A. DEFINITIONS

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

i. Standard definitions:

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

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

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

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

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

6. **Cashless facility** 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.

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

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

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

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

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

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

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

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

15. **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.

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

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. **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.

19. **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;

20. **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.

21. **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

22. **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.

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

24. **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.

25. **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.

26. **Maternity expense** 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.

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

28. **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.

29. **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.

30. **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.

31. **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

32. **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

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

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

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

36. **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.

37. **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.

38. **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.
    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.

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

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

41. **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.

42. **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.

43. **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.

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

45. **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.

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

ii. Specific Definitions

47. **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.

48. **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.

49. **Dependent Child** means Your child (natural or legally adopted), who is financially dependent on You and does not have his/her independent sources of income.

50. **Dependent Parents** means Your father or mother who are financially dependent on You.

51. **Dependent sibling** means your brother or sister if they are unmarried and still financially dependent on You.

52. **Dependent Spouse** means Your legally married spouse as long as he/she continues to be married to You.

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

54. **Insured Person** means a person named in the Schedule who is covered under this Policy, for whom the insurance is proposed and the appropriate premium has been received.

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

56. **Policy Period** means the period starting with the commencement date mentioned in the Schedule till the end date mentioned in the Schedule.

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

58. **Post-Natal Medical Expenses** means medical expenses incurred for the insured mother post the delivery.

59. **Pre-Natal Medical Expenses** means medical expenses incurred for the insured mother during the maternity period prior to delivery.

60. **Proposal** means that portion of the Policy which sets out Your/Insured Person's personal details, the type of insurance cover in force, the Policy Period and the Sum Insured.

61. **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.

62. **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.

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

64. **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 under the Policy. Any Annexure or Endorsement to the **Schedule** shall also be a part of the **Schedule**.

65. **Schedule of Benefits** means that portion of the Policy which sets out the three Plans of the Policy that may be opted by the Insured Person and the benefits available to You / Insured Person under each Plan in accordance with the terms of the Policy.

66. **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).

67. **Voluntary Deductible** means the Deductible You have opted for, and is the amount stated in the Schedule, which shall be borne by the Insured Person in respect of each and every Hospitalization claim incurred in the Policy Year. Our liability to make any payment for each and every claim under the Policy is in excess of the Deductible. Each and every Hospitalization would be considered as a separate claim.

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

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

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

B. Scope of cover

Insurance Plans: This Policy provides You options of 3 (three) plans namely Vital Plan, Superior Plan and Premiere Plan with each Plan having further Sum Insured options as specified in the Schedule of Benefits. The Schedule will specify the Sum Insured and the Plan which is in force for each of the Insured Persons. For a complete description of the benefits available under the applicable Plan as well as any specific limits on the amount payable under any particular benefit under the applicable Sum Insured and Plan, please refer to the "Schedule of Benefits" attached to this Policy.

Benefits: The Policy covers the Reasonable and Customary Charges incurred towards the medical treatment taken by the Insured Person during the Policy Period following an Illness or Injury that occurs during the Policy Period, subject always to the availability of the Sum Insured and any specific limits specified in the Schedule of Benefits and the terms, conditions and exclusions specified in this Policy document.

The benefits available under the Policy are listed below. The applicable Plan specified in the Schedule of Benefits will specify whether the benefit in respect of which a claim arises is in force under the applicable Plan for the Insured Person.

Benefit 1. Hospitalization Medical Expenses
We will pay the Reasonable and Customary Charges for Medical Expenses that are incurred during the Hospitalisation of the Insured Person for Medically Necessary treatment required due to an Illness or Injury sustained by the Insured Person during the Policy Period.

Benefit 2. Day Care Treatment expenses
We will pay the Reasonable and Customary Charges for Medically Necessary Day Care Treatment taken by the Insured Person on advanced technological Surgical Procedures requiring less than 24 hours of Hospitalization as listed out in Annexure I of the Policy wordings.

Benefit 3. Pre-hospitalisation Medical Expenses
We will pay the Reasonable and Customary Charges for Pre- hospitalisation Medical Expenses that are incurred with respect to the Insured Person for up to 60 days immediately prior to the date of the Insured Person's admission to Hospital that is specified under the applicable Plan/Sum Insured for the Insured Person, provided that We have accepted a claim for Hospitalisation
Medical Expenses under Benefit 1.

Benefit 4. Post-hospitalisation Medical Expenses
We will pay the Reasonable and Customary Charges for Post- hospitalisation Medical Expenses that are incurred with respect to the Insured Person for up to the period immediately following the Insured Person's discharge from Hospital that is specified under the applicable Plan/Sum Insured for the Insured Person, provided that We have accepted a claim for Hospitalisation Medical Expenses under Benefit 1.

Benefit 5. Maternity Expenses
We will pay the Reasonable and Customary Charges for Maternity Expenses/Treatment incurred for the Insured Person's delivery, subject to the following:

1. If the Insured Person is Your Dependent Spouse, this benefit will be applicable only if We have received at least 3 continuous annual premiums under the Health Total Insurance Policy in respect of You and Your Dependent Spouse and provided that at least 24 months of continuous coverage have elapsed from the inception of the first Health Total Policy with Us.
2. If the Insured Person is You , this benefit will be applicable only if We have received at least 5 continuous annual premiums under the Health Total Policy in respect of You and provided that at least 48 months of continuous coverage have elapsed from the inception of the first Health Total Policy with Us.
3. Our maximum liability per pregnancy (delivery/termination) will be subject to the specified sub-limit as shown in the Schedule of Benefits.
4. We will cover Reasonable and Customary Charges for Pre- natal Medical Expenses incurred on Hospitalisation for a period of 90 days immediately prior to the date of delivery and Reasonable and Customary Charges for Post-natal Medical Expenses incurred on Hospitalisation for upto a period of 45 days immediately following the date of delivery provided that this benefit is applicable only if Superior Plan or Premiere Plan are in force for the Insured Person.
5. Any expenses related to Ectopic Pregnancy (abdominal operation for extra uterine pregnancy), which is proved by submission of Ultra Sonographic Report would not be covered under this Benefit, but would be considered a claim made under Benefit 1.

Benefit 6. Organ Donor Expenses
We will pay the Reasonable and Customary Charges incurred for an organ donor's treatment for the harvesting of the organ donated provided that:
1. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act, 1994 and the organ donated is for the use of the Insured Person; We will not pay the donor's screening expenses or pre and post hospitalisation expenses or for any other medical treatment for the donor consequent on the harvesting;
2. We have accepted claim under Benefit 1 for the Insured Person and the Insured Person has been Medically Advised to undergo an organ transplant;
3. Costs directly or indirectly associated with the acquisition of the donor's organ will not be covered.

Benefit 7. Patient Care
We will pay for the Reasonable and Customary Charges for a Qualified Nurse for the Insured Person for a period of up to 10 days immediately following the Insured Person's discharge from Hospital provided that:
a) the Insured Person is above 60 years of age;
b) the Insured Person's Hospitalisation was due to Illness or Injury sustained during the Policy Period;
c) the treating Medical Practitioner has recommended that the nursing charges are Medically Necessary;
d) We will not be liable to make payment under this Benefit in excess of the per day limits specified in the Schedule of Benefits;
e) We will not be liable to make payment under this Benefit for any Insured Person in excess of 30 days during a Policy Year.

Benefit 8. Accidental Hospitalization
We will increase the Sum Insured by 25% of the available balance of the Sum Insured (excluding the Cumulative Bonus, if any) if the Insured Person is Hospitalised during the Policy Year due to an Accident which occurred during the Policy Year provided that no increase to the Sum Insured will exceed Rs.10,00,000 and this increase to the Sum Insured will only be available for claims arising under Benefit 1.

Benefit 9. Accompanying Person
We will make payment of the amount specified in the Schedule of Benefits for each completed day of Hospitalisation for the Accompanying Person of an Insured Person provided that the Insured Person is a Dependent Child who is less than 12 years of age and the Dependent Child is undergoing Medically Necessary Hospitalisation due to an Injury or Illness that occurred during the Policy Period. We will not make payment under this Benefit in respect of an Insured Person for more than 30 days in any Policy Year.
For the purpose of this Benefit, "Accompanying Person" means the Insured Person's mother, father, grandmother or grandfather or any immediate family member of the Insured Person.

Benefit 10. Road Ambulance Charges
We will reimburse ambulance charges from home to Hospital or between Hospitals. We will reimburse payments up to a maximum of the amount specified in the Schedule of Benefits per Hospitalisation if Vital Plan is in force and actual expenses in case of Hospitalization in a Network Provider if Superior Plan or Premiere Plan are in force. In case of Hospitalization in a Non Network Provider We will reimburse upto the amount specified in the Schedule of Benefits depending on the Plan in force. We will reimburse payments under this Benefit only in respect of ambulance services of a Hospital or a registered service provider and only upon You producing the bills in original.

Benefit 11. Emergency Medical Evacuation (applicable for Superior Plan and Premiere Plan only)
We will reimburse expenses up to a maximum of 5% of the Sum Insured (excluding the Cumulative Bonus, if any) incurred in a Policy Year for the Insured Person's Medically Necessary medical evacuation in an emergency, provided that:
a. the evacuation is recommended by a Medical Practitioner who certifies that the severity of the Insured Person's Injury or Illness warrants the medical evacuation for receipt of Emergency Care.
b. It is a Condition Precedent that these expenses are authorized by Us if the evacuation is required in respect of an Insured Person's Illness and the medical evacuation is from the place of local hospitalization to any other Hospital within India.
c. For medical evacuation following an Accident during the Policy Period, We will reimburse under this Benefit expenses incurred for medical evacuation from the place where the Accidental Injury occurred or the place of local Hospitalisation immediately following the Accident to any other Hospital within India.
d. For medical evacuation following an Illness during the Policy period, We will reimburse under this Benefit expenses incurred for medical evacuation from the place of local Hospitalisation to any other Hospital within India.
e. For claims made under this Benefit, We will reimburse expenses for transportation of the Insured Person and Medical Expenses incurred during the course of evacuation provided that it is Medically Necessary that treatment is provided to the Insured Person en route.

Benefit 12. Domiciliary Hospitalisation Expenses
We will reimburse Reasonable and Customary Charges up to a maximum of 10% of the Sum Insured (excluding the Cumulative Bonus, if any) for Medical Expenses incurred on the Domiciliary Hospitalisation of the Insured Person for an Illness or Injury which occurred during a Policy Year provided that:
a) The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the Reasonable and Customary Charges of any Medically Necessary treatment for the entire period subject to other terms of the Policy;
b) Expenses incurred for pre and post Domiciliary Hospitalisation treatment will not be payable;
c) No payment will be made if the condition for which the Insured Person requires medical treatment is:
(i) Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis, cough and cold or Influenza;
(ii) Arthritis, Gout or Rheumatism;
(iii) Chronic Nephritis or Nephritic Syndrome;
(iv) Diarrhoea or any type of dysentery, including Gastroenteritis;
(v) Diabetes Mellitus or Insipidus;
(vi) Epilepsy;
(vii) Hypertension;
(viii) Psychiatric or Psychosomatic disorders of all kinds;
(ix) Pyrexia of unknown origin

Benefit 13. OPD Treatment (applicable for Superior Plan and Premiere Plan only)
We will reimburse the Reasonable and Customary Charges arising from Medical Expenses incurred on OPD Treatment for consultation, diagnostic tests and medications for prescribed drugs for the Insured Person due to an Illness, Injury or a pregnancy covered under Benefit 5 provided that diagnostic tests and medications must be prescribed by a Medical Practitioner.
Our liability under this Benefit will be restricted to the following:
a) If Superior Plan is in force We shall reimburse expenses towards consultation and diagnostic tests prescribed by the Medical Practitioner.
b) If Premiere Plan is in force We shall reimburse expenses towards consultation, diagnostic tests and medications prescribed by the Medical Practitioner.

c) In case of bills for any prescribed drugs/medicines Our liability will be restricted to 80% of admissible bills.
d) In case of dental consultations and diagnostics Our liability will be restricted to 70% of admissible bills.
e) Expenses under (a) to (d) individually or in aggregate cannot exceed the Out Patient Medical Expenses limit specified in the Schedule of Benefits.
f) Only Allopathic treatment will be covered under this Benefit.

Benefit 14. Child Vaccination Benefits (applicable for Premiere Plan only)
We will cover Reasonable and Customary Charges for vaccinations of the Insured Person up to the per annum limit specified in the Schedule of Benefits provided that the Insured Person is a Dependant Child who is upto 12 years of age.

Benefit 15. Newborn Baby (applicable for Superior Plan and Premiere Plan only)
If We have accepted a maternity benefits claim under Benefit 5, then We will also:
a. Cover the Reasonable and Customary Charges for Medical Expenses towards the Medically Necessary treatment of the Insured Person's Newborn Baby while Insured Person is Hospitalised as an in-patient for delivery and cover the Newborn Baby as an Insured Person until the expiry date of the Policy Year in which the Newborn Baby is born, within the Sum Insured as applicable for the Insured Person (mother) without payment of any additional premium.
b. Cover the Reasonable and Customary Charges for vaccination expenses of the Newborn Baby upto the specified sublimit under the Schedule of Benefits for vaccinations, until the Newborn Baby completes one year of age. If the Policy ends before the Newborn Baby has completed one year, then We will only cover such vaccinations until the Newborn Baby completes one year, and only if We have accepted the Newborn Baby as an Insured Person at the time of Renewal of the Policy and We have received the premium accordingly.
c. Include the Newborn Baby as an Insured Person under the Policy from the Policy Year immediately succeeding the Policy Year in which the Newborn Baby is born provided that We have received the premium due, to include the Newborn Baby as an Insured Person.

Benefit 16. E-Opinion in respect of an Illness or Injury
a. If an Insured Person suffers an Illness or Injury during the Policy Period in respect of which a claim has been admitted under Benefit 1, then at the Insured Person's request We will arrange a maximum of two e-opinions (in a Policy Year) from a Medical Practitioner selected by the Insured Person from Our panel. The e-opinion will be based only on the information and documentation provided to the Medical Practitioner by or on behalf of the Insured Person.
b. While claiming under this Benefit and deciding to obtain an e-opinion, each Insured Person expressly agrees that:
(i) It is entirely for the Insured Person to decide whether to obtain an E-opinion, from which Medical Practitioner in Our panel to take the e-opinion and the use (if any) to which the e-opinion so obtained is put.
(ii) We do not provide an e-opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other persons' reliance on the same, or the use to which the E-opinion is put.
(iii) We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations whatsoever made by any Medical Practitioner in Our Panel or in any e-opinion or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

Benefit 17. Alternative Treatment
We will reimburse Reasonable and Customary Charges for Medical Expenses incurred with respect to the Insured
Person for Hospitalization under Ayurveda, Unani, Siddha or Homeopathy provided that the Treatment has been undergone in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/ National Accreditation Board on Health for that Alternative Treatment.
Specific Exclusions applicable to this Benefit:
a. All preventive and rejuvenation treatments (non-curative in nature) including without limitation, treatments that are not Medically Necessary are excluded.
b. Pre-hospitalisation Medical Expenses, Post-hospitalisation Medical Expenses, Day Care Treatment and outpatient Medical Expenses are excluded.
c. Any Alternative Treatment other than Ayurveda, Unani, Siddha or Homeopathy.

Benefit 18. Medical Treatment Abroad (applicable for Premiere Plan only)
a. The benefits under this Section will be available if the Insured Person has been continuously covered under Premiere Plan of Health Total Policy for a continuous period of 48 months.
b. We shall reimburse the Reasonable and Customary Charges for Medical Expenses for treatment of the Insured Person incurred outside India for the following diseases subject to the terms below:
(i) Craniotomy & Craniectomy: only as a treatment for cancers;
(ii) Lung Lobectomy that involves removal of one of the three divisions of the lungs for lung cancer;
(iii) Liver Lobectomy that involves removal of 70% of liver mass in case of liver failure;
(iv) Major organ transplant;
(v) Bone marrow transplant;
(vi) Repair of Aortic Aneurysm;
(vii) Heart valve replacement;
(viii) Coronary Artery Bypass Graft.
c. We shall cover only those Medical Expenses that would otherwise have been payable under Benefit 1. For the purpose of this Benefit, Hospital shall mean "Any institution established for Inpatient care and Day Care Treatment of Accidental Injury or Illness and which has been registered as a hospital as per the laws, rules and regulations applicable for the country where the treatment is taken." The term 'Hospital' shall not include a place of rest, a place for the aged, a place for drug addicts or a place for alcoholics or a hotel, health spa or massage centre or the like.
d. Any payments under this Benefit shall always be made in India, in Indian rupees and on a reimbursement basis only. The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of Hospitalisation, shall be used for conversion of foreign currency amounts into Indian rupees for payment of any claim under this Benefit. If on the date of Hospitalisation the RBI rates are not published, the rates next published by the RBI shall be considered for conversion.
e. It is a Condition Precedent that a prior written notice of at least 15 days is given to Us before the treatment described in this Benefit is taken outside India.

Benefit 19. Wellness Care
The Insured Person will be eligible for "Wellness Benefits" as per the Plan in force under the Policy. These wellness benefits will include health risk evaluation and annual health checkups as applicable for respective Plans, the updated details of which would be available on Our website. These would be conducted through Our tie up arrangements.

The annual health checkup can be conducted from 2nd year of the policy with Us, for the insured persons who were already covered under the

policy. The annual heath checkup would include tests as given below as applicable for respective plans:

Vital Plan: Complete Blood count, Urine Routine, Random Blood Sugar (maximum two insured persons per policy /per policy year irrespective of family size)

Superior Plan: Complete Blood Count, Urine Routine, Fasting blood Sugar, Post Prandial Blood Sugar, ECG, Serum Creatinine (maximum three insured persons per policy /per policy year irrespective of family size)

Premiere Plan: Complete Blood Count, Urine Routine, Fasting blood Sugar, Post Prandial Blood Sugar, ECG, Serum Creatinine (maximum four insured persons per policy/ per policy year irrespective of family size)
While availing the wellness benefits, each Insured Person expressly agrees that:

a. Annual health checkups will be provided at Our Diagnostic Centres only.
b. All decisions regarding which wellness benefit to avail and to what use to put the same to are to be solely made by the Insured Person;
c. We do not provide/assume responsibility for:
   (i) the wellness benefits or make any representation as to the adequacy or accuracy of the same;
   (ii) any actual or alleged errors, omissions or representations whatsoever made by any of Our wellness service providers or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

Benefit 20. Cumulative Bonus

a) If no claim has been made in respect of any Benefits with the exception of any claim under Benefit 13 and the Policy is Renewed with Us without any break, We will apply a bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 50% of the Sum Insured for this Policy Year. The maximum bonus for any Policy Year will not exceed 100% of the Sum Insured of the first Policy Year.
b) If a Cumulative Bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the Cumulative Bonus by 50% of the Sum Insured in the following Policy Year. However this reduction will not reduce the Sum Insured below the base Sum Insured of the Policy.
c) In case the Insured Person is porting a similar Policy from Us /another insurance company, portability if requested by the Insured Person, shall be applicable to the previous policy along with enhanced sum insured (base sum insured+ Cumulative Bonus) acquired under the previous policies. The premium applicable would be for the enhanced sum insured (Sum Insured + Cumulative Bonus) and if the same is not available, to the next higher Sum Insured available if requested by the Insured Person. However portability shall be applicable to the previous sum insured and the cumulative bonus.
d) In case You have opted for the 'Family Floater' option as specified in the Schedule, the Cumulative Bonus so applied will only be available to those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

Benefit 21. Restoration of the Sum Insured

If the Sum Insured and Cumulative Bonus (if any) is exhausted due to claims incurred and paid during the Policy Year or incurred during the Policy Year and accepted as payable, then it is agreed that a Restore Sum Insured (equal to 100% of the Sum Insured) will be automatically available for the particular Policy Year, provided that:

a) The Restore Sum Insured will be enforceable only after the Sum Insured and the Cumulative Bonus have been completely exhausted in that Policy Year;
b) The Restore Sum Insured can only be used for claims made by the Insured Person in respect of Benefits 1-4;
c) The Restore Sum Insured cannot be used for claims based on Maternity Expenses/Treatment;
d) The Restore Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an Illness (including its complications) for which a claim has been paid in the current Policy Year under Benefits 1-4;
e) Only the Sum Insured (excluding Cumulative Bonus) will be considered as Restore Sum Insured;
f) The Restore Sum Insured will only be applied once for the Insured Person during a Policy Year;
g) If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

If the Policy is opted by You on a 'Family Floater' basis as specified in the Schedule, then the Restore Sum Insured will only be available in respect of claims made by those Insured Persons who were Insured Persons under the Policy before the Sum Insured and Cumulative Bonus was exhausted.

C. Schedule of Benefits

		Vital Plan			Superior Plan			Premiere Plan	
Eligibility	Sum Insured (in ₹)	3 lakhs	5 lakhs	10 lakhs	15 lakhs	20 lakhs	25 lakhs	50 lakhs	1 crore
	Minimum age at entry	1 day	1 day	1 day	1 day	1 day	1 day	1 day	1 day
	Maximum age at entry	None	None	None	None	None	None	None	None
	Maximum renewal age	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long
	Individual SI / family floater SI options	Both	Both	Both	Both	Both	Both	Both	Both
	Family definition	S+Sp+2 C+2P (1+5)	S+Sp+2 C+2P (1+5)	S+Sp+2 C+2P (1+5)	Extended family up to 15 members	Extended family up to 15 members	Extended family up to 15 members	Extended family upto 15 members	Extended family up to 15 members
Hospitalisation Benefits	Hospitalisation	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI
	Day care treatment	√	√	√	√	√	√	√	√
	Pre-hospitalisation	60 days	60 days	60 days	60 days	60 days	60 days	60 days	60 days
	Post-hospitalisation	90 days	90 days	90 days	120 days	120 days	120 days	180 days	180 days
	Restoration of SI	√	√	√	√	√	√	√	√
	Cumulative bonus - 50% for every claim-free year to max 100%	√	√	√	√	√	√	√	√
	Maternity benefit - normal delivery (in ₹)	15,000	20,000	25,000	30,000	40,000	40,000	50,000	50,000
	Maternity benefit - LSCS (caesarian) (in ₹)	25,000	35,000	45,000	50,000	60,000	60,000	1,00,000	1,00,000
	Pre-natal hospitalisation (within maternity limits)	×	×	×	90 days	90 days	90 days	90 days	90 days
	Post-natal hospitalisation (within maternity limits)	×	×	×	45 days	45 days	45 days	45 days	45 days
	Organ donor expenses	√	√	√	√	√	√	√	√
	New born baby benefits: Automatic cover within mother's / floater Sum Insured up to expiry date of policy	×	×	×	√	√	√	√	√
	New born baby benefits: Reasonable vaccination benefits up to 1 year of age (in ₹)	×	×	×	Max 3,500	Max 3,500	Max 3,500	Max 5,000	Max 5,000
	Patient care (above 60 years) - per day benefit up to max (in ₹)	350/day	350/day	350/day	500/day	500/day	500/day	1,000/day	1,000/day
	Patient care (above 60 year) - maximum	10 days per Hospitalisation and 30 days per policy year							
	Accidental hospitalisation - 25% increase subject to maximum of ₹10 lakh	√	√	√	√	√	√	√	√
	Accompanying person (up to 12 years) ₹ 500 /day to maximum of 30 days	√	√	√	√	√	√	√	√

	Domiciliary hospitalisation expenses - maximum up to 10% of SI	√	√	√	√	√	√	√	√
	Alternative treatments Ayurveda / Unani / Sidha / Homeopathy - reimbursement	√	√	√	√	√	√	√	√
Medical Treatment Abroad	Medical treatment abroad	×	×	×	×	×	×	√	√
	Medical treatment abroad - waiting period							4 years	4 years
Road Ambulance	Road ambulance charges - network hospitals (in ₹)	1,500	1,500	1,500	Actuals	Actuals	Actuals	Actuals	Actuals
	Road ambulance charges - non network hospitals (reimbursement up to a maximum) (in ₹)	1,500	1,500	1,500	2,000	2,000	2,000	5,000	5,000
Emergency Medical Evacuation	Emergency medical evacuation - 5% of SI (reimbursement up to a maximum)	×	×	×	√	√	√	√	√
E-Opinion	E-Opinion for illness / injury (maximum 2 per policy year)	√	√	√	√	√	√	√	√
**Out-patient Medical Expenses	Out-patient consultations and diagnostics (reimbursement up to a maximum (in ₹)	×	×	×	3,000 for Individual option/ 10,000 for floater option	3,000 for Individual option/ 10,000 for floater option	3,000 for Individual option/ 10,000 for floater option	10,000 for Individual option /20,000 for floater option	10,000 for Individual option /20,000 for floater option
	Prescribed medicines (reimbursement up to a maximum) (in ₹)	×	×	×	×	×	×		
Child Vaccination Benefits	Child vaccination benefits (reimbursement up to a maximum) (in ₹)	×	×	×	×	×	×	Up to 12 years of age (5,000 per annum)	Up to 12 years of age (5,000 per annum)
Wellness Benefits	Wellness including medical tests at designated centres	√	√	√	√	√	√	√	√
Family Discount	Family Discount 10% (Individual SI Policies)	√	√	√	√	√	√	√	√
Voluntary Deductible	Discount in lieu of voluntary deductible	√	√	√	√	√	√	√	√
Waiting Periods	Pre-existing disease								
	Compulsory waiting period	2 years	2 years	2 years	2 years	2 years	2 years	2 years	2 years
	Pre-existing disease - max liability 3rd year onwards	50%	50%	50%	50%	50%	50%	50%	50%
	Pre-existing disease - 4th Year onwards	100%	100%	100%	100%	100%	100%	100%	100%
	General waiting periods								
	30-day - fresh proposals excluding accidental hospitalisation	√	√	√	√	√	√	√	√
	2-year waiting period for listed conditions	√	√	√	√	√	√	√	√

	4-year waiting period - joint replacement and organ transplant	√	√	√	√	√	√	√	√
Compulsory Co-pay	20% co-payment where entry age is from 60 year to 64 years	√	√	√	√	√	√	√	√
	25% co-payment where entry age is from 65 year to 69 years	√	√	√	√	√	√	√	√
	30% co-payment where entry age is from 70 year to 74 years	√	√	√	√	√	√	√	√
	40% co-payment where entry age is 75 years and above	√	√	√	√	√	√	√	√

**Out-patient medical expenses. (Applicable for Superior and Premiere Plan)
In case of bills for any prescribed drugs/medicines, our liability will be restricted to 80% of admissible bills. In case of dental consultations and diagnostics, our liability will be restricted to 70% of admissible bills.

