FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

PROSPECTUS
HEALTH SUPER SAVER

A. SALIENT FEATURES OF THE POLICY

1. Hospitalization medical expenses for:
   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, 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
2. Pre-Hospitalisation Medical Expenses.
3. Post-Hospitalisation Medical Expenses.
4. Day Care expenses.
5. Maternity Expenses.
6. Alternative Treatment.
7. Organ Donor Expenses.
8. Emergency Ambulance.
9. Home Health Care Services

B. 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:

I. Standard definitions

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **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.

3. **AYUSH Day Care Centre**:
   AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

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

7. **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.

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

9. **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.

10. **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.

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

12. **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.

13. **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.

14. **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.

15. **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.

16. **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;

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

18. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
    b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        (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

19. **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.

20. **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.

21. **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.

22. **Maternity expenses mean:**
    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.

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

24. **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.

25. **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.

26. **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.

27. **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.

28. **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

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

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

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

32. **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.

33. **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.

34. **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.

35. **Pre-existing Disease** means any condition, ailment, 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 or its reinstatement.

36. **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.

37. **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.

38. **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.

39. **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.

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

41. **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.

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

II. Specific Definitions:

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

44. **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.

45. **Break in policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

46. **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.

47. **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.

48. **Family** includes You, Your Spouse, Your up to 4 dependent children up to the age of 25 years and two dependent parents and/or parent in laws.
    If the child above 18 years is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

49. **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

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

51. **Home Health Care** is a range of health care services and Medically Necessary treatment that can be given at home for an Illness or Injury. These shall include services such as nursing care, investigations, medication (intravenous), chemotherapy, dialysis, transfusions, physiotherapy and postsurgical care.

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

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

54. **Plan tenure** means the total number of years under the plan which the insured has opted, which will include initial year(s) of 100% premium payment and year(s) for which super saver discount, if any, can be given as per plan opted.
e.g. (Health Super Saver 2X Plan will have a Plan tenure of 4 years wherein if the first 2 years of policy are claim free, insured is eligible for Super Saver discount for next consecutive 2 years, or up to first claim, whichever is earlier

Note: Increase/ decrease in Sum Insured, change of sub limit option and/or change of plan is allowed only at the start of plan tenure.

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

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

57. **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.

58. **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.

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

60. **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.

61. **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.

62. **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).

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

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

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

C. SCOPE OF COVER

Insurance Plans: This Policy provides You options of 2 (Two) plans namely Health Super Saver 1X plan and Health Super Saver 2X plan. The Schedule will specify the Plan which is in force.

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

1. **Hospitalization medical expenses** for:
   i. Room rent, Board & Nursing Expenses as provided by the Hospital/ Nursing Home
   ii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees
   iii. 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

2. **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 Hospitalisation Medical Expenses under Section C. 1

3. **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 Hospitalisation Medical Expenses under Section C. 1

4. **Day Care expenses** – **We** shall pay for expenses incurred under **Day Care Treatment** requiring less than 24 hours of **Hospitalisation** as per the attached list.

5. **Maternity Expenses** – **We** shall pay for **Reasonable and Customary Medical expenses** incurred with respect to the **Insured Person's maternity expenses,** subject to following conditions**:**
   i. This benefit will be applicable only if the insured person has completed the mandatory waiting period of 9 months from policy inception with us.
   ii. We will cover Pre-natal Medical Expenses incurred on Hospitalisation for a period of 90 days immediately prior to the date of delivery and Post-natal Medical Expenses incurred on Hospitalisation for up to a period of 45 days immediately following the date of delivery.
   iii. Maximum liability per policy year for maternity (delivery/ medically recommended and lawful termination of pregnancy) including Pre-natal and Post-natal hospitalisation medical expenses will be subject to the plan opted (specified in Section G.II 3 B. C.)
   iv. 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 a claim made under Hospitalisation Medical Expenses (Section C. 1)

6. **Alternative Treatment**
   We will reimburse Reasonable and Customary Charges for Medical Expenses incurred with respect to the Insured Person for Hospitalization under Ayurveda, Unani, Siddha or Homeopathy provided that the Treatment has been undergone in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/ National Accreditation Board on Health for that Alternative Treatment.

Specific Exclusions applicable to this Benefit:

i. All preventive and rejuvenation treatments (non-curative in nature) including without limitation, treatments that are not medically Necessary are excluded.
ii. Pre-hospitalisation Medical Expenses, Post-hospitalisation Medical Expenses, Day Care Treatment and outpatient Medical Expenses are excluded.
iii. Any Alternative Treatment other than Ayurveda, Unani, Siddha or Homeopathy.

7. **Organ Donor Expenses**

The **Medical Expenses** incurred for an organ donor's treatment for the harvesting of the organ donated provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with THE TRANSPLANTATION OF HUMAN ORGANS (AMENDMENT) BILL, 2011 and the organ donated is for the use of the Insured Person, and
ii. We will not pay the donor's screening expenses or pre and post hospitalisation expenses or for any other medical treatment for the donor consequent on the harvesting
iii. We have accepted claim under hospitalisation for the Insured Person and the Insured Person has been Medically Advised to undergo an organ transplant;
iv. Costs directly or indirectly associated with the acquisition of the donor's organ will not be covered.
v. These expenses shall be covered under the recipient's policy.

8. **Emergency Ambulance**

We will reimburse the ambulance charges up to a maximum of Rs. 1000 per **Hospitalisation** from Home to Hospital or between Hospitals or Hospital to Home, if necessary, provided that We have accepted a claim for Hospitalisation Medical Expenses under Section C.1. **We** will reimburse payments under this benefit only in respect of ambulance services of a **Hospital** or a registered service provider and only upon **You** producing the bills in original.

9. **Home Health Care Services**

We will cover the reasonable and customary charges towards Medical Expenses incurred for Home Health Care Services during the Policy Period and availed through empanelled Service Provider on Cashless Facility basis, only if the following conditions are fulfilled:

a) Medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:
   a. the condition of the patient is such that he/she is not in a condition to be moved to a Hospital, or
   b. the patient takes treatment at home on account of non-availability of bed / room in a Hospital
   c. non -availability of Hospital Services due to any prevailing conditions /Government Notification.
   d. Chemotherapy and dialysis at home
   e. 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.
b) The duration of Home care treatment should be restricted to reasonable and customary time and not more than the period of hospitalisation the patient would have undergone otherwise.
c) Treatment under this benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
d) Post-surgical care through Home Health Care Services, where the initial hospitalization for surgical management of the condition was at our empanelled network hospital and we have accepted an inpatient hospitalization claim on cashless basis.
e) Pre and Post hospitalization expenses (both inclusive) are restricted up to 3% of the admissible claim amount for each hospitalization under these services. However this condition will not be applicable for services availed for Post-Surgical care.
f) The Home Health Care Services shall be covered only subject to Cashless authorization approved by us.
g) The Home Health Care Services are provided through our empanelled Service Provider or our empaneled network.
h) Only Allopathic treatment shall be covered under this section.
i) Sub limits as mentioned in Section G.II. 3. B. c), d) and e) shall also be applicable for Home Health Care Services
j) Home Health care services shall not cover 24 hour-a-day attendant/nursing services.

D. EXCLUSIONS

1. **Waiting Periods**

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

a) **Pre-Existing Diseases - Code- Excl01**

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 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 24 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.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
vi. List of specific diseases/procedures:

- **24 months waiting period:**
  i. Cataracts
  ii. Benign Prostatic Hypertrophy
  iii. Hernia of all types
  iv. Hydrocele
  v. Para nasal sinuses

vi. Deviated Nasal Septum
vii. Fistulae
viii. Hemorrhoids
ix. Fissure in ano
x. Dysfunctional Uterine Bleeding
xi. Fibromyoma
xii. Endometriosis
xiii. Hysterectomy
xiv. all internal or external tumors/ cysts/ nodules/ polyps of any kind including breast lumps with exception of malignant tumor or growth
xv. Surgery for prolapsed inter vertebral disc unless arising from Accident
xvi. Surgery of Varicose Veins, Varicose Ulcers
xvii. Congenital Internal Illness/ disease/ defect/ anomaly, genetic diseases/ disorders
xviii. Any types of gastric or duodenal Ulcers
xix. Stones in the Urinary and Biliary systems
xx. Surgery on ears/ tonsils/ adenoids

- **48 months waiting period:**
  i. Joint replacement Surgery due to Degenerative condition
  ii. Age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is necessitated by Accidental Bodily Injury
  iii. Listed Mental and Psychiatric **Illness**
    a) F01 Vascular dementia
    b) F20 Schizophrenia
    c) F30 Manic episode
    d) F31 Bipolar affective disorder
    e) F32-33 Depressive disorders
    f) F41 Other anxiety disorders
    g) F50 Eating disorders
    h) F60 Specific personality disorders
    i) F84 Pervasive developmental disorders
    j) F40.9 Phobic anxiety disorder, unspecified
    k) F05 Delirium, not induced by alcohol and other psychoactive substances
  iv. Behavioural and Neuro developmental disorders
    a) Disorders of adult personality
    b) Disorders of speech and language including stammering, dyslexia

c) 30-day waiting period- Code- Excl03

i. 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.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

2. **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, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

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 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

3. **Specific 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:

o) Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an **Accident**.

p) Vaccination/ inoculation (except as post bite treatment)

q) 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**.

r) Dental treatment or **Surgery** of any kind unless requiring **Hospitalisation** as a result of accidental Bodily **Injury**.

s) Intentional self-**Injury**

t) Venereal/ Sexually Transmitted disease other than HIV/AIDS.

u) Congenital External **Illness**/ disease/ defect anomaly.

v) Any expenses related to donor screening, treatment, donor's pre and post **Hospitalisation** expenses or any other medical treatment for the donor consequent to **Surgery**.

w) Outpatient Diagnostic, Medical and **Surgical Procedures** or OPD treatments

x) Non-prescribed drugs and medical supplies

y) Hormone replacement therapy

z) Medical Practitioner's home visit charges during pre and post **Hospitalisation** period, Attendant Nursing charges.

aa) 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) **Domiciliary treatment**, except for claims under Home Health care services.

dd) **Injury** or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.

ee) Stem cell storage

ff) Any kind of service charge, surcharge levied by the hospital.

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

hh) Standard list of excluded items as mentioned in Annexure 1.

ii) Any specific exclusion(s) as applied by us, specified in the schedule and accepted by the insured.

E. ELIGIBILITY

- Age at entry is restricted to 70 years.
- Proposer to have the highest Sum Insured.
- Family should be covered without any selection.
- In case married, spouse to be covered mandatorily.
- For floater policy, in case married and parents are getting covered, then spouse should be covered mandatorily.
- For floater policy, in case married and parents-in-law are getting covered, then spouse should be covered mandatorily.
- For floater policy, in case parents and parents-in-law are getting covered, then spouse should be covered mandatorily and both sets of parents and parents-in-law can be covered. However cross selection of 1 parent and 1 parent in law is not allowed
- In case the insured is covered in some other health insurance product then copy of the policy is to be provided to allow selection of the insured.
- In case the child completes the age of 25 years or is above 18 years and is financially independent, after completion of plan tenure, he/she will be covered in a separate policy with new plan tenure on individual sum insured basis

Policy Term	1 year
Minimum Age at entry	Day 1 (for child) 18 years (for adults)
Maximum Age at entry	25 years (for child) 70 Years (for adults)
Renewal	Lifelong

- Pre-insurance medical examination, for any insured, will be conducted on the basis of age of the Insured and Sum Insured opted, subject to the proposal form is clean (without health declaration).
- In case the policy is issued for that particular client, the client is eligible for 100% of reimbursement of pre-insurance medical tests charges.
- All pre-insurance medical tests will have to be done at the Future Generali empanelled diagnostic centres only.
- The test 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.

F. SUM INSURED

Sum Insured options available in the product are: INR 3 Lacs, 4 Lacs, 5 Lacs, 6 Lacs, 10 Lacs, 15 Lacs, 20 Lacs, 25 Lacs, 50 Lacs

G. General Terms and Clauses

I. Standard General Terms and Clauses

i. **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)

ii. **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

iii. **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.

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

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

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

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

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

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

viii. **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.

ix. **Cancellation**
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 on Annual basis
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. Premium paid on Instalment basis
In case the Policy is issued, 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

a) 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.
b) 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.

x. **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.

xi. **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.

xii. **Premium Payment in instalments**

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.

xiii. **Claim Settlement**

i. 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.
ii. 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.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(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)

xiv. **Renewal**

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

a) The Company shall endeavour 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 ground 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.
e) Coverage is not available during the grace period.
f) No loading shall apply on renewals based on individual claims experience

xv. **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.

xvi. **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.

xvii. **Redressal of Grievance**

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

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

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

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

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Kindly refer the annexure on Grievance Redressal Procedures.

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

II. **Specific Terms and Clauses**

1. Condition Precedent to the contract

i. In case the policy is issued on individual sum insured basis, all the members covered under the policy will have the same plan. However the sum insureds for members can be different.

ii. In case the policy is issued on family floater sum insured basis, all the members covered under the policy will have the same plan and sum insured.

iii. **Portability**

In addition to Section G. I. iv

For the purpose of this product the Portability is applicable only for the waiting periods. Portability is not applicable for Maternity Benefit and for Super Saver discount.

iv. **Migration**

In addition to Section G. I. v

For the purpose of this product the Migration is applicable only for the waiting periods. Migration is not applicable for Maternity Benefit and for Super Saver discount.

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**.

a) In case policy is on individual/ family floater sum insured basis, the new member(s) can be added in the policy only at the beginning of next plan tenure.
b) In case of cover to be offered for new member during an ongoing plan tenure, separate policy can be issued for new additional member(s) with a new plan tenure on individual sum insured basis with a family discount, provided the application has been accepted by **Us** and the applicable premium has been paid.
c) In case of separate policy issued to insured with new plan tenure under 1X Plan or 2X plan on individual sum insured basis at the time of renewal, due to claim reported under previous policy Family discount will not be applicable
d) In case the child completes the age of 25 years or is above 18 years and is financially independent, after completion of plan tenure, he/she can be covered in a separate policy with new plan tenure on individual sum insured basis.

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

We will reimburse 100% of the cost of any pre-insurance medical examination conducted at our empanelled diagnostic centre, 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) **Policy Period**

The policy is issued on annual basis only.

(vi) **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**.

(vii) **Cancellation**

In addition to Section G. I. ix

a) No refund of premium shall be due on cancellation if the Insured Person has made a claim under this Policy.
b) In case of policies with annual premium payment, in the event of death of an insured member in a particular policy period, the corresponding premium for the insured person for the subsequent (unutilized) Policy period shall be refunded under both individual and floater policies, subject to no claim in the underlying policy period by the deceased member. In case of claim in the underlying policy period by the deceased member, the subsequent (unutilized) policy period premium of the deceased member shall not be refunded.
c) In the case of policy with instalment premium option, in the event of death of any insured person, the coverage for deceased person shall not continue for subsequent Policy period and subsequent policy period instalment premium for the deceased person shall not be applicable, subject to no claim in the underlying policy period and the instalment premium, if any shall be refunded on pro-rata basis.

(viii) **Premium Payment in instalments**

In addition to Section G. I. xii

a) The payment will be accepted through E-NACH / ACH/ ECS / any other mode approved by Government of India.
b) 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.
c) 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.
d) 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.
e) In case of change of plans at renewal - fresh ACH/ECS/E-Mandate form shall be submitted along with the proposal form specifying the instalment premium amount and the frequency of instalment.

f) A fresh policy with all waiting periods would be issued.
g) If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered.

3. 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/ treatment under Home Health care services.
   (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 Section G.II. 3. A. b (i), or submission of any documents as stipulated under Section G II. 3. 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**

In addition to Section G. I. xiii

i. Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified in Section G II. 3. A. b (iii) above
ii. In case of 'pending' claims, We will ask for submission of incomplete documents.
iii. 'Rejected' claims will be informed to the Insured Person in writing with reason for rejection.

B. **Basis of claims payment**

a) **Claims related to Any One Illness**

All claims relating to Any One Illness shall be deemed to be part of the same original claim.

b) **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**.

c) **Base Sub limits**

Our maximum liability towards expenses incurred during hospitalization (inclusive of pre and post hospitalization) for the specified conditions/ procedures are as per the 3 options given below:

a. Standard Option - The maximum liability for the specified conditions/ procedures will be as per the table below:

All values are in INR									
Procedure/Treatment	**Sum Insured**								
	300000	**400000**	**500000**	**600000**	**1000000**	**1500000**	**2000000**	**2500000**	**5000000**
Listed Mental and Psychiatric Illness [#] a) F01 Vascular dementia b) F20 Schizophrenia c) F30 Manic episode d) F31 Bipolar affective disorder e) F32-33 Depressive disorders f) F41 Other anxiety disorders g) F50 Eating disorders h) F60 Specific personality disorders i) F84 Pervasive developmental disorders j) F40.9 Phobic anxiety disorder, unspecified k) F05 Delirium, not induced by alcohol and other psychoactive substances	60000	80000	100000	120000	200000	300000	400000	500000	1000000
Cataract surgery (per eye)	30000	40000	50000	60000	100000	150000	150000	150000	150000
Maternity* – Normal Delivery	15000	15000	25000	25000	35000	50000	50000	50000	50000
Maternity* – LSCS (Caesarean)	25000	25000	35000	35000	45000	50000	60000	75000	100000

[#] Per policy period

*Maternity limit includes Pre-natal and Post- natal hospitalisation expenses.

b. Double option - The maximum liability for the specified conditions/ procedures will be as per the table below:

All values are in INR									
Procedure/Treatment	**Sum Insured**								
	300000	**400000**	**500000**	**600000**	**1000000**	**1500000**	**2000000**	**2500000**	**5000000**
Listed Mental and Psychiatric Illness [#] a) F01 Vascular dementia b) F20 Schizophrenia c) F30 Manic episode d) F31 Bipolar affective disorder e) F32-33 Depressive disorders f) F41 Other anxiety disorders g) F50 Eating disorders h) F60 Specific personality disorders i) F84 Pervasive developmental disorders j) F40.9 Phobic anxiety disorder, unspecified k) F05 Delirium, not induced by alcohol and other psychoactive substances	120000	160000	200000	240000	400000	600000	800000	1000000	2000000
Cataract surgery (per eye)	60000	80000	100000	120000	200000	300000	300000	300000	300000
Maternity* – Normal Delivery	30000	30000	50000	50000	70000	100000	100000	100000	100000
Maternity* – LSCS (Caesarean)	50000	50000	70000	70000	90000	100000	120000	150000	200000

[#] Per policy period

*Maternity limit includes Pre-natal and Post- natal hospitalisation expenses.

c. Nil sublimit option – Under this option, Our maximum liability for the specified conditions/ procedures will be as per the actuals expenses or up to the sum insured, whichever is less:

i. Listed Mental and Psychiatric Illness
a) F01 Vascular dementia
b) F20 Schizophrenia
c) F30 Manic episode
d) F31 Bipolar affective disorder
e) F32-33 Depressive disorders
f) F41 Other anxiety disorders
g) F50 Eating disorders
h) F60 Specific personality disorders
i) F84 Pervasive developmental disorders
j) F40.9 Phobic anxiety disorder, unspecified
k) F05 Delirium, not induced by alcohol and other psychoactive substances

ii. Cataract surgery (per eye)

iii. Maternity (Normal Delivery or Caesarean Section)

d) **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), shall be restricted to 50% of the sum insured opted, per policy period.

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. Intravitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. Bronchial 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.

e) **Optional Sub limits**

i. The below sub limits shall be applicable for sum insured from INR 3 Lacs up to 10 Lacs if the Insured has opted for it.
ii. The Medical Expenses incurred during hospitalization (inclusive of pre and post hospitalization) due to the below listed treatments shall be limited to actual expenses or up to the Sub limits (whichever is less).

All values are in INR.

Procedure/Treatment	**300000**	**400000**	**500000**	**600000**	**1000000**
Coronary Artery Bypass Grafting (CABG)	150000	200000	225000	275000	300000
Percutaneous Transluminal Coronary Angioplasty (PTCA)	150000	200000	225000	275000	300000
Total Knee Replacement (per knee)	150000	200000	225000	275000	300000
Total Hip Replacement (per hip)	150000	200000	225000	275000	300000
HIV/ AIDS[#]	60000	80000	100000	120000	200000

[#] Per policy period

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.

4. Conditions for renewal of the contract

(i) **Renewal**
In addition to Section G. I. xiv

a) Your Health Super Saver Policy shall be renewable lifelong
b) For Renewal Proposal received after completion of Grace Period of 30 days, all the conditions would apply afresh.
c) 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
d) 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.
e) Increase/ decrease in Sum Insured, change of sub limit option and/or change of plan is allowed only at the start of plan tenure.
f) In case of enhancement of sum insured the waiting period shall apply afresh to the extent of sum insured increase.

(ii) **Possibility of Revision of Terms of the Policy including the Premium Rates**
In addition to Section G. I. xvi
The existing rates will continue to be applicable for policyholders till the end of ongoing plan tenure.

(iii) **Super Saver Discount**

a) For Health Super Saver 1X plan option, in case, your first year of plan tenure is claim free, you are eligible for Super Saver discount of 80% in the consecutive year
b) For Health Super Saver 2X plan option, in case, your first 2 years of plan tenure are claim free, you are eligible for Super Saver discount of 80% for next consecutive 2 years, or up to first claim, whichever is earlier
c) The plan opted will be common for all members covered under the policy irrespective of Individual and Floater sum insured options.
d) In case there is no claim paid for an insured in an individual policy, the Super Saver discount would be applied for that respective individual's premium only. In case of claim paid in the first year under 1X plan or in the first 3 years under 2X plan for any insured under the individual policy, the Super Saver discount will not be applicable to the respective insured. However at the time of subsequent renewal year, Insured has an option to start a new plan tenure under 1X Plan or 2X plan. In such case, he/she shall be covered under a separate policy with new plan tenure on individual sum insured basis without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases.
e) In case there is no claim paid for any of the insureds covered under the floater policy, the Super Saver discount would be applied on total policy premium. In case of claim paid for any insured under the floater policy, the Super Saver discount will not be applicable. However the policy can be renewed with a new plan tenure under 1X Plan or 2X plan without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases.
f) Increase/ decrease in Sum Insured, change of sub limit option and/or change of plan is allowed only at the start of plan tenure.
g) Irrespective of the plan tenure, premiums applicable are on yearly basis
h) For the purpose of the Super Saver discount calculation, paid claim and outstanding claims are considered.

Illustration 1: Health Super Saver 1X Plan opted by the insured

Health Super Saver 1X Plan opted by the insured				
Plan Option	**Policy Period**	**Claim/ No Claim**	**Super Saver Discount Applicable**	**Premium Applicable**
Health Super Saver 1X Plan	1	No Claim	Not Applicable as plan tenure started	100%
	2	Claim/ No Claim	Applicable	20%
Renewal (New Plan Tenure) (1x plan opted)	3	Claim	Not Applicable as new plan tenure started	100%
Renewal (New Plan Tenure) (1x plan opted)	4	No Claim	Not Applicable as New plan tenure started	100%
	5	Claim	Applicable	20%

Illustration 2: Health Super Saver 2X Plan opted by the insured

Health Super Saver 2X Plan opted by the insured				
Plan Option	**Policy Period**	**Claim/ No Claim**	**Super Saver Discount Applicable**	**Premium Applicable**
Health Super Saver 2X Plan	1	No Claim	Not Applicable as plan tenure started	100%
2nd year of plan tenure	2	No Claim	Not Applicable	100%
3rd year of plan tenure	3	No Claim	Applicable	20%
4th year of plan tenure	4	No Claim	Applicable	20%
Renewal (New Plan Tenure)	5	No Claim	Not Applicable as new plan tenure started	100%
2nd year of plan tenure	6	No Claim	Not Applicable	100%
3rd year of plan tenure	7	Claim	Applicable	20%
Renewal (New Plan Tenure)	8	No Claim	Not Applicable as new plan tenure started	100%
2nd year of plan tenure	9	No Claim	Not Applicable	100%
3rd year of plan tenure	10	No Claim	Applicable	20%
4th year of plan tenure	11	No Claim	Applicable	20%

Note: For the purpose of the Super Saver discount calculation, paid claim and outstanding claims are considered.

H. MANDATORY DISCLOSURES

a) Your Health Super Saver 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.
   i. For individual plan Insured would be charged as per the completed age at every renewal.
   ii. For Family floater plan, premium would applicable as per the completed age of all the insured members. A standard individual premium would be applicable for the primary insured. For the remaining dependant members, floater discounts will be applicable on their respective premium.
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 Renewals 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 premium will be applicable on basis of findings in pre-insurance medical examination.
g) Family discount of 10% in case of policies with more than 1 member covered under single proposal with Individual sum insureds. The family discount will not be applicable in case of only single person being covered at Renewal.

I. 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 / 1800 209 1016
Toll Free Fax: 1800 103 9998 / 1800 209 1017
Email: fgh@futuregenerali.in

Annexure 1

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.	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

Annexure 2: Premium rates exclusive of Goods & Services Tax (age in completed years)

A. Individual Premium

a) Health Super Saver 1X Plan

Age Bands/SI	3 lakhs	4 lakhs	5 lakhs	6 lakhs	10 lakhs	15 lakhs	20 lakhs	25 lakhs	50 lakhs
0-17	3535	4246	4686	5262	6548	7395	8580	9515	12054
18-25	5863	7022	7739	8677	10774	12153	14084	15339	19477
26-30	6194	7418	8175	9165	11379	12835	14873	16174	20543
31-35	6509	7792	8587	9626	11948	13476	15615	16959	21542
36-40	7423	8880	9782	10961	13597	15332	17760	19228	24431
41-45	8518	10183	11214	12562	15576	17558	20333	21950	27897
46-50	10762	12857	14154	15850	19641	22134	25626	27549	35031
51-55	14632	17389	19095	21327	26315	29597	34192	36161	46006
56-60	19155	22779	25023	27957	34516	38831	44872	47461	60406
61-65	25085	29846	32794	36648	45263	50931	58866	62267	79270
66-70	32847	39093	42960	48017	59320	66756	77166	81628	103936
71-75	42980	51164	56230	62854	77662	87404	101043	106888	136114
>=76	54653	65066	71512	79941	98782	111177	128531	135969	173156

b) Health Super Saver 2X Plan

Age Bands/SI	3 lakhs	4 lakhs	5 lakhs	6 lakhs	10 lakhs	15 lakhs	20 lakhs	25 lakhs	50 lakhs
0-17	3703	4447	4908	5510	6856	7741	8981	9940	12596
18-25	5992	7176	7909	8867	11010	12419	14392	15665	19894
26-30	6339	7590	8365	9378	11643	13133	15219	16540	21009
31-35	6775	8110	8936	10017	12432	14021	16246	17626	22393
36-40	7719	9233	10170	11396	14135	15937	18460	19969	25376
41-45	9034	10799	11891	13319	16512	18613	21554	23241	29543
46-50	11534	13778	15166	16983	21043	23714	27453	29483	37496
51-55	15668	18624	20454	22846	28195	31714	36641	38752	49310
56-60	20546	24438	26847	29998	37041	41674	48161	50941	64841
61-65	26958	32079	35248	39394	48659	54755	63289	66946	85233
66-70	35372	42102	46268	51717	63895	71907	83124	87932	111968
71-75	46389	55225	60694	67847	83835	94354	109080	115392	146948
>=76	56401	67149	73803	82503	101952	114747	132660	140338	178723

B. Floater Discount:

Applicable discount is as per following table:

Age Bands/SI	Floater Discount		Age Bands/SI	Floater Discount
0-17	60%		**51-55**	40%
18-25	55%		**56-60**	35%
26-30	50%		**61-65**	35%
31-35	45%		**66-70**	35%
36-40	45%		**71-75**	35%
41-45	40%		**>=76**	25%
46-50	40%			

*Premiums exclusive of Goods & Services Tax.

**Age in completed years

*** For Family Floater, premium applicable for the primary insured will be the standard individual premiums. For the remaining dependant members, floater discounts will be applicable on their respective premium.

**** 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 3: Schedule of Benefits

<table>
<tr><th colspan="4">HEALTH SUPER SAVER</th></tr>
<tr><td>A</td><td>Eligibility</td><td>Sum Insured options (in ₹)</td><td>3 Lacs, 4 Lacs, 5 Lacs, 6 Lacs, 10 Lacs,15 Lacs, 20 Lacs, 25 Lacs, 50 Lacs</td></tr>
<tr><td></td><td></td><td>Entry age of Proposer</td><td>18 years – 70 years</td></tr>
<tr><td></td><td></td><td>Entry age of Child</td><td>From birth – 25 years</td></tr>
<tr><td></td><td></td><td>Maximum Renewal Age</td><td>Lifelong</td></tr>
<tr><td></td><td></td><td>Sum Insured options</td><td>Individual/ Family Floater</td></tr>
<tr><td></td><td></td><td>Policy Term</td><td>Annual basis</td></tr>
<tr><td></td><td></td><td>Family Definition (Individual/ Family Floater)</td><td>Self, Spouse and up to 4 Children, 2 Dependent Parents And /Or 2 Dependent Parent In Laws</td></tr>
<tr><td></td><td></td><td>Plans</td><td>Health Super Saver 1X plan, Health Super Saver 2X plan
The plan opted will be common for all members covered under the policy irrespective of Individual and Floater sum insured options.</td></tr>
<tr><td>B</td><td>Coverages</td><td>Hospitalisation Expenses</td><td>Covered</td></tr>
<tr><td></td><td></td><td>Pre- Hospitalisation Expenses</td><td>60 days</td></tr>
<tr><td></td><td></td><td>Post-Hospitalisation Expenses</td><td>90 days</td></tr>
<tr><td></td><td></td><td>Day Care Treatment</td><td>Covered</td></tr>
<tr><td></td><td></td><td>Maternity Expenses</td><td>Covered with a waiting period of 9 months, inclusive of Pre-natal and Post-natal hospitalisation as per the plan opted under the Base Sub Limits</td></tr>
<tr><td></td><td></td><td>Alternative Treatment</td><td>Hospitalization for Ayurveda, Unani, Siddha or Homeopathy covered</td></tr>
<tr><td></td><td></td><td>Organ Donor Expenses</td><td>Hospitalization expenses are covered (excluding donor screening charges, pre and post hospitalization)</td></tr>
<tr><td></td><td></td><td>Emergency Ambulance</td><td>Maximum up to Rs.1000 per hospitalization</td></tr>
<tr><td></td><td></td><td>Home Health Care Services</td><td>a) Available through our empanelled Service Provider or our empaneled network on Cashless facility basis.
b) Pre and Post hospitalization expenses (both inclusive) are restricted up to 3% of the admissible claim amount.</td></tr>
<tr><td>C</td><td>Waiting Periods</td><td>30 days</td><td>Applicable, except for Accidental Hospitalization</td></tr>
<tr><td></td><td></td><td>2 Years</td><td>Applicable for listed conditions</td></tr>
<tr><td></td><td></td><td>4 Years</td><td>Applicable for listed conditions</td></tr>
<tr><td></td><td></td><td>Pre-existing Diseases</td><td>2 Years</td></tr>
<tr><td>D</td><td>Discount</td><td>Super Saver Discount</td><td>a) For Health Super Saver 1X plan option, in case, your first year of plan tenure is claim free, you are eligible for Super Saver discount of 80% in the consecutive year.
b) For Health Super Saver 2X plan option, in case, your first 2 years of plan tenure are claim free, you are eligible for Super Saver discount of 80% for next consecutive 2 years, or up to first claim, whichever is earlier.
c) In case there is no claim paid for an insured in an individual policy, the Super Saver discount would be applied for that respective individual's premium only. In case of claim paid in the first year under 1X plan or in the first 3 years under 2X plan for any insured under the individual policy, the Super Saver discount will not be applicable to the respective insured. However at the time of subsequent renewal year, Insured has an option to start a new plan tenure under 1X Plan or 2X plan. In such case, he/she shall be covered under a separate policy with new plan tenure on individual sum insured basis without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases.
d) In case there is no claim paid for any of the insureds covered under the floater policy, the Super Saver discount would be applied on total policy premium. In case of claim paid for any insured under the floater policy, the Super Saver discount will not be applicable. However the policy can be renewed with a new plan tenure under 1X Plan or 2X plan without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases.
e) Increase/ decrease in Sum Insured, change of sub limit option and/or change of plan is allowed only at the start of plan tenure.
Note: For the purpose of the Super Saver discount calculation, paid claim and outstanding claims are considered</td></tr>
<tr><td></td><td></td><td>Family Discount</td><td>10% discount is applicable in case two or more family members are covered with individual sum insured basis in the same policy
Note : Family discount will not be applicable, if the Insured opts for a new plan tenure under 1X Plan or 2X plan at the time of renewal due to claim reported under previous policy.</td></tr>
<tr><td>E</td><td>Instalment option (monthly, quarterly, half yearly) with Loading</td><td colspan="2">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>Sublimit for Specified procedure's</td><td colspan="2">a) Base Sub limits (Standard Option/ Double option/ Nil sub limits option)
b) Mandatory Sub limits for Modern Treatment Methods and Advancement in Technologies
c) Optional Sub limits – applicable for sum insured from INR 3 Lacs up to 10 Lacs if the Insured has opted for it</td></tr>
<tr><td>G</td><td>Loadings and Discount applicable for options under the Sub limits</td><td colspan="2">a) Loading applicable for Base Sub Limits options are as given below, loading shall be applicable on respective person's premium
<table>
<tr><th>Option</th><th>Loading (%)</th></tr>
<tr><td>Standard Option</td><td>0%</td></tr>
<tr><td>Double Option</td><td>22%</td></tr>
<tr><td>Nil Sub Limit Option</td><td>30%</td></tr>
</table>
b) Discount of 5% shall be applicable on respective person's premium if Optional Sub Limit is opted
In case of family floater, the loading/ discount will be applicable at the policy level.</td></tr>
</table>