

GALAXY PRIVILEGE

UIN: GHIHLIP26044V012526

POLICY WORDING

I. Preamble

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

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

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

II Definitions

STANDARD DEFINITIONS

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

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

"Authority" means the Insurance Regulatory and Development Authority of India

"AYUSH Day Care Centre" means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without In-patient services and must comply with all the following criterion.

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

"AYUSH Hospital" is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

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

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

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

"Cashless facility" means a facility extended by the Insurer to the Insured where, the payments of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions are directly made to the network provider by the Insurer to the extent preauthorization approved.

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

"Congenital Anomaly" refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

- Internal Congenital Anomaly** - Congenital Anomaly which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly.
- External Congenital Anomaly** - Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly.

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

"Day care Centre" means any institution established for day care treatment of illness and / or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:

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

"Day Care treatment" means medical treatment, and / or surgical procedure which is:

- i. Undertaken under general or local anesthesia in a hospital / day care centre in less than 24 hours because of technological advancement, and
- ii. Which would have otherwise required a hospitalisation of more than 24 hours.

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

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

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

"Domiciliary hospitalisation" means medical treatment for an illness/Disease/Injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

"Emergency care" means management for an illness or Injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the Insured person's health.

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

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

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

"Hospital" A hospital means any institution established for in-patient care and day care treatment of illness and/ or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

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

"Hospitalisation" means admission in a hospital for a minimum period of 24 consecutive "in-patient care" hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

"Illness" means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

- a. **Acute condition** - Acute condition is a disease, illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/ Injury which leads to full recovery.
- b. **Chronic condition** - A chronic condition is defined as a disease, illness, or Injury that has one or more of the following characteristics:
 1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests.
 2. It needs ongoing or long-term control or relief of symptoms.
 3. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
 4. It continues indefinitely.
 5. It recurs or is likely to recur.

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

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

"Intensive Care Unit" means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

"ICU (Intensive Care Unit) Charges" means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

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

"Medical Practitioner" Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

"Medically Necessary Treatment" means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

- i) is required for the medical management of the illness or injury suffered by the insured.
- ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity.
- iii) must have been prescribed by a medical practitioner.
- iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

"Network Provider" means hospitals or health care providers enlisted by an Insurer, TPA or jointly by an insurer and TPA to provide medical services to an Insured by a cashless facility.

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

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

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

"Post-hospitalisation Medical Expenses" means Medical Expenses incurred during predefined number of days immediately after the Insured Person is discharged from the hospital provided that:

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

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

- a. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

- b. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

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

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

"Qualified Nurse" means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

"Reasonable and Customary charges" means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

"Renewal" means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

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

"Surgery" or "Surgical Procedure" means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

Specific Definition

"Accidental Emergency" means a traumatic bodily injury which, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a person's health or result in loss of life.

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

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

"Aggregate Deductible" means the aggregate of admissible hospitalisation expenses in a policy year up to which the Company is not liable.

"All Other Major Surgeries" means Intestinal obstruction-acute /sub acute/chronic, Bilo Pancreatic surgery, Gastro-Intestinal surgeries, Total Knee Replacement surgery, Total Hip Replacement surgery, Other major surgeries of joints, Hemi Orthro Plasty surgeries, Surgeries on Prostrate, Surgery related to Genito-Urinary

“Assisted Living” Assisted living is a residential setting for seniors or any individual with disabilities, who need help with daily tasks due to loss of independent living, but don't require the care of a nursing home or 24/7 medical attention. It provides a homelike environment, personal care services, 24-hour supervision, and health-related services. Assisted living aims to balance independence and support, allowing residents to maintain as much autonomy as possible while receiving necessary assistance.

“Company/Insurer” means Galaxy Health Insurance Company Limited.

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

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

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

"Diagnostic Tests" Investigations, such as X-Ray or blood tests, to find the cause of symptoms and medical condition.

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

“Digital ICU (Intensive Care Unit)” is a healthcare delivery model that leverages advanced technologies, such as telemedicine, artificial intelligence, and data analytics, to remotely monitor, manage, and coordinate the care of critically ill patients in real-time. It enables remote intensivists and critical care specialists to collaborate with on-site clinicians to provide high-quality, evidence-based care.

“Disease of Spine” includes injuries to the spine and/or Infections to the spine and/or a blocked blood supply and/or compression by a fractured bone and/or a tumour resulting in neurological sequelae.

“Emergency” shall mean a serious medical condition or symptom resulting from Injury or Illness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.

“Family” includes Self and Spouse.

“Hazardous Sport / Hazardous Activities” means engaging whether professionally or otherwise in any sport or activity, which is potentially dangerous to the Insured Person (whether trained, or not). Such Sport/Activity including but not limited to Winter sports, Ice hockey, Skiing, Skydiving, Parachuting, Ballooning, Scuba Diving, Bungee Jumping, Mountain Climbing, Riding or Driving in Races or Rallies, caving or pot holing, hunting or equestrian activities, diving or under-water activity, rafting or canoeing involving rapid waters, yachting or boating outside coastal waters, jockeys, horseback, Polo, Circus

personnel, army/navy/air force personnel and policemen whilst on duty, persons working in underground mines, explosives, magazines, workers whilst involved in electrical installation with high-tension supply, nuclear installations, handling hazardous chemicals.

“Head Injury” If a person sustained traumatic injury to brain / skull with (or) without loss of consciousness.

“Home” means the Insured Person's place of residence.

“Home Care Treatment” means treatment availed by the Insured Person at home, which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

- a) The Medical practitioner advice 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.

“Hospice Care” is defined as Care given for patients with terminal diseases, advanced Chronic Medical conditions who are estimated to live for few months, if the natural history of the disease follows its usual course. Hospice Care begins when curative treatment is no longer deemed possible for the terminally ill medical conditions Hospice Care benefits include access to a multidisciplinary treatment team specialized in end-of-life care, can be accessed at the company Network facility.

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

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

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

“Period of Insurance” means the period as specifically appearing in the Policy Schedule and commencing from the Policy Period Start Date of the first Policy taken by the Insured Person from the company and then, running concurrent to current Policy subject to continuous renewal of such Policy with us.

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

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

"Policy Year" means a period of twelve months beginning from the Policy Period Start Date and ending on the last day of such twelve-month period.

“Policy term” means the period between the commencement date and expiry date specified in the schedule.

“Poly Trauma” If a person sustained two or more severe injuries/ fractures in two or more areas of the body.

“Rehabilitation” is defined as “a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment”.

“Stroke” Any cerebrovascular incident producing permanent neurological sequelae.

“Sum Insured” Sum Insured means the Sum Insured Opted for and for which the premium is paid.

Zones:

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

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

III. COVERAGE

A. Base Cover:

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

The coverage provided only applies to the relevant covers opted by the insured person, as specified in the policy schedule and if during the period stated in the Policy Schedule the insured person sustains bodily injury or contracts any disease or suffer from any illness requiring Hospitalisation and incurs expenses at any Nursing Home / Hospital in India as an In-patient, the Company will indemnify the Insured Person such expenses as are reasonably and necessarily incurred under the heads given below but not exceeding the Sum Insured stated in the Policy schedule.

1. Inpatient Treatment

- Room rent inclusive of boarding, nursing charges, Residential/Duty Medical Officer charges during Hospitalisation as charged by the Hospital upto 2% of Sum Insured subject to a maximum of Rs. 10,000/- per day.
- ICU charges including Digital ICU covered upto 3% of Sum Insured subject to a maximum of Rs.20,000/- per day.
- Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees covered upto 35% of the Sum Insured per hospitalisation.
- Anesthesia, Blood, Oxygen, Operation theatre charges, 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 subject to maximum of 60% of sum insured per hospitalisation. 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. Road Ambulance: Expenses incurred towards the ambulance charges upto Rs.2,500/- per hospitalisation and upto Rs. 5,000/- per policy period is payable, provided that the hospitalisation claim is admissible.

- for transportation of the insured person by private ambulance service to go to hospital when this is needed for medical reasons or

- for transportation of the insured person by private ambulance service from one hospital to another hospital for better medical treatment or
- 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

3. Pre-Hospitalisation and Post Hospitalisation Expenses:

Medical expenses incurred immediately before the insured person is hospitalized and following the Insured Person's discharge from Hospital for a period not exceeding 30 days subject to a maximum of Rs.10,000/- is payable.

Note: Maximum payment under Pre hospitalisation and Post Hospitalisation put together shall not exceed 30 days subject to maximum of Rs.10,000/-.

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

5. Treatment of Cataract: Expenses incurred on treatment of Cataract is subject to the limit of Rs.35,000/- per eye and Rs.50,000/- per policy period is payable / per member.

Note: The above limit is inclusive of pre and post hospitalisation.

6. 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 50% of 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
V	Deep Brain Stimulation
VI	Other Modern Treatment - Balloon Sinuplasty - Bronchial Thermoplasty - IONM – (Intra Operative Neuro Monitoring) - Stereotactic Radio Surgeries - Vaporisation of Prostate - Oral Chemotherapy - Uterine Artery Embolization & High-Intensity Focussed Ultrasound

7. AYUSH Treatment: Medical expenses for Inpatient Hospitalisation incurred on treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha 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

8. Second Medical Opinion (Domestic): To avail this service, the insured must provide complete medical records. Upon receiving the request, the company inhouse medical team will review the information and advise the member on their medical

condition. The medical opinion will be made available directly to the Insured by the Doctor. To utilize this benefit, all medical records should be forwarded through Post/Courier.

Note:

- This should be specifically requested by the Insured Person
- 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.

9. Repatriation of Mortal Remains: Following an admissible claim for hospitalisation under the policy, the Company shall reimburse upto Rs.15,000/-in a policy year, towards the cost of repatriation of mortal remains of the insured person (including the cost of embalming and coffin charges) to the residence of the Insured as recorded in the policy.

10. Home care treatment: The Company will pay for expenses towards treatment availed by the Insured Person at home up to 5% of Sum Insured or upto Rs.1,00,000/- whichever is less. 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 Inpatient
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 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.

11. Co-payment: This policy is subject to 25% co-payment for all claims.

Note: Co-payment is not applicable on sublimits as follows;

- a. Cataract
- b. Repatriation of Mortal Remain
- c. Home care treatment
- d. Sub-limits on the Major Diseases/Surgeries and All other Major Surgeries
- e. Supportive Care (Optional cover)
- f. Recovery and Enrichment Care (Optional Cover)

12. Sub-limits on the Major Diseases / Surgeries and All other Major Surgeries: The expenses incurred towards the listed diseases / conditions are payable upto the amount specified in table given below;

Limit per person, per policy period for each diseases / Condition (individual) in (Rs.)		
Sum Insured (Rs.)	Neurological Diseases, Heart Diseases, Auto Immune Disease, Cancer (Including Chemotherapy / Radiotherapy) Medical Renal Diseases (Including Dialysis) Treatment of Breakage of Long Bones	All other major surgeries
5,00,000	3,00,000	2,50,000
10,00,000	4,00,000	3,00,000
15,00,000	4,50,000	3,50,000
20,00,000	5,00,000	4,00,000
25,00,000	5,50,000	4,50,000

Limit per policy period for each diseases / Condition (floater) in (Rs.)		
Sum Insured (Rs.)	Neurological Diseases, Heart Diseases, Auto Immune Disease, Cancer (Including Chemotherapy / Radiotherapy) Medical Renal Diseases (Including Dialysis) Treatment of Breakage of Long Bones	All other major surgeries
5,00,000	4,00,000	3,50,000
10,00,000	6,00,000	5,00,000
15,00,000	7,00,000	5,50,000
20,00,000	8,00,000	6,00,000
25,00,000	9,00,000	7,00,000

13. 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 offers 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 following table shows the discount on premium available under the Wellness Program. Both on Individual and Floater Plans are available.

Wellness Coins Earned	Discount in Premium
Above 251- 400 Coins	2%
401-550 Coins	4%
551-700 Coins	6%
701- 850 Coins	8%
Above 850 Coins	10%

Distribution of discount can avail as per members in an individual / floater policy size with Weightage	1A - Self	1:0
	2A - Self / Spouse	1:1

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

Galaxy Privilege - Gala Fit Galaxy – Pro Active Program			
S. No.	Activity - For Each Insured	Monthly coin	Yearly
1	To enrol in the Wellness Program using the mobile app, enter your personal mobile number and upload a valid ID proof		20
2	Sleep pattern - Having minimum of 7 hrs of sleep / day -monitored monthly basis	5/month	60
3	Target Steps count / per day (monitored monthly basis) > 5,000 for crossing 25 days / month	10/month	120
4	community engaging activity - Enrolling for yoga / spiritual programs/ health clubs on monthly basis certificate can be uploaded to considered for coins	10/month	120
5	Condition Management Program (CMP): To record BMI, general health check ups by physician (only 70 coins) • Member with Lifestyle disease – can provide quarterly (3*70 coins) assessment records		210
6	Preventive check-up I. ENT check-up (40) II. Eye check-up (40) III. Dental check up with reports (40)		140
7	Standard medical test – Complete any 8 out of the first 10 standard medical tests to earn 80 coins. Optional test from 11 to 17		240
	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. Vitamin B12 and Vitamin D (20C)	

Galaxy Privilege - Gala Fit Galaxy – Pro Active Program			
S. No.	Activity - For Each Insured	Monthly coin	Yearly
	12. (HHH) serology test (20 C) 13. PSA (M) (20 C) 14. Mammogram test (F) (20 C)	15. PAP smear test (F) (20 C) 16. ECHO (20 C) 17. Cancer profile markers (20 C)	
8	Only for members who have submitted proof of wellness utilisation during last policy year. (10) Also Sharing a success story (90)		100
9	Watching the video program through the Galaxy Health app - With attendance above 80%		10
		Total coins	1000
	Additional benefits available in the wellness via app - Access to health gadgets integration - Alarm to take drinking water or for medication Video content type as follows, - Awareness on the food types and diet - Emotional & Mental Health - Engaging with Grandchild care or new generations, to overcome commutation issues - Lifestyle disease management (Asthma, Blood pressure. Cholesterol, diabetes) - All basic videos on health		

• 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.

• 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.

• Target Steps count

Regular walking offers numerous benefits for both physical and mental health. Aiming for over 5,000 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. Members who meet this target for 20 days in a month will receive 80% of the monthly coins, i.e., 8 coins for surpassing 5,000 steps.

• Community engaging activities

Engaging in Community activities is essential for health care, providing numerous benefits for both physical and mental well-being, and helping to prevent lifestyle diseases and stress. This program includes a variety of activities such as yoga / spiritual programs/ health clubs / community engaging activities. 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.

• 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 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

• 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 17 test are optional.

Only for members who have submitted proof of wellness utilisation during last policy year.

Members who enrolled in the wellness program last year, if they can be able to provide the proof for the same, then they can be able to avail 10 coins

Sharing a success story

Members who enrolled in the wellness program last year and are sharing their success stories should submit a video recording featuring clear visuals of their face and audible content. The video should be between 60 to 90 seconds in duration

Enrolling with program in Galaxy health app

The Company mobile application features an interactive wellness program with activities for disease prevention, psychological enhancement and social awareness. The program is gender and age-based, and insured participants receive coins to add to their wellness bucket.

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.
- 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 a models proposed - For two adult model

S.No.	2A Model	62 years old (Male)	56 years old (Female)
1	Enrolling to Wellness Program	20	Not Enrolled
2	Sleep pattern	40	0
3	Target Steps count	68	0
4	Enrolling engaging activity	60	0
5	Preventive check-up	0	0
6	Condition Management Program (CMP)	140	0
7	Provide the standard medical test	80	0
8	Old participants	120	0
9	Enrolling with program in Galaxy health app	0	0
	Total	528	0
Note - cumulation of coins $(528 + 0)/2 = 264 = 2\%$ discount applicable during the renewal of the policy.			

B. Optional Covers:

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

14. Consumables: If there is an admissible claim under inpatient / day care under this policy, then Items as per List I will become payable upto sum insured. Further, the Company also covers Admission/Registration charges, Record charges and Insurance Processing charges will be payable upto the sum insured.

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

Deductible Option	Discount offered
Rs.25,000/-	10%
Rs. 50,000/-	15%
Rs. 1,00,000/-	20%

Note:

- Voluntary Aggregate Deductible will apply on aggregate basis for all hospitalisation expenses during the policy year which fall under basic cover.
- Voluntary Aggregate 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).

16. Supportive Care:

A. Rehabilitation and Pain Management: The company will pay the medical expenses for Rehabilitation and Pain Management as per the table given below,

Sum Insured (Rs.)	Limit Per Policy Year (Rs.)	
Individual	Individual	Floater
5,00,000	25,000	30,000
10,00,000		
15,00,000	50,000	60,000
20,00,000		
25,00,000		

Rehabilitation: The company will pay the expenses for rehabilitation, if availed at authorized centres as an In-patient/ Out-patient, and if there is an admissible claim for In-patient

hospitalisation for an injury, disease or illness specified below.

- Poly Trauma
- Head injury
- Diseases of the spine
- Stroke

Pain Management Treatment – Up to the limit as mentioned above	
S.No.	Name of the covered pain management treatment
1	Lumbar and cervical medial branch block with RF ablation for lumbar and cervical facet joint arthritis
2	Caