on the admissible hospitalisation bill, excluding claim related to pre and post hospitalisation.

b) **Optional co-payment** – You have the option to choose additional co-payment of 20% or 30% on each and every claim on the admissible hospitalisation bill, excluding claim related to pre and post hospitalisation. Discount on premium will be applicable if additional co-payment is opted by the Insured.

c) Our liability, would be over and above the co-payments mentioned in Section VII 1 (i) a) and b), for each and every admissible claim.

d) The co-payment mentioned in Section VII 1 (i) a) shall continue lifelong.

(ii) **Sub limits Applicable under the policy**

a) **Mandatory Sub limits for Modern Treatment Methods and Advancement in Technologies**

The Medical Expenses incurred for the below listed treatments or procedures, as inpatient or as day care treatment (inclusive of pre and post hospitalization), is restricted to 50% of the sum insured opted, per policy period. These Sub limits are applicable for all Plans under the product.

i. Uterine Artery Embolization and HIFU
ii. Balloon Sinuplasty
iii. Deep Brain stimulation
iv. Oral chemotherapy
v. Immunotherapy- Monoclonal Antibody to be given as injection
vi. Intra vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. Bronchical Thermoplasty
x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

Co-payments will not be applicable in case of a claim for the listed procedures mentioned in the Sub-limits Section.

(iii) **Portability- Applicable under the policy**

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

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

(iv) **Migration**

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

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

2. **Conditions applicable during the contract**

(i) **Due Care**

Where this **Policy** requires **You** to do or not to do something, then the complete satisfaction of that requirement by **You** or someone claiming on **Your** behalf is a precondition to any obligation under this **Policy**. If **You** or someone claiming on **Your** behalf fails to completely satisfy that requirement, then **We** may refuse to consider **Your** claim. **You** will cooperate with **Us** at all times.

(ii) **Insured**

Only those persons named, as the Insured in the **Schedule** shall be covered under this **Policy**. The details of the Insured are as provided by **You**. An individual may be added as an insured during the **Policy Period** after the application has been accepted by **Us,** an additional premium has been paid and **Our** agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person as an Insured.

(iii) **Cost of pre-insurance medical examination**

We will reimburse 50% of the cost of any pre-insurance medical examination conducted at our empanelled diagnostic center, once the Proposal

is accepted and the Policy is issued for that Insured Person.

(iv) **Communications**

a) Any communications, notifications or declarations meant for Us must be in writing and delivered to Our address specified in the Schedule.
b) Any communication meant for You will be sent by Us to Your address shown in the Schedule. You must notify Us immediately of any change in Your address.
c) Our agents are not authorized to receive communications, notices or declarations on Our behalf.

(v) **Fraud**

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

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

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

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

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

(vi) **Multiple Policies**

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

(vii) **Policy Period**

The **Policy** can be issued for tenure of 1 year, 2 years and 3 years.

(viii) **Territorial Limits and Law**

a) **We** cover Accidental Bodily **Injury** or sickness sustained by the Insured Person during the **Policy Period** anywhere in India.
b) All medical/ surgical treatments including investigations under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency (Indian Rupees).
c) The construction, interpretation and meaning of the provisions of this **Policy** shall be determined in accordance with Indian Law.
d) The **Policy** constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by **Us**, which approval shall be evidenced by an endorsement on the **Schedule**.

(ix) **Free Look Period**

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

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

(x) **Cancellation**

I. 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

A. Premium paid in Single Instalment

a) In case the Policy Period is one year, the Company shall refund premium for the unexpired policy period as detailed below.

Period on risk	Rate of premium refunded
Up to one month	75% of annual rate
Up to three months	50% of annual rate
Up to six months	25% of annual rate
Exceeding six months	Nil

b) 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%.

