

Arogya Sanjeevani Policy, Galaxy Health Insurance Company Limited

UIN: GHIHLIP26045V012526

POLICY WORDING

I. Preamble

"This Insurance contract between the Proposer and Galaxy Health Insurance Company Limited (hereinafter referred to as the 'Company') is based on the details contained in the Proposal given by the Proposer to the Company.

This insurance contract is drawn based on the material facts and particulars with regard to the health condition including the relevant diagnostic tests carried and observations made based on such test results as given with the Proposal. The Proposer confirms that the details contained in the Proposal are true and correct and that the Proposer has provided all the details about his/her/their health condition proposed for insurance and the policy is issued based on the principles of *uberrimae fidei*.

In consideration of receipt of premium and subject to the applicable laws and regulations of IRDAI in force and the policy terms and conditions, the Company will pay the claim reasonably and necessarily incurred up to the limits specified against the respective benefit in any Policy Year."

2. Operative Clause

If during the policy period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital / Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

3. Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

Standard Definitions

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

Anyone Illness means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

Authority means the Insurance Regulatory and Development Authority of India.

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.

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:

1. Central or State Government AYUSH Hospital; or
2. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
3. 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.

Ayush Treatment refers to the medical and/hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Break in policy means the period of gap that occurs at the end of the existing policy term / instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

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 approved.

Condition Precedent means a Policy term or conditions upon which the Insurer's liability under the Policy is conditional upon.

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 is called Internal Congenital Anomaly.

b. **External Congenital Anomaly** - Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly.

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.

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

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 the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:

- i. Has qualified nursing staff under its employment
- ii. Has qualified medical practitioner/s in charge
- iii. Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- iv. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel

Day Care treatment means 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 hours 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

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

Disclosure to information norm means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or non-disclosure of any material fact.

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.

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.

If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected. The same is applicable for both Indemnity and Benefit products.

Availability of insurance coverage during grace period: If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

- i. Minimum 10 beds for multi-speciality and 5 beds for Single Speciality.
- ii. 24 hours Medical Practitioner & Nursing Staffs.
- iii. Medical Records Department (MRD).
- iv. IT Solutions - Minimum System Requirements with internet facility.
- v. Pollution Control Board Certificate or Any Government Registration certificate.
- vi. Operation Theatre with basic Requirements - Surgical Facility
 - ❖ ICU (or) HDU is Mandatory - Surgical facility
 - ❖ Ventilator is Mandatory, if the number of beds is >50
 - ❖ C-ARM is Mandatory for Orthopaedic Speciality
 - ❖ All other facilities required as per Clinical Establishment Act

Hospitalisation 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.

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:

1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests.
2. It needs ongoing or long-term control or relief of symptoms.
3. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
4. It continues in definitely.
5. It recurs or is likely to recur.

Injury means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

Inpatient care means treatment for which the Insured person has to stay in a hospital for more than 24 hours for a covered event.

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.

ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

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.

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.

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.

Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

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.

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

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

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.

Post-hospitalisation 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 Hospitalisation was required, and
- ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for pre-existing diseases and specific waiting periods from one insurer to another insurer.

Pre-existing Disease means any condition, ailment, injury or disease:

- a. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
- b. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Pre-hospitalisation Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalisation of the Insured Person provided that:

- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
- The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

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.

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.

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.

Room Rent means the amount charged by a hospital towards room and boarding expenses and shall include associated medical expenses.

Specific waiting period means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

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 of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

Specific Definition

Admission means admission in a hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness.

Age or Aged shall mean the completed age as on last birthday, and which means completed years as at the Policy Start date.

Claim means a demand made by Insured/Policyholders or on Insured/Policyholders behalf for payment of Medical Expenses or any other expenses or benefits, as covered under the Policy.

Company/Insurer means Galaxy Health Insurance Company Limited.

Contribution is essentially the right of an insurer to call upon other insurers, liable to the same Insured, to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Disease means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner.

Diagnosis shall mean diagnosis by a Medical Practitioner, supported by clinical, radiological, histological, histo-pathological and laboratory evidence and surgical evidence wherever applicable.

Family means the Family that consists of the proposer and any one or more of the family members as mentioned below:

- i. Legally wedded spouse.
- ii. Parents and Parents-in-law.
- iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

Hazardous Sport/Hazardous Activities means engaging whether professionally or otherwise in any sport or activity, which is potentially dangerous to the Insured Person (whether trained, or not). Such Sport/Activity including but not limited to Winter sports, Ice hockey, Skiing, Skydiving, Parachuting, Ballooning, Scuba Diving, Bungee Jumping, Mountain Climbing, Riding or Driving in Races or Rallies, caving or pot holing, hunting or equestrian activities, diving or under-water activity, rafting or canoeing involving rapid waters, yachting or boating outside coastal waters, jockeys, horseback, Polo, Circus personnel, army/navy/air force personnel and policemen whilst on duty, persons working in underground mines, explosives, magazines, workers whilst involved in electrical installation with high-tension supply, nuclear installations, handling hazardous chemicals.

In-Patient means an Insured Person who is admitted to Hospital and stays there for a minimum period of 24 hours for the sole purpose of receiving treatment.

Instalment: Instalment means frequency of Premium amount paid through Monthly/ Quarterly/Half-yearly mode by the Policy Holder/ Insured.

Insured Person means the name/s of persons named in the schedule of the Policy.

Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available, what is excluded from the cover and the terms & conditions on which the Policy is issued.

Policy Period means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Schedule.

Policy Schedule means the Policy Schedule attached to and forming part of Policy.

Policy Year means a period of twelve months beginning from the Policy Period Start Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.

Sub-limit: Sub-limit means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.

Sum Insured: Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

4. COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

1. Hospitalisation

The Company shall indemnify medical expenses incurred for Hospitalisation of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
- ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.
- iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital
- iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

1.1 Other expenses

- i. Expenses incurred on treatment of cataract subject to the sub limits
- ii. Dental treatment, necessitated due to disease or injury
- iii. Plastic surgery necessitated due to disease or injury
- iv. All the day care treatments
- v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

Note:

- i. Expenses of Hospitalisation for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
- ii. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/ payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to sum insured as specified in the policy schedule in any AYUSH Hospital.

3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per eye in one policy year.

4. Pre Hospitalisation

The Company shall indemnify pre-hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalisation covered under the policy.

5. Post Hospitalisation

The company shall indemnify post hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalisation covered under the policy.

6. Modern Treatments: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

- A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- B. Balloon Sinuplasty
- C. Deep Brain stimulation
- D. Oral chemotherapy
- E. Immunotherapy- Monoclonal Antibody to be given as injection
- F. Intra vitreal injections
- G. Robotic surgeries
- H. Stereotactic radio surgeries
- I. BronchicalThermoplasty
- J. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- K. IONM - (Intra Operative Neuro Monitoring)
- L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions

7. The expenses that are not covered in this policy are placed under List-I of Annexure-I. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-I respectively.

8. A. Cumulative Bonus (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

- i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
- ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
- iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
- iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and

there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons

- v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
- vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
- vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
- viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

B. No Claim Discount: (in lieu of Cumulative Bonus): If the insured has opted no claim discount, then the insured person shall be entitled for a discount of % on the renewal premium of each claim free year.

Sum Insured	No claim discount %
Rs.50,000 to Rs.1,50,000	6%
Rs.2,00,000 to Rs.4,50,000	3%
Rs.5,00,000 and above	1%

Note:

- i. Provided, insured has not made any hospitalisation claim in a policy year.
 - ii. The customer should opt for either cumulative bonus or No claims discount during the first purchase of this policy as well as at the time of renewal of this policy.
 - iii. This discount is not cumulative in nature
9. **Co-payment:** Each and every claim under the Policy shall be subject to a co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

5. Exclusions:

The Company shall not be liable to make any payments under this policy in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of;

A. Standard Exclusions

1. Pre-Existing Diseases- Code Excl 01

- a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) 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.

- d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Specified Disease/Procedures waiting period - Code Excl 02

- A. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- C. 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.
- D. The waiting period for listed conditions shall apply even if contracted after the policy inception or declared and accepted without a specific exclusion.
- E. 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.
- F. List of specific diseases/procedures

24 Months waiting period

- i. Benign ENT disorders
- ii. Tonsillectomy
- iii. Adenoidectomy
- iv. Mastoidectomy
- v. Tympanoplasty
- vi. Hysterectomy
- vii. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
- viii. Benign prostate hypertrophy
- ix. Cataract and age related eye ailments
- x. Gastric/ Duodenal Ulcer
- xi. Gout and Rheumatism
- xii. Hernia of all types
- xiii. Hydrocele
- xiv. Non Infective Arthritis
- xv. Piles, Fissures and Fistula in anus
- xvi. Pilonidal sinus, Sinusitis and related disorders
- xvii. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
- xviii. Calculi in urinary system ,Gall Bladder and Bile duct, excluding malignancy.
- xix. Varicose Veins and Varicose Ulcers
- xx. Internal Congenital Anomalies

36 Months waiting period

- i. Treatment for joint replacement unless arising from accident
- ii. Age-related Osteoarthritis & Osteoporosis

3. 30-day Waiting Period – Code Excl 03

- i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

4. Investigation and Evaluation - Code Excl 04

- a) Expenses related to any admission, primarily for diagnostics and evaluation purposes only are excluded
- b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

5. Rest Cure, Rehabilitation and Respite care Code Excl 05

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

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

6. Obesity/Weight Control - Code Excl 06

Expenses related to the surgical treatment of obesity that does not fulfill 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 Type 2 Diabetes

7. Change-of-Gender Treatments - Code Excl 07

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

8. Cosmetic or Plastic Surgery - Code Excl 08

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 medical necessity, it must be certified by the attending Medical Practitioner.

9. Hazardous or Adventure Sports - Code Excl 09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, Para jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

10. Breach of Law - Code Excl 10

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

11. Excluded Providers – Code Excl 11

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.

12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof - Code Excl 12

13. Treatments received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons – Code Excl 13

14. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure - Code Excl 14

15. Refractive Error - Code Excl 15: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

16. Unproven Treatments - Code Excl 16

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.

17. Sterility and Infertility - Code Excl 17

Expenses related to 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

18. Maternity Expenses - Code Excl 18

- a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
- b) expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

B. Specific Exclusions

19. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

20. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

- a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a

level of radioactivity capable of causing any illness, incapacitating disablement or death.

- b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
- c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or- biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

21. Any expenses incurred on Domiciliary hospitalisation and OPD treatment (covered if Galaxy Smart Outpatient rider is opted).

22. Treatment taken outside the geographical limits of India.

23. Existing disease/s, disclosed by the insured and mentioned in the policy schedule under permanent exclusion (based on insured's consent), for specified ICD codes. Code-Excl 38

6. Conditions

Standard Conditions

1. Disclosure of Information: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

2. Claim Settlement

A. 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.

B. For Cashless Treatment:

- a. Call the 24 hour help-line for assistance – 18002030007. Senior Citizens may call at 18002030007
- b. Inform the ID number for easy reference
- c. On admission in the hospital, produce the ID Card issued by the Company at the Hospital Helpdesk
- d. Obtain the Pre-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk. (Insurers shall also provide pre-authorization to the policyholder through Digital mode).
- e. The Treating Doctor will complete the hospitalisation/ treatment information, and the hospital will fill up expected cost of treatment. This form is submitted to the Company
- f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.
- g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits.
- h. In case of emergency hospitalisation information to be given within 24 hours after hospitalisation
- i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.galaxyhealth.com or contact the nearest branch. KYC (Identity proof with Address) of the proposer, as per AML Guidelines

In non-network hospitals payment must be made up-front and then reimbursement will be effected on submission of documents.

Note: The Company reserves the right to call for additional documents wherever required.

Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person can go ahead with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

C. Notification of Claim: Upon the happening of the event, notice with full particulars shall be sent to the Company within 24 hours from the date of occurrence of the event irrespective of whether the event is likely to give rise to a claim under the policy or not.

Note: Conditions C and D are precedent to admission of liability under the policy. The Company will examine and relax the time limit mentioned in these conditions depending upon the merits of the case.

D. Documents to be submitted for reimbursement: The reimbursement claim is to be supported with the following documents in original and submitted within the prescribed time limit

- i. Duly filled in claim forms with treating doctor signature.
- ii. Pre/Post Hospitalisation investigations and treatment papers.
- iii. All investigations reports including Radiological films (Xray, CT scan, MRI and USG) and Biopsy during hospitalisation.
- iv. Discharge Summary from the hospital
- v. Cash receipts from hospital, chemists
- vi. Cash receipts and reports for tests done
- vii. Receipts from doctors, surgeons, anaesthetist
- viii. Certificate from the attending doctor regarding the diagnosis.
- ix. KYC (Identity proof with Address) of the proposer, as per AML Guidelines
- x. Copy of PAN Card
- xi. NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code
- xii. CKYC No. of the proposer (if available)
- xiii. Legal heir/succession certificate, wherever applicable

Note:

- i. Call the 24 hour help-line for assistance - 18002030007. Senior Citizens may call at 18002030007.
- ii. The Company authorized doctor may examine the insured if required
- iii. The Company reserves the right to call for additional documents wherever required.

3. Provision for Penal Interest

- i) The Company shall settle or reject a claim, as the case may be, within 15 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
- v) "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.

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:

A policyholder can file for claim settlement as per his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer. In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

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. Cancellation

- i. The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall
 - a) refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.
 - b) refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

Note: 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.

- ii. 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.

8. Migration: In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits 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 to the migrated policy.

9. Portability:

- a) A policyholder desirous of porting his/her policy to another insurer shall apply to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal. Insurers are free to consider proposal for portability, but in all such cases acquiring insurer shall ensure that there is no break in policy.
- b) The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.

10. Renewal of Health Insurance policy:

- a) A health insurance policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate.
- b) An Insurer shall not deny the renewal on the ground that the policyholder had made a claim (s) in the preceding policy years.
- c) An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
- d) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

- e) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
- f) Coverage is not available during the grace period.
- g) No loading shall apply on renewals based on individual claims experience

11. 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. 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 and deductibles as per the policy contract.

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

- i. The grace period of 15 days (where premium is paid on a monthly instalments) and 30 days (where premium is paid in quarterly/half yearly instalments) is available on the premium due date, to pay the premium. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.
- ii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, Waiting Periods for Pre-Existing Diseases, Moratorium Period etc.) accrued under the policy shall be protected.
- iii. No interest will be charged if the instalment premium is not paid on due date.
- iv. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vi. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

13. Possibility of Revision of Terms of the Policy including the Premium Rates: The Company may revise or modify the terms of the policy including the premium rates with the extant guidelines. The insured person shall be notified three months before the changes are effected.

14. 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 30 days from date of receipt of the policy document whether electronically or otherwise to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not incurred 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

15. Redressal of Grievance: In case of any grievance the insured person may contact the Company through

Website : www.galaxyhealth.com

Toll free : 18002030007

Senior Citizens may call at 18002030007

E-mail : gro@galaxyhealth.com

Phone No. : 044 - 4001 7238

Courier : Prestige Polygon – 12th Top Floor (P), No. 471, Anna Salai, Nandanam, Chennai – 600 035.

Insured person may also approach the Grievance officer 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 redressal officer (GRO) at corporate office - 044 - 4001 7238

For updated details of grievance officer, kindly refer the link <https://www.galaxyhealth.com/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. For the details of Insurance Ombudsman, please visit: <https://cioins.co.in/Complaint/Online>

Grievance may also be lodged at IRDAI integrated Grievance Management System - <https://bimabharosa.irdai.gov.in/>

16. Nomination:

- a) The policyholder shall give his nomination for the purpose of payment of claims. In the event of death of the policyholder, the claim proceeds will be paid to the nominee.
- b) Nomination can be changed any time during the term of the policy

17. Withdrawal of policy

- a) In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- b) Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

Specific Conditions

18. The Insured Person/s shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim.

19. The premium under this policy shall be payable in advance. No receipt of premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance of fulfilment of the terms, provision, conditions and endorsements of this policy by the Insured Person/s, in so far as they relate to anything to be done or complied with by the Insured Person/s, shall be a condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions, and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of the Company.

20. Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged injury or diseases requiring Hospitalisation when and as often as the same may reasonably be required on behalf of the Company at Company's cost.

21. All claims under this policy shall be payable in Indian currency.

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

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

24. **Notice & Communication:** Any notice, direction or instruction given under this Policy by the policy holder/claimant shall be in writing and delivered by hand, post or email to Galaxy Health Insurance Company Limited, Prestige Polygon – 12th Top Floor (P), No. 471, Anna Salai, Nandanam, Chennai – 600 035, Toll Free No.18002030007, E-Mail: support@galaxyhealth.com

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery or e-mail.

25. **Territorial Limit:** All investigations/treatments under this policy shall have to be taken in India.

26. **Automatic change in Coverage under the policy:** The coverage for the Insured Person(s) shall automatically terminate:

- 1. In the case of his/her (Insured Person) demise. However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund

of premium of the deceased insured person for the balance period of the policy will be effective.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

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

28. Endorsements (Changes in Policy)

- i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
- ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

29. Change of Sum Insured: Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

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

31. Relief under Section 80-D: Insured Person is eligible for relief under Section 80-D of the IT act in respect of the premium paid by any mode other than cash.

32. Customer Service: If at any time the Insured Person requires any clarification or assistance, the insured may contact Galaxy Health Insurance Company Limited, Prestige Polygon – 12th Top Floor (P), No. 471, Anna Salai, Nandanam, Chennai – 600 035, during business hours of normal working days.

TABLE OF BENEFITS

Name	Arogya Sanjeevani Policy, Galaxy Health Insurance Company Limited.
Product Type	Individual/Floater
Category of Cover	Indemnity
Sum Insured (Rs.in Lakhs)	0.50/1/1.5/2/2.5/3/3.5/4/4.5/5/5.5/6/6.5/7/7.5/8/8.5/9/9.5/10 On Individual basis - Sum Insured shall apply to each individual family member On Floater basis - Sum Insured shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. a) Policy can be availed for Self and the following family members b) legally wedded spouse. c) Parents and Parents-in-law . d) Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	For Yearly, Half-yearly, Quarterly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and monthly mode of payment a fixed period of 15 days be allowed as grace period.
Hospitalisation Expenses	Expenses of hospitalisation for a minimum period of 24 consecutive hours only shall be admissible Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Centre.
Pre Hospitalisation	For 30 days prior to the date of hospitalisation
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Road Ambulance	Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.
Modern treatments	Covered upto 50% of Sum Insured
Sublimit for room / doctors fee	1. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital/Nursing Home up to 2% of the Sum Insured subject to maximum of Rs.5,000/- per day. 2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital / Nursing Home up to 5% of the Sum Insured subject to maximum of Rs.10,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or Rs.40,000/-, whichever is lower, each eye, in a policy year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered upto sum insured, during each Policy year as specified in the policy schedule.

Name	Arogya Sanjeevani Policy, Galaxy Health Insurance Company Limited.										
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 3 years										
Cumulative bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of Sum Insured. In the event of claim the cumulative bonus shall be reduced at the same rate.										
No Claim Discount (in lieu of Cumulative Bonus)	<table><tr><th>Sum Insured</th><th>No claim discount %</th></tr><tr><td>Rs.50,000 to Rs.1,50,000</td><td>6%</td></tr><tr><td>Rs.2,00,000 to Rs.4,50,000</td><td>3%</td></tr><tr><td>Rs.5,00,000 and above</td><td>1%</td></tr></table>			Sum Insured	No claim discount %	Rs.50,000 to Rs.1,50,000	6%	Rs.2,00,000 to Rs.4,50,000	3%	Rs.5,00,000 and above	1%
Sum Insured	No claim discount %										
Rs.50,000 to Rs.1,50,000	6%										
Rs.2,00,000 to Rs.4,50,000	3%										
Rs.5,00,000 and above	1%										
Co Pay	5% co pay on all claims										

Annexure-I

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

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES 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	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES

Sl No	Item
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 FOOTWEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II - Items that are to be subsumed into Room Charges

SI 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	TOOTHPASTE
13	TOOTHBRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX

SI No	Item
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

SI 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 AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER

SI No	Item
12	SURGICAL BLADES, HARMONICSCALPEL, 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 costs of treatment

SI 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/SPRIT/ DISINFECTANTS ETC

SI No	Item
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

List of Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District
AHMEDABAD: Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Near S.V. College, Tilak Marg, Relief Road, Ahmedabad - 380 001, Gujarat. Tel.: 079 - 25501201/02 • oio.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU: Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru - 560 078. Tel.: 080 - 26652048/26652049 • Email: oio.bengaluru@cioins.co.in	Karnataka.
BHOPAL: Office of the Insurance Ombudsman, LIC of India Zonal Office Bldg, 1st floor, "Jeevan Shikha", South Wing, 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal - 462 011. Tel.: 0755 - 2769201/2769202/2769203/2769200 • Email: oio.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR: Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar - 751 009. Tel.: 0674 - 2596461/2596455/2596429/2596003 Email: oio.Bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH: Office Of The Insurance Ombudsman, LIC of India Office Bldg, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh - 160 017. Tel.: 0172-2706468/2773101/2990938/2706196/2707468/2772101/2990942 Email: oio.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonapat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh& Chandigarh.
CHENNAI: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI - 600 018. Tel.: 044 - 24333668/24333678 • Email: oio.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI: Office of the Insurance Ombudsman, 2/2 A, 1st Floor, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 46013992 • Email: oio.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.
GUWAHATI: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Pan Bazar, S.S. Road, Guwahati - 781001. Tel.: 0361 - 2632204/2631307/2732937/2632205 • Email: oio.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 2331212 /23376991/23376599/23328709/23325325 Email: oio.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR: Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Road, Ambedkar Circle, Jaipur - 302 005. Tel.: 0141 - 2740363 • Email: oio.jaipur@cioins.co.in	Rajasthan.
KOCHI: Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Ernakulam, Kochi - 682 011. Tel.: 0484 - 2358759/2358734/2358336 • Email: oio.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.

KOLKATA: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339/22124341 ● Email: oio.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW: Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 ● Email: oio.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 ● Email: oio.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
NOIDA : Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Noida-201301, Dist: Gautam Buddha Nagar, Uttar Pradesh. Tel.: 0120-2514252/2514253/4027589 ● Email: oio.noida@cioins.co.in	State of Uttrakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA: Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068/22547067 ● Email: oio.patna@cioins.co.in	Bihar, Jharkhand
PUNE: Office of the Insurance Ombudsman, Jeevan Darshan- Jeevan Darshan LIC of India Office Bldg, 3rd Floor, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020-24471175 ● Email: oio.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
THANE : Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West), Thane - 400604 Tel: 022- 20812868/20812869 ● Email: oio.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.
For the details of Insurance Ombudsman, please visit: https://cioins.co.in/Complaint/Online	



GALAXY HEALTH INSURANCE COMPANY LIMITED

Registered Office: "Prestige Polygon", 12th Top Floor (P), #471, Anna Salai, Nandanam, Chennai - 600 035

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