

**Prospectus****Galaxy Marvel****Unique Identification No.: GHIHLIP26042V012526**

Galaxy Marvel provides comprehensive protection with an extensive cover that caters the needs of an Individual and Family Floater with wide range of optional covers such as Partner Protect, Enhanced Multiplier, Assisted Living, Nursing at Home, Wealth for Health, Premium Promise, Consumables and more.

❖ Plan Name

- Neo Plan
- Prime Plan

❖ Eligibility:

- **Neo Plan: Individual** -16 days to Lifelong
- **Prime Plan: Individual** – 16 days to 65 years

Floater:

- **Neo Plan: Adult:** 18 to Lifelong
Dependent Children: 16 days to 30 years
- **Prime Plan: Adult:** 18 to 65 years
Dependent Children: 16 days to 30 years

❖ Type of Cover: Individual / Family Floater**❖ Family Size:** Upto 2 Adults + 3 Children (Parents and Parents-in-law can be covered separately under 1A or 2A).**❖ Mid Term Inclusion:** Newly Married/ Wedded spouse, Newborn baby and/or legally adopted child subject to payment of premium on pro-rata basis**Note:**

1. Waiting periods as stated in the policy will be applicable from the date of inclusion of such newly married/ wedded spouse, Newborn baby and/or legally adopted child.
2. Midterm Inclusion of Newly Married/ Wedded spouse, Newborn baby and legally adopted child is available only under floater policies.
3. Such midterm inclusion will be subject to underwriter's approval

❖ Zone Based Pricing:

Zone A: Gujarat, Haryana, Rajasthan, Punjab, Chandigarh, NCR of Delhi, Mumbai, Thane, Ghaziabad and Noida.



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Zone B: Hyderabad including K V Ranga Reddy and Medchal Malkajgiri, Secunderabad, Patna, Goa, Himachal Pradesh, Bengaluru, Thiruvananthapuram, Ernakulam, Bhopal, Indore, Pune, Nashik, Chennai, Lucknow and Kolkata.

Zone C: Rest of India

❖ Policy Term: 1 / 2 / 3 / 4 / 5 Years

Note: Where the policy is issued for more than 1st year, the Sum Insured including sublimits, automatic restoration benefit (if applicable) is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year or 3rd years or 4th year or 5th year cannot be utilized in the 1st year itself except for Advance Access (if opted).

❖ Sum Insured Options (Rs. In Lakhs): 5 / 7.5 / 10 / 15 / 20 / 25 / 100 / 200

❖ Instalment Options and Loading percentage: Monthly: 3%/Quarterly: 2%/Half-yearly: 1%

For Long-term: 12*: 3% loading / 4*: 2% loading / 2*: 1% loading / Annual: No Instalment Loading and No Long Term discount

*Premium will be paid by the insured within the first year of policy. Further, first long-term discount will be applied and then instalment loading will be applied.

Note:

1. For long term policies, in case if the insured is paying single premium at the inception of the policy - long term discount will be applicable.
2. For long term policies, in case if the insured is paying monthly/quarterly/half yearly options for the entire policy tenure, 3%/2%/1% respectively loading will be applied and no long-term discount will be applied.

❖ Long Term Discount:

- Two years policy: 10% discount on 2nd year premium.
- Three years policy: 12.5% discount on 2nd and 3rd year premium.
- Four year policy : 14% discount on 2nd, 3rd, and 4th year premium and
- Five year policy : 15% discount on 2nd, 3rd, 4th, and 5th year premium.

❖ Pre-acceptance medical screening: No pre-acceptance medical screening. For those who declare adverse medical history, company may subject them to undergo pre-policy medical check-up. 100% cost of such medical examination is borne by the company

❖ Discounts Offered (Applicable for Neo Plan and Prime Plan):

S. No.	Description	Explanation

GALAXY HEALTH INSURANCE COMPANY LIMITED

Reg. Office: Prestige Polygon – 12th Top Floor (P), No. 471, Anna Salai, Nandanam, Chennai – 600035.

T: 044 – 4001 7227 | Website: www.galaxyhealth.com | CIN: U65120TN2023PLC165765 IRDAI Reg. No.:167



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1.	Online Purchase Discount	5% discount for online purchase first purchase and their renewals. (If the policy is first purchased online and the same is renewed online, then 5% discount will be given for such renewals too)									
2.	Discount In lieu of Commission	Upto 15% discount									
3.	Long Term Discount	• Two years policy: 10% discount on 2nd year premium. • Three years policy: 12.5% discount on 2nd and 3rd year premium. • Four year policy : 14% discount on 2nd, 3rd, and 4th year premium and • Five year policy : 15% discount on 2nd, 3rd, 4th, and 5th year premium.									
4.	Early Renewal Discount	2.5% discount on renewal premium, if the premium is paid before 30 days from the date of expiry of this policy.									
5.	NRI / OCI Benefit	15% discount on premium is applicable if all persons proposed for Insurance are NRI / OCI									
6.	Gala Fit - Pro Active Care (Engaging Wellness Program)	Discount available up to 20% on the renewal premium (Kids also included in this program)									
7.	Premium Waiver	• For Critical Illness/Accidental Death: If the insured diagnosed with the listed Critical illness for first time or Accidental death, then premium waiver of next one year renewal premium is applicable. • For Voluntary Organ Donor: 2-years premium waiver to the insured person/s who donates organs, provided the insured is already policyholder/s in this policy subject to conditions									
8.	Preferred Partner Network	15% discount if the insured opts this optional cover									
9.	No claim discount in lieu of Bonus	Sum Insured in Lakhs (Rs.)		5	7.5	10	15 and above				
		Discount		4%	4%	2%	1%				
10.	Option to Choose Voluntary Aggregate Deductible (OR)		Percentage of Discount								
		Deductible/ Sum Insured (Rs.in Lakhs)	0.10	0.25	0.50	1	2	3	4	5	10
		5	6%	15%	27%	43%	55%	70%	75%	78%	79%
		7.5	5%	13%	24%	40%	53%	66%	70%	71%	76%
		10	5%	12%	22%	36%	48%	60%	63%	64%	72%

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		15	4%	11%	20%	32%	43%	54%	58%	60%	68%
		20	4%	10%	18%	29%	40%	51%	54%	57%	67%
		25	4%	9%	17%	28%	39%	49%	53%	56%	66%
		100	3%	7%	14%	23%	31%	40%	43%	46%	56%
		200	2%	6%	12%	19%	26%	33%	35%	37%	44%
11.	Option to Choose Voluntary Co-payment	Voluntary Co-Payment									
		Co-payment Percentage			% discount						
		10%			10%						
		20%			20%						
		30%			30%						
		40%			40%						
		50%			50%						
12.	Room Rent Modification		Room Category			% discount in the premium					
			Single Private A/c room			5%					
			Share Accommodation			10%					
			General Ward			15%					
13.	Sublimits on the Specific Diseases/Treatments	Policy type			Individual			Floater			
		Percentage of Discount			10%			15%			

Note: Maximum Discount up to 80%, if Voluntary Aggregated Deductible Optional cover is opted.

Maximum Discount up to 50%, if Voluntary Aggregated Deductible Optional cover is NOT opted.

❖ Medical Underwriting Loading:

The Company may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance).

- The maximum risk loading for an individual will not exceed 125% per diagnosis/medical condition, with an overall cap of 250% per insured person.
- This loading applies from the policy's commencement date, including any subsequent renewals with the company.
- The company will notify the insured of the applicable risk loading or exclusion, or both, through a counter offer.
- The insured must respond to the company with their consent and any additional premium (if required) within 7 days of receiving the counter offer.
- If the insured neither accepts the counter offer nor responds within 7 days, the company will cancel the proposal and refund the premium.
- The company will issue the policy only after receiving the insured's consent and any additional premium (if required).

❖ Coverage

A. Base Covers (Applicable for Neo Plan and Prime Plan)



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1. Inpatient Treatment

- a. Room rent (Any room) inclusive of boarding, nursing charges, Residential/Duty Medical Officer charges during Hospitalisation as charged by the Hospital where the Insured Person availed medical treatment.
- b. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees.
- c. Anesthesia, Blood, Oxygen, Operation theatre charges, ICU charges, Digital ICU, Surgical appliances, Medicines and Drugs, Diagnostic materials and X-ray, Diagnostic imaging modalities, investigation test, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses with regard to coronary stenting, medicines, Implants and other similar items the Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping.

2. Day Care Procedures/Treatment: All day care Procedures/Treatment are covered upto sum insured.

3. Pre- Hospitalisation Expenses: Medical expenses incurred immediately before the insured person is hospitalized for a period up to 90 days are payable.

4. Post-Hospitalisation Expenses: Medical Expenses incurred in respect of the Insured Person immediately following the Insured Person's discharge from Hospital upto 180 days are payable.

5. Road Ambulance: Expenses incurred towards ambulance charges for the following are payable, provided the hospitalization claim is admissible.

- i. for transportation of the insured person by private ambulance service to go to hospital when this is needed for medical reasons or
- ii. for transportation of the insured person by private ambulance service from one hospital to another hospital for better medical treatment or
- iii. for transportation of the insured person from the hospital where treatment is taken to their place of residence (if it is in same city) provided the requirement of an ambulance to the residence is certified by the medical practitioner.

6. AYUSH Treatment: Medical expenses for Inpatient Hospitalisation incurred on treatment under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines in a AYUSH Hospital is payable upto the sum insured.

Note : Claims under Yoga and Naturopathy system of treatment will be payable subject to prior approval from the Company.

7. Modern Treatment: 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 sum insured (including Pre and Post hospitalisation expenses) during the policy year;

Procedures/Treatments	
I	Robotic Surgeries
II	Immunotherapy – Monoclonal Antibody to be given as injection
III	Stem Cell Therapy Hematopoietic stem cells for bone marrow transplant for haematological conditions
IV	Intravitreal Injection - Allowed Maximum 3 injections per eye (6 injection both eyes) per policy period



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V	Deep Brain Stimulation
VI	Other Modern Treatment a. Balloon Sinuplasty b. Bronchial Thermoplasty c. IONM – (Intra Operative Neuro Monitoring) d. Stereotactic Radio Surgeries e. Vaporisation of Prostate f. Oral Chemotherapy g. Uterine Artery Embolization & High-Intensity Focussed Ultrasound

- 8. Domiciliary Hospitalisation:** Coverage for medical treatment (Including AYUSH) for a period exceeding three days, for an illness/disease/injury, which in the normal course, would require care and treatment at a hospital but, on the advice of the attending Medical Practitioner, is taken whilst confined at home under any of the following circumstances.

- The condition of the patient is such that he/she is not in a condition to be moved to a Hospital, or
- The patient takes treatment at home on account of non-availability of room/bed in a hospital.

However, this benefit shall not cover Asthma, Bronchitis, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all types of Dysenteries including Gastroenteritis, Diabetes Mellitus and Insipidus, Epilepsy, Hypertension, Influenza, Cough and Cold, all Psychiatric or Psychosomatic Disorders, Pyrexia of unknown origin for less than 10 days, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Arthritis, Gout and Rheumatism.

- 9. Home Care Treatment:** The Company will pay for expenses towards treatment availed by the Insured Person at home upto 10% of Sum Insured or upto Rs.5,00,000/- whichever is less in a policy year. It is available only for the specified conditions mentioned below, which in normal course would require care and treatment at a hospital but is actually taken at home.

The below listed are covered

1. Fever and Infectious diseases which can be managed as In-patient
2. Uncomplicated Urinary tract infections but needing Parenteral Antibiotics
3. Asthma and COPD -Mild Exacerbations needing Home Nebulization
4. Acute Gastritis/Gastroenteritis.
5. I.V. Chemotherapy [Where advised by the doctor]
6. Palliative Cancer care requiring medical assistance
7. Acute Vertigo
8. Diabetic foot and Cellulitis
9. IVDP [Cervical and Lumbar disc diseases]
10. Major Surgeries/Arthroplasties needing IV Antibiotics Post Discharge
11. Care for Brain and Spinal Injury Cases Post Discharge
12. Post CVA Care at Home after Discharge
13. Multi-drug resistance TB treatment

Note:

- a. The Medical practitioner advises the Insured person to undergo treatment at home.
- b. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment
- c. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
- d. Insured can avail "Home Care Treatment" service, if availed from the list of Network service provider



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given in the Company website "www.galaxyhealth.com"

- e. Exclusion No.1: Pre-Existing disease (Code Excl 01), Exclusion No.2: Specified disease (Code Excl 02), Exclusion No.3: Initial waiting period (Code Excl 03) are applicable and the above mentioned sub-limit will apply.

- 10. Bariatric Surgery:** Expenses incurred on hospitalisation including pre-hospitalisation and post hospitalisation for bariatric surgical procedure and its complications thereof are payable subject to limits as per the table given below.

Sum Insured	Upto the Limit Per Policy Year (Rs.)
5,00,000	3,00,000
7,50,000	3,00,000
10,00,000	3,00,000
15,00,000	3,00,000
20,00,000	6,00,000
25,00,000	6,00,000
1,00,00,000	6,00,000
2,00,00,000	7,00,000

Conditions:

- This benefit is subject to a waiting period of 24 months from the date of first commencement of this policy and continuous renewal thereof with the Company
- The minimum age of the insured at the time of surgery should be above 18 years
- This benefit shall not apply where the surgery is performed for
 - Reversible endocrine or other disorders that can cause obesity
 - Current drug or alcohol abuse
 - Uncontrolled, severe psychiatric illness
 - Lack of comprehension of risks, benefits, expected outcome, alternatives and lifestyle changes required with bariatric surgery
 - Bariatric surgery performed for Cosmetic reasons
- The indication for the procedure should be found appropriate by two qualified surgeons and the insured person shall obtain prior approval for cashless treatment from the Company.
- To make a claim, the insured person should satisfy the following criteria as devised by NIH (National Institute of Health)
 - The BMI should be greater than 40 or greater than 35 with co-morbidities (like Diabetes, High Blood Pressure etc.)
 - The insured person is unable to lose weight through traditional methods like diet and exercise

- 11. Organ Transplantation Expenses:** Hospitalisation medical expenses incurred to the Insured Person for inpatient organ transplantation treatment, including the harvesting of the donated organ will be covered upto sum insured subject to a waiting period of 24 months from the date of first inception of this policy with the Company.

Note : Organ transplant on the Insured Person shall satisfy the requirements of the Transplantation of Human Organs Act of 1994 and any amendments thereto.

12. Organ Donor Expenses**i. For Donor:**

The expenses incurred by the Donor, (if any) for the complications that necessitate a Redo Surgery / ICU admission will be covered, subject to the following,

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1. The donation confirms to the Transplantation of Human Organs Act 1994 and any amendments thereafter and the organ is for the use of the Insured Person.
2. The organ transplant is certified in writing by a Medical Practitioner as Medically Necessary Treatment for the Insured Person.
3. A waiting period of 24 months from the date of first commencement of this policy.

Note:

- i. The coverage limit under this benefit is over and above the Limit of Coverage and upto the Sum Insured.
- ii. This additional Sum Insured can be utilized by the Donor and not by the Insured.

ii. For Insured:

If the Insured person donates organ, In-patient hospitalisation expenses incurred for organ transplantation are payable upto the sum insured, subject to the following,

- a. The donation conforms to the Transplantation of Human Organs Act 1994 and any amendments thereafter and the organ is for the use of the Insured Person.
- b. The organ transplant is certified in writing by a Medical Practitioner as Medically Necessary Treatment for the Insured Person.
- c. A waiting period of 24 months from the date of first commencement of this policy.

The following are not covered (applicable for both Donor and Insured):

- a. Stem cell donation is considered medically necessary treatment, except for bone marrow transplant.
- b. Pre-hospitalisation or Post-hospitalisation Medical Expenses of the organ donor.
- c. Screening or any other Medical Expenses related to the organ donor, which are not incurred during the duration of Insured Person's Hospitalisation for organ transplant.
- d. Transplant of any organ/tissue where the transplant is Unproven / experimental treatment or investigational in nature.
- e. Expenses related to organ transportation or preservation.
- f. Any other medical treatment for the donor, which is directly or indirectly consequence to harvesting.

- 13. E-Domestic Second Medical Opinion:** Insured can obtain a Second Medical Opinion from our panel of available medical practitioners. All the medical records provided by the Insured Person will be submitted to the Doctor chosen by online and the medical opinion will be made available directly to the Insured by the Doctor. To utilize this benefit, all medical records should be forwarded to the mail-id: Expertreview@galaxyhealth.com.

Note:

- This should be specifically requested by any of the Insured Person/ Proposer.
- This opinion is given based only on the medical records submitted without examining the patient.
- The second opinion should be only for medical reasons and not for medico-legal purposes.
- Any liability due to any errors or omission or consequences of any action taken in reliance of the second opinion provided by the Medical Practitioner is outside the scope of this policy.
- Utilizing this facility alone will not be considered as a claim.
- Medical Records / Documents submitted for utilizing this facility will not prejudice the company's right to reject a claim in terms of policy.
- Utilisation of this cover will not have an impact on Bonus / No Claim Discount.

- 14. Newborn Baby cover:** Hospitalisation expenses for treatment of newborn is covered up to the limits (including for twins/ triplets/ quadruplets) specified below incurred in a hospital/ nursing home for any disease, illness or accidental injuries.



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- a) **For one year policy term:** The coverage for newborn baby starts from day-1 after its birth till the expiry date of the policy year, as per the table given below subject to availability of the sum insured.
- b) **For Long term policies (For 2 years / 3 years/4 years and 5 years policy term):** The coverage for Newborn Baby starts from day-1 after its birth till the expiry date of the policy year. Further, newborn will be covered under this policy by paying additional premium as per the revised/existing family size and coverage shall be up to chosen sum insured for subsequent year/s.

Sum Insured (Rs.)	Limit per policy year (Rs.)
5,00,000 /- to 25,00,000/-	10% of sum insured or upto Rs.2,50,000/-, whichever is less
1,00,00,000/- and 2,00,00,000/-	10% of sum insured or upto Rs.5,00,000/- whichever is less

Newborn will be covered from day 1, provided, if the insured women submit the Antenatal scan in 12th week and 20th week of the pregnancy (Subject to underwriting).

Note:

- Insured women shall be covered under the policy for a continuous period of 12 months without break in this policy.
- Intimation about the birth of the Newborn baby should be given to the Company and policy has to be endorsed for this cover to commence.
- Exclusion no. 3 initial waiting period (Code Excl 03) as stated under this policy shall not apply for the Newborn Baby.
- All other terms, conditions and exclusions shall apply for the Newborn Baby.
- The Exclusion No.1: Pre-Existing disease (Code Excl 01), Exclusion No.2: Specified disease (Code Excl 02), and the above-mentioned sub-limit will not apply for treatment related to Congenital Internal disease/defects for the newborn.

- 15. Nanotechnology:** The company will cover medical expenses incurred towards the hospitalisation of the insured person for surgical procedures or treatments involving nanotechnology, upto 25% of sum insured.

Note:

- Nanotechnology plays a pivotal role in the medical field, particularly in diagnostics, treatment, wound healing and regeneration. This includes antibiotic or drug delivery systems with site-specific treatment (targeted drug delivery) in areas such as Cancer treatment, neurodegenerative disorders and surgeries to reduce complications.
- The Waiting period and coverage are subjected to eligibility of the claim as per Policy terms and conditions. The Indication and necessity of this advanced treatment will be evaluated by our Medical practitioner, and this should be supported by Literature Evidence as well as should be recognised by the ICMR (Indian Council for Medical Research).

- 16. Automatic Restoration:** The policy provides automatic restoration of sum insured upto 100% each time for unlimited number of times for any illness/disease/injury. This reset can be utilized for a subsequent hospitalisation for same illness or different illness including modern treatment and accidents.

Conditions

- a) Available immediately upon partial/ full utilization of the sum insured



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- b) On partial utilization of the Sum Insured, it will be reset up to extent of utilization.
- c) On full utilization of the Sum Insured, it will be reset to 100%.
- d) The maximum payable amount for a single claim under reset benefit shall not be more than the Sum Insured.
- e) Any unutilized Reset Benefit will not be carried forward to any subsequent Policy Years.

Note: The Order of utilization is as follows:

- a) Sum Insured
- b) Bonus
- c) Enhanced Multiplier 3X or 10X (if opted)
- d) Automatic Restoration

17. Premium waiver:

- a. For Critical Illness / Accidental Death:** During the policy year, if the insured is diagnosed (first diagnosis/instance) with any of the critical illness specified under Annexure - II (or) in case of Death of insured due to Accident, Premium will be waived off during renewal for the next one policy year and such premium waiver will be given up to the expiring sum insured and for existing insured members, once in a life time of the policy, subject to the submission of proof such as Medical Certificate confirming the diagnosis of Critical Illness (or) Death Certificate respectively.

Note:

1. In case of floater policy, if the insured under the policy is diagnosed with the specified critical illness / in case of death of the insured due to Accident, the premium waiver will be available on the floater policy premium.
2. In case of multi-individual policy, if the proposer who is also insured under the policy is diagnosed with the specified critical illness / in case of death of the insured due to Accident, the premium waiver will be available on the multi-individual policy premium.

b. For Voluntary organ donor:

This benefit gives a **2-year** premium waiver on the renewal policy of an insured person who donates organs, subject to the following,

1. Upon confirmation by the company medical team and subject to admissible claim
2. Proof of donation should be submitted to avail the waiver of premiums.

- 18. a. Bonus:** The Company will provide a Bonus of 100% of the sum insured, provided there is no claim in the previous policy year or 25% of the sum insured, if there is a claim in the previous policy year.

Conditions

1. The policy should be continuously renewed with the Company.
2. The bonus will be calculated on the expiring Sum Insured.
3. If the insured opts to reduce the sum insured at the subsequent renewal, the limit of indemnity by way of such Bonus shall not exceed such reduced sum insured.
4. The benefit is applicable only for once during the policy year and it is not cumulative in nature.

Illustration:

Policy year	Claim / No Claim in the policy year	Sum Insured	Bonus Available	Total Sum Insured at the
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				commencement of policy year
1 st	No claim	5,00,000	-	5,00,000
2 nd	Claim	5,00,000	5,00,000	10,00,000
3 rd	Claim	5,00,000	1,25,000	6,25,000
4 th	No claim	5,00,000	1,25,000	6,25,000
5 th	No claim	5,00,000	5,00,000	10,00,000
6 th	No claim	5,00,000	5,00,000	10,00,000

b. No Claim Discount (in lieu of Bonus): Policy is eligible for no claim discount in lieu of bonus as per the table given below:

Sum Insured (Rs.)	5,00,000	7,50,000	10,00,000	15,00,000 and above
Discount	4%	4%	2%	1%

Note:

- i. 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.
- ii. This discount will be provided on renewal premium of each claim free year, and it is not cumulative in nature.

Illustration: If the insured opts for higher sum insured at the time of renewal, the discount shall be calculated on the previous year premium, and the same discounted amount shall be applied on the renewed premium. Illustration is given below for better understanding.

Policy Type	Fresh	
Sum Insured (Rs.)	5,00,000	
Family Size	2A	
Zone	A	
Self and Spouse Age	36 and 31	
Base Premium (Rs.)	11,854	A
Add: GST at 18% (Rs.)	2,134	B = A * 18
Total Premium (Rs.)	13,988	C = A+B
During Renewal, Insured enhanced sum Insured to Rs.10,00,000/- and opted No Claim discount		
Policy Type	Renewal	
Sum Insured Enhanced to (Rs.)	10,00,000	
Family Size	2A	
Zone	A	
Self and Spouse Age	37 and 32	
Base Premium (Rs.)	13427	D
Less: No Claims Discount at 4% (Rs.)	474	E = A*4%
Sub-total (Rs.)	12,953	F = D-E
Add: GST at 18% (Rs.)	2,332	G = F*18%



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Total Premium (Rs.)	15,285	H = F+G
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19. NRI/OCI Benefit – The Company will provide a discount of 15% on base cover premium to Non-Resident Indians / Overseas Citizens of India, provided that the Insured Person(s)-

- Provides declaration upon Policy Issuance and subsequent renewals that they are Non-Resident Indians / Overseas citizens of India based abroad in entirety for the Policy Year.
- Provides proof of overseas residence for the upcoming year upon each renewal to continue availing the discount
- Possesses and provides other relevant identity proof documents as mandated for Citizenship of India
- Has an Indian bank account for premium/claims payment.

If the Insured person ceases to be a Non-Resident Indian / Overseas Citizens of India, then no further discount shall be applicable upon renewal.

Note: If case of Floater policy, all the insured persons covered should be Non-Resident Indian/Overseas Citizens of India to avail this discount.

20. Gala Fit - Pro Active Care (Engaging Wellness Program)

The Company insurance program integrates a comprehensive wellness initiative. Unlike traditional wellness programs that focus solely on exercise and regular health check-ups to earn rewards and discounts, the company program goes a step further. The Company promote interactive care that seamlessly integrates into the insured person daily activities, recognizing even the smallest efforts towards a healthier lifestyle. This wellness program offer a diverse range of activities designed to enhance physical health, provide psychological enrichment, encourage social engagement, and foster community building. Additionally, improve the Insured Person overall lifestyle.

The Company recognize and reward the Insured Person activities with certificates and coins. These activities are tracked and monitored by the Company, and the accumulated reward coins can be used to receive discounts on policy renewals for the following year. By enrolling and connecting the Insured Person health gadgets with the company mobile application, the Company promote healthy lifestyles through preventive care coverage. These initiatives aim to help insured individuals reduce the risk of chronic and lifestyle diseases. The company program is designed to be interactive and motivating, encouraging the Insured Person to always maintain best health.

This Wellness Program is enabled and administered online through Galaxy Health Mobile Applications. The Company have the wellness program available based on the age. One is for adults and dependent child 18 years and above and other one is for children above 7 years to below 18 years of age. The following table shows the discount on premium available under the Wellness Program. Both on Individual or Floater Plans are available.

Gala Fit - Pro-Active Care (Engaging Wellness Program)	
Wellness Coins Earned	Discount in Premium
Above 251- 400 Coins	4%
401-550 Coins	8%
551-700 Coins	12%
701- 850 Coins	16%
Above 850 Coins	20%

Distribution of discount can avail as per members in a floater policy

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Family size	Weightage
2A - Self / Spouse	1:1
2A +1C - Self / Spouse / Dependent Children 18 years and above	1:1:1
2A + 2C - Self / Spouse / Two Dependent Children above 7 years of age to below 18 years of age	1:1:1:1
2A +3C - Self / Spouse / Two Dependent Children above 7 years of age to below 18 years of age / one child below 7 years of age.	1:1:1:1:0

Note : In case of two-year policy, total number of wellness points earned in two-year period will be divided by two.

Please refer the illustrations to understand the weightage and calculation of discount in premium

Gala Fit – Pro Active Care Program for Adults + Dependent child age 18 years and above			
S No	Activity - For Each Insured	Monthly coins	Yearly coins
1	Enrolling in Wellness Program, in mobile application by individual mobile number with ID proof		10
2	Register under organ donation plan (share details)		10
3	Sleep pattern - Having minimum of 7 hours of sleep / day -monitored monthly basis	5 / month	60
4	Blood donation (maximum twice per year allowed) (10 coins*2)		20
5	Participation in physical activities a) Wellness program (like Gym / Health club subscription) b) Marathon, cycling, Trekking and similar activities, Indoor and outdoor sports	5 / activity) *(2/ month)	120
6	Target Steps count / per day (monitored monthly basis) Recognise with Galaxy team certificate via E-mail ▪ >5,000 ▪ >8,000	10 for 5000+ steps Or 15 for 8000+ steps	180
7	Preventive check-up 1. ENT check-up (20 coins) 2. Eye check-up (including Glaucoma test for 40+years .members) (20 coins) 3. Dental check up with reports (10 coins)		50
8	Condition Management Program (CMP): (per policy period) – To record BMI, general health checks up by physician (only 60 coins) ▪ Member with Lifestyle disease – can provide once every four month (thrice a policy period) (3*60 coins) assessment records ▪ Wellness team analysis– if progression noted then coins credited		180
9	Only for members who have submitted wellness assistance last policy year. 1. Reduce in BMI from obese to normal compared to previous year reports (25 coins) 2. Sharing a success story (5 coins)		30

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10	Submission of Vaccination			
	- 100 Coins – HPV	- 10 Coins - Other vaccine		100
11	Provide the standard medical test			220
	1. Complete blood test with haemoglobin 2. Urine routine 3. USG abdomen 4. S.creatinine 5. ECG 6. HbA1C 7. Pulmonary function 8. Cholesterol	9. Thyroid profile 10. Bone density 11. (HHH) serology test (20 Coins) 12. PSA (M) (20 Coins) 13. Mammogram test (F) (20 Coins) 14. PAP smear test (F) (20 Coins) 15. ECHO (20 Coins) 16. Cancer profile markers (20 Coins)		
12	Enrolling with video programs in Galaxy health app and successful completion of the program			20
	Total			1000
Additional benefits available in the wellness via app				
- Domain for complete medical records of the members (Digital Vault) - Access to health gadgets - Water intake alarm - Diet program including calories - Location detectors for blood bank, hospital (with label for network and non-network), Rehabilitation centre, Pharmacy, diagnostic centre, physiotherapy centre and clinics				
Under s.no 12 (wellness program – in app) - attending Counselling / workshop for the following				
- Pregnancy - Postpartum condition - Emotional & Mental Health - Menopausal syndrome - Stress management - Life balance management				

The following list of activity for Dependent children

Gala Fit – Pro Active Care Integrated Health Program for Dependent children above 7 to below 18 years of age			
S. No.	Activity	Monthly coins	Yearly coins
1	Avail coins for Enrolling in Wellness Program, by parent's mobile number & Dependent Children photo proof		50
2	Submission of Vaccination ▪ As per Indian government vaccination chart (50 Coins) ▪ Preventive vaccines as per medical board suggestions (20 Coins)		70



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3	Engaging-in mental enrichment program ▪ Singing / dancing program / Story telling / drawing	(10 / activity) *(2 / month)	240
4	Engaging-in physical activities ▪ Indoor and outdoor sports, Swimming, Trekking and similar activities. ▪ Sharing certificate of participating in sports	(15 / activity) * (2/ month)	360
5	Preventive check 1. ENT check-up (50 Coins) 2. Eye check-up (50 Coins) 3. Dental check up with reports once in every Six month (40*2 coins)	50 50 40*2	180
6	Interactive video program in Galaxy health app - *Two Programs minimum and maximum of 5 programs	20*5	100
	Total		1000
Additional benefits available in the wellness via app - Domain for complete medical records of the members (Digital Vault) - Access to health gadgets - Water intake alarm - Diet program including calories Under s.no 6 (wellness program – in app) - attending Counselling / workshop for the following - Emotional & Mental Health - Child behaviour care - Stress management - Life balance management - Drawing and Painting Competition - Co-Curricular Activities Participation - Participation in Quiz			

• Enrolling to Wellness Program

To enrol in the wellness program, participants must provide a photo ID proof and policy details via the mobile application. Upon activation, they will receive coins for the program, which ends on the policy expiring date of the current year.

• Register under organ donation plan

Organ donation involves a person to donate their organs for transplantation to someone in need. This registration of voluntary organ donation for Nobel cause is acknowledged by us. Once registered with a standard organ donor bank, the insured can share their registration details and upload the certificate to earn wellness coins.

• Sleep pattern

Sleep is crucial for physical and mental health, enhancing emotional wellbeing, hormonal balance, physical health, and brain function. A minimum of 7 hours of sleep per day is required, and members who achieve 25 days of over 7 hours of sleep receive monthly coins. The cumulation of monthly points is used at the end for discount during policy renewal.

• Blood donation



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Blood donation is a vital process where individuals voluntarily have blood drawn to help those in need of transfusions or medical treatments. The insured can provide their blood donation certificate details every six months. For every submission, the insured will receive the coins.

• Participation in physical activities

Engaging in physical activity is essential for health care, providing numerous benefits for both physical and mental well-being, and helping to prevent lifestyle diseases. The Company program includes a variety of activities such as trekking, marathons, cycling, and both indoor and outdoor sports. Participants who have engaged in these activities are required to submit valid certificates. One or two activity certificates per month can be uploaded via the mobile application to earn coins.

• Target Steps count

Regular walking offers numerous benefits for both physical and mental health. Aiming for over 8,000 steps per day can significantly contribute to maintaining good health. The Company program, available at monthly, rewards members who meet specific step targets. If a member walks 5,000 or more steps per day for at least 25 days in a month, they can earn 10 coins. Achieving 8,000 or more steps per day for at least 25 days in a month will earn them 15 coins. Members who meet these targets for more than 20 days in a month will receive 80% of the monthly coins, i.e., 8 coins for surpassing 5,000 steps and 12 coins for surpassing 8,000 steps.

• Preventive check-up

Basic medical consultation for ENT, eye and dental. The insured persons must undergo checkup under these specific specialists and provide the OP consultation papers to avail coins.

• Condition Management Program (CMP)

This is categorised as basic plan and chronic disease management plan

The basic plan includes a general physician conducting a routine health check-up of the insured, covering BMI, blood pressure, and other vital signs. The results of this check-up can be recorded and shared with the company via the Company mobile application. As an incentive, members will receive coins for completing this one-time activity.

• For the chronic disease management plan.

Individuals diagnosed with lifestyle diseases, or any other medical conditions are eligible to participate in this three-part integrated activity. Participants must undergo consultations and medical evaluations related to their diagnosed conditions. Activity reports must be uploaded once every four months.

Participants are required to follow prescribed treatments and engage in lifestyle programs and activities to improve their health. Progress is monitored every four months through follow-up doctor visits and relevant medical investigations. Based on the consolidation of these three reports, coins may be granted based on health progression.

Example 1: -

If a member is suffering from uncontrolled hypertension, they must provide the first consultation paper, along with the requested investigations suggested by the treating doctor, during the first month of the current policy period (e.g., April). These records should be uploaded to the system.

After four months, a second set of records, including the consultation taken (e.g., August) and the corresponding investigations, should be uploaded via the mobile application. This is the second part of the activity. Then after another four months, the third part of the activity is taken, a third set of documents, including the consultation form (e.g., December) and the suggested investigations, should be uploaded.

The Company will evaluate the uploaded documents to assess any progression or reduction in the member's health condition. If there is a noted improvement, the insured will be awarded coins. Additionally, the medical



Prospectus

team will review the consultation papers to check for any progression in the insured's condition. If no progression is noted, they will guide the insured to subscribe to certain wellness programs.

• BMI management: -

This activity is for insured individuals who participated last year and requires them to provide their current BMI. If their BMI is within the healthy range, they will receive coins. Participants are also encouraged to submit a feedback video sharing their success with the wellness program. Coins are also available for this activity.

S. No.	Name of the Ailment	Criteria to get the Wellness points
1.	Obesity (If BMI is above 29)	Reducing BMI by three points and maintaining the same BMI in policy year
2.	Overweight (If BMI is between 25 and 29)	Reducing BMI by two points and maintaining the same BMI in policy year

• Submission of Vaccination certificate

There are two types of coins provided under this activity.

One under adult activity and other one under children above 7 years of age to below 18 years of age.

• Under Adult

Please submit the vaccine certificate if the Insured Person have received a vaccine as per the suggested list of vaccine guided by the Indian Ministry of Health. Coins will be awarded to acknowledge participation, with the coins varying based on the type of vaccine administered. For example, if the Insured Person receives the HPV vaccine (a three-stage vaccine), a specific number of coins will be given. For the other type of coins provided in children wellness plan.

• Government-Published Vaccine Chart for Children

The Company urge all parents and guardians to ensure their children participate in this vaccination program. Please administer the recommended vaccines, as advised by the Ministry of Health, to the Insured Person children and provide an updated list of completed vaccinations. In line with current medical advancements, if a physician recommends any additional preventive vaccines and the Insured Person child has received them, the Company will acknowledge those as well. As a token of appreciation for completing this activity, the Company will distribute coins.

• Provide the standard medical test

The Company wellness program offers a variety of diagnostic tests to evaluate the health status of the insured and screen for age-related diseases. Participants can choose from a basic list of tests and have the option to select additional specific tests. Wellness coins are awarded based on their selections. Any 8 tests from first 10 tests are required to accumulate the coins under this activity. From 11 test to 16 test are optional.

