FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Surrogacy Health Cover
Prospectus

1. SALIENT FEATURES OF THE POLICY

1.1 Inpatient Hospitalization:
1.2 Pre-Hospitalization Medical Expenses
1.3 Post-Hospitalization Medical Expenses
1.4 Day Care Treatment
1.5 Robotic Surgeries
1.6 Emergency Ground Ambulance

2. BASE COVER

2.1 Inpatient Hospitalization:

We shall indemnify reasonable and customary charges for medical expenses incurred by the,

a) Insured Person who is a Surrogate Mother, towards hospitalization for treatment of complications arising out of pregnancy and post-partum delivery complications **or**
b) Insured Person who is an Oocyte Donor, towards hospitalization for treatment of complications arising due to Oocyte retrieval,

at a hospital / Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, during the policy year and up to the Sum Insured as specified in the Schedule of Benefits .

The cover for medical expenses shall be for the following:

i. Room rent, boarding, nursing expenses as provided by the Hospital / Nursing Home covered up to 1% of the Sum Insured per day.
ii. Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) expenses covered up to Sum Insured.
iii. Surgeon, Anesthetists, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating Medical Practitioner / Surgeon or to the hospital.
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Special Condition:

1. No woman shall act as a surrogate mother by providing her own gametes.
2. Intending woman cannot be an Oocyte donor.

2.2 Pre-Hospitalization Medical Expenses:

We shall indemnify reasonable and customary charges for Pre-Hospitalization Medical Expenses incurred, related to an admissible hospitalization requiring Inpatient care, for a fixed period 15 days prior to the date of admissible Hospitalization covered under the Policy during Policy period.

Special Condition:

i. We have accepted a claim under Section 2.1 (Inpatient Hospitalization), Section 2.4(Day Care Treatment) or Section 2.5 (Robotic Surgeries) in respect of that Insured Person.
ii. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

2.3 Post-Hospitalization Medical Expenses:

We shall indemnify reasonable and customary charges for Post-Hospitalization Medical expenses incurred, related to an admissible Hospitalization requiring Inpatient care, for a fixed period 30 days from the date of discharge from the Hospital, following an admissible hospitalization covered under the Policy during policy period.

Special Condition:

i. We have accepted a claim under Section 2.1 (Inpatient Hospitalization), Section 2.4 (Day Care Treatment) or Section 2.5 (Robotic Surgeries) in respect of that Insured Person.
ii. Post-hospitalization Medical Expenses can be claimed under this Section on Reimbursement basis only.

2.4 Day Care Treatment

We shall indemnify reasonable and customary charges for medical expenses incurred towards Day Care treatments only for the contingencies mentioned as per clause 2.1.a or 2.1.b.

2.5 Robotic Surgeries:

We shall indemnify reasonable and customary charges for medical expenses incurred towards robotic surgeries (wherever medically indicated), required only for the contingencies mentioned as per clause 2.1.a or 2.1.b, either as In-Patient Hospitalization or as part of Day Care Treatment in a Hospital, up to 50% of Sum Insured as specified in the Schedule of Benefits.

2.6 Emergency Ground Ambulance:

We shall reimburse up to the limits as specified in the Schedule of Benefits of this Policy, towards transportation of the Insured Person by road ambulance for any emergency diagnosed during the policy period provided that:

Special Condition:

i. The medical condition of the insured person requires immediate ambulance services from the place of occurrence of an Emergency to the nearest Hospital.
ii. The expenses incurred on road ambulance are subject to a maximum of Rs. 3000 per hospitalization event.
iii. The Ambulance service offered by a healthcare or Registered Ambulance Service Provider.
iv. The original ambulance bills and payments receipt is submitted to us.
v. We have accepted a claim under Section 2.1(Inpatient Hospitalization), Section 2.4(Day Care Treatment) or Section 2.5 (Robotic Surgeries) above in respect of the same period of hospitalization.
vi. Any payment under this benefit will be excluded if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purpose only.

3. WAITING PERIOD

We shall not be liable to make any payment under this Policy directly or indirectly for following expenses till the expiry of the waiting period as mentioned below:

1. **First 30 Days Waiting Period -Code- Excl03**

a) Expenses related to treatment of Surrogate Mother or Oocyte donor as mentioned under the clause 2.1.a or 2.1.b, within 30 days from the policy commencement date shall be excluded.