B. Premium paid in Multiple Instalments

a) 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	No Refund
Quarterly	1st Quarter	12.5% of the respective quarter premium
	2nd Quarter	12.5% of the respective quarter premium
	3rd Quarter and above	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

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

Instalment Frequency	Cancellation request received	Rate of Premium refunded
Monthly	Anytime within the Policy Period	No Refund
Quarterly	1st Quarter of 1st Policy Year	12.5% of the respective quarter premium
	2nd Quarter of 1st Policy Year	12.5% of the respective quarter premium
	3rd Quarter of 1st Policy Year and above	No Refund
Half-Yearly	Up to first 3 months of the 1st Policy Year	25% of the half-yearly instalment premium
	Above first 3 months to 6 months of the 1st Policy Year	12.5% of the half-yearly instalment premium
	Above first 6 months of the 1st Policy Year and thereafter	No refund

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

III. In case of one-year or long-term policies with single premium payment, in the event of death of an insured member in a particular policy year, the corresponding premium for the insured person for the subsequent (unutilized) Policy period(s) shall be refunded under both individual and floater policies, if there has been no claim in the underlying policy year by the deceased member. If there has been a claim in the underlying policy year by the deceased member, the subsequent (unutilized) policy year(s) premium of the deceased member shall not be refunded.

IV. Similarly, in the case of one-year and long-term policy with installment premium option, in the event of death of any insured person in a particular Policy Year, the coverage for deceased person shall not continue for subsequent Policy period(s) and subsequent policy period(s) installment premium for the deceased person shall not be applicable. If deceased person has not given a claim in the underlying policy year, the deceased member's premium for the underlying installment period shall be refunded on pro-rata basis.

V. 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.

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

(xi) **Special Conditions applicable for Policies issued with Premium Payment on Instalment Basis**.

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

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. 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.
iv. No interest will be charged If the instalment premium is not paid on due date
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.
viii. If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered
ix. Duly filled and signed ACH/ECS/E-Mandate form shall be submitted along with the proposal form specifying the instalment premium amount and the frequency of instalment.
x. On successful registration of the mandate of the ECS mandate, the premium shall be auto debited as per the frequency opted.
xi. In case of withdrawal of ECS, a written communication will be required from policyholder
xii. In case there is failure in transaction in ECS mode or the instalment premiums are not received within the grace period, the Policy will get cancelled.
xiii. A fresh policy with all waiting periods would be issued

Policy Term	1 Year		2 Years		3 Years	
Instalment Option	Not Opted	Opted (Options – Monthly/ Quarterly/ Half-yearly)	Not Opted	Opted (Options – Monthly/ Quarterly/ Half-yearly)	Not Opted	Opted (Options – Monthly/ Quarterly/ Half-yearly)
Grace Period (applicable at the time of renewal)	30 days					
Grace Period (applicable post instalment payment date for the premium to be paid)	Not Applicable	15 days	Not Applicable	15 days	Not Applicable	15 days

xiv. Given below are the loadings applicable on Standard premiums in case of installments

Instalment frequency	Loading on standard premiums
Monthly	5%
Quarterly	4%
Half-yearly	3%

(xii) **Nomination**

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

(xiii) **Moratorium Period**

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

3. **Condition Precedent to Admission of Liability**

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

4. **Conditions when a claim arises**

A. **Claims Procedure**

If You meet with any accidental Bodily Injury or suffer an Illness that may result in a claim, then as a condition precedent to Our liability, You must comply with the following:

a) Cashless treatment is only available at a Network Provider. In order to avail cashless treatment, the following procedure must be followed by **You**:
   (i) For availing **cashless** at a **Network Provider**, We must be called at **Our** call centre and a request for pre-authorisation must be made by way of the written form prescribed by **Us**.
   (ii) After considering the request and obtaining any further information or documentation that **We** have sought, We may, if satisfied, send the **Network Provider** an authorisation letter. Such pre-authorization shall be issued by **Us** within 24 hours of receiving the complete information.
   (iii) The authorisation letter, the ID card issued to **You** 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-authorisation letter at the time of the Insured Person's admission to the **Hospital**.
   (iv) If the above procedure is followed, **You** 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-authorisation 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.

