A. Salient Features of the policy

If **You** contract any disease or suffer from any **Illness** or **Accident** and if such **Illness** or **Accident** shall require **You** to incur **Inpatient care**/**Emergency Care** expenses for medical/ surgical treatment at any **Hospital** in India, upon **Medical Advice** of the duly qualified **Medical Practitioner**, **We** will pay **You** the amount of such expenses in excess of the **Deductible** per hospitalisation that are the reasonable charges which are medically necessarily and incurred in respect by or on behalf of **You** up to limits indicated but not exceeding the **Sum Insured** during the period stated in the Policy **Schedule**. In the event of any claims becoming admissible under the **Policy**, **We** will pay to **You** or the Nominee as under:

1. **Room Rent**, Board & Nursing Expenses as provided by the **Hospital**/ **Nursing Home** charges.
2. Surgeon, Anaesthetist, **Medical Practitioner**, Consultants, Specialists Fees.
3. Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Cost of Pacemaker, prosthesis/ internal implants and any **Medical Expenses** incurred which is integral part of the operation.
4. Pre– hospitalisation **Medical Expenses** incurred within 60 days prior to **Hospitalisation** due to **Illness**/ **Injury** sustained.
5. Post– hospitalisation **Medical Expenses** incurred within 90 days after the date of discharge from the **Hospital**.

Deductible amount stated in the **Schedule** shall be borne by **You** in respect of each and every Claim made under this **Policy**. **Our** liability to make any payment under the **Policy** is in excess of the **Deductible**. For the purpose of calculation of the **Deductible** per hospitalisation any expenses incurred on room and boarding, nursing expenses, surgeon's, anesthetist, **Medical Practitioner**s, consultants and specialist's fees, anesthesia, Blood, Oxygen, Operation theater charges, surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-ray, cost of Pacemaker and similar expenses will be taken into account. However Pre- hospitalisation and Post- hospitalisation expenses will not be taken into account.

B. Definitions

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

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

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

4) **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.

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 excluding non-payable items as per the policy terms and conditions.

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

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

10) **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.

11) **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.

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

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

14) **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.

15) **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.

16) **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)

17) **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.

18) **Family** means and includes You, Your Spouse and Your two dependent child/children up to the age of 25 years.

19) **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.

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

21) **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;

22) **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.

23) **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

24) **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.

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

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

27) **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.

28) **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.

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

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

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

32) **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.

33) **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.

34) **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

35) **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

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

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

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

39) **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.

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

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

42) **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.

43) **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 issued by the insurer or its reinstatement.

   (Note: Reinstatement is applicable for Life Insurance policies)

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

45) **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:
   a. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
   b. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

46) **Primary Insurer** means the insurer with whom the Insured Person first lodges his claim for Hospitalization expenses.

47) **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.

48) **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.

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

50) **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.

51) **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.

52) **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.

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

54) **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**.

55) **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.

56) **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).

57) **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.

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

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

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

c. EXCLUSIONS

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

a. **Pre-Existing Disease- Excl 01**
i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

b. **Specified disease/procedure waiting period- Code- Excl02**
i. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 36 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. In case of change in plan from a lower deductible plan to higher deductible plan this Exclusion shall apply afresh only to the extent of the amount by which the limit of indemnity has been increased (i.e. enhanced sum insured) if the policy is a renewal of similar (high deductible policy) policy without break in cover.

c. **List of specific diseases/procedures:**

i. 36 months waiting period:
a. Joint replacement surgery due to degenerative condition
b. Age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is necessitated by Accidental Bodily Injury

ii. 30 days waiting period Excl -03
a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.
d. This Exclusion shall apply only to the extent of the amount by which the limit on indemnity has been increased if the Policy is a renewal of similar policy (high deductible policy) without break in cover.

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

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

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

c) **Obesity/ Weight Control: Code- Excl06**
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

d) **Change-of-Gender treatments: Code- Excl07**

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

e) **Cosmetic or Plastic Surgery: Code- Excl08**
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medically necessity, it must be certified by the attending Medical Practitioner.

f) **Hazardous or Adventure sports: Code- Excl09**
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, 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 or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

j) **Code- Excl13**
Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or a Hospital where the Hospital has effectively become the Insured Person's home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

k) **Code- Excl14**
Dietary supplements and substances which are available naturally and that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedures.

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

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

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

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

p) 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).
q) Circumcision, unless necessary for treatment of a disease, not excluded hereunder or as may be necessitated due to an accident.
r) Vaccination (except as post-bite treatment) inoculation
s) Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, durable medical equipment (including but not limited to cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Asthmatic condition, wheel chair, crutches, artificial limbs, belts, braces, stocking, Glucometer and the like), namely that equipment used externally for the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose, such cost of all appliances/ devices whether for diagnosis or treatment after discharge from the hospital.
t) Dental treatment or surgery of any kind unless requiring hospitalisation as a result of accidental Bodily injury.
u) Venereal /Sexually Transmitted disease other than HIV/AIDS, intentional self-Injury.
v) Congenital external illness/ disease/ defect anomaly.
w) Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.
x) Costs incurred on all methods of treatment including Alternative treatments/ AYUSH treatment other than Allopathy.
y) Outpatient Diagnostic, Medical and Surgical procedures or treatments (OPD treatment),Non-prescribed drugs and medical supplies, Hormone replacement therapy.
z) Stem cell storage.
aa) Doctor's home visit charges during pre and post hospitalization period, Attendant Nursing charges
bb) Expenses related to donor screening, treatment, excluding surgery to remove organs from the donor in case of a transplant surgery. We will not pay the donor's pre-and post-hospitalization expenses or any other medical treatment for the donor consequent to surgery.

cc) Surgery to correct deviated septum and hypertrophied turbinate.
dd) Personal comfort and convenience items or services such as television, telephone, barber or beauty service guest service and similar incidental services and supplies.
ee) Treatment received outside India.
ff) Standard list of excluded items as mentioned in Annexure 2 and on our website https://general.futuregenerali.in

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

D. Eligibility :

1. **Age Eligibility**
   a. Age of entry: 3 Months – 65 Years. Renewable lifelong
   b. Children from 3 Months – 5 years can be covered if both the parents are insured with **Us**
   c. Children from 6 years to 18 years can be covered if either of the parents is covered with **Us**.
   d. Children from 18 year to 25 years can be covered as self proposer or as dependents.

2. **Pre Acceptance Medical Tests**
   a. **Pre-acceptance medical tests** are not required for all proposers less than 55 years, if the **Proposal** form is clean.
   b. For age 55 years and above medical tests are required.
   c. In case the **Policy** is issued for that particular client, the client is eligible for 50% of reimbursement of pre-acceptance medical tests charges.
   d. All pre-acceptance medical tests will have to be done in Future Generali empanelled diagnostic centers only. The reports would be valid for a period of 30 days from the date of test conducted.
   e. **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.

E. General Conditions

1. **Condition Precedent to the contract**

a) 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

b) Migration

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

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

2. **Conditions applicable during the contract**

A. **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.

B. **Insured**

Only the person named, as the Insured in the Schedule shall be covered under this Policy. The details of the Insured are as provided by You. Cover under this Policy shall be withdrawn upon such Insured giving 15 days written notice to be received by Us.

C. **Cost of pre-insurance medical examination**

We will reimburse 50% of the cost of any pre-insurance medical examination once the proposal is accepted and the policy is issued for that insured. 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.

D. **Communications**

i. Any communication meant for Us must be in writing and be delivered to Our address shown in the Schedule. Any communication meant for You will be sent by Us to Your address shown in the Schedule or the last registered address.
ii. All notifications and declarations for Us must be in writing and sent to the address specified in the Schedule. Agents are not authorized to receive notices and declarations on Our behalf.
iii. You must notify Us of any change in address.