4. EXCLUSIONS

We shall not be liable to make any payment under the Policy, in respect of any expenses incurred with respect to or arising out of any of the following:

4.1 Standard Exclusions

1. **Investigation & Evaluation-Code- Excl04**
   a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. **Rest Cure, rehabilitation and respite care-Code- Excl05**
   a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
      i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
      ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. **Breach of law: Code- Excl10**
   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4. **Excluded Providers: Code-Excl11**
   Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

8. **Unproven Treatments:(Code- Excl16)**

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.2 Specific Exclusions

1. Commercial Surrogacy / Traditional surrogacy
2. Expenses incurred for Delivery (both for Normal & C-Section)
3. Assisted reproductive technology procedures & any complications arising out of these procedures except for complications arising due to Oocyte retrieval.
4. Regular antenatal or post-natal treatment check-ups.
5. Nuclear damage caused by, contributed to, by or arising from ionizing radiation or contamination by radioactivity from:
   a. any nuclear fuel or from any nuclear waste
   b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission)
   c. nuclear weapon material
   d. nuclear equipment or any part of that equipment
6. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.
7. [1]Experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, chiropractic, reflexology and aromatherapy.
8. Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event / activity that is against law with a criminal intent.
9. All preventive care, vaccination/inoculation (except as post bite treatment), vitamins and tonics Convalescences, general debility, "Run Down" condition, rest cure, congenital external illness/disease/ defect.
10. Outpatient diagnostic, medical and Surgical Procedures or treatment, non -prescribed drugs and medical supplies, hormone replacement therapy and expenses related to domiciliary hospitalization shall not be covered.
11. Stem Cell storage.
12. Any kind of service charge, surcharge levied by the hospital.
13. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
14. Any medical treatment taken outside India.
15. Non –Payable items: The expenses that are not covered in this policy are placed under List-I of Annexure II.
16. Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.
17. Expenses incurred towards any disease / illness / injury other than the contingencies mentioned in clause 2.1.a or 2.1.b.

5. GENERAL TERMS AND CONDITIONS

[1] Specific Exclusion No. 7 modified to cover AYUSH treatment in the scope of Product

5.1 Standard terms and conditions.

I. Condition Precedent to the contract

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

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

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

4. **Complete Discharge**
   Any payment to the Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital for any benefit under the Policy shall be valid discharge towards payment of claim by the company to the extent of that amount for the claim.

5. **Multiple Policies**
   i. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim if the claim is within the limits of and according to the terms of the chosen policy.
   ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.
   iii. If the amount to be claimed exceeds the sum insured under a single policy after, the Insured Beneficiary shall have the right to choose insurers from whom he/she wants to claim the balance amount.

iv. Where an insured has policies from more than one insurer to cover the same risk on an indemnity basis, the insured shall only be indemnified for the treatments costs in accordance with the terms and conditions of the chosen policy.
v. Under this product, no insured can take more than one policy from any or all insurers.
vi. In the case of this product, the maximum liability of all policies put together from all insurers cannot exceed the maximum sum insured under this product.

6. Fraud

If any claim made by the insured person, is in any respect of 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 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.

7. Cancellation

i. The policyholder may cancel this policy by giving 7 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.
   - In case the Policy Period is one year, and the cancellation happens during the risk period on the Policyholders request, the Company shall refund premium for the unexpired policy period on pro-rata basis, where no claims are reported under the policy.
   - In case the Policy Period exceeds one year, we shall refund premiums on a pro-rata basis for the unexpiry policy, where no claims are reported under the policy.
ii. 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.
iii. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud, or non-cooperation by the insured person by giving 15 days' written notice. There would be no refund of the premium upon cancellation on the above-mentioned grounds.

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

v. In the event of death of an Insured Person,

Policy Period – 1 Year

- If no claims in the Policy - We shall refund the premium for the unutilized Policy period on pro rata basis.
- If claims incurred in the Policy - No refund shall be made

Policy Period – 3 Years

- If no claims in the Policy - We shall refund the premium for the unutilized Policy period on pro rata basis.
- If claims are incurred in the Policy – The premium pertaining to the deceased Insured Person for the unutilized current Policy Year shall not be refunded. However, premium pertaining to the deceased Insured Person for the unutilized subsequent Policy Years (if any), shall be refunded.

8. Migration

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

i. The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

9. Moratorium Period

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

10. Portability

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

i. The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

11. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three (3) months before the changes are affected.

12. Withdrawal of Policy

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

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

13. Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals of the policy. The insured shall be allowed free look period of thirty days from date of receipt of the Policy documents to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

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

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

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

14. Redressal Of Grievance

In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.

Website: https://general.futuregenerali.in/

Toll Free: 1800-220-233 / 1860-500-3333 / 022-67837800
Email: Fgcare@futuregenerali.in
Courier: Grievance Redressal Cell, Future Generali India Insurance Company Ltd.
Lodha I –Think Techno Campus, B Wing –2nd Floor, Pokhran Road –2, Off Eastern Express Highway behind TCS, Thane West – 400607

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

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

For updated details of grievance officer, kindly refer the link
https://general.futuregenerali.in/customer-service/grievance-redressal

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

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

15. 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 Insured Person, the Company will pay the nominee (as named in the Policy Schedule /Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

5.2 Specific terms and conditions

I. Condition Precedent to the contract

a. Material Change

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

b. Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

c. Records to be maintained.

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

d. Territorial Jurisdiction

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

e. Eligibility Criteria

It is Condition Precedent that this cover can be availed on mandatory submission of the following documents, in addition to the submission of the Proposal Form, at the time of proposal underwriting.

For Surrogacy

a) Certificate of a medical indication in favor of either or both members of the intending couple or intending woman necessitating gestational surrogacy from a District Medical Board.

b) Eligibility certificate issued by appropriate authority in favor of the woman to act as surrogate mother.

For Oocyte Donor

a) Written informed consent of all parties (Commissioning Couple / Woman and Oocyte Donor) seeking ART procedure.

For other eligibility details, refer to Section 7 (Schedule of Benefits).

f. Pre-Policy Medical Examination - Not applicable for this product.
All proposals with any medical declaration will be referred to the Retail Health Underwriter.

g. Underwriting and Loadings - Loading maximum up to 100% in multiples of 25% per illness shall be applicable based on underwriting discretion.

II. Condition applicable during the contract

a. Alterations in the Policy

The Proposal form, Policy schedule constitutes the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policy holder and us. No change or alteration will be effective or valid unless approved in writing, which will be evidenced by a written endorsement, signed and stamped by the Company.

b. Revision and modification of the Policy Product

i. Any revision or modification will be done with the approval of the Authority.
ii. The existing Policy will continue to remain in force till its expiry.

c. Terms and conditions of the Policy

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

d. [2]AYUSH Coverage:

Expenses incurred on hospitalization under AYUSH systems of medicine shall be covered without any sub-limits. However, all preventive and rejuvenation treatments which are non-curative in nature shall not be covered

6. CLAIM PROCEDURES

6.1 Procedure for cashless claims:

i. Treatment may be taken in a network provider and is subject to preauthorization by us or our authorized TPA.
ii. Cashless request form available with the network provider and TPA shall be completed and sent to us/TPA for authorization.
iii. We/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.
iv. At the time of discharge, the insured person must verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
v. We / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
vi. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to us/ TPA for reimbursement.

6.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to us within the prescribed time limit as specified hereunder.

Sr. No	Type of Claim	Prescribed Time limit
1	Reimbursement of hospitalization, day care and prehospitalization expenses	Within thirty days of date of discharge from hospital
2	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

6.3 Notification of Claim

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

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

6.4 Documents to be submitted.

The claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form.

[2] Clause number d. newly inserted to cover AYUSH treatments at par with Allopathic Treatments, wherever applicable, in the product to provide an option for the Insured Persons to choose treatment of their choice.

ii. Photo Identity proof of the patient.
iii. First consultation letter.
iv. Medical practitioner's prescription advising admission.
v. Original vouchers/ invoice of original bill.
vi. Original Hospital bills giving a detailed break up of all expense heads mentioned in the bill.
vii. Money receipt duly signed with a revenue stamp.
viii. Discharge summary including complete medical history of the patient along with other details. (in case of Reimbursement)
ix. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner.
x. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
xi. Sticker/Invoice of the Implants, wherever applicable.
xii. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable.
xiii. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
xiv. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines.
xv. Legal heir/succession certificate, wherever applicable.
xvi. Any other relevant document required by us/TPA for assessment of the claim.

Note:

1. We shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, we shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to our satisfaction.
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

We shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, we will make the payment of benefit as per the contract. In case If the claim is repudiated, we will inform the Insured about the same in writing with reasons for repudiation.

6.5 Services Offered by TPA (To be stated where TPA is involved)

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

6.6 Payment of Claim

All claims under the policy shall be payable in Indian currency only.

7. SCHEDULE OF BENEFITS

Name	Surrogacy Health Cover
Coverage Basis	Individual
Category of Cover	Indemnity Only
Proposer Eligibility	1. For Covering Surrogate Mother - Any one member of the intending couple or an intending woman Intending Couple – means legally Married Couple who is of Indian origin and intend to become parents through Surrogacy due to medical indication necessitating gestational surrogacy. Intending Woman – means an Indian Woman who is a widow or divorcee who intend to avail the Surrogacy. Age Eligibility: (i) Intending Couple: Male Member - 26 to 55 Years. Female Member - 23 to 50 years (ii) Intending Woman: 35 to 45 Years. **OR** 2. For Covering Oocyte Donor – Any one member of the commissioning couple or a woman who approaches the ART clinic or bank to obtain their authorized services. Commissioning Couple – means an infertile married couple who approach an Assisted Reproductive Technology clinic or Assisted Reproductive Technology bank for obtaining the services authorized of the said clinic or bank. Woman - means any woman who approaches an assisted- reproductive technology clinic or assisted reproductive technology bank for obtaining the authorized services of the clinic or bank. Age Eligibility: (i) Commissioning Couple: Male Member - 21 to 55 Years. Female Member - 21 to 50 years (ii) Women – Age 21 years & above
Insured Eligibility	1. Surrogate Mother – means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through Surrogacy from the implantation of embryo in her womb. Age Eligibility: 25 to 35 years on the day of implantation (should be a married woman having a child of her own) Note: No woman shall act as a surrogate mother by providing her own gametes.

	OR 2. Oocyte Donor – means a woman who provides her Oocyte with the objective of enabling an infertile couple or woman to have a child. Age Eligibility: 23 to 35 years Note: Intending woman cannot be an Oocyte donor.
Condition Precedent	It is Condition Precedent that this cover can be availed on mandatory submission of the following documents, in addition to the submission of the Proposal Form, at the time of proposal underwriting. **For Surrogacy** a) Certificate of a medical indication in favor of either or both members of the intending couple or intending woman necessitating gestational surrogacy from a District Medical Board. b) Eligibility certificate issued by appropriate authority in favor of the woman to act as surrogate mother. **For Oocyte Donor** a) Written informed consent of all parties (Commissioning Couple / Woman and Oocyte Donor) seeking ART procedure.
Sum Insured Available (INR)	In favor of Surrogate Mother – ₹ 2L, 3L, 5L In favor of Oocyte Donor - ₹ 1L, 3L
Policy Period	Surrogate Mother – 3 Years. Oocyte Donor – 1 Year The Policy can be issued for the above-mentioned policy period for one time only. The policy shall not be available for renewals after the completion of the Policy period.
Scope of Cover	The Policy offers hospitalization cover for the events defined below: (A) Surrogate Mother - In-patient Hospitalization / Day Care expenses towards complications arising out of pregnancy and post- partum delivery complications. **OR** (B) Oocyte Donor - In-patient hospitalization / Day Care expenses towards complications arising due to oocyte retrieval. The benefit specified under Point (A) & (B) above shall be covered up to Sum Insured as specified in the Policy Schedule. Note: The Policy can be purchased for any one of the covers and not both, at a given point in time.

Other Hospitalization Expenses Covered	(i) Room Rent Limit: Normal Room- up to 1% of Sum Insured. ICU-Actuals covered up to Sum Insured. (ii) Pre-Hospitalization Medical Expenses-15 Days. (iii) Post Hospitalization Medical Expenses- 30 Days. (iv) Day Care Treatment - Covered up to Sum Insured. (v) Robotic surgeries -Covered up to 50% of Sum Insured. (vi) Emergency Ground Ambulance - covered up to Rs 3000 per hospitalization event.
Premium Frequency	Single
Renewal of the Policy	Not Applicable
Portability and Migration	Not applicable

Premium Table: (exclusive of GST)

Surrogate Mother: (3 years)

Age Band	2 Lakhs	3 Lakhs	5 Lakhs
26-30	75,712	85,121	96,615
31-35	91,344	102,893	116,906

Oocyte Donor: (1 year)

Age Band	1 Lakhs	3 Lakhs
23-35	19,234	51,492

Premium Illustration

Premium Illustration in respect of policies offered on individual basis for Surrogate Mother			
Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)	Coverage opted on an individual basis covering multiple members of the family under a single policy. (Sum Insured is available for each member of the family)	Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)

	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount (if any)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater discount (if any)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
27	96,615	500,000	Not Applicable as the Sum Insured under this product is only on Individual Basis				Not Applicable as the Sum Insured under this product is only on Individual Basis			
	Total premium for member is Rs. 96,615 excl. GST. Sum Insured available for each individual is Rs. 5 Lakhs.		Not Applicable as the Sum Insured under this product is only on Individual Basis				Not Applicable as the Sum Insured under this product is only on Individual Basis			

Premium Illustration in respect of policies offered on individual basis for Oocyte Donor										
Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount (if any)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater discount (if any)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
25	51,492	300,000	Not Applicable as the Sum Insured under this product is only on Individual Basis				Not Applicable as the Sum Insured under this product is only on Individual Basis			
	Total premium for member is Rs. 51,492 excl. GST. Sum Insured available for each individual is Rs. 3 Lakhs.		Not Applicable as the Sum Insured under this product is only on Individual Basis				Not Applicable as the Sum Insured under this product is only on Individual Basis			

ISO No. FGH/UW/RET/290/03

Annexure II—NON-MEDICAL EXPENSES

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

SI No	Item
1.	BABY FOOD
2.	BABY UTILITES CHARGES
3.	BEAUTY SERVICES
4.	BELTS/ BRACES
5.	BUDS
6.	COLD PACK/HOT PACK
7.	CARRY BAGS
8.	EMAIL / INTERNET CHARGES

9.	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVENYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG/ SHORT/ HINGED)
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES

53.	SUGAR FREE TABLETS
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY

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

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

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

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