* All benefits are given within the base Sum Insured except Accidental Hospitalisation.
SI : Sum insured, S: Self, Sp: Spouse, C: Child, P: Parent

D. EXCLUSIONS

1. Exclusions applicable for all Benefits other than Benefit 13

i. Waiting Periods

We will not pay for any expenses incurred in respect of any claims arising out of or howsoever related to any of the following (other than for a claim made under Benefit 13):

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 24 months of continuous coverage after the date of inception of the first policy with us.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

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

(i) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12/24/ 36/48 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
(ii) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
(iii) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
(iv) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
(v) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
(vi) List of specific diseases/procedures:

I. **Waiting period of 48 months**:
a) Organ transplant
b) Rheumatoid Arthritis
c) Gout
d) joint replacement Surgery due to degenerative condition
e) Age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is Medically Necessary due to Injury.

II. **Waiting period of 24 months**:
a) Internal Congenital Anomalies
b) Cataracts,
c) Benign Prostatic Hypertrophy
d) Hernia of all types
e) Deviated Nasal Septum
f) Hypertrophied Turbinate
g) Hydrocele
h) All types of sinuses
i) Fistulae, hemorrhoids, fissure in ano
j) Dysfunctional uterine bleeding, Fibromyoma, Endometriosis, Hysterectomy,
k) All internal or external tumors/cysts/nodules/polyps of any kind including breast lumps with exception of malignant tumor or growth,
l) Surgery for prolapsed inter vertebral disc unless arising from Accident,
m) Surgery of varicose veins and varicose ulcers
n) Any types of gastric or duodenal ulcers,
o) Stones in the urinary and biliary systems,

p) Surgery on ears and tonsils.

III. 30 days waiting period Excl -03

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

2. Exclusions applicable for all Benefits

i. Standard Exclusions

We will not pay for any expenses incurred in respect of any claims made under the Policy, 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.

Please note that this exclusion will not be applicable for Benefit 13.

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

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

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

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

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);

a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

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

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

e) **Cosmetic or Plastic Surgery: Code- Excl08**

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

f) **Hazardous or Adventure sports: Code- Excl09**

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc. unless specifically agreed by the Insurance Company.

g) **Breach of law: Code- Excl10**

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

h) **Excluded Providers: Code- Excl11**

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

i) **Code- Excl12**

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

j) **Code- Excl13**

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

k) **Code- Excl14**

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

l) **Refractive Error: Code- Excl15**

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

m) **Unproven Treatments**: **Code- Excl16**

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

n) **Birth control, Sterility and Infertility: Code- Excl17**

Expenses related to Birth Control, sterility and infertility. This includes:

(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

ii. Specific Exclusions

We will not pay for any expenses incurred in respect of any claims made under the Policy, arising out of or howsoever related to any of the following:

o) Injury or Illness 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).
p) Circumcision, unless necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an Accident.
q) Vaccination/inoculation (except as post bite treatment) except to the extent covered under Benefits 14 and 15.
r) Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, durable medical equipment (including but not limited to cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and oxygen concentrator for asthmatic condition, wheel chair, crutches, artificial limbs, belts, braces, stocking, Glucometer 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.
s) Venereal /Sexually Transmitted disease other than HIV/AIDS,
t) External Congenital Anomaly and related Illness/ defect.
u) Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.
v) Stem cell storage.
w) Non-prescribed drugs and medical supplies, hormone replacement therapy.
x) Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
y) Outpatient diagnostic, medical and Surgical Procedures or treatments, However this exclusion will not be applicable for Benefit 13.
z) Dental Treatment or Surgery of any kind unless requiring Hospitalisation as a result of Injury. However this exclusion will not be applicable for Benefit 13. .
aa) A Medical Practitioner's home visit charges during pre and post Hospitalization period and attendant nursing charges, except to the extent covered under Benefit 7. However this exclusion will not be applicable for Benefit 13.
bb) Treatment outside India except as specified under Benefit 18.
cc) Intentional self-Injury.
dd) Standard list of excluded items as mentioned in Annexure II and on our website https://general.futuregenerali.in
ee) Any specific exclusion(s) applied by Us, specified in the Schedule and accepted by the insured.

3. Specific Exclusions for OPD Treatment claims under Benefit 13

We will not pay for any expenses incurred in respect of any claims made under Benefit 13, arising out of or howsoever related to any of the following:

a) Any expenses in excess of the maximum amount payable under the outpatient medical expenses limit specified in the Schedule of Benefits.
b) Cost of an Annual Health Check-up.
c) Any expenses for OPD Treatment including dental expenses in case of Vital Plan.
d) Any expenses for prescribed medications in case of Superior Plan.
e) Any expenses for consultation, diagnostics, medications which are not duly supported with medical documents from the Medical Practitioner mentioning:
(i) Diagnosis;
(ii) Referral for diagnostic test;
(iii) Prescription for medications.
f) Costs incurred on all methods of treatment except Allopathic.

E. Policy Options: Individual & Family floater

F. Family Definitions:

Vital Plan - Self, spouse, dependent children and dependent parents. Children will be covered as dependents upto 25 years of age.

Superior and Premiere Plan - Self, spouse, dependent or non- dependent children, dependent or non-dependent parents, Dependent Siblings, daughter in law, son in law, parents in law, grandparents and grandchildren.

Dependent Sum Insured Criteria - In case of individual Sum Insured option, dependents sum insured can be upto two Sums Insured lower than Self /Proposer's sum insured (in applicable plan(s)).

Sums Insured Available in the product are as below:

	Vital Plan			Superior Plan			Premiere Plan	
Sum Insured (in Rs)	**3 lakhs**	**5 lakhs**	**10 lakhs**	**15 lakhs**	**20 lakhs**	**25 lakhs**	**50 lakhs**	**1 Crore**

Example:

Family Member	Self-Plan	Self-Sum Insured (Rs)	Dependent Eligible Plan	Dependent Eligible Sum Insured (Rs)
Self	Premiere	1crore	Premiere	1crore / 50 lakhs
			Superior	25 lakhs
Self	Superior	25 lakhs	Superior	25 lakhs/ 20 lakhs/ 15 lakhs
Self	Superior	15 lakhs	Superior	15 lakhs
			Vital	10 lakhs /5 lakhs

G. Age Eligibility

Minimum Age At Entry	1 day
Maximum Age At Entry	None

Maximum Renewal Age	Life Long
Minimum policy term	1 year
Maximum Policy term	3 years

Life Long Renewals: The policy if renewed continuously without any break will be renewed lifelong.

Sums Insured – Ranging from ₹ 3 lakhs to ₹ 1crore.