b) If pre-authorisation as above is denied by **Us** or if treatment is taken in a **Hospital** which is Non-Network or if **You** do not wish to avail cashless facility, then:
   (i) **We** must be given Notification of Claim in writing immediately and in any event within 48 hours of the commencement of the Illness or Injury. You must immediately consult a Medical Practitioner and follow the advice and treatment that he/she recommends. **You** must take reasonable steps or measures in good faith to minimise the quantum of any claim that may be made under this **Policy**.
   (ii) **You** must have **Yourself** examined by **Our** medical advisors if **We** ask, the cost for which will be borne by **Us**.
   (iii) **You** or someone claiming on **Your** behalf must promptly and in any event within 15 days of discharge from a **Hospital** give **Us** the necessary documents, 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:

      a. The claim form specified by Us duly completed and signed by the claimant or a family member;
      b. first consultation letter;
      c. first prescription from the Medical Practitioner;
      d. original vouchers;
      e. original Hospital bills giving a detailed break up of all expense heads mentioned in the bill;
      f. Money receipt duly signed with a revenue stamp;
      g. birth/death certificate (as applicable);
      h. the original Hospital discharge card;
      i. all original laboratory and diagnostic test Reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram etc;
      j. 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;
      k. 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.

   (iv) In the event of **Your**/**Insured Person**'s death, **You**/**Insured Person**'s nominee/legal heir claiming on his/her behalf must inform Us in writing immediately and send **Us** a copy of the post mortem report (if any) within 14 days.
   (v) If **We** are not given notice/ documentation within the time frames set out above, then **We** may accept the claim notice/ documentation if it is demonstrated to **Us** that the delay was for reasons beyond the control of the claimant.
   (vi) The periods for intimation as stipulated under 4. A. b (i), or submission of any documents as stipulated under 4. A. b (i), (iii) and (iv) will be waived in case of any hardships being faced by the insured or his representative which is supported by some documentation

c) **Claim Settlement**
   i. Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified in Section 4. A. b (iii) above
   ii. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
   iii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of

receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iv. 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.

v. 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.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

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

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

B. **Basis of claims payment**

a) **Claims for Day Care Treatment**

The Day Care Treatments listed are subject to the exclusions, terms and conditions of the **Policy** and will not be treated as independent coverage under the **Policy**.

b) **Co-Payments applicable under the policy**

Co-Payments and sub limits for specified procedures, as mentioned in Section VII. 1. (i) and (ii) will be applicable under the **Policy**

C. **Reimbursement Claims**

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

D. **Policy Currency**

We shall make payment in Indian Rupees only.

E. **Dispute Resolution**

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

F. **Redressal of Grievance**

Insured person may approach the grievance cell at any of the company's branches with the details of grievance.
For updated details of grievance officer, kindly refer the Annexure on Grievance Redressal Procedures

Insured can also refer to the Grievance Redressal Procedures at our website link
https://general.futuregenerali.in/general-insurance/pdf/Grievance_Redressal_Procedures.pdf

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

5. **Conditions for renewal of the contract**

(i) **Renewal**

i. The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
ii. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. 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.
vi. Coverage is not available during the grace period.
vii. No loading shall apply on renewals based on individual claims experience
viii. Future Aarogya Bima Policy shall be renewable lifelong
ix. In case of a Renewal within Grace Period of 30 days Policy will be considered as continuous for the purpose of all waiting periods and Health Check-up benefit.
x. For Renewal Proposal received after completion of Grace Period of 30 days, all waiting periods would apply afresh.
xi. 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.
xii. If any **Dependent Child** has completed 25 years at the time of **Renewal**, then such person can be covered under a separate policy.
xiii. No increase/ decrease in Sum Insured 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 the **Proposal** before the expiry of the Policy
xiv. In case of enhancement of sum insured the waiting period shall apply afresh to the extent of sum insured increase.

(ii) **Withdrawal of Policy**

i. 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.
ii. 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.

(iii) **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 effected.
- 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.

VIII. Mandatory Disclosures

a) **Your** Future Aarogya Bima **Policy** shall be renewable lifelong if renewed continuously without any break in insurance.

b) The brochure/ prospectus mentions the premium rates as per the age slabs/ Sum Insured. The premium would applicable as per the completed age of the eldest member in the family at every renewal.

c) The premiums as shown in the prospectus/ brochure are subject to revision as and when approved by the regulator. However such revised

premiums would be applicable only from subsequent **Renewal**s and with due notice whenever implemented.

d) **Renewals** will not be refused or cancellation will not be invoked by **US** except on ground of fraud, moral hazard, misrepresentation or non-cooperation by the insured. If **You** prefer to cancel the **Policy** the cancellation will be on short period basis.

e) There will be no loading on premium for adverse claims experience.

f) Medical loading on individual's premium will be applicable on basis of findings in pre-insurance medical examination.

g) Long term discount will be applicable as mentioned below, in case of single premium payment for policy term of more than one year.

Number of years	Discount
1 year	Nil
2 years	5%
3 years	10%

h) Direct sales discount – A discount of 15% in lieu of intermediary commissions if policy is taken directly from the insurer and /or Online.

i) No increase/ decrease in Sum Insured during the currency of the **Policy**. However increase/decrease in Sum Insured or change in cover, addition/deletion of Insured Persons, etc will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy.

j) Detailed exclusions are given under Section IV of the Prospectus.

IX. Payment of Premium

a) As per table annexed

In case of any claims please 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

Annexure 1: Premium rates exclusive of Goods & Services Tax (age in completed years)

a) **Individual Premium**

Individual Premium									
Age in years	**Plan A**			**Plan B**			**Plan C**		
	2 L	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**
0 – 17	1992	2488	3318	1530	1914	2567	1267	1588	2143
18-25	2354	2940	3922	1830	2289	3070	1515	1899	2563
26-30	2799	3496	4664	2137	2673	3586	1805	2262	3053
31-35	3159	3945	5263	2415	3021	4052	2038	2555	3448
36-40	3721	4647	6199	2847	3561	4777	2402	3011	4064
41-45	4574	5713	7622	3503	4382	5877	2955	3704	4999
46-50	5897	7365	9825	4517	5651	7580	3811	4777	6446
51-55	7393	9233	12317	5665	7087	9506	4778	5990	8083
56-60	8995	11234	14987	6895	8626	11570	5815	7290	9837
61-65	10448	13049	17407	8157	10204	13687	6879	8623	11636
66-70	12135	15156	20218	9474	11852	15898	7924	9932	13404
71 years and above	14095	17604	23484	10961	13711	18392	9078	11380	15357

b) **Family Floater Premium**

Family Floater Premium – 2 Adults									
Age in years	**Plan A**			**Plan B**			**Plan C**		
	2 L	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**
18-25	3413	4263	5687	2654	3319	4452	2197	2754	3716
26-30	4059	5069	6763	3099	3876	5200	2617	3280	4427
31-35	4581	5720	7631	3502	4380	5875	2955	3705	5000
36-40	5395	6738	8989	4128	5163	6927	3483	4366	5893
41-45	6632	8284	11052	5079	6354	8522	4285	5371	7249
46-50	8551	10679	14246	6550	8194	10991	5526	6927	9347
51-55	10720	13388	17860	8214	10276	13784	6928	8686	11720
56-60	13043	16289	21731	9998	12508	16777	8432	10571	14264
61-65	15150	18921	25240	11828	14796	19846	9975	12503	16872
66-70	17596	21976	29316	13737	17185	23052	11490	14401	19436
71 years and above	20438	25526	34052	15893	19881	26668	13163	16501	22268

Family Floater Premium – 1 Adult + 1 Child									
Age in years	**Plan A**			**Plan B**			**Plan C**		
	2 L	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**
18-25	3413	4263	5687	2654	3319	4452	2197	2754	3716
26-30	3919	4894	6530	2992	3742	5020	2527	3167	4274
31-35	4265	5326	7105	3260	4078	5470	2751	3449	4655
36-40	4837	6041	8059	3701	4629	6210	3123	3914	5283
41-45	5718	7141	9528	4379	5478	7346	3694	4630	6249
46-50	6782	8470	11299	5195	6499	8717	4383	5494	7413
51-55	8132	10156	13549	6232	7796	10457	5256	6589	8891
56-60	9670	12077	16111	7412	9273	12438	6251	7837	10575
61-65	10970	13701	18277	8565	10714	14371	7223	9054	12218
66-70	12742	15914	21229	9948	12445	16693	8320	10429	14074
71 years and above	14800	18484	24658	11509	14397	19312	9532	11949	16125

Family Floater Premium – 1 Adult + 2 Children									
Age in years	**Plan A**			**Plan B**			**Plan C**		
	2 L	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**
18-25	4473	5586	7452	3477	4349	5833	2879	3608	4870
26-30	5038	6293	8395	3847	4811	6455	3249	4072	5495
31-35	5370	6707	8947	4106	5136	6888	3465	4344	5862
36-40	5954	7435	9918	4555	5698	7643	3843	4818	6502
41-45	6861	8570	11433	5255	6573	8816	4433	5556	7499
46-50	7666	9575	12773	5872	7346	9854	4954	6210	8380
51-55	8872	11080	14780	6798	8504	11407	5734	7188	9700
56-60	10344	12919	17235	7929	9920	13306	6687	8384	11313
61-65	11493	14354	19148	8973	11224	15056	7567	9485	12800
66-70	13349	16672	22240	10421	13037	17488	8716	10925	14744
71 years and above	15505	19364	25832	12057	15082	20231	9986	12518	16893

Family Floater Premium – 1 Adult + 3 Children									
Age in years	**Plan A**			**Plan B**			**Plan C**		
	2 L	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**
18-25	5532	6909	9217	4301	5379	7215	3560	4463	6023
26-30	6158	7691	10261	4701	5881	7889	3971	4976	6717
31-35	6476	8087	10789	4951	6193	8307	4178	5238	7068
36-40	7070	8829	11778	5409	6766	9076	4564	5721	7722
41-45	8005	9998	13339	6130	7669	10285	5171	6482	8748
46-50	8551	10679	14246	6550	8194	10991	5526	6927	9347
51-55	11694	12003	16012	7365	9213	12358	6211	7787	10508
56-60	11019	13762	18359	8446	10567	14173	7123	8930	12050
61-65	12015	15006	20018	9381	11735	15740	7911	9916	13381
66-70	13955	17429	23251	10895	13630	18283	9113	11422	15415
71 years and above	16209	20245	27007	12605	15768	21151	10440	13087	17661

Family Floater Premium – 2 Adults + 1 Child									
Age in years	**Plan A**			**Plan B**			**Plan C**		
	2 L	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**
18-25	4473	5586	7452	3477	4349	5833	2879	3608	4870
26-30	5178	6468	8628	3953	4945	6634	3339	4185	5648
31-35	5686	7101	9473	4347	5438	7294	3668	4599	6206
36-40	6512	8132	10848	4982	6232	8360	4204	5269	7112
41-45	7776	9712	12957	5955	7449	9991	5024	6297	8498
46-50	9435	11784	15720	7227	9042	12128	6098	7643	10314
51-55	11459	14311	19091	8781	10985	14734	7406	9285	12529
56-60	13717	17132	22855	10515	13155	17644	8868	11117	15001
61-65	15672	19574	26111	12236	15306	20531	10319	12935	17454
66-70	18203	22734	30327	14211	17778	23847	11886	14898	20106
71 years and above	21143	26406	35226	16442	20567	27588	13617	17070	23036

Family Floater Premium – 2 Adults + 2 Children									
Age in years	**Plan A**			**Plan B**			**Plan C**		
	2 L	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**
18-25	5532	6909	9217	4301	5379	7215	3560	4463	6023
26-30	6298	7866	10494	4808	6014	8069	4061	5090	6869
31-35	6792	8482	11315	5192	6495	8712	4382	5493	7413
36-40	7628	9526	12708	5836	7300	9793	4924	6173	8331
41-45	8919	11140	14863	6831	8545	11460	5762	7223	9748
46-50	10320	12889	17194	7905	9889	13265	6669	8360	11281
51-55	12198	15234	20323	9347	11694	15685	7884	9884	13337
56-60	14392	17974	23979	11032	13802	18512	9304	11664	15739
61-65	16194	20226	26981	12643	15816	21215	10662	13366	18036
66-70	18809	23492	31338	14685	18371	24642	12282	15395	20776
71 years and above	21847	27286	36400	16990	21252	28508	14071	17639	23803

Family Floater Premium – 2 Adults + 3 Children									
Age in years	**Plan A**			**Plan B**			**Plan C**		
	2 L	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**	**2 L**	**3 L**	**5 L**
18-25	6591	8232	10982	5124	6409	8596	4242	5317	7176
26-30	7417	9264	12360	5663	7083	9503	4783	5994	8090
31-35	7898	9863	13158	6038	7553	10130	5095	6388	8620
36-40	8744	10920	14568	6690	8368	11226	5645	7076	9550
41-45	10063	12569	16768	7707	9640	12929	6501	8149	10998
46-50	11204	13994	18668	8582	10737	14402	7241	9076	12247
51-55	12938	16158	21555	9914	12402	16636	8362	10483	14145
56-60	15067	18817	25103	11549	14449	19380	9740	12211	16477
61-65	16717	20878	27851	13051	16326	21899	11006	13797	18618
66-70	19416	24250	32349	15158	18963	25437	12678	15891	21446
71 years and above	22552	28166	37574	17538	21938	29427	14525	18208	24571

* Plan A – with mandatory co-payment of 10%
Plan B – with mandatory co-payment of 10% and additional co-payment of 20%
Plan C – with mandatory co-payment of 10% and additional co-payment of 30%

**Age in completed years
*** Premium would applicable as per the age of the eldest member in the family.
**** The premiums above are subject to revision as and when approved by the regulator. However such revised premiums would be applicable only from subsequent renewals and with due notice whenever implemented.

Annexure 2: Illustration showing claims payment

Sum Insured (in ₹)	300000	Room, Boarding and Nursing Expenses as provided by the Hospital/ Nursing Home up to 1% of Sum Insured per day or actual, whichever is lower.(i.e. ₹. 3000/day)	
Hospital Stay	5 days		
Diagnosis	Hip replacement		
Total Hospitalization Bill(in ₹)	250000		
Particulars	**Amount**	**Per day room opted**	
Room rent	20000	5000 {(=20000+5000)/5}	
Nursing charges	5000		
Surgeon charges	80000		
OT rent	20000		
Cost of Implant	60000	In case of Non-ICU room with higher room rent limit, co-payment shall applicable on the Associated Medical expenses (excluding pharmacy, consumables, implants, medical devices and diagnostics) applicable to Non ICU-Room.	
Medicines	25000		
Investigations	20000		
Non-Medical Expenses	20000		
Total Bill	250000		
Claims process			
Allowable cost post NME deduction	230000	(=250000-20000)	
Less: 15 % Co-payment for higher room rent	18750	15% applicable on associated medical expenses (excluding pharmacy and consumables, implants and medical devices, diagnostics) [=15% * (Room + Nursing + Surgeon + OT)]	
Admissible amount post deduction	211250	(=230000-18750)	In case Modern method of treatment is opted,

of Room rent Co payment			restriction applicable- Max up to 50% of Sum Insured limit per policy period.
Admissible amount post Plan Copayment (in ₹)	190125	Plan A (10% mandatory co-pay) (=211250*90%)	150000 (Max up to 50% of SI)
	147875	Plan B (10% mandatory co-pay + 20% additional co-pay) (=211250*70%)	147875
	126750	Plan C (10% mandatory co-pay + 30% additional co-pay) (=211250*60%)	126750

Annexure 3: Schedule of Benefits

<table>
<tr><th colspan="4">Future Aarogya Bima</th></tr>
<tr><td rowspan="9">A</td><td rowspan="9">Eligibility</td><td>Sum Insured options (in ₹)</td><td>2 Lacs, 3 Lacs, 5 Lacs</td></tr>
<tr><td>Entry age of Proposer</td><td>18 years – 70 years</td></tr>
<tr><td>Entry age of Child</td><td>From birth – 25 years</td></tr>
<tr><td>Maximum Renewal Age</td><td>Lifelong</td></tr>
<tr><td>Individual/ Family Floater Sum Insured options</td><td>Individual/ Family Floater</td></tr>
<tr><td>Policy Term</td><td>1/ 2/ 3 years</td></tr>
<tr><td>Family Definition* – Individual SI</td><td>S+Sp+4C+2P</td></tr>
<tr><td>Family Definition* – Family Floater SI</td><td>S+Sp+3C</td></tr>
<tr><td>Plan options</td><td>1. Plan A – with Mandatory co-payment of 10%
2. Plan B – with Mandatory co-payment of 10% and additional co-payment of 20%
3. Plan C – with Mandatory co-payment of 10% and additional co-payment of 30%

The above co-payment shall be applicable on each and every claim on the admissible hospitalisation bill, excluding claim related to pre and post hospitalisation.</td></tr>
<tr><td rowspan="2">B</td><td rowspan="2">Hospitalisation Benefits</td><td>Hospitalisation</td><td>Covered</td></tr>
<tr><td>Room rent including Boarding, Nursing expenses</td><td>up to 1% of Sum Insured per day</td></tr>
<tr><td rowspan="2">C</td><td rowspan="2">Other Benefits</td><td>Day Care Treatment</td><td>Covered</td></tr>
<tr><td>Pre- Hospitalisation for 60 days and Post-Hospitalisation for 90 days</td><td>Pre and Post hospitalisation combined expenses subject to 2% of Sum Insured opted</td></tr>
<tr><td>D</td><td>Discount</td><td colspan="2">1. Long term discount (2 and 3 years policy term) in case of single payment of premium - 5% discount for 2 year policy, 10% for 3 years policy.
2. 5% for family Discount if more than 1 member is covered under single proposal with Individual sum insured</td></tr>
<tr><td>E</td><td>Instalment option (monthly, quarterly, half yearly) with Loading</td><td colspan="2">Available for policy term of 1 /2/3 years. Loadings on standard premium will be applicable in case instalment facility is opted for premium payment.
<table>
<tr><th>Instalment frequency</th><th>Loading on standard premiums</th></tr>
<tr><td>Monthly</td><td>5%</td></tr>
<tr><td>Quarterly</td><td>4%</td></tr>
<tr><td>Half-yearly</td><td>3%</td></tr>
</table></td></tr>
<tr><td>F</td><td>Waiting Periods</td><td colspan="2">1. 48 months Waiting Period for Pre-existing Disease
2. 48 months Waiting Period for any mental illness and psychiatric illness
3. 48 months Waiting Period for any hospitalisation expenses in connection with treatment for AIDS and/ or infection with HIV
4. 48 months Waiting Period for any hospitalisation expenses in connection with treatment for Behavioural and Neuro developmental disorders
5. 30 days Waiting Period, except for Accidental Hospitalization
6. 24 months Waiting Period for listed conditions</td></tr>
<tr><td>G</td><td>Co-payments</td><td colspan="2">Co-payments will be applicable:
1. as per plan opted
2. in case of admission in room with higher room rent</td></tr>
<tr><td>H</td><td>Sub limit</td><td colspan="2">Mandatory Sub limits for Modern Treatment Methods and Advancement in Technologies

Co-payments will not be applicable in case of a claim for the listed procedures mentioned in the Sub-limits Section.</td></tr>
<tr><td>I</td><td>Pre-insurance medical examination</td><td colspan="2">1. Applicable for proposal form with any medical declaration for any sum insured
2. Mandatory Pre-insurance medical examination for age above 50 years</td></tr>
</table>

(* S- Self, Sp – Spouse, C – Dependent Child, P – Dependent Parents)

Annexure 4

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

Sl No.	Item
1.	BABY FOOD
2.	BABY UTILITES CHARGES
3.	BEAUTY SERVICES
4.	BELTS/ BRACES
5.	BUDS
6.	COLD PACK/HOT PACK
7.	CARRY BAGS
8.	EMAIL / INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVENYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG/ SHORT/ HINGED)
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53.	SUGAR FREE TABLETS
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY

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

Sl No.	Item
1.	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU-DE-COLOGNE / ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP
19.	DISINFECTANT LOTIONS
20.	LUXURY TAX
21.	HVAC
22.	HOUSE KEEPING CHARGES
23.	AIR CONDITIONER CHARGES
24.	IM IV INJECTION CHARGES
25.	CLEAN SHEET
26.	BLANKET/WARMER BLANKET
27.	ADMISSION KIT
28.	DIABETIC CHART CHARGES
29.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30.	DISCHARGE PROCEDURE CHARGES
31.	DAILY CHART CHARGES
32.	ENTRANCE PASS / VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES
35.	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36.	PATIENT IDENTIFICATION BAND / NAME TAG
37.	PULSEOXYMETER CHARGES

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

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

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

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

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