SUKSHMA HOSPI-CASH GROUP
(Micro-Insurance Product)
PROSPECTUS

A. SALIENT FEATURES OF THE POLICY

1. You can claim for each day of hospitalization as per your plan.
2. ICU benefit available for maximum period of 10 days for each hospitalization and maximum 20 days during the policy period.
3. Per day benefit will be 2 times when hospitalized in an ICU.
4. The product is offered from 6 months to 65 years and renewable lifelong.
5. Children above age of 6 months are eligible if the parent(s) are concurrently insured with Generali Central

Policy Term	1 year
Min Age at entry	6 months
Max Age at entry	65 years
Renewal	Lifelong
Policy Coverage Options	a. Individual basis b. Family Floater basis, covering Self, Spouse, and up to a maximum of three dependent children (up to 25 yrs)

6. No increase/decrease in Plan is allowed during the currency of the policy
7. Change in plan can be allowed at the time of renewal
8. The hospitalization benefit would be uniform for all the members covered under Family Floater policy and/or Individual policy
9. Continuity would be offered from similar Hospital cash policy.
10. Premium paid is exempt under the section 80 D of Income Tax.
11. Portability can be offered as per the Portability guidelines from a similar Hospital Cash Policy.

B. DEFINITIONS

I. **Standard Definitions**:

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

2. [1]**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
   a) Having qualified registered AYUSH Medical Practitioner(s) in charge
   b) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
   c) Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3. [2]**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 AYUSH Hospital, standalone or co-located with in-

[1] Inserted definition of AYUSH Day Care Centre
[2] Inserted definition of AYUSH Hospital

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:

1. Having at least 5 in-patient beds;
2. Having qualified AYUSH Medical Practitioner in charge round the clock;
3. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
4. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. [3]**AYUSH Treatment** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

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

6. **Congenital Anomaly: 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.

7. **Day care centre** means any institution established for **Day Care Treatment** of **Illness** and / or injuries or a medical set -up within a **Hospital** and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified **Medical Practitioner** AND must comply with all minimum criteria as under:-
   - has qualified nursing staff under its employment
   - has qualified medical practitioner/s in charge
   - has a fully equipped operation theatre of its own where surgical procedures are carried out
   - maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

8. **Day Care Treatment** refers to medical treatment, and/or **Surgical Procedure** which is:
   i. undertaken under General or Local Anesthesia in a **Hospital**/**Day care centre** in less than 24 hrs because of technological advancement, and
   ii. which would have otherwise required a **Hospitalisation** of more than 24 hours.

   Treatment normally taken on an out-patient basis is not included in the scope of this definition.

9. **Deductible** is 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.

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

11. **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.

[3] Inserted definition of AYUSH Treatment

12. **Grace period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

    Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period..

13. **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;

14. **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.

15. **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

16. **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.

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

18. **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.

19. **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 .

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

21. **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.

22. **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

23. **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

24. **Pre-existing Disease** means any condition, ailment, injury or disease:
    a. That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.

25. **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

26. **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.

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

II. **Specific Definitions:**
[4]

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

29. **Family** means and includes **You**, **Your** Spouse & Your dependent child/ children (up to a maximum of three children and up to the age of 25 years)
    i. The maximum number of days of **Hospitalisation** as mentioned in the **Schedule** would float over all members of each Family under the **Policy**.
    ii. In the event of more than one **Family** member being hospitalised at the same time, the number of days each member has been hospitalised would be added, and the maximum allowable for the whole **Family**

[4] Specific Definition – Alternative Treatment removed.

would be restricted to the number of days as mentioned in the **Schedule** (maximum number of days would float over the **Family**) under the **Policy.**

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

31. **Policy Period** means the period between the commencement date and the expiry date specified in the **Schedule** and includes both the commencement date as well as the expiry date.

32. **Proposal** means the application (Proposal) form for insurance cover submitted to Us along with all information which has enabled Us in considering whether and on what terms to offer this insurance

33. **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.

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

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

36. **We, Our, Us, Insurer** means Generali Central Insurance Company Limited.

37. **You, Your, Yourself** means the Insured person shown in the **Schedule.**

Please note

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

C. POLICY BENEFITS

In the event of Injury/ Bodily Injury or Illness first occurring or manifesting itself during th**e Policy Period** and causing the, Insured's Hospitalisation within the Policy Period, the Company will pay:

I. The Hospital Cash benefit for each continuous and completed period of 24 hours of Hospitalisation necessitated solely by reason of the said Accidental Bodily Injury or Sickness, for a maximum of 5 days/ 10 days/ 15 days/ 20 days/ 25 days as per the schedule

OR

II. Two times the Hospital Cash benefit for each continuous and completed period of 24 hours required to be spent by the Insured in the Intensive Care Unit of a Hospital, during any period of Hospitalisation necessitated solely by reason of the said Accidental Bodily Injury or illness. The benefit would be limited for a maximum period as mentioned in the table below:

Options	Daily Hospital Cash	Daily ICU Cash Benefit
5 days	Maximum up to 5 days	Maximum up to 5 days for each hospitalization and maximum up to 5 days during the policy period
10 days	Maximum up to 10 days	Maximum up to 5 days for each hospitalization and maximum up to 10 days during the policy period

15 days	Maximum up to 15 days	Maximum up to 10 days for each hospitalization and maximum up to 10 days during the policy period
20 days	Maximum up to 20 days	Maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period
25 days	Maximum up to 25 days	Maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period

a) *In case of Sec I (Daily Hospital Cash) and II (Daily ICU Cash) the maximum benefits would however be restricted to* **5 days/ 10 days/ 15 days/ 20 days/25 days** *as per the plan opted for each* ***Hospitalization*** *or all* ***Hospitalizations*** *during the* ***Policy*** *period, for both sections individually or put together.*

b) *In case the* ***Hospitalization*** *exceeds the maximum stipulated under Sec I (Daily Hospital Cash) as per the selected plan while adjudicating any claim the benefits under ICU would have precedence over non ICU* ***Hospitalization****.*

c) *In case the* ***Hospitalization*** *in ICU exceeds the per* ***Hospitalization*** *maximum limit of 5 days/ 10 days or the per* ***Policy*** *period limit of 5 days/ 10 days/ 20 days, the remaining period of* ***Hospitalization*** *in ICU will be paid as per non ICU* ***Hospitalization*** *benefits subject to the overall* ***Policy*** *maximum of* **5 days/ 10 days/15 days/ 20 days/ 25 days***.*

d) **For Family Floater cover:**
- The maximum number of days of **Hospitalization** as mentioned in the **Schedule** would float over all members of each Family under the **Policy**
- In the event of more than one **Family** member being hospitalized at the same time, the number of days each member has been hospitalized would be added, and the maximum allowable for the whole **Family** would be restricted to the number of days as mentioned in the **Schedule** (maximum number of days would float over the **Family**) under the **Policy**

e) An insured event shall be deemed to be a continuous and completed period of 24 hours as mentioned below:
   a. continuous and completed period of minimum 12 hours of Day Care Treatment, or
   b. continuous and completed period of minimum 24 hours of **Hospitalization** (other than **Day Care Treatment)**

The hospitalization benefit should be uniform for all the members covered under Family Floater policy and/or Individual policy

III. Optional Benefits

The Company hereby agrees, subject to the terms, exclusions and conditions herein contained or otherwise expressed hereon, to extend the cover and include the following benefits on payment of additional premium, and reimburse the Insured Person (or his Nominee/ legal heir, as the case may be) a sum specified in the Schedule to this Policy in the manner indicated on occurrence of the following.

Claims under the extensions mentioned hereunder shall be admissible only consequent to the admissibility of the claim under the corresponding benefits as mentioned in the Schedule.

a. Deductible:

Our liability to pay each and every claim under any Benefit will be in excess of any **Deductible** applicable to that **Benefit** (if any) as specified in the **Schedule**.

Number of days stated in the Schedule shall be deducted in respect of each and every Claim made under this Policy.

Deductible will be applicable for each separate incident reported for claims payment, even though the claim may be registered under the same benefit more than once subject to the terms and conditions of the Policy

Discount will be available if any of the deductible type is opted by the Insured(s)

b.Convalescence Benefit:
This is an optional cover which can be obtained on payment of additional premium for all the Insured Persons under the Policy. A fixed amount towards convalescence for Hospitalisation more than 10 consecutive days will be payable only once per Hospitalisation event. This benefit is payable only if there is an admissible claim under any of the daily benefits.

This benefit will be applicable for the following options:
(i) 15 days (ii) 20 days (iii) 25 days.

The benefit will vary as per the plan opted

c. Maternity Benefit Expense Cover:
This is an optional cover which can be obtained on payment of additional premium for all the Insured Persons under the Policy. When Maternity Expenses Benefit is opted for in the policy, Exclusion D. ii. 11 of the policy stands deleted. Option for Maternity Benefits has to be exercised at the inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during currency of the policy.

Special conditions applicable to Maternity Expenses Benefit Extension:

This Hospital Cash Benefit is applicable for each continuous and completed period of 24 hours of **Hospitalisation** arising from or traceable to pregnancy, child birth including normal/ caesarean section, for a maximum of **5 days / 10 days /15 days/ 20 days/25 days** as per the **Schedule**

These Benefits are admissible only if incurred in Hospital as in-patient in India. Maternity Benefit cover will be available to females within age band of 0-45 years only
Maternity Benefit loading will be applicable to the corresponding female member only, if opted.

A waiting period of 9 months is applicable for payment of any claim related to normal delivery, caesarean section and complications of maternity (including and not limited to medical complications). The waiting period stands waived if additional premium is paid for the same.

1. Claim in respect of delivery for only first two children and/ or operations associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who are already having two or more living children will not be eligible for this benefit. In case the first delivery is a twin (more than 1 child) delivery, then the second delivery will not be covered.

2. Pre-natal and post natal expenses including expenses for the new born baby are not covered.

d.Pre-existing Disease Cover:
This is an optional cover which can be obtained on payment of additional premium for all the Insured Persons under the Policy. Pre-existing disease loading will be applicable to the corresponding family member only.
When Pre-Existing Disease Cover is opted for in the policy, Exclusion, Section D. i. 1 of the Policy stands deleted.

D. EXCLUSIONS

i. Waiting Period

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

1 Benefits will not be available for Any condition, ailment or **Injury** or related condition(s) for which **You** have been diagnosed, received medical treatment, had signs and/or symptoms, prior to inception of **Your** first **Policy**, until 48 consecutive months have elapsed, after the date of inception of the first **Policy** with **Us**.

This Exclusion shall cease to apply if **You** have maintained the **Policy** with **Us** for a continuous period of 36 months, without break from the date of **Your** first Sukshma Hospi-Cash **Policy** with **Us**

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.

2 Without derogation from the above point no. (1), any **Hospitalisation** during the first consecutive 24 months during which **You** have the benefit of a Health Insurance **Policy** with **Us** in connection with cataracts, benign prostatic hypertrophy, hernia of all types, hydrocele, all types of sinuses, fistulae, hemorrhoids, fissure in ano, dysfunctional uterine bleeding, fibromyoma, endometriosis, hysterectomy, all internal or external tumors/ cysts/ nodules/ polyps of any kind including breast lumps (except malignant conditions), **Surgery** for prolapsed inter vertebral disc unless arising from **Accident**, **Surgery** of varicose veins, varicose ulcers.

This exclusion Period shall apply for a continuous Period of 36 months from the date of **Your** first Sukshma Hospi-Cash **Policy** with **Us** if the above referred **Illness** were present at the time of commencement of the **Policy** and if **You** had declared or were aware of such **Illness** at the time of proposing the **Policy** for the first time.

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.

3 Without derogation from the above point No.(1), any **Hospitalisation** during the first 12 months during which **You** have the benefit of a Health Insurance **Policy** with **Us** in connection with any types of gastric or duodenal ulcers, stones in the urinary and biliary systems, **Surgery** on ears/ tonsils/ adenoids.

This exclusion period shall apply for a continuous period of 36 months from the date of **Your** first Sukshma Hospi-Cash **Policy** with **Us** if the above referred **Illness** were present at the time of commencement of the **Policy** and if **You** had declared or were aware of such **Illness** at the time of proposing the **Policy** for the first time.

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.

4 **Hospitalisation** during the first consecutive 36 months during which **You** have the benefit of the **Policy** with **Us** in connection with joint replacement **Surgery** due to degenerative condition, Age related osteoarthritis and Osteoporosis unless such joint replacement **Surgery** is necessitated by accidental Bodily **Injury**.

This exclusion period shall apply for a continuous period of 36 months from the date of **Your** first Sukshma

Hospi-Cash **Policy** with **Us** if the above referred **Illness** were present at the time of commencement of the **Policy** and if **You** had declared or were aware of such **Illness** at the time of proposing the **Policy** for the first time.

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.

5 **Hospitalisation** for any **Illness** diagnosed within 30 days, of the commencement of the **Policy** Period except those incurred as a result of **Injury**.

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.

ii. **Standard Exclusions**

1. **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.

2. **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.

3. **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.

4. **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

5. **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.

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

7. **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.

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

9. **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.

10. **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

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

iii. **Specific Exclusions**

12. Injury or Disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not).

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

14. Vaccination (unless post bite) inoculation.

15. Dental Treatment or Surgery of any kind unless requiring Hospitalisation as a result of Injury.

16. The treatment of obesity (including morbid obesity) and other weight control programs, services and supplies.

17. Hospitalisation for General debility, “Run-down” condition or rest cure, sexually transmitted disease other than HIV/ AIDS, intentional self-Injury.

18. **Hospitalisation** arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphtropic Virus type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) and its variants or mutants.

19. Congenital external Illness/ disease/ defect anomaly.

20. Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.

21. [5]Costs incurred on all methods of treatment except Alternative and than Allopathy treatment.

[5] **Modified the wording to cover AYUSH treatment into the scope of the Product**

22. Stem cell implantation/ surgery/ storage.

23. Any treatment received in convalescent home, health hydro, nature care clinic or similar establishments.

24. Hormone replacement therapy

25. Any treatment including Surgery to remove organs from the donor in case of a transplant surgery.

26. Any Hospitalisation received out of India.

E. POLICY OPTIONS

Individual and/or Family floater basis

F. FAMILY DEFINITIONS

Family means Self, Spouse & up to a maximum of three dependent children (up to 25 yrs)

The minimum age for covering children is 6 months.

The maximum age for covering children as dependents is 25 yrs. Above 25 yrs can be covered as self-proposers.

If any Dependent Child has completed 25 years at the time of Renewal, then such Insured Person can be covered under a separate policy. The continuity benefits will be passed on to the separate policy taken by such Insured Person.

G. General Terms and clauses

I. Standard 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 thirty 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. **Migration**

The Policyholder shall have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy, preferably 30 days before the policy renewal date.
If the Policyholder (including all members under family cover and group insurance policies) is presently covered and has been continuously covered without any lapses under the previous health insurance policy, then the credit gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy, shall be transferred to the migrated Policy.

5. **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.

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. **Moratorium Period**

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

8. **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.

9. **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

10. **Redressal of Grievance**
In case of any grievance the insured person may contact the company through
Website: https://generalicentralinsurance.com
Toll Free: 1800-220-233 / 1860-500-3333 / 022-67837800
Email: GCIcare@generalicentral.com
Courier: Grievance Redressal Cell, Generali Central Insurance Company Limited.
Unit No. 301, 3rd Floor Part, Building No. 8, Mindspace IT/ITES SEZ,MIDC Industrial Area, Airavali, Navi Mumbai, Thane District – 400 708.

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 GCIGRO@generalicentral.com or call at: 7900197777

For updated details of grievance officer, kindly refer the link https://www.generalicentralinsurance.com/customer-service/grievance-redressal
If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

II. **Specific Terms and clauses**

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

12. **Insured**
Only those persons named, as the Insured in the **Schedule** shall be covered under this **Policy**. The details of the Insured are as provided by **You**. A person may be added as an insured during the **Policy** Period after his application has been accepted by **Us**, an additional premium has been paid and **Our** agreement to extend cover has been indicated by it, issuing an endorsement confirming the addition of such person as an Insured. Cover under this **Policy** shall be withdrawn from any Insured upon that Insured giving 14 days written notice to be received by **Us**.

13. **Communications**
a) Any communication meant for **Us** must be in writing and be delivered to **Our** address shown in the **Schedule**. Any communication meant for **You** will be sent by **Us** to **Your** address shown in the **Schedule**.
b) All notifications and declarations for **Us** must be in writing and sent to the address specified in the **Schedule**. Agents are not authorized to receive notices and declarations on **Our** behalf.

c) **You** must notify **Us** of any change in address.

14. **AYUSH COVERAGE**

[6]Expenses incurred on hospitalization due to accident and illnesses, under AYUSH systems of medicine shall be covered, However, all preventive and rejuvenation treatments which are non-curative in nature shall not be covered.

15. **Payment of Claims**

A. Claims procedure

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

a) You or someone claiming on Your behalf must inform Us in writing immediately, and in any event within 48 hours of hospitalization. You must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.
b) You must take reasonable steps or measure to minimise the quantum of any claim that may be made under this Policy.
c) You shall expeditiously provide the Company with any and all information and documentation in respect of the Hospitalisation. The claim and/ Our liability hereunder that may be requested, and You shall submit Yourself for examination by the Company's medical advisors as often as may be considered necessary by Us. The cost of such medical examination will be borne by Us.
d) You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation (written details of the quantum of any claim along with certified copies of discharge card, hospital bill and receipt) and other information if We ask for to investigate the claim or Our obligation to make payment for it.
e) In the event of the death of the insured person, nominee 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.
f) Mandatory documents required to process claim are
    i. Completely filled Sukshma Hospi-Cash **Policy** Claim form (original)
    ii. Discharge certificate/ card containing all the relevant details from **Hospital** (photocopy)
    iii. Final **Hospital** bill with receipt (photocopy)
    iv. All reports and prescriptions (photocopy)
    v. First Prescription/ Consultation Letter from your Doctor
    vi. Original Money Receipt duly signed with a Revenue Stamp
    vii. Copy of Proposer/ Employee Photo ID Proof & Address Proof

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

h) On receipt of claim documents as mentioned above or any other relevant document as required by the company from You, We shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Company will make the payment of benefit as per the contract. In case if the claim is repudiated, We will inform the claimant about the same in writing with reason for repudiation

B. Claim settlement

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of

[6] Clause number 14. newly inserted to cover AYUSH treatments at par with Allopathic Treatments, wherever applicable, in the product to provide an option for the Insured Persons to choose treatment of their choice

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

vi. Settled claims will be forwarded for payment

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

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

C. Basis of Claims payment

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

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

c) We shall make payment in India in Indian Rupees only.

d) The Company shall only make payment under this Policy to the Insured or in the event of death or total incapacitation of the Insured to the Proposer/ Nominee. Any payment made in good faith by the Company as aforesaid shall operate as a complete and final discharge of the Company’s liability to make payment under this Policy for such claim.

e) An insured event shall be deemed to be a continuous and completed period of 24 hours as mentioned below
   a. continuous and completed period of minimum 12 hours of **Day Care Treatment, or**
   b. continuous and completed period of minimum 24 hours of **Hospitalisation** (other than **Day Care Treatment)**.

f) Deductible will be applicable for each separate incident reported for claims payment, even though the claim may be registered under the same benefit more than once subject to the terms and conditions of the Policy

g) **For Family Floater cover:**
   - The maximum number of days of Hospitalisation as mentioned in the Schedule would float over all members of each Family under the Policy
   - In the event of more than one Family member being hospitalised at the same time, the number of days each member has been hospitalised would be added, and the maximum allowable for the whole Family would be restricted to the number of days as mentioned in the Schedule (maximum number of days would float over the Family) under the Policy.

16. **CANCELLATION**

a) The policyholder may cancel this policy by giving 7 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below

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) For Family floater policies, in the event of the death of any of the insured members, the cover ceases to exist for that insured and the remaining members would continue to have the coverage until the end of the policy period
c) 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.
d) 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.
e) If no claim has been made then We shall refund a pro-rata premium for the unexpired Policy Period.

17. **RENEWAL**

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

a) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
b) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
c) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
e) Coverage is not available during the grace period.
f) No loading shall apply on renewals based on individual claims experience
g) Your Sukshma Hospicash Policy shall be renewable lifelong
h) For Renewal Proposal received after completion of Grace Period of 30 days, all waiting periods would apply afresh.
i) 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**. The premiums as shown in the brochure/ prospectus are subject to revision as and when approved by the regulator. However such revised premiums would be applicable only from subsequent **Renewals** and with due notice whenever implemented.
j) If any Dependent Child has completed 25 years at the time of Renewal, then such Insured Person can be covered under a seperate policy. The continuity benefits will be passed on to the separate policy taken by such Insured Person

18. **JURISDICTION**

Each party agrees that the Indian courts shall have exclusive jurisdiction to settle any dispute which may arise out of or in connection with this Policy.

19. **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 waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

20. **COMPLIANCE WITH POLICY PROVISIONS**

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

21. **TERRITORIAL LIMITS AND LAW**

a) We cover Hospital Cash benefit due to Accidental Bodily injury or Sickness sustained by the Insured Person during the Policy Period anywhere in India only.
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. 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.

22. **Entire Contract**

The Policy and the proposal form constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the Schedule.

23. **Examination of Medical Records**

We may examine Your medical reports/ records relating to the insurance under this Policy at any time during the Policy Period and up to three years after the Policy expiry, or until final adjustment (if any) and resolution of all claims under this Policy

H. PREMIUMS

As per Annexure.

I. CLAIMS ADMINISTRATION

In case of any claims please contact Claims Department
Generali Central Health (GCH)
Generali Central Insurance Company Limited.
Qubix Business Park, Building No. Block IT – 1, Ground Floor, Plot No. 2, Blueridge Township, Near Rajiv Gandhi Infotech Park, Phase – 1, Village Hinjawadi, Taluka Mulshi, Pune, Maharashtra - 411057Toll Free Number: 1800 103 8889
Toll Free Fax: 1800 103 9998 Email: GCH@generalicentral.com

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

Name:_____
Signature: _____
Date:_____ **Place:** _____

J. SCHEDULE OF BENEFITS

Plans A, B, C, D, E, F G, H, I, J can be offered for different options 5 days/ 10 days/ 15 days/ 20 days/ 25 days

Option - 5 Days											
Sno	**Benefits**		**Plans**								
			A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
1	Daily Hospital Cash (in INR), maximum up to 5 days		100	200	300	400	500	600	700	800	900	1000
2	Daily ICU Cash (in INR), subject to maximum up to 5 days for each hospitalization and maximum up to 5 days during the policy period		200	400	600	800	1000	1200	1400	1600	1800	2000
Optional Benefits												
3	Deductible		1 day/ 2 days/ 3 days as opted									
4	Maternity Benefit Expenses Cover	with 9 months waiting period	Optional									
		without 9 months waiting period	Optional									
5	Pre-Existing Disease Cover		Optional									

Option – 10 Days											
Sno	**Benefits**		**Plans**								
			A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
1	Daily Hospital Cash (in INR), maximum up to 10 days		100	200	300	400	500	600	700	800	900	1000
2	Daily ICU Cash (in INR), subject to maximum up to 5 days for each hospitalization and maximum up to 10 days during the policy period		200	400	600	800	1000	1200	1400	1600	1800	2000
Optional Benefits												
3	Deductible		1 day/ 2 days/ 3 days as opted									
4	Maternity Benefit Expenses Cover	with 9 months waiting period	Optional									
		without 9 months waiting period	Optional									
5	Pre-Existing Disease Cover		Optional									

Option - 15 Days										
Sno	**Benefits**	**Plans**								
		A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
1	Daily Hospital Cash (in INR), maximum up to 15 days	100	200	300	400	500	600	700	800	900	1000
2	Daily ICU Cash (in INR), subject to maximum up to 10 days for each hospitalization and maximum up to 10 days during the policy period	200	400	600	800	1000	1200	1400	1600	1800	2000
Optional Benefits											
3	Deductible	1 day/ 2 days/ 3 days as opted									

4	Convalescence Benefit, Fixed amount (in INR) beyond 10 consecutive days will be payable once per Hospitalisation event		1000	1000	1000	1000	1500	1500	1500	2000	2000	2000
5	Maternity Benefit Expenses Cover	with 9 months waiting period	Optional									
		without 9 months waiting period	Optional									
6	Pre-Existing Disease Cover		Optional									

Option - 20 Days											
Sno	**Benefits**		**Plans**									
			A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
1	Daily Hospital Cash (in INR), maximum up to 20 days		100	200	300	400	500	600	700	800	900	1000
2	Daily ICU Cash (in INR), subject to maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period		200	400	600	800	1000	1200	1400	1600	1800	2000
Optional Benefits												
3	Deductible		1 day/ 2 days/ 3 days as opted									
4	Convalescence Benefit, Fixed amount (in INR) beyond 10 consecutive days will be payable once per Hospitalisation event		1000	1000	1000	1000	1500	1500	1500	2000	2000	2000
5	Maternity Benefit Expenses Cover	with 9 months waiting period	Optional									
		without 9 months waiting period	Optional									
6	Pre-Existing Disease Cover		Optional									

Option - 25 days											
Sno	**Benefits**		**Plans**									
			A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
1	Daily Hospital Cash (in INR), maximum up to 25 days		100	200	300	400	500	600	700	800	900	1000
2	Daily ICU Cash (in INR), subject to maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period		200	400	600	800	1000	1200	1400	1600	1800	2000
Optional Benefits												
3	Deductible		1 day/ 2 days/ 3 days as opted									
4	Convalescence Benefit, Fixed amount (in INR) beyond 10 consecutive days will be payable once per Hospitalisation event		1000	1000	1000	1000	1500	1500	1500	2000	2000	2000
5	Maternity Benefit Expenses	with 9 months waiting period	Optional									
		without 9 months waiting	Optional									

	Cover	period	
6	Pre-Existing Disease Cover		Optional

a) In case of Sec I (Daily Hospital Cash) and II (Daily ICU Cash) the maximum benefits would however be restricted to **5 days/ 10 days/ 15 days/ 20 days/ 25 days** as per the plan opted for each **Hospitalisation** or all **Hospitalisations** during the **Policy** period.

b) In case the **Hospitalisation** exceeds the maximum stipulated under Sec I (Daily Hospital Cash) as per the selected plan while adjudicating any claim the benefits under ICU would have precedence over non ICU **Hospitalisation**.

c) In case the **Hospitalisation** in ICU exceeds the per **Hospitalisation** maximum limit of 5 days/ 10 days or the per **Policy** period limit of 5 days/ 10 days/ 20 days *(as per the plan opted)*, the remaining period of **Hospitalisation** in ICU will be paid as per non ICU **Hospitalisation** benefits subject to the overall **Policy** maximum of **5 days/ 10 days/ 15 days/ 20 days/ 25 days**

d) **For Family Floater cover:**
   - The maximum number of days of **Hospitalisation** as mentioned in the **Schedule** would float over all members of each Family under the **Policy**
   - In the event of more than one **Family** member being hospitalised at the same time, the number of days each member has been hospitalised would be added, and the maximum allowable for the whole **Family** would be restricted to the number of days as mentioned in the **Schedule** (maximum number of days would float over the **Family**) under the **Policy**

ANNEXURE

1) **Age Band wise Individual Premium Table exclusive of Goods & Service Tax**

5 Days		
Per day Benefit	**Upto 45 years (in Rs.)**	**Above 45 years (in Rs.)**
Rs 100/day	38	55
Rs 200/day	73	110
Rs 300/day	109	165
Rs 400/day	144	218
Rs 500/day	180	273
Rs 600/day	215	328
Rs 700/day	250	381
Rs 800/day	286	436
Rs 900/day	321	491
Rs 1000/day	359	546

10 DAYS		
Per day Benefit	**Upto 45 years (in Rs.)**	**Above 45 years (in Rs.)**
Rs 100/day	42	59
Rs 200/day	83	115
Rs 300/day	123	173
Rs 400/day	163	230
Rs 500/day	204	288
Rs 600/day	246	344
Rs 700/day	286	400
Rs 800/day	326	459
Rs 900/day	367	515
Rs 1000/day	407	573

15 Days		
Per day Benefit	**Upto 45 years (in Rs.)**	**Above 45 years (in Rs.)**
Rs 100/day	46	63
Rs 200/day	91	125
Rs 300/day	136	186
Rs 400/day	181	249
Rs 500/day	226	310
Rs 600/day	270	371
Rs 700/day	315	433
Rs 800/day	360	496
Rs 900/day	405	557
Rs 1000/day	450	618

20 Days		
Per day Benefit	**Upto 45 years (in Rs.)**	**Above 45 years (in Rs.)**
Rs 100/day	50	67
Rs 200/day	99	133
Rs 300/day	147	199
Rs 400/day	196	263
Rs 500/day	244	330
Rs 600/day	292	396
Rs 700/day	341	460
Rs 800/day	391	526
Rs 900/day	439	592
Rs 1000/day	488	657

25 days		
Per day Benefit	**Upto 45 years (in Rs.)**	**Above 45 years (in Rs.)**
Rs 100/day	54	70
Rs 200/day	105	139
Rs 300/day	159	209
Rs 400/day	210	278
Rs 500/day	262	347
Rs 600/day	315	417
Rs 700/day	367	486
Rs 800/day	418	555
Rs 900/day	471	625
Rs 1000/day	523	694

2) **Family Floater discount:**

For Family floater Policy, the number of the days of hospitalization, chosen as per the Plan will float over the members of the Floater policy

Premium for the primary insured remains at actuals from the individual table

For remaining dependent members, discounts applicable as table below (on their respective individual premium)

Plan Limit	Family Floater Discount			
	2nd member	3rd member	4th member	5th member
5 days	9.00%	12.50%	15.50%	18.25%
10 days	6.50%	7.50%	8.25%	9.25%
15 days	5.75%	6.00%	6.50%	6.75%
20 days	5.40%	5.60%	5.80%	6.00%
25 days	5.30%	5.40%	5.60%	5.70%

Primary member/ Proposer will always be the member with highest age. For calculation of family floater premium, the discount is applied in the descending order of age of the persons covered in the family.

An illustration of calculation for Family Floater option:

Plan Limit: 15 days
Benefit Amount: Rs.300 per day
Family Floater: Self (Age: 49 years), Spouse (Age: 47 years), 1 Child (Age: 16 years) Self-Premium:Rs.186

Spouse Premium: Rs.186 (Individual Premium)*(5.75% discount) =Rs. (186-10.70) = Rs. 175.31 Child Premium: Rs.136 (Individual Premium)*(6% discount) =Rs. (136-8.16) = Rs. 127.84
Total Premium=186+175.31+127.84=Rs. 489.15

3) **Optional Covers:**
   a) **Maternity with 9 months waiting period applicable:** Loading of 30% on the premium as per the plan opted will be applied
   b) **Maternity without 9 months waiting period applicable:** Loading of 40% on the premium as per the plan opted Maternity Benefit loading will be applicable to the corresponding female member only, if opted.
   c) **Pre-existing disease cover:** Pre-existing disease loading of 20% on the premium will be applicable to the corresponding family member only
   d) **Convalescence Benefit:**
   Individual Premiums is mentioned below, exclusive of Goods & Service Tax.

Per day Benefit	Convalescence Benefit Amount	Upto 45 years (in Rs.)	Above 45 years (in Rs.)
Rs 100/day to Rs 400/day	Rs. 1000	4	15
Rs 500/day to Rs 700/day	Rs. 1500	6	22
Rs 800/day to Rs 1000/day	Rs. 2000	7	29

e) **Deductible:** It is a cost-sharing requirement under this product that provides that the company will not be liable for a specified number of days in case of hospitalization which will apply before any benefits are payable by the company. There are 3 deductible options which the company plans to provide- 1 day, 2 days or 3 days. The discount rates will be applicable as per the table mentioned below in case deductible is opted.

Deductible Option	Discount Rate
1 Day	6%
2 Days	20%
3 Days	35%

4) **Direct Sales Discount**
An additional discount of 15% will be applicable in case the proposal comes through direct sales channel

Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | IRDAI Regn. No.: 132 | CIN: U66030MH2006PLC165287 | Website: www.generalicentralinsurance.com | Email ID: gcicare@generalicentral.com| Toll-free Phone: 1800 220 233 / 1860 500 3333/ 022 6783 7800
ISO No: GCH/HP/SHG/PRS/001