Change in Sum Insured /Plan applicable at renewals only-

a) All proposals wherein change in sum insured or plan is required, to be referred.
b) Fresh proposal form to be filled.
c) No increase/decrease in Sum Insured/Plan during the currency of the policy.
d) Increase in Sum Insured can be allowed up to two slabs higher. Whereas increase in Plan can be allowed up to one plan higher.
e) For age group above 60 years, increase in Plan would not be allowed.
f) For age group up to 50 years increase in sum insured up to ₹ 10 Lacs (within Vital Plan) can be allowed without medical examination (in case of no claim / no health declaration).
g) For Superior/ Premiere Plan (Sum Insured above 10 lakhs), medical examination is required irrespective of age.
h) For age group above 50 years increase in sum insured can be allowed with medical examination.
i) Decrease in Sum Insured allowed up to one slab lower only, in case of no claim in any preceding Health Total policies.
j) The Dependent Sum insured criteria will apply for enhancement of sum insured for dependent.
k) Sum insured enhancement would be allowed for age group lower than 50 years in case of portable policies.
l) For every Sum insured enhancement the following wording to appear on the face of the policy "For the enhanced Sum Insured, the waiting periods will apply afresh".

Example – The increased in Sum insured

Sr. No	Plan	Sum Insured INR	Eligibility	
			Plan	Sum Insured
1.	Vital Plan	3 lakhs	Plan 1	5 lakhs / 10 lakhs
2.	Vital Plan	5 lakhs	Plan 1	10 lakhs
			Plan 2	15 lakhs
3.	Superior Plan	15 lakhs	Plan 2	20 lakhs / 25 lakhs
4.	Premiere Plan	20 lakhs	Plan 2	25 lakhs
			Plan 3	50 lakhs

In case of SI enhancement for proposals with age falling under pre-acceptance medical grid as mentioned earlier or proposals with positive declarations, they should be referred 1 month prior to the renewal date for test advice, so that the renewal is in time and there is no break. This applies for our company and other company renewals.

Copayment Applicability:
In case an insured enters the policy at the age given in the table, the respective copayments will be applicable on each and every admissible claim

Age	Co-payment
60 yrs to 64 yrs	20%
65 yrs to 69 yrs	25%
70 yrs to 74 yrs	30%
75 yrs and above	40%

Pre-acceptance medical tests:
Pre-acceptance medical tests are not required for all proposers upto the age of 50 years for Vital Plan in case of clean proposal form (i.e. without any health declaration). For age 51 years and above, medical tests are required.

Compulsory medical tests for Superior and Premiere plan for completed age 18 years and above.

H. Medical Tests

Plans	Vital		Superior		Premiere	
Age band	**Up to 50 years**	**Above 50 years**	**From 18 years to 50 years**	**Above 50 years**	**From 18 years to 50 years**	**Above 50 years**
Medical tests	Not required	Required	Required	Required	Required	Required
Series details	Not Applicable	Series 3	Series 4	Series 8	Series 7	Series 8

*No tests required for children below 18 years for any plan
** Age in completed years

SERIES 3:
(FMR, ECG, LAB2 (F & PP (BSL) + CBC + S. Cholesterol + S. Creatinine + Urinalysis + Lipid Profile (S. Cholesterol+ HDL+ LDL+S. Triglycerides) + LFT (Total Bilirubin+ SGOT+ SGPT + A. Phosphatase + GGTP + Proteins (total)+ RFT (Renal Function Test)-Bl. Urea + S. Electrolytes.)

SERIES 4:
(FMR, ECG + LAB 3 (F & PP (BSL) + CBC + S. Cholesterol + S. Creatinine + Urinalysis + Lipid Profile (S. Cholesterol + HDL + LDL + S. Triglycerides) + LFT (Total Bilirubin + SGOT + SGPT + A. Phosphatase + GGTP + Proteins (total) + RFT + HbsAg + HbA1C + HIV1&2)

SERIES 7:
(FMR, ECG, +CTMT (stress test) + LAB 3((F& PP (BSL) + CBC + S. Cholesterol + S. Creatinine + Urinalysis + Lipid Profile (S. Cholesterol + HDL +

LDL + S. Triglycerides) + LFT (Total Bilirubin + SGOT + SGPT + A. Phosphatase + GGTP + Proteins(total) + RFT + HbsAg + HbA1C + HIV1&2)

SERIES 8:
(FMR, ECG, 2D Echo + LAB 3 ((F & PP (BSL) + CBC + S. Cholesterol + S. Creatinine + Urinalysis + Lipid Profile (S. Cholesterol + HDL + LDL + S. Triglycerides) + LFT (Total Bilirubin + SGOT + SGPT + A. Phosphatase + GGTP + Proteins (total) + RFT +HbsAg + HbA1C + HIV1&2)

FMR: Full Medical Report by an MD Physician

ECG: Electrocardiogram reported by an MD Physician
Lab 2: includes Fasting Blood Glucose, Post prandial blood sugar, Complete Blood Count (incl Diff), Lipid Profile- Serum Cholesterol, HDL Cholesterol , LDL Cholesterol, Serum Triglycerides ,Urinalysis (chemical & microscopic), Liver Function tests – (Serum Bilirubin, SGOT , SGPT, Serum Alkaline Phosphatase ,GGTP), Renal Function Tests – (Serum Creatinine, Blood Urea ,Total Proteins and Serum Electrolytes.)

LAB 3: includes Fasting Blood Glucose, Post prandial blood sugar , Complete Blood Count (incl Diff), Lipid Profile - Serum Cholesterol, HDL Cholesterol , LDL Cholesterol, Serum Triglycerides , S .creatinine, Urinalysis (chemical & microscopic), Liver Function tests (Serum Bilirubin , SGOT , SGPT ,Serum Alkaline Phosphatase, GGTP, Total Proteins), Renal Function Tests – (Blood Urea and Serum Electrolytes), HbA1C, HbsAg, HIV 1&2.

I. Underwriting Criteria

Taking into account the proposal form and /or the medical reports following decisions & loadings are applicable

Declared condition(s) in proposal form / revealed in medical tests conducted	Underwriter decision
Hypertension (controlled*)	Accept with loadings
Diabetes (controlled*)	Accept with loadings
Hypertension (uncontrolled**)	Decline
Diabetes (uncontrolled**)	Decline
History of treated viral fever, typhoid, pneumonia	Accept
History of treated fractures /dislocations	Accept
Severe obesity (BMI above 34)	Decline
Combination of any two or more conditions which includes condition(s) 4 or 5 (reference – **Loading pattern)**	Decline
Positive history of any other ailment	To be Reviewed for Acceptance / Declinature

Ailment	Controlled*	Uncontrolled **
Hypertension	Up to 150 mmHg systolic and up to 100 mmHg diastolic	Above 150 mmHg systolic and above 100 mmHg diastolic.
Diabetes (either Fasting/ PP)	From 15 mg/dl & upto 30 mg/dl over the maximum **Normal range** #	Above 30 mg/dl over the maximum **Normal range** #