E. **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.

F. **Multiple Policies**

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

G. **Territorial Limits and Law**

i. This Policy is restricted to insured events occurring in and Medical Expenses incurred in India.

ii. The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian Law.

iii. 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.

H. **Free Look Period**

i. 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.

ii. 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.

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

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

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

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

I. **Cancellation**

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

ii. We may cancel this insurance by giving You at least 15 days written notice, and if no claim has been made then We shall refund a pro-rata 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

iii. For Family floater policies, in the event of the death of any of the insured members, the cover ceases to exist for that insured and the remaining members would continue to have the coverage until the end of the policy period. Refund in case of the deceased member will be as per pro-rate premium, subject to no claim.

iv. 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.

v. 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.

J. **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.

K. **Moratorium Period**

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

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

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

4. **Conditions when a claim arises**

A. **Claims Procedure**

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

comply with the following:

i) Cashless treatment is only available at a Network Provider. In order to avail of cashless treatment, the following procedure must be followed by You:

a) Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, You must call Us and request pre-authorisation by way of the written form We will provide.

b) After considering Your request and after obtaining any further information or documentation we have sought, We may if satisfied send You or the Network Hospital, a pre-authorisation letter. The pre-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 Hospital identified in the pre-authorisation letter at the time of Your admission to the same.

c) If the procedure above is followed, You will not be required to directly pay for the Hospitalisation Expenses above the deductible in the Network Hospital that We are liable to indemnify under Section II above and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Pre-authorisation does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Hospitalisation Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy. You shall, in any event, be required to settle all other expenses directly.

ii) If pre-authorization as per 4. A. i. above is denied by Us or if treatment is taken in a Non-Network Hospital or if You do not wish to avail cashless facility, then:

a) You or someone claiming on Your behalf must give Notification of Claim in writing immediately, and in any event within 48 hours of the aforesaid Illness or Bodily Injury. You must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.

b) You must take steps or measure to minimise the quantum of any claim that may be made under this Policy.

c) You must have Yourself examined by Our medical advisors if We ask for this, at the insurers cost.

d) You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the necessary documents (written details of the quantum of any claim along with all original supporting documentation, including but not limited to first consultation letter, original vouchers, bills and receipts, birth/death certificate (as applicable)) and other information We ask for to investigate the claim or Our obligation to make payment for it.

e) In the event of the death of the insured person, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if conducted) within 30 days.

f) The periods for intimation or submission of any documents as stipulated (**a**), (**d**), and (**e**) will be waived in case of any hardships being faced by the insured or his representative which is supported by some documentation.

**Note: Waiver of conditions (a) and (e) may be considered where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible from him or any other person to give notice or file claim within the prescribed time limit. This would also be considered in case of every claim where insured may have intimated primary insurer only, as he may not know initially that his claim will cross deductible.*

iii) In case the originals are required by the primary insurer, we would return the original documents to the primary insurer after stamping the documents for the amount we have settled under the policy.

B. **Settlement of Claims:**

a. Our doctors will scrutinize the claims and flag the claim as settled/ Rejected/ Pending within the period of 30 days of the receipt of the last 'necessary' documents.

b. 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.

c. 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.

d. 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)

e. Pending claims will be asked for submission of incomplete documents.

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

C. **Basis of claims payment**

a) If You suffer a relapse within 45 days of the date when You last obtained medical treatment or consulted a Medical Practitioner and for which a claim has been made, then such relapse shall be deemed to be part of the same claim.

b) If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

c) We shall make payment in Indian Rupees only.

D. **Complete Discharge**

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

E. **Dispute Resolution**

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

F. **Redressal of Grievance**

Insured person may approach the grievance cell at any of the company's branches with the details of grievance.
For updated details of grievance officer, kindly refer the Annexure on Grievance Redressal Procedures
Insured can also refer to the Grievance Redressal Procedures at our website link
https://general.futuregenerali.in/general-insurance/pdf/Grievance_Redressal_Procedures.pdf

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

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

A. **Renewal**

a) The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
b) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
c) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
d) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
e) 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.
f) Coverage is not available during the grace period.
g) No loading shall apply on renewals based on individual claims experience.
h) The brochure / prospectus mentions the premium rates as per the age slabs/ sum insured for the completed age at every renewal and 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
i) For Renewal Proposal received after completion of Grace Period of 30 days, all waiting periods including for Health Check-up, would apply afresh.
j) There is no Cumulative Bonus available under the Policy.

B. **Compliance with Policy Provisions**

Failure by You or the Insured Person to comply with any of the provisions in this Policy may invalidate all claims hereunder.

C. **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.

D. **Possibility of Revision of Terms of the Policy Including the Premium Rates**

- The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.
- The premiums as shown in the brochure/ prospectus are subject to revision as and when approved by the IRDAI. However such revised premiums would be applicable only from subsequent Renewals and with due notice whenever implemented.

F. Mandatory Disclosures

a) **Your** Health Surplus 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**. Insureds would be charged as per the completed age at every **Renewal**. In case of Family Floater, floater discounts will be applicable for the remaining members (other than primary insured) as per the table given under Section G of the Prospectus.
c) The premiums as shown in the prospectus/ brochure are subject to revision as and when approved by the regulator. However such revised premiums would be applicable only from subsequent **Renewal**s and with due notice whenever implemented.
d) **Renewal**s will not be refused or cancellation will not be invoked by **Us** except on ground of fraud, moral hazard or misrepresentation. 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) Terms for enhancing the **Sum Insured**:
   i. No increase in **Sum Insured** during the currency of the **Policy**.
   ii. In case of change in plan from a lower Deductible plan to higher Deductible plan Exclusions shall apply afresh only to the extent of the amount by which the limit of indemnity has been increased (i.e. enhanced Sum Insured).
g) Detailed exclusions are given under Section c of the Prospectus.

G. Payment of Premium

As per table annexed

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

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

Signature	Place
Name	Date

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

Annexure 1: Premium illustration: (All figures in Rs) Goods and Services Tax Extra

Plan	A	B	C	D	E
Sum Insured (in Rs)	**3 lakhs**	**5 lakhs**	**5 lakhs**	**7 lakhs**	**10 lakhs**
Deductible (in Rs)	**2lakhs**	**2 lakhs**	**3 lakhs**	**3 lakhs**	**5 lakhs**
3 months -17 years	**1008**	**1430**	**1414**	**1885**	**2172**
18-35 years	**1248**	**1596**	**1514**	**2207**	**2530**
36-45 years	**1759**	**2477**	**2386**	**3450**	**3909**
46-55 years	**2912**	**3905**	**3810**	**4680**	**5427**
56-65 years	**4596**	**5977**	**5733**	**6772**	**7738**
66-70 years	**7888**	**9555**	**9430**	**11325**	**14308**
71-75 years	**10944**	**12777**	**12044**	**14611**	**18278**
76-80 years	**15777**	**16711**	**15777**	**19044**	**24178**
81- 85 years	**18144**	**19217**	**18144**	**21901**	**27804**
86- 90 years	**16329**	**17296**	**16330**	**19711**	**25024**
91 years & Above	**1377**	**1761**	**1670**	**2207**	**2790**

Family Floater Discounts: Premium for the primary insured remains as per table above.
For remaining members discounts applicable on their respective premium as table below.

Age	Floater Discount
3 months -17 years	60%
18-35 years	55%
36-45 years	50%
46-55 years	45%
56-65 years	40%
66-70 years	35%
71-75 years	30%
76-80 years	25%
81- 85 years	20%
86- 90 years	20%
91 years & Above	20%

Annexure 2

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

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

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

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

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

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

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

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

ISO No. FGH/UW/RET/60/04