- **Enrolling with program in Galaxy health app** :The Company mobile application features an interactive wellness program with activities for disease prevention, psychological enhancement, social awareness, child community enrichment, and intellectual development. The program is gender and age-based, and insured participants receive coins to add to their wellness bucket.

Wellness for Kids

Three categories for children participating in the following categories

- Mental enrichment program
- Physical health activity



Prospectus

- Community interactive activities

The program is designed for children above 7 years of age below 18 years of age are eligible to participate in the following program to enhance their wellness.

• Mental enrichment program

This aims to improve mental well-being and cognitive functioning through various activities. Participants earn coins based on the uploaded certificates, which can be uploaded up to two per month.

- Pottery, arts and Crafting, Drawing, Painting competitions
- Music therapy, playing musical instruments, Singing and dancing performances
- Cooking classes
- Participation in Role-playing in one act plays (drama), Quiz, skits on social issues, storytelling / narrating, debate meet at zonal level or above.
- Creative Article writing, publications article in newspapers.
- Participation in Science exhibition competition (Science Olympiad, zonal level, State level & National level)
- Meditation sessions, vipassana, puzzle-solving, chess, abacus, motivation counselling, memory exercises.

• Physical health activity

Engaging in physical activity helps children become more active and healthy individuals in the future. List of physical activity kids engaged will be eligible to avail these benefits.

- Team sports (Cricket, Football, Hockey, Basketball and Volleyball)
- Individual sports (Athletics, Swimming, Archery, Boxing, Gymnastics, Tennis, Badminton, Cycling, swimming)
- Enrolling in Gym/Yoga/ Health club subscription
- Trekking, Marathon, cycling and similar activities
- Traditional self-defence martial arts, Martial arts (Karate/ Taekwondo/Judo/ Kickboxing)

• Community interactive activities

There are many engaging community activities that can bring younger citizens together and foster a sense of connection.

- Scouts & Guides
- NCC (National Cadet Corps) NSS (National Service Scheme)
- Volunteer interactive activities (animal shelters, clean-ups in park, river, seashore and similar activities, food banks, natural calamities, old-age camp)
- Blood donation camps
- Health and wellness seminars (State level & National level)

Note: Points will be accumulated based on the submission of proof of Engaging or award/prize winning certification

Important Note:

- Member must download the application within 30 days from the inception date of the policy.
- The investigation requested and OPD consultation and preventive health check-up must be made from registered diagnostic laboratories and physician
- The Participants in the Interactive program must complete the program, to get the monthly coin,
- The app based pre recordings must be seen without skipping the videos
- To get coins, for monthly basis, minimum 25 days in a month must be achieved the target step count.
- If the member completes 20 days can avail partial coins for that month.



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- The uploaded certificates and reports are validated and then only the coins are added.
- The reward coins are not carried forward to next year (for annual renewal of policy).
- The wellness coins are not transferable to other members in the policy.

Terms and conditions under wellness activity

- Any information provided by the Insured in this regard shall be kept confidential.
- There will not be any cash redemption against the wellness reward points.
- Insured should notify and submit relevant documents, reports, receipts etc for various wellness activities within one month of undertaking such activity/test.
- For services that are provided through empanelled service provider, Galaxy Health is only acting as a facilitator; hence would not be liable for any incremental costs or the services.
- Insured should consult his/her doctor before availing/taking the medical advice/services. The decision to utilize these advice/services is solely at Insured person's discretion.
- The Company reserve the right to remove the wellness reward points if found to be achieved in unfair manner.
- Galaxy Health, its group entities, or affiliates, their respective directors, officers, employees, agents, vendors, are not responsible or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which a Member claims to have suffered, sustained or incurred, by way of and / or on account of the Wellness Program.
- Services offered are subject to guidelines issued by IRDAI from time to time.

Illustration of benefits two models proposed

- First for two adult model
- Second is for two adult and one child below 18 years of age.

S. No.	2A Model	61 years old (Male)	49 years old (Female)
1	Enrolling to Wellness Program	10	10
2	Register under organ donation plan	0	10
3	Sleep pattern	0	35
4	Blood donation	10	0
5	Participation in physical activities	0	60
6	Target Steps count	180	120
7	Preventive check-up	20	10
8	Condition Management Program (CMP)	180	60
9	Old participants	0	0
10	Submission of Vaccination certificate	10 (Hepatitis B)	100
11	Provide the standard medical test	0	100
12	Enrolling with program in Galaxy health app	10	20
	Total	420	505
Note - cumulation of coins $(420 + 505) / 2 = 462 = 8\%$ discount applicable during the renewal of the policy.			



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S. No.	2A +1C model	50 years old (Male)	41 years old (Female)	9 years old (Kid)
1	Enrolling to Wellness Program	10	10	50
2	Register under organ donation plan	10	10	N/A
3	Sleep pattern	50	0	N/A
4	Blood donation	10	0	N/A
5	Participation in physical activities	120	0	210
6	Target Steps count	100	120	N/A
7	Preventive check-up	40	40	90
8	Condition Management Program (CMP)	60	180	N/A
9	Old participants	30	0	N/A
10	Submission of Vaccination certificate	10	0	50
11	Provide the standard medical test	100	100	N/A
12	Enrolling with program in Galaxy health app	20	0	60
13	Participation in mental enrichment program	N/A	N/A	120
	Total	560	460	580
Note - Cumulation of coins $(560 + 460 + 580) / 3 = 533 = 8\%$ discount applicable during renewal of the policy.				

B. OPTIONAL COVERS- (Applicable for Neo Plan and Prime Plan)

The following optional covers can be opted on payment of additional premium / discount on premium.

- 21. Insta Care Cover from 31st Day :** If Insured Person has Pre-Existing Disease (PED) related to the list of Diseases/illnesses/Conditions mentioned below at the time of issuance of first Policy with the Company, then by choosing this Optional cover and by paying an additional premium , the applicable Pre-Existing Disease(PED)waiting period related to the below listed four diseases/illness/conditions shall be reduced to 30 days and coverage will be available from 31st Day under In-patient / Day Care Treatment. This optional cover cannot be opted during mid-term of the policy/ at the time of renewal / at the time of Portability.

List of diseases/illnesses/conditions covered under this optional cover:

- Asthma** is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath.
- Blood pressure (Hypertension)** is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.
- Cholesterol (Hyperlipidaemia)** is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease.
- Diabetes mellitus** is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages every organ in the body, which causes serious health consequences.

- 22. Partner Protect:** This cover provides continuity benefit for the following waiting periods served by the member (a) Initial waiting period, (b) Pre-Existing Disease (PED) waiting period, (c) Specific Waiting Period,



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to the spouse added in future and this will be offered only if the age of the proposed newly added spouse at the time of entry is up to 35 years.

Note:

- Insured can only add his / her newly married spouse.
- This optional cover can be opted only by the insured covered under individual policy. For such included spouse coverage will be on Individual basis till expiry of the policy.
- Newly married spouse **MUST** be added within 3 months from the date of marriage to get the benefits under this optional cover. (Subject to Underwriting).
- Insured should submit marriage certificate / any other valid proof of marriage to add the spouse.
- The newly married spouse can be added only if the marriage has happened after taking this policy.

23. Delivery Expenses:

- Expenses for a Delivery including Normal Delivery or Caesarean section (Pre-natal and Postnatal expenses are also covered) subject to the limits mentioned in the table given below;

Sum Insured (Rs.)	Normal (Limit per Policy year Rs.)	Caesarean (Limit per policy year Rs.)
5,00,000	25,000	50,000
7,50,000 / 10,00,000 / 15,00,000 /	50,000	1,00,000
20,00,000 / 25,00,000 / 1,00,00,000 / 2,00,00,000	1,00,000	2,00,000

- Antenatal Scan:** During pregnancy both 12th and 20th week of Antenatal scan are covered (Maximum 2 Scans per delivery) within the above-mentioned delivery limit.

Note:

- Maximum 2 deliveries are allowed in the lifetime.
- Pre-hospitalisation and Post Hospitalisation expenses are not applicable for this cover.
- Both self and spouse should be covered under this policy for a minimum period of 2 years continuously without break either individual or floater sum insured (or) insured women alone should be covered under this policy for 3 years continuously without break.
- There is no waiting period for subsequent deliveries

Important Note: Delivery expenses will not cover medical termination of Pregnancy and Intra Uterine death. However, Still birth will be covered as per the limit of the policy.

24. Assisted Reproduction Treatment: The Company will reimburse medical expenses incurred on Assisted Reproduction Treatment as per the table given below, where indicated, for sub-fertility subject to:

- For the purpose of claiming under this benefit, inpatient treatment is not mandatory.
- Automatic Restoration of Sum Insured shall not be applicable for this benefit.
- Both self and spouse should be covered under this policy for a minimum period of 2 years continuously without break either individual or floater sum insured.
- Company will pay for one Assisted Reproduction Treatment cycle in a policy year

Sum Insured (Rs.)	Upto the Limit Per policy Year (Rs.)
5,00,000	1,00,000
7,50,000	1,00,000
10,00,000	1,00,000
15,00,000	1,00,000

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20,00,000	2,00,000
25,00,000	2,00,000
1,00,00,000	2,00,000
2,00,00,000	2,00,000

Special Exclusions:

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

1. Pre and Post treatment expenses.
2. Sub-fertility services that are deemed to be unproven, experimental or investigational.
3. Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.
4. Reversal of voluntary sterilization.
5. Treatment undergone for second or subsequent pregnancies except where the child from the first delivery / previous deliveries is/are not alive at the time of treatment.
6. Payment for services rendered to a surrogate.
7. Costs associated with cryopreservation and storage of sperm, eggs and embryos.
8. Selective termination of an embryo.
9. Services done at unrecognized centre.
10. Surgery / procedures that enhances fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery / procedures.

- 25. Enhanced Multiplier 3X or 10X :** If the Insured Person has opted for this optional cover, the Company will provide an additional cumulative Bonus of 100% of sum insured, irrespective of any claims in previous policy year maximum upto 3 times of sum insured or upto 10 times of sum insured (based on the plan opted), provided that the Policy has been continuously renewed with the Company.

Note:

- i. The bonus will be calculated on the expiring Sum Insured.
- ii. In case, the Insured Person opts out of this cover at the time of renewal, all the bonus accumulated under Enhanced Multiplier (3X or 10X) will be reduced to zero.
- iii. The customer can opt either Enhanced Multiplier (3X or 10X).

- 26. Premium Promise:** The insured premium is locked at entry when a policy is purchased. The same premium will be charged for subsequent renewals until a claim is paid or completion of age 55 years whichever is earlier.

Conditions

- This benefit will be available for those purchased this policy up to the entry age of 50 years.
- No additional premium will be charged in the middle of the tenure in case of claims. At the time of renewal (in case of a claim), the premium will be charged as per the current age of the insured at renewal.
- In case of multi tenure policies, the premium for the entire tenure will be charged as per the entry age.
- **Floater Plan:** During the renewal of this policy, If the insured adds a member to the floater plan, then the premium will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.



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- **Individual Plan:** During the renewal of this policy, If the insured adds a member to an individual plan and convert it into a Floater plan, then the premium will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.
- If the eldest member is no longer part of the Floater plan, then the Floater premium will be calculated as per the original entry age of the eldest member amongst the remaining members during the renewal of this policy and lock the premium at that age, till a claim is paid.
- If a floater plan, splits into multiple policies, then the Company will carry forward the locked age at which the floater policies were taken by individuals in the policies carried forward, till a claim is paid.
- Once insured crosses the age of 55 years irrespective of claim, premium will be charged as per Insured's current age and the Company will continue to charge as per the age at renewal.
- Claims under Personal Accident and Hospital Cash optional covers will not have an impact on Premium Promise.
- In the event of price change due to product revision, the premium will be charged based on the original age slab of the revised product.

Note: This cover is available as an inbuilt under Prime Plan

27. Wealth for Health: If the insured opted this cover and there is no claim for a block of 5 consecutive policy years under this policy, then the Company shall refund the first policy year's base cover premium into his/her digital wallet, provided the policy is renewed continuously.
The amount in the wallet can be redeemed for outpatient consultation, pharmacy, diagnostics, non-payables and for payment of renewal premium.

28. Consumables: If there is an admissible claim under inpatient / day care under this policy, then Items as per Lists enclosed (Annexure-I) will become payable upto sum insured. Further, the Company also covers Admission / Registration charges, Record charges and Insurance Processing charges in addition to the List of items given in Annexure -I.

Note: This cover is available as an inbuilt under Prime Plan.

29. High End Diagnostics: The Company will indemnify the reasonable charges incurred for the following diagnostic tests only on OPD basis during the policy period, if required as part of a medically necessary treatment subject to the limit of Rs.25,000/- per policy year.

1. Brain Perfusion imaging
2. Computed Tomography (CT) guided Biopsy
3. Computed Tomography (CT) Urography
4. Digital Subtraction Angiography (DSA)
5. Liver Biopsy
6. Magnetic Resonance Cholangiography Scan
7. Positron Emission Tomography– Computed Tomography (PET/CT)
8. Positron emission tomography – Magnetic Resonance Imaging (PET/ MRI)
9. Renogram
10. Magnetic Resonance Imaging with Magnetic Resonance Venography and Magnetic Resonance Angiography

Automatic Restoration shall not be applicable for High End Diagnostics cover.

Note: Claim payment only under this cover does not form part of the Base Sum Insured and will not impact Bonus.



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30. Air Ambulance: Air ambulance expenses are payable subject to an admissible hospitalisation claim, the Insured Person(s) is/are eligible for reimbursement of expenses incurred towards the cost of air ambulance service up to 10% of Sum insured, provided that

- It is for emergency care of the insured person which requires immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot be provided.
- Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency
- It is prescribed by a Medical Practitioner and is Medically Necessary;
- The insured person is in India and the treatment is in India only
- Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s.

Note : The Company will not cover the following expenses:

- Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital
- Any transportation or Air Ambulance expenses incurred outside the geographical territory of India.

31. Assisted Living: Any diseases / condition resulting in loss of independent living and requiring trained skilful assistance covered up to the limits mentioned in the table given below,

Sum Insured (Rs.)	Individual per policy year (Rs.)	Floater per policy year (Rs.)
5,00,000	10,000	15,000
7,50,000	15,000	25,000
10,00,000	20,000	30,000
15,00,000	25,000	40,000
20,00,000	30,000	50,000
25,00,000	35,000	60,000
1,00,00,000	50,000	75,000
2,00,00,000	75,000	1,00,000

The Indication and necessity of this cover will be evaluated by our medical practitioner and this benefit is provided if the following conditions are satisfied: -

- There must be an admissible claim under the policy for the condition, for which assisted living benefit is sought for.
- The Medical condition should have resulted in loss of independent living requiring skilful assistance for performing daily tasks.
- The Justification and need for Assisted living shall be certified by the treating Medical Practitioner.

32. Nursing at Home: The company will pay the expenses incurred, up to the limits mentioned in the table below post Hospitalization for the medical services of a Qualified Nurse at the insured residence, provided that the engagement of such Qualified Nurse is certified as necessary by a Medical Practitioner.

Sum Insured (Rs.)	Individual per policy year (Rs.)	Floater per policy year (Rs.)
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5,00,000	3,000	5,000
7,50,000	5,000	7,500
10,00,000	7,500	10,000
15,00,000	10,000	12,500
20,00,000	12,500	15,000
25,00,000	15,000	20,000
1,00,00,000	20,000	25,000
2,00,00,000	25,000	30,000

Note: Claim under this optional cover will be payable only if there is an admissible claim under the policy.

- 33. Durable Medical Equipment/CAPD:** If the insured person has opted this cover, then the expenses incurred towards renting or purchase of any of the listed medical devices / CAPD up to 10% of sum insured or Rs. 1 Lakh whichever is less will be payable during the policy year, if the same has been prescribed by the treating Medical Practitioner post hospitalisation for the same condition for which hospitalisation claim was admissible.

List of Durable Medical Equipment Covered under this optional Cover:

- CPAP/ BIPAP Machine
- Ventilator
- Wheelchair
- Prosthetic device
- Suction Machine
- Commode Chairs
- Infusion pump
- Continuous Passive motion devices in case of Knee Replacement
- Oxygen concentrator

Note: The insured should claim either under Listed Durable Medical Equipment or CAPD (Continuous Ambulatory Peritoneal Dialysis).

- 34. Compassionate Travel:** In the event of the insured person being hospitalized for a life-threatening emergency at a place away from his usual place of residence as recorded in the policy, the Company will reimburse the transportation expenses by air and train incurred upto Rs.25,000/- for one immediate family member and for travel towards the place where hospital is located.

Note :

- This benefit is payable if the claim for hospitalisation is admissible.
- Payment under this benefit does not form part of the sum insured but will impact the Bonus.

- 35. Hospital Cash:** On payment of additional premium, Subject to an admissible Hospitalisation claim, Cash Benefit of Rs.1,000/- for each completed day of Hospitalisation for a maximum of 10 days per policy year is payable.

- This benefit is subject to an excess of first 24 hours of Hospitalisation for every claim.
- Claims under this optional cover will not reduce the Sum Insured.



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- c) Claims under this optional cover are valid only if the claim is admissible either under this policy or any other insurance policy.
- d) Claims only under this optional cover, without claims on the base cover will not affect the Premium Promise, Bonus/ No Claim discount/Enhanced Multiplier 3X or 10X.

36. Outpatient Benefit: The Company will indemnify reasonable and customary expenses incurred for the below listed coverage during the policy year up to the limits mentioned in the policy schedule. The cover is applicable for each policy year if this cover is opted for more than one year.

Table of benefits A: Individual - Limit Per Policy Year (Rs.)

Benefits	Silver	Gold	Platinum	Diamond
Section A. Tele-consultation	Unlimited - GP + Specialists	Unlimited - GP + Specialists	Unlimited - GP + Specialists	Unlimited - GP + Specialists
Section B. i. In-clinic Doctor Consultations ii. Prescribed Pathology & Radiology	Rs.5,000/-	Rs.7,500/-	Rs.10,000/-	Rs.10,000/-
Section C - Prescribed Pharmacy	Not Covered	Not Covered	Not Covered	Rs.2,000/-

Table of benefits B: Floater - Limit Per Policy Year (Rs.)

Benefits	Silver	Gold	Platinum	Diamond
Section A. Tele-consultation	Unlimited - GP + Specialists	Unlimited - GP + Specialists	Unlimited - GP + Specialists	Unlimited - GP + Specialists
Section B. i. In-clinic Doctor Consultations ii. Prescribed Pathology & Radiology	Rs.7,500/-	Rs.10,000/-	Rs.13,000/-	Rs.13,000/-
Section C. Prescribed Pharmacy	Not Covered	Not Covered	Not Covered	Rs.3,000/-

In consideration of the premium paid and subject to the terms, conditions, exclusions, and definitions contained herein, the Company agrees as follows:

Section A. Tele Consultation Cover (applicable under all plans)

Coverage:

If at any time during the policy period, insured members suffers from any Illness or Injury, he / she can avail treatment from Medical Practitioner/ Physician/Doctor listed on the digital platform via video, audio, or chat channel, where the Insured/ Insured Member will be able to select the speciality of doctor and will be able to consult the Doctor available at the time of call. This cover shall be in compliance with the Telemedicine Practice Guidelines dated 25th of March 2020, Medical Council of India and as amended from time to time. This cover will be available only on cashless basis.

Exclusions for Tele Consultation Cover



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1. Tele consultation outside the digital platform of Insurer or concerned Service Provider's application/website video/audio/chat consultation, In-clinic/physical consultation is not covered under this section.
2. Teleconsultation benefit is not transferrable to any other person/member.
3. If the benefit is not availed during the policy period, the benefit cannot be carried forward to the subsequent Policy period.
4. Reimbursement of expenses incurred for teleconsultation benefit is excluded.
5. 30-day Waiting Period (Code-Excl03)
 - a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
 - b) This exclusion shall not, however apply if the Insured Member has continuous coverage for more than twelve months.
 - c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Section B. i. In-Clinic Consultation Cover (applicable for all plans)

Coverage: If at any time during the policy period, insured members suffers from any Illness or Injury, he / she can avail treatment from Medical Practitioner/ Physician/Doctor in person from network centres will be payable up to the limit as specified in the Table of Benefits mentioned above in a policy year. This service can be availed through cashless or reimbursement mode.

In-clinic doctor consultations: Expenses incurred towards Outpatient consultation(s) from a General Medical Practitioner and/or a Specialist Medical Practitioner and/or AYUSH treatment are payable up to the limits mentioned in the Table of Benefits mentioned above in a policy year

- i. **Dental Treatment Expenses:** Applicable only for the initial consultation. Costs for dental check-ups related to infections, acute incidents, or accidents as an outpatient at our any networked facility in India are covered.
- ii. **Ophthalmic Treatment Expenses:** Applicable only for the initial consultation. Costs for eye check-ups related to infections, acute incidents, or accidents as an outpatient at our any networked facility in India are covered.
- iii. **AYUSH (Non-Allopathic Treatment Expenses):** Outpatient consultation expense for Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy systems of medicine at institutes recognized by the Government of India or accredited by the Quality Council of India/National Accreditation Board on Health.

Note: Please refer **Table 1** for Coverage under specialisations (inclusions & exclusions)

Specific exclusions applicable for In-Clinic Consultation:

1. Other expenses of investigations, medicines, surgical or non-surgical procedures or any medical, non-medical items are not covered under this cover.
2. Vaccination
3. If the benefits are not availed during the Policy period, the benefit cannot be carried forward to the subsequent Policy period.
4. Claims pertaining to Ante Natal/Maternity (Pre and Post) consultations and investigations
5. Dietician/nutritionist consultations/sessions will not be covered under this cover/benefit.

Section B. ii. Prescribed Pathology & Radiology



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Coverage: If at any time during the policy period, insured members suffers from any Illness or Injury, he / she can avail the cashless service for investigations prescribed by a registered Medical Practitioner for pathology or radiology from prescribed network centres of the Service Provider up to the limit as specified in the Table of Benefits mentioned above in a policy year. This service can be availed through cashless or reimbursement mode.

If the required Pathology or radiology lab is not available in the prescribed network of the Service Provider, the Insured/ Insured Member/s can claim the expenses by way of reimbursement process.

Note:

1. **Section B (i) In-Clinic Consultation Cover and Prescribed Pathology & Radiology** limit will be applicable for both the covers.
2. Prescribed Pathology & Radiology test must be done within 15 days of the doctor prescription

Specific exclusions applicable for Prescribed Pathology & Radiology Cover

1. If the Investigation cover is not availed in the respective Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
2. Pathology and Radiology test claims related to Ante Natal/Maternity (Pre and Post).
3. Any preventive health tests
4. Lab or Radiology tests prescribed by AYUSH (Non-Allopathic) Doctors (Non-MBBS) Invasive tests as given below.

List of Invasive Tests (excluded from Prescribed Pathology & Radiology Cover)

S. No	Invasive Test Names	S. No	Invasive Test Names
1	Bronchoscopy guided biopsy	20	Hysteroscopy biopsy
2	Bronchoscopy	21	Incisional biopsy of breast
3	Colonoscopy Biopsy	22	Lumbar Puncture
4	Colonoscopy	23	Lymph node biopsy
5	Core biopsy of Breast	24	MRI Fusion Biopsy
6	Coronary Angiography	25	MRI guided breast biopsy
7	CSF biopsy	26	Office Hysteroscopy
8	CSF liquid biopsy	27	Oral biopsy
9	CT Angiography	28	Pleural Biopsy
10	CT guided biopsy of growth- Abdomen/ Chest/ Pelvic/ Paraspinal region	29	Pleural fluid cytology
11	CT guided bone biopsy	30	Pleuroscopic Biopsy
12	CT guided lung biopsy	31	Prostate needle biopsy
13	Cystoscopy	32	Tru-cut biopsy breast
14	Cystoscopy with bladder biopsy	33	Upper GI Endoscopic Biopsy
15	Diagnostic Laparoscopy	34	Upper GI Endoscopy
16	Endometrial Biopsy	35	Urethroscopy
17	ENT Endoscopic biopsy	36	USG guided biopsy of abdominal organs
18	Excision biopsy of any lump	37	USG guided biopsy of pelvic organs
19	Fine Needle Aspiration Cytology- FNAC	38	USG guided kidney biopsy



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Section C. Prescribed Pharmacy: (Applicable only for Diamond Plan).**Coverage:**

If at any time during the policy period, Insured/Insured member suffers from any illness/injury, he or she can avail medicines prescribed by medical practitioner from network providers up to the limits specified in the table of benefits mentioned above. This cover will be available only on cashless basis.

Note –

- i. Minimum order value of Rs.250/- is applicable.
- ii. Expenses towards the pharmacy shall be payable up to the limits mentioned, within 15 days from the date of doctor's prescription.
- iii. In case of chronic diseases – Coverage under this benefit is payable for maximum period of 60 days from the date of doctor's prescription.

Exclusions for Doctor Prescribed Pharmacy Cover

1. Claims without prescription.
2. Over the Counter medicines/products purchased without prescription, products such as but not limited to Cereals, Horlicks, Threptic, vitamins, supplements, medical devices etc.
3. Reimbursement for Over the counter/non-Prescribed medicine/products/drugs/Consumables is excluded in this benefit. Health supplements, Nutraceuticals, foods for special dietary use, foods for special medical purpose, foods with added probiotics and/or foods with added prebiotics, vaccinations, medical devices, vitamins, tonics, or other related products.
4. The expenses incurred on purchase of AYUSH medicines.
5. Medications prescribed by AYUSH (Non-Allopathic) doctors, or any AYUSH (Non-Allopathic) medications.

Specific Conditions (Applicable for all Plans):

- i. Payment of any claim under this coverage shall not be construed as a waiver of Company's right to repudiate any claim on grounds of non disclosure of material fact or pre-existing disease, for hospitalization expenses under hospitalization provisions of the policy contract.
- ii. For Long Term Policies if the coverage is opted, the benefits given in the coverage table A and B shall be applicable for each Policy period.
- iii. If a customer cancels a scheduled in-clinic doctor appointment with Prescribed Pathology & Radiology booking service less than one hour prior to the appointment time, or fails to attend, the amount credited to their wallet for that service will not be refunded or restored.
- iv. **Co-payment:** The Insured shall bear 20% of co-payment for claims made on reimbursement basis, only in absence of Cashless Network/Emergency clinics / hospitals / diagnostic labs. Co-payment will not apply on cashless service. Co-payment of 20% shall be applicable for all pharmacy reimbursement claims under this OPD plan.

37. Accidental Death and Permanent Total Disablement: On payment of additional premium, at any time during the Period of Insurance, if the Insured Person shall sustain any bodily injury resulting solely and directly from Accident caused by external, violent and visible means then the Company will pay as under:

1. **Accidental Death of Insured Person:** If following an Accident that causes death of the Insured Person within 12 Calendar months from the date of Accident, then the Company will pay an amount as compensation the Sum Insured mentioned in the Schedule
2. **Permanent Total Disablement of the Insured Person:** If following an Accident which caused permanent impairment of the Insured's mental or physical capabilities, then the Company will pay



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the benefits as provided in the “Table of Benefits – B1”, depending upon the degree of disablement provided that:

- The disablement occurs within 12 Calendar months from the date of the Accident.
- The disablement is confirmed and claimed for, prior to the expiry of a period of 60 days since occurrence of the disablement.

Condition:

- If the Accident affects any physical function, which was already impaired prior to the accident, a deduction as per “Table – B2” will be made in respect of this prior disablement.
- In the event of Permanent Total Disablement, the Insured Person will be under obligation:
 - To have himself/herself examined by doctors appointed by the Company / and the Company will pay the costs involved thereof.
 - To authorize doctors to provide treatments or give expert opinion and any other authority to supply the company with any information that may be required. If the obligations are not met with due to whatsoever reason, the Company shall be relieved of its liability to pay.
- This optional cover is applicable for the person specifically mentioned in the Schedule.
- Where a claim has been paid during the policy period the cover under this optional cover ceases until the expiry of the policy for the insured who made a claim under this optional cover. Upon renewal the cover applies to the person specifically chosen again. However, even if the sum insured under this optional cover is exhausted by way of claim, the coverage under health will continue until expiry of the policy period.
- Any claim under health portion will not affect the Sum Insured under this optional cover.
- Where there is an admissible claim for Accidental Death during the policy period, the health cover will continue for the remaining insured persons.
- Where there is an admissible claim for Permanent Total Disability during the policy period, the health cover would continue until the expiry of the policy for all the insured persons covered including the person who has made a claim for Permanent Total Disability and renewal thereof.

Table of Benefits – B1	
Benefit	Percentage of the Basic Sum Insured
Accidental Death – Benefit 1	100%
Permanent Total Disablement – Benefit 2	100%
Total and Irrevocable loss of	
a. Sight of both eyes	100%
b. Physical separation of two entire hands	100%
c. Physical separation of two entire feet	100%
d. One entire hand and one entire foot	100%
e. Sight of one eye and loss of one hand	100%
f. Sight of one eye and loss of one entire foot	100%
g. Use of two hands	100%
h. Use of two feet	100%
i. Use of one hand and one foot	100%
j. Sight of one eye and use of one hand	100%
k. Sight of one eye and use of one foot	100%



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Table – B2			
Physical function already impaired prior to accident			Percentage Of Sum Insured Deducted
1	Loss of all toes	All	20
	Loss of Great toe	both phalanges	5
	Loss of Great toe	one phalanx	2
	Other than Great, if more than		
	One toe lost, for each toe	For each toe	1
2	Loss of hearing both ears	Both ears	75
	Loss of hearing one ear	One ear	30
3	Loss of four fingers and thumbs of One hand		40
4	Loss of four fingers		35
	Loss of thumb both phalanges	Both phalanges	25
		One phalanx	10
5	Loss of index finger three phalanges	Three phalanges	10
	Two phalanges	Two phalanges	8
	One phalanx	One phalanx	4
6	Loss of middle finger	Three phalanges	6
		Two phalanges	4
		One phalanx	2
7	Loss of ring finger	Three phalanges	5
		Two phalanges	4
		One phalanx	2
8	Loss of little finger	Three phalanges	4
		Two phalanges	3
		One phalanx	2
9	Loss of metacarpals	First or second	3
		Additional (third fourth or fifth)	2
10	Any other Permanent partial disablement		Percentage as assessed by the Medical Board or by the government doctor

1. **Geographical Scope:** This optional cover applies Worldwide.
2. Claims under this optional cover will not have an impact on Premium Promise and Bonus / No Claim Discount.

38. Health Check-up*: Expenses incurred towards cost of health check-up is payable upto the limits mentioned in the table given below:

Sum Insured (Rs.)	Individual (Upto the limits per policy year (Rs.))	Floater (Upto the limits per policy year (Rs.))
5,00,000	1,500	2,500
7,50,000	2,000	5,000



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10,00,000	2,000	5,000
15,00,000	4,000	8,000
20,00,000	5,000	10,000
25,00,000	5,000	10,000
1,00,00,000	8,000	15,000
2,00,00,000	12,000	20,000

Note :

1. Available at network hospital for every year (irrespective of claims) from first purchase of this policy.
2. Any unutilized health check-up limit cannot be carried forward to the next Policy Year. Payment under this cover will not reduce the sum insured and will not impact on Premium Promise /Bonus/No claim discount.
3. Payment of any claim under this coverage shall not be construed as a waiver of Company's right to repudiate any claim on grounds of non-disclosure of material fact or pre-existing disease, for hospitalization expenses under hospitalization provisions of the policy contract.
* **Health Check-up** means a routine physical or wellness check, is a comprehensive assessment of overall health of the insured including blood tests and other screenings. It helps to detect potential health issues early, monitor chronic conditions, and ensures that the health of the insured is on track.

39. Preferred Partner Network: If the insured person has opted this cover, the insured person shall be entitled for a discount of 15% on premium subject to the following conditions.

- a. The treatment as applicable under In-patient treatment/Day care treatment / AYUSH treatment is to be taken in a hospital listed under the “Preferred Partner Network” available in our website www.galaxyhealth.com.
- b. In case if the treatment is taken in a hospital which is outside “Preferred Partner Network” list, a co-payment of 15% will be applicable (over and above other co-payment, if any) on each and every claim (except in case of accident).

40. a. Reduction in Pre-Existing Diseases (PED) waiting period (Applicable for Neo Plan): On payment of additional premium, at the time of inception of the first policy with the Company, the Insured Person has the option to opt for reduction of waiting period in respect of Pre-Existing Diseases from 36 months to 12 months or 24 months. This optional cover cannot be opted during mid-term of the policy/at the time of renewal/portability.

b. Reduction in Pre-Existing Diseases (PED) waiting period (Applicable for Prime Plan): On payment of additional premium, at the time of inception of the first policy with the Company, the Insured Person has the option to opt for reduction of waiting period in respect of Pre-Existing Diseases from 24 months to 12 months. This optional cover cannot be opted during mid-term of the policy/at the time of renewal/portability.

41. Reduction in Specific Disease Waiting Period: On payment of additional premium, at the time of inception of the first policy with the Company, the Insured Person has the option to opt for reduction of waiting period in respect of Specific Diseases waiting period from 24 months to 12 months. This optional cover cannot be opted during mid-term of the policy/at the time of renewal/portability.

42. Room Rent Modification: The insured person has the option to modify the room type category to Single Private A/c room or Shared accommodation or General ward and can avail discount on premium.



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If the Insured Person is admitted in a room category that is higher than the one that is opted in this policy, then the Insured Person shall bear a ratable proportion of the Associated medical expenses in the proportion of the difference between room rent of the entitled room category to the room rent actually occupied.

Note: Associated Medical expenses which vary based on the room occupied by the insured person will be considered in proportion to the room rent stated in the policy schedule or actuals whichever is less. Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room rent.

- 43. Voluntary Aggregate Deductible:** The insured person has option to choose Voluntary Aggregate Deductible and can avail discount on premium. In case Voluntary Deductible is opted as mentioned in the Policy Schedule, the Insured Person will be liable to bear the specified Deductible amount.

Note:

- Voluntary Deductible will apply on aggregate basis for all hospitalisation expenses during the policy year which fall under basic cover.
- Voluntary Aggregate Deductible will not be available in case voluntary co-payment has been opted.
- Voluntary Deductible if chosen by the Insured Person(s) shall be applicable to all Base Covers under the Policy except Gala Fit-Pro Active Care (Engaging Wellness Program).

- 44. Voluntary Co-payment:** The insured person has option to choose Voluntary Co-payment and can avail discount on premium. In case Voluntary Co-payment is opted as mentioned in the Policy Schedule, the Insured Person will be liable to bear the specified Co-payment percentage (over and above other co-pay, if any) of admissible claim amount of each and every claim amount.

- Voluntary Co-payment if chosen by the Insured Person(s) shall be applicable on Base Covers except Gala Fit-Pro Active Care (Engaging Wellness Program).
- Voluntary Co-payment will not be available in case Voluntary Aggregate Deductible has been opted.

- 45. Sub-limits on the Specific Diseases/Treatments:** If the insured chooses this optional cover, then there shall be sub-limits on listed treatments and procedures upto the amount specified in the table given below. The Company' liability shall be limited to such extent.

Listed Treatments and Procedures are as follows.

- Neurological Diseases
- Heart Diseases
- Auto Immune Diseases
- Cancer (Including Chemotherapy / Radiotherapy)
- Medical Renal Diseases (Including Dialysis)
- Treatment of Breakage of Long Bones

Sum Insured (Rs.)	Individual Policy (Rs.) (Limits per Policy year)	Floater Policy (Rs.) (Limits per Policy year)
5,00,000	3,00,000	3,50,000
7,50,000	4,00,000	6,00,000
10,00,000	4,50,000	7,00,000
15,00,000	5,00,000	8,00,000



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20,00,000	5,50,000	9,00,000
25,00,000	6,00,000	10,00,000
1,00,00,000	7,50,000	12,50,000
2,00,00,000	10,00,000	15,00,000

46. Advance Access: On payment of additional premium, for single premium payment of 5-year policy term, the sum insured of the subsequent policy year shall be made available for utilisation of admissible claim in the current policy year.

Note:

- The cover is applicable for admissible claim under base cover only.
- This benefit would however be subject to all applicable limits, copayments, deductibles as per the policy.
- This benefit can be utilised once during the policy term.
- Upon utilisation of this optional cover, an unutilised sum insured, shall be carried forward to the subsequent policy year.

Illustration:

Sum Insured per policy year – Rs.10 Lakhs

Policy term – 5 years

Policy Year	Sum Insured (Rs.)	Admissible claim (Rs.)	Claims Payable
Year 1	10 Lakhs		
Year 2	10 Lakhs	12 Lakhs	Rs. 12 Lakhs (Sum Insured of Rs. 10 Lakhs from Year 2 and Rs. 2 Lakhs from Year 3 sum insured)
Year 3	8 Lakhs		As Rs.2 lakhs sum Insured of Year 3 was utilized in the Year 2
Year 4	10 Lakhs		
Year 5	10 Lakhs		

The order of utilization is as follows;

- Sum Insured
- Bonus
- Enhanced Multiplier
- Automatic Restoration
- Advance Access

Illustration for Utilisation of Benefits:

Illustration for Utilisation of Benefits
Scenario - 1

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Policy term	5 years
Sum Insured	5 Lakhs
Bonus	0
Enhanced Multiplier (3X opted)	0
Advance Access	5 lakhs
Total cover available	10 lakhs
Automatic Restore trigger on subsequent claim	

Scenario 1 - Fresh

Claim 1			
Year 1	Claim amount	7 Lakhs	
	Claim paid	7 lakhs	(5 Lakhs from Sum Insured and 2 lakhs from Advance access). Automatic Restoration of sum insured will trigger from subsequent claims
	Available Balance sum insured for Year 2	3 lakhs	Advance access Rs. 3 lakhs only is available as sum insured for Year 2.
	Claim 2		
	Available Sum Insured for current year	5 lakhs	Restored sum insured of 5 lakhs
	Claim amount	4 Lakhs	
	Claim paid	4 lakhs	4 lakhs from restored sum insured
	Available Balance sum insured	5 lakhs	(5 lakhs from restored sum insured as the restoration is for unlimited number of times)
Claim 1			
Year 2	Sum Insured available for second year	9.25 lakhs	(3 Lakhs from Available sum insured of second year as 2 lakhs has been utilised under Advance access cover in the Year 1) +1.25 lakhs from Bonus + Rs. 5 lakhs Enhanced Multiplier
	Claim amount	10 Lakhs	
	Claim paid	9.25 lakhs	(9.25 Lakhs from available Sum Insured). (Autorestoration of sum insured will trigger from subsequent claims)
	Available Balance sum insured	5 lakhs	100% of Restored sum insured trigger for subsequent claim.Hence, 5 lakhs is available as sum insured

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Claim 2		
Available Sum Insured	5 lakhs	Restored sum insured of 5 lakhs
Claim amount	5 Lakhs	
Claim paid	5 lakhs	(paid from 5 lakhs of restored sum insured)
Available Balance sum insured	5 lakhs	(5 lakhs from restored sum insured as the restoration is for unlimited number of times)

Scenario – 2 (Renewal policy of Scenario – 1)

Policy term	5 years	
Sum Insured	5 Lakhs	
Bonus	5 lakhs	(from fresh policy Scenario 1- Assuming there is claim in 1st and 2nd year. From 3rd year to 5th year bonus is 5 lakhs maintained as there is no claim)
Enhanced Multiplier	10 Lakhs	Utilised Rs.5 lakhs enhanced multiplier in the year 2 of previous policy Period
Advance Access	5 lakhs	
Total cover available	25 lakhs	

Scenario 2 (Renewal)			
Claim 1			
Year 1	Claim amount	10 Lakhs	
	Claim paid	10 lakhs	(5 Lakhs from Sum Insured and 5 lakhs from Bonus)
	Available Balance sum insured	15 lakhs	10 lakhs from Enhanced Multiplier and 5 lakhs from Advance access
	Claim 2		
	Available Sum Insured	20 lakhs	10 lakhs from Enhanced Multiplier and 5 lakhs from Advance access and Automatic restoration of 100% Rs.5 lakhs also available
	Claim amount	10 Lakhs	

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	Claim paid	10 lakhs	10 lakhs from Enhanced Multiplier
	Available Balance sum insured	10 lakhs	5 lakhs from restored sum insured as the restoration is for unlimited number of times and 5 lakhs from Advance access
Year 2	Claim 1		
	Sum insured	16.25 lakhs	5 lakhs sum insured + 1.25 lakhs Bonus + 5 lakhs Enhanced Multiplier + 5 lakhs advance access
	Claim amount	13 Lakhs	
	Claim paid	13 lakhs	5 lakhs sum insured + 1.25 lakhs Bonus + 5 lakhs Enhanced Multiplier utilised +1.75 advance access
	Available Balance sum insured	8.25 lakhs	100% of Restored sum insured trigger for subsequent claim.Hence, 5 lakhs restored sum insured + 3.25 Advance access
	Claim 2		
	Available Sum Insured	8.25 lakhs	Restored sum insured of 5 lakhs
	Claim amount	8 Lakhs	
	Claim paid	5 lakhs	(paid from 5 lakhs of restored sum insured)(as advance access can be utilised only once during the policy term)
	Available Balance sum insured	5 lakhs	(5 lakhs from restored sum insured)
Year 3	Claim 1		
	Available Sum Insured	9.50 lakhs	Sum Insured of 3.25 lakhs(advance access utilised in year 2) + 1.25 lakhs bonus +5 lakhs Enhanced Multiplier
	Claim amount	10 Lakhs	
	Claim paid	9.50 lakhs	Sum Insured of 3.25 lakhs + 1.25 lakhs bonus +5 lakhs Enhanced Multiplier
	Available Balance sum insured	5 lakhs	(5 lakhs from restored sum insured as the restoration is for unlimited number of times)
	Claim 2		
	Available Sum Insured	5 lakhs	Restored sum insured of 5 lakhs
	Claim amount	8 lakhs	
	Claim paid	5 lakhs	5 lakhs restored sum insured

**Prospectus**

	Available Balance sum insured	5 lakhs	Restored sum insured of 5 lakhs
Year 4	Available Sum Insured	11.25 lakhs	Sum insured of 5 lakhs + 1.25 lakhs bonus + 5 lakhs Enhanced Multiplier

IV. EXCLUSIONS: (Applicable for Neo Plan and Prime Plan)**A. Standard Exclusions****1. Pre-Existing Diseases - Code- Excl 01:**

A. Applicable for Neo Plan: 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.

Applicable for Prime Plan: Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with 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. **Applicable for Neo Plan:** 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.

Applicable for Prime Plan: Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Specified disease/procedure 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 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

1. Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, Diseases related to Thyroid, Benign diseases of the breast.

2. Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal Tunnel Syndrome, Trigger Finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology.



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3. All treatments (Conservative, Operative treatment) and all types of intervention for Diseases related to Tendon, Ligament, Fascia, Bones and Joint Including Arthroscopy and Arthroplasty / Joint Replacement [other than caused by accident].
4. All types of treatment for Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system, Prolapse of Intervertebral Disc (other than caused by accident).
5. All treatments (conservative, interventional, laparoscopic and open) related to Hepato-pancreato-biliary diseases including diseases of liver, Gall bladder and Pancreatic calculi. All types of management for Kidney calculi and Genitourinary tract calculi.
6. All types of Hernia.
7. Desmoid Tumour, Umbilical Granuloma, Umbilical Sinus, Umbilical Fistula.
8. All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Cervix, Uterus, Fallopian tubes, Ovaries, Uterine Bleeding, Pelvic Inflammatory Diseases.
9. All Diseases of Prostate, Stricture Urethra, all Obstructive Uropathies.
10. Benign Tumours of Epididymis, Spermatocoele, Varicocele, Hydrocele.
11. Fistula, Fissure in Ano, Haemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence
12. Varicose veins and Varicose ulcers.
13. All types of transplant and related surgeries.
14. Congenital Internal disease / defect - [except for Newborn Coverage (14)].

Note: Waiting period for the following benefits are as follows

- a. **Delivery Expenses (Optional Cover):** Both self and spouse are covered under this policy for a period of 2 years continuously without break either under Individual or floater sum insured (or) if insured women alone covered under this policy for 3 years continuously without break.
- b. **Assisted Reproduction Treatment (Optional Cover):** A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person
- c. **Newborn Baby Cover:** If insured women is covered under this policy for a continuous period of 12 months without break or if the insured women submit 12th and 20th week of ante natal scan at the time of pregnancy.
- d. **Organ Transplantation Expenses:** A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person.
- e. **Organ Donor Expenses:** A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person.
- f. **Bariatric Surgery:** A waiting period of 24 months from the date of first inception of this policy with the Company.
- g. **Hospital Cash (Optional Cover):** The above-mentioned specified disease/procedure waiting period – **Code Excl 02** is applicable.

3. 30-day waiting period – Code Excl 03

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

4. Investigation & Evaluation – Code Excl 04

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- 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:
 - a. 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
 - b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
- 6. Obesity/ Weight Control (except to the extent covered under Coverage 10)– Code Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions
 - i. Surgery to be conducted is upon the advice of the Doctor
 - ii. The surgery/Procedure conducted should be supported by clinical protocols
 - iii. The member must be 18 years of age or older and
 - iv. Body Mass Index (BMI)
 1. greater than or equal to 40 or
 2. 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:
 - a. Obesity-related cardiomyopathy
 - b. Coronary heart disease
 - c. Severe Sleep Apnea
 - d. Uncontrolled Type2 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**



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13. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons – **Code 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 eyesight due to refractive error less than 7.5 diopters.
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 (Except to the extent covered under Coverage 24) – Code Excl 17:** Expenses related to sterility and infertility. This includes.
 - a. Any type of contraception, sterilization
 - b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - c. Gestational Surrogacy
 - d. Reversal of sterilization
18. **Maternity – Code Excl 18 (Except to the extent covered under Coverage 23)**
 - i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy.
 - ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

B. Specific Exclusions

19. Circumcision (unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident), Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA -**Code- Excl 19**
20. Congenital External Condition / Defects / Anomalies -**Code- Excl 20**
21. Convalescence, general debility, run-down condition, Nutritional deficiency states -**Code- Excl 21**
22. Intentional self -injury-**Code- Excl 22**
23. Injury/disease caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) -**Code- Excl 24**
24. Injury or disease caused by or contributed to by nuclear weapons/ materials -**Code- Excl 25**
25. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion -**Code- Excl 26.**
26. Unconventional, Untested, Experimental therapies -**Code- Excl 27**
27. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy -**Code- Excl 28**
28. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalisation warranted. - **Code- Excl 29**



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29. All treatment/Interventions for Erectile Dysfunctions - **Code- Excl 30**
30. Inoculation or Vaccination (except for post-bite treatment and for medical treatment for therapeutic reasons) -**Code- Excl 31**
31. Cost of spectacles and contact lens, hearing aids, Cochlear implants and procedures, walkers and crutches, wheel chairs, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis, infusion pump and such other similar aids. -**Code- Excl 35 (Except to the extent covered under Optional cover “Durable Medical Equipment/CAPD”)**
32. Any hospitalisation which are not medically necessary / does not warrant hospitalisation-**Code-Excl 36**
33. Other Excluded Expenses as detailed in the website www.galaxyhealth.com (**Except to the extent covered under Coverage 28**) - **Code Excl 37**
34. 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**
35. Expenses for venereal disease or any sexually transmitted disease except HIV/AIDS.
36. Dental Treatment, Diagnostics, Dental Procedures or Surgery of any kind unless requiring Hospitalisation as a result of accidental Injury.

C. Specific Exclusions – Accidental Death and Permanent Total Disablement (Optional cover 37)

1. Any claim relating to events occurring before the commencement of the cover or otherwise outside the Period of Insurance.
2. Any injuries/conditions which are Pre-existing conditions.
3. Any claim arising out of Accidents that the Insured Person has caused.
 - i. intentionally or
 - ii. by committing a crime / involved in it or
 - iii. as a result of / in a state of drunkenness or addiction (drugs, alcohol)
4. Insured Person engaging in Air Travel unless he/she flies as a fare-paying passenger on an aircraft properly licensed to carry passengers. For the purpose of this exclusion Air Travel means being in or on or boarding an aircraft for the purpose of flying therein or alighting there from.
5. Accidents that are results of war and warlike occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, seizure capture arrest restraints detentions of all kings princes and people of whatever nation, condition or quality whatsoever.
6. Participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.
7. Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from.
 - a. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self sustaining process of nuclear fission) of nuclear fuel
 - b. Nuclear weapons material

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- c. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof
 - d. Nuclear, chemical and biological terrorism
8. Any claim arising out of sporting activities in so far as they involve the training or participation in competitions of professional or semi-professional sports persons.
 9. Participation in Hazardous Sport / Hazardous Activities.
 10. Persons who are physically challenge unless specifically agreed and endorsed in the policy.
 11. Any loss arising out of the Insured Person's actual or attempted commission of or wilful participation in an illegal act or any violation or attempted violation of the law.
 12. Any payment in case of more than one claim under the policy during the period of insurance by which the maximum liability of the Company in that period would exceed the amount specified in the Schedule.
 13. Any other claim after a claim has been admitted by the Company and becomes payable for Death and Permanent Total Disablement as mentioned in the table.
 14. Any claim arising out of an accident related to pregnancy or childbirth, infirmity, whether directly or indirectly.
 15. Any claim for Death or Permanent Total Disablement of the Insured Person from self-endangerment unless in self-defence or to save human life.

❖ **CONDITIONS: (Applicable for Neo Plan and Prime Plan)****Standard Conditions**

- ❖ **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 policy holder.

❖ **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



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- 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 or refer to the list of Networked Hospitals provided with the policy document. 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

- E. **For Accidental Death Claims (Optional cover 37):**

- i. Claim Intimation
- ii. Claim Form duly filled and signed
- iii. Death Certificate
- iv. Death Summary
- v. Post-mortem Certificate, if conducted
- vi. First Information Report (FIR) / Spot Panchanama / Inquest Panchanama (wherever applicable)
- vii. Police Investigation report (wherever applicable)
- viii. Viscera Sample Report (wherever applicable)
- ix. Forensic Science Laboratory report (wherever applicable)
- x. Legal Heir Certificate (in case nomination has not been filled by deceased)



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xi. Succession Certificate (wherever applicable)

F. For Permanent Total Disablement Claims:

- i. Claim Intimation
- ii. Claim Form duly filled and signed
- iii. Police Investigation report (wherever applicable)
- iv. Photograph of the Insured with reflecting disablement
- v. Medical Certificate from treating doctor
- vi. Investigation reports
- vii. First Information Report (FIR)/Spot Panchanama/ Inquest Panchanama (wherever applicable)
- viii. Certificate from Government doctor confirming the disability
- ix. Leave certificate from the employer
- x. Treatment Papers.

G. For Outpatient Benefit (Optional Cover 36):

- **Utilization Mode:** The insured can avail the above service in following below methods,
- i. **Cashless through Online Booking:** - Teleconsultation, In-clinic doctor consultations, undergoing Prescribed Pathology and Radiology and buying Prescribed pharmacy.
 - ii. **Reimbursement:** - In-clinic doctor consultations, undergoing tests through Prescribed Pathology and Radiology and buying medicine through Prescribed pharmacy. The insured should send the documents to the company within 15 days from the date of utilisation of the benefits

Utilization Mode	Cashless & Online	Cashless + Reimbursement	
Benefits	Tele-consultation	i. In-clinic Doctor Consultations ii. Prescribed Pathology & Radiology	Prescribed Pharmacy

➤ **Utilisation terms: -**

- i. All the claims must be raised on Galaxy App only.
- ii. Allopathic doctors (MBBS/MD/MS doctor with a valid registration number) can only treat patients within their own field. Similarly, AYUSH (Non-Allopathic) doctors can only treat patients within their own field

Claim Process/Service Delivery Process Specific to this cover (Any change in the process would reflect on the app)

A. Tele-Consultation Cover Service Delivery Process:

I. Digital platform of Service Provider App / Service Provider Website

- a) Start by downloading the Galaxy Wellness app.
- b) Sign-up using the registered mobile number.
- c) Add policy details in the “Manage policy” section.
- d) Under my “Active Plans”, select the purchased product/Plan.
- e) Select doctor benefit option.
- f) Select Insured Member and choose “Tele (Insta)Consultation” option
- g) Choose specialization and submit.

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- h) The doctor will join the call for instant consultation.

In-Clinic consultation Service Delivery process**I. Digital platform of Service Provider App / Service Provider Website**

- a) Start by downloading the Galaxy Wellness app.
- b) Sign-up using the registered mobile number.
- c) Add policy details in the "Manage policy" section.
- d) Under my "Active Plans", select the purchased product/Plan.
- e) Select doctor benefit option.
- f) Select Insured Member and choose In-Clinic or Hospital visit
- g) Select the doctor/clinic or hospital from available network.
- h) Enter estimated amount
- i) Enter the date of redemption and confirm.
- j) SMS with voucher link shared on the registered mobile number.
- k) Share the voucher code to avail cashless doctor consultation benefit at respective hospital.
- l) In case the estimated amount is lower than the actual consultation amount, balance amount will be reinstated in the Insured's benefit account
- m) Similarly, in case the estimated amount is higher than the actual consultation amount, voucher will be generated for balance amount and will be deducted from Insured's benefit amount.

B. Prescribed Investigations Cover – Pathology & Radiology Service Delivery Process**I. Digital platform of Service Provider App / Service Provider Website**

- a) Start by downloading the Galaxy Wellness app.
- b) Sign-up using the registered mobile number.
- c) Add policy details in the "Manage policy" section.
- d) Under my "Active Plans", select the purchased product/Plan.
- e) Select Lab benefit option.
- f) Select Insured Member and choose book prescribed tests.
- g) Select lab/hospital from available network and enter estimated amount
- h) Enter the date of redemption and confirm.
- i) SMS with voucher link shared on the registered mobile number.
- j) Share the voucher code to avail cashless Investigations Cover – Pathology & Radiology benefit at respective hospital/ lab.
- k) In case the estimated amount is lower than the actual test amount, balance amount will be reinstated in the Insured's benefit account
- l) Similarly, in case the estimated amount is higher than the actual test amount, voucher will be generated for balance amount and will be deducted from Insured's benefit amount

C. Prescribed Pharmacy Cover**I. Digital platform of Service Provider App / Service Provider Website**

- a) Start by downloading the Galaxy Wellness app.
- b) Sign-up using the registered mobile number.
- c) Add policy details in the "Manage policy" section.
- d) Under my "Active Plans", select the purchased product/Plan.
- e) Select Prescribed Pharmacy benefit option.
- f) Choose "Order medicine by uploading prescription" option.
- g) Upload prescription.
- h) The Insured Person will receive call to confirm the medicines and payment details.

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- i) The payment for the Insured Person order will be deducted from the benefit amount available in the Insured Person prescribed pharmacy benefit.
- j) Any additional amount (if any) needs to be paid by customer either on our application or via cash on delivery
- k) The Insured Person will receive the medicines at the Insured Person doorstep delivered by our pharmacy partner.
- **Documents to be submitted for reimbursement (Outpatient Benefit):**
The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.
 - a. Duly completed claim form, and
 - b. Certificate from the attending doctor regarding the diagnosis
 - c. Prescription of the treating doctor
 - d. Receipt from the treating doctor / hospital / Physiotherapist
 - e. Receipt from Pharmacy / chemists
 - f. Receipts and reports for tests done
 - g. KYC (Identity proof with Address) of the proposer, as per AML Guidelines
 - h. NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code
 - i. CKYC No. of the proposer (if available)

In case of Accidents and emergency treatments, insured person can claim for Outpatient consultation expenses, Pathology and Radiology and Pharmacy expenses in non-network hospitals also.
The bills or receipts produced should be within the policy period

H. High End Diagnostics (Optional Cover 29):

1. Certificate from treating doctor regarding the diagnosis
2. Investigation reports of the listed diagnostics
3. Cash receipts for the diagnostics done

I. Assisted Living and Nursing at home (Optional Cover 31 and 32):

1. Discharge summary
2. Certificate from treating doctor on diagnosis
3. Cash receipts for the payment to assistant / Nursing incharge

J. Durable Medical Equipment/CAPD (Optional Cover 33):

1. Certificate from treating doctor
2. Rental receipt / purchase receipts of medical devices.

K. Compassionate Travel (Optional Cover 34):

1. Certificate from treating doctor
2. Proof of travel ticket

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.

❖ Renewal of Health Insurance policy:



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- 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

❖ Withdrawal of policy

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

❖ **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.

❖ **Premium Payment in Instalments:** If the insured person has opted for Payment of Premium on an instalment basis i.e. Annually or Half Yearly or Quarterly or Monthly or two or four or twelve 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/annual/2/4/12 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. The same is applicable for both Indemnity and Benefit products.

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- 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.

❖ **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.

❖ **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 policy holder.

❖ **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.

❖ **Multiple Policies:**

a) Indemnity 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.

b) Benefit based Policies:

On occurrence of the insured event, the policyholders can claim from all Insurers under all policies.

❖ **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.

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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.

- i. 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.
- ii. In case of long term policies the refund will be given after adjusting the long term discount/instalment loading availed by the insured/ policyholder.

❖ **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.

❖ **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

❖ **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 – 600035.

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>



Prospectus

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

- ❖ **Automatic Expiry:** The insurance under this policy with respect to each relevant Insured Person policy shall expire immediately on the earlier of the following events
 - Upon the death of the Insured Person. This means that, the cover for the surviving members of the family will continue, subject to other terms of the policy.
 - Upon exhaustion of the Sum Insured, Limit of Coverage.
- ❖ **Revision of Sum Insured:** Reduction or enhancement of Sum Insured is permissible only at the time of renewal. The acceptance for enhancement and the amount of enhancement will be at the discretion of the Company and subject to **Exclusion Code Excl 01, Exclusion Code Excl 02 and Exclusion Code Excl 03.**
- ❖ **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.
- ❖ **Important Note:** IRDAI or its officials do not involve in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint.
- ❖ **Prohibition of Rebates:** Section 41 of Insurance Act 1938 (Prohibition of rebates): No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupee.

GALAXY HEALTH INSURANCE COMPANY LIMITED

Reg. Office: Prestige Polygon – 12th Top Floor (P), No. 471, Anna Salai, Nandanam, Chennai – 600035.

T: 044 – 4001 7227 | Website: www.galaxyhealth.com | CIN: U65120TN2023PLC165765 IRDAI Reg. No.:167



Prospectus

BENEFIT ILLUSTRATION

ILLUSTRATION (Excluding Tax)

Benefit Illustration in respect of policies offered on individual and family floater basis (Zone A) (without Optional covers)

Age of the Members Insured (in yrs)	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (in lakhs) (Rs.)	Premium (Rs.)	Discount, (if any)	Premium After Discount (Rs.)	Sum Insured (in lakhs) (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount*, (if any)	Premium After Discount (Rs.)	Sum Insured (in lakhs) (Rs.)
Illustration 1 (2A)										
44	9189	5	9189	Nil	9189	5	17,092	3309	13,783	5
40	7903	5	7903		7903	5				
Total Premium for all members of the family is Rs.17,092/- , when each member is covered separately. Sum insured available for each individual is Rs.5 lakhs			Total Premium for all members of the family is Rs. 17,092/- , when they are covered under a single policy. Sum insured available for each family member is Rs.5 lakhs				Total Premium when policy is opted on floater basis is Rs.13783/- , Sum insured of Rs.5 lakhs is available for the entire family (2A)			
Illustration 2 (2A+1C)										
48	11720	5	11720	Nil	11720	5	26,609	5,324	21,285	5
45	9189	5	9189		9189	5				
20	5700	5	5700		5700	5				
Total Premium for all members of the family is Rs. 26,609/- , when each member is covered separately. Sum insured available for each individual is Rs.5 lakhs			Total Premium for all members of the family is Rs. 26,609/- , when they are covered under a single policy. Sum insured available for each family member is Rs.5 lakhs				Total Premium when policy is opted on floater basis is Rs.21,285/- , Sum insured of Rs.5 lakhs is available for the entire family (2A+1C)			
Note: Premium rates specified in the above illustration are standard premium rates without considering any optional covers										