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

- Loading on the standard premium rates would be applicable based on health status of the proposed insured person on the basis of the adverse health conditions declared on the proposal form and findings of medical tests conducted.
- The loading of premium will be applicable on the particular insured's premium only.
- This would be applicable in both Individual and Floater options

J. Loading pattern

	Condition	Loading%		Condition	Loading%
1	**Diabetes (controlled)**		**5**	**Serum creatinine**	
a	Diabetes (up to + 15 mg/dl above ***Normal range**)	10%	a	up to 0.3 mg/dl above the maximum ***Normal range**	10%
b	Diabetes (+16 mg/dl to + 30 mg/dl above ***Normal range**)	20%	b	From 0.5 up to 0.8 mg/dl above the maximum ***Normal range**	15%
2	**Hypertension (controlled)**		**6**	**Serum Cholesterol**	
a	Hypertension (140/90 mmHg)	10%	a	Above +25 mg/dl to +50 mg/dl above the maximum ***Normal range**	10%
b	Hypertension (141 to 150 mmHg Systolic / 91 to 100 mm Hg diastolic)	20%	b	+51 mg/dl to +100 mg/dl above the maximum ***Normal range**	20%
3	**Asthma**		**7**	**Serum Triglycerides**	
a	Asthma (not on steroids)	10%		Above +20 mg/dl to + 45 mg/dl above the maximum ***Normal range** up to 100 mg/dl	10%
b	Asthma (on steroids)	20%		Above+46 mg/dl to 75 mg/dl of the maximum* **Normal range**	20%
4	**Obesity**		**8**	**Smoking**	10%
A	(BMI from 30 to 32)	15%			
B	(BMI from 32.1 to 34)	25%			

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

- Insured is eligible for 100% of reimbursement of pre-acceptance medical tests charges subject to policy issuance and 64 VB compliance.
- Pre-acceptance medical tests need to be done in the empaneled diagnostic centres only
- The tests would be considered valid for a period of one month from the date the tests have been conducted.

Discounts/Other loadings applicable under the product

1. **Individual Sum Insured Option** - 10% Family discount in case of more than one insured covered under the same policy
2. **Long-term discount** (applicable in case of single payment for more than one year)

Number of years	Discount
1 year	Nil
2 years	7.5%
3 years	10%

3. **Voluntary deductible discount** –

Vital Plan		Superior Plan		Premiere Plan	
Deductible	Discounts	Deductible	Discounts	Deductible	Discounts
Rs 10,000	10%	Rs 50,000	15%	Rs 1,00,000	15%
Rs 25,000	15%	Rs 75,000	20%	Rs 2,50,000	20%
Rs 50,000	20%	Rs 1,00,000	25%	Rs 5,00,000	25%

4. **Installment Loading** - In case of policies which are on long term basis (a Policy Period of more than one year), facility of installment is available. Given below are the loadings applicable on Standard premiums in case of installments.

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

5. **Floater discount:** As per table given in Annexure I

6. **Direct Sales Discount -** A discount of 15% in lieu of intermediary commissions if policy is taken directly from the insurer and /or Online.

7. **Loading on Claim experience** - There will be no loading on premium for adverse claims experience

K. General Terms and Clauses

I. Standard General Terms and Clauses

1) **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)

2) **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.

3) **Free Look Period**
The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to
   i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
   ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
   iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

4) **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.

5) **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.

6) **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.

7) **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.

8) **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.

9) **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.

10) **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.

11) **Redressal of Grievance**

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

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

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

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

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

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

II. Specific Terms and Clauses

(i) 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

Portability will be applicable for waiting periods under Benefit 1 to 4 except maternity benefit.

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 all the accrued continuity benefits in waiting periods as per the IRDAI guidelines on migration.

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

Migration will be applicable for waiting periods under Benefit 1 to 4 except maternity benefit.

(ii) Conditions applicable during the contract

1. **Communications**

a) Any communications, notifications or declarations meant for Us must be in writing and delivered to Our address specified in the

Schedule.

b) Any communication meant for You will be sent by Us to Your address shown in the Schedule. You must notify Us immediately of any change in Your address.

c) Our agents are not authorized to receive communications, notices or declarations on Our behalf.

2. **Territorial Limits and Law**

a) Except as provided in Benefit 18, We shall cover only treatment and investigations covered in terms of this Policy that is taken during the Policy Period and takes place anywhere in the territory of India.

b) The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law.

c) The Policy constitutes the complete contract of insurance between Us and You/Insured Person. 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.

3. **Cancellation**

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

A. Premium paid in Single Instalment

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

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

b) In case the **Policy Period** exceeds one year, We shall refund premium on a pro-rata basis by reference to the time period for which cover is provided, subject to a minimum retention of premium of 25%.

B. Premium paid in Multiple Instalments

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

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

II. 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 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.

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

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

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

4. **Premium Payment in instalments**

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

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

viii. The payment will be accepted through E-NACH / ACH/ ECS / any other mode approved by Government of India.

ix. On successful registration for the mandate/ E-NACH/ any other mode approved by Government of India, the premium shall be auto debited as per the frequency opted.

x. In case of withdrawal of E-NACH/ ACH/ ECS / any other mode approved by Government of India, a written communication will be required from policyholder.

xi. In case there is failure in transaction in E-NACH/ ACH/ ECS mode/ any other mode approved by Government of India or the instalment premiums are not received within the grace period, the Policy will get cancelled. A fresh policy with all waiting periods would be issued.

xii. If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered. This provision will not apply to claims arising under Benefit 13.

(iii) **Condition when a claim arises**

1. **Claims Procedures**

If the Insured Person meets with any Injury or suffer an Illness that may result in a claim under the Policy, then as a Condition Precedent to

Our liability, the following must be complied with:

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

b) If a pre-authorisation request is denied by Us or if treatment is taken in a Hospital other than a Network Provider or if You/ Insured Person does not wish to avail of the Cashless Facility, then:
   (i) We must be given Notification of Claim in writing immediately and in any event within 48 hours of the commencement of the Illness or Injury. The Insured Person must immediately consult a Medical Practitioner and follow the advice and treatment that he/she recommends.
   (ii) The Insured Person must take reasonable steps or measures in good faith to minimise the quantum of any claim that may be made under this Policy.
   (iii) The Insured Person must submit to examination by Our medical advisors if We ask, the cost for which will be borne by Us.
   (iv) We must be given promptly, and in any event within 15 days of the Insured Person's discharge from a Hospital, the documentation including written details of the quantum of any claim along with all original supporting documentation, including but not limited to the following, and other information We ask for to investigate the claim for Our obligation to make payment for it:
      a. The claim form specified by Us duly completed and signed by the claimant or a family member;
      b. first consultation letter;
      c. first prescription from the Medical Practitioner;
      d. original vouchers;
      e. original Hospital bills giving a detailed break up of all expense heads mentioned in the bill;
      f. Money receipt duly signed with a revenue stamp;
      g. birth/death certificate (as applicable);
      h. the original Hospital discharge card;
      i. all original laboratory and diagnostic test Reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram, etc;
      j. If medicines have been purchased in cash and if this has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner and the supporting medicine bill from the chemist;
      k. If diagnostic or radiology tests have been paid for in cash and it has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner advising the tests, the actual test reports and the bill from the diagnostic centre for the tests.

c) In the event of Your/Insured Person's death, You/Insured Person's nominee/legal heir claiming on his/her behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 14 days.

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

2. **Basis Of Claims Payment**

a) Claims related to Pre-existing Diseases:
We shall indemnify upto 50% of the admissible claim amount in respect of a claim arising from any Pre-existing Diseases that are specifically listed in the Schedule where the claim arises during the third year of continuous Renewal with Us of the Policy for the same Sum Insured and Plan. We shall indemnify upto 100% of the admissible claim amount in respect of a claim arising from any Pre-existing Diseases that are specifically listed in the Schedule from the fourth year of continuous Renewal with Us of the Policy for the same Sum Insured and Plan. The above clause is applied subject to portability regulations.

b) Claims related to Surgery for cataracts: Our obligation to make payment in respect of Surgery for cataracts (after the expiry of the two years period referred to in Section D (1)(b) vi II above, shall be restricted to 10% of the Sum Insured for each eye, and a maximum of Rs.1,00,000/- per eye.

c) Claims related to Any One Illness: All claims relating to Any One Illness shall be deemed to be part of the same original claim.

d) Claims for Day Care Treatment: The Day Care Treatments listed are subject to the exclusions, terms and conditions of the Policy and will not be treated as independent coverage under the Policy.

e) Claims between 2 Policy Year
If the claim event falls within two Policy Years, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Year, including the Deductibles for each Policy Year. Such eligible claim amount to be payable shall be reduced to the extent of premium to be received for the Renewal/due date of premium of the Health Total Policy, if not received earlier.

3. **Co-Payments Applicable under the Policy**

The following Co-payments shall be applicable for claims under all Benefits other than Benefit 13:

a) Any Insured Person aged 60 years to 64 years, being covered for the first time in a Health Total Policy shall bear 20% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.
b) Any Insured Person aged 65 years to 69 years, being covered for the first time in a Health Total Policy shall bear 25% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.
c) Any Insured Person aged 70 years to 74 years, being covered for the first time in Health Total Policy shall bear 30% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.
d) Any Insured Person aged 75 years and above, being covered for the first time in Health Total Policy shall bear 40% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.

4. **Voluntary Deductible Applicable under the Policy for all claims under Benefit 1**

a) If a Voluntary Deductible has been opted and is in force under the Policy, Our liability would be over and above the Voluntary Deductible amount for each and every claim made under Benefit 1.
b) Wherever Co-payments are applicable, as per Section K. II. 3. above, the same would be applied on the admissible claim amount after the application of Voluntary Deductible, if any.

5. **Policy Currency**

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

6. **Reimbursement Claims**

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

7. **Claim settlement**

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)
v. Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified in Section K. II.(iii) 1. b). iv). above
vi. In case of 'pending' claims, We will ask for submission of incomplete documents.
vii. 'Rejected' claims will be informed to the Insured Person in writing with reason for rejection.

(iv) **Conditions for renewal of the contract**

1. **Renewal**

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. 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.
v. Coverage is not available during the grace period.
vi. No loading shall apply on renewals based on individual claims experience
vii. Health Total Policy shall be renewable lifelong
viii. For Renewal Proposal received after completion of grace period of 30 days, all waiting periods including for health check-up, would apply afresh.
ix. The brochure/ prospectus mentions the premiums as per the age slabs/ Sum Insured and the same would be charged as per the completed age at every Renewal.
x. 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.
xi. No increase/ decrease in Sum Insured during the currency of the Policy. However increase/decrease in Sum Insured or change in cover, will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal before the expiry of the Policy
xii. In case of enhancement of sum insured the waiting period shall apply afresh to the extent of sum insured increase.

2. **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.

Annexure I – Premium rates exclusive of Goods & Services Tax (age in completed years)

	VITAL			SUPERIOR			PREMIERE	
Age / Sum Insured	**3,00,000**	**5,00,000**	**10,00,000**	**15,00,000**	**20,00,000**	**25,00,000**	**50,00,000**	**1,00,00,000**
0-17	4,418	5,061	6,856	8,019	10,400	12,451	18,054	21,304
18-25	4,645	6,213	8,471	10,198	11,923	13,661	19,808	23,374
26-30	4,718	6,718	8,501	10,515	12,034	14,429	20,922	24,688
31-35	4,724	6,739	8,582	10,687	12,523	16,031	23,245	27,429
36-40	4,999	6,752	8,639	10,731	13,942	16,875	24,469	28,873
41-45	5,468	7,227	9,394	12,793	16,858	20,622	29,902	35,284
46-50	8,074	10,033	13,726	17,094	22,453	27,490	39,861	47,035
51-55	11,799	14,866	20,290	25,088	30,870	36,638	53,125	62,688
56-60	15,216	18,311	25,997	31,379	37,228	41,447	60,098	70,916
61-65	29,734	34,638	41,816	44,878	48,235	53,934	78,204	92,281
66-70	37,151	43,613	49,846	53,201	55,518	61,221	88,770	104,749
71-75	41,096	48,884	56,204	60,241	61,674	67,657	98,103	115,761
76-80	55,102	64,911	71,342	75,324	78,468	84,246	122,157	144,145
81-85	65,661	79,968	85,763	89,886	94,353	102,736	148,967	175,781
>85	67,559	81,522	87,236	91,935	101,603	116,036	168,252	198,538

Floater Premium rates:
Premium applicable for the primary insured will be the standard individual premiums from the premium table. For remaining dependant members, floater discounts applicable on their respective premium is as per table below.

Applicable discount is as per following table:

Age Band	Discount Rates	Age Band	Discount Rates
0-17	60%	51-55	40%
18-25	55%	56-60	35%
26-30	50%	61-65	35%
31-35	45%	66-70	35%
36-40	45%	71-75	35%
41-45	40%	76-80	25%
46-50	40%	81-85	25%
		>85	20%

For example – In case of a family of Self, spouse and 1 child, the premium for floater for Sum Insured Rs. 10,00,000 would be charged in the following manner –

	Self	**Spouse**	**Child**
Age band (in years)	**36-40**	**31-35**	**0-17**
Premium as per Individual rate table (in Rs)	8639	8582	6856
Applicable premium (in Rs)	8639	4720 (45% discount applied on the respective person's premium)	2742 (60% discount applied on the respective person's premium)
Total Premium to be charged (in Rs)	= 8639+4720+2742 =16101		

L. 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
FGH/UW/RET/86/05

Annexure II

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

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

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

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

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

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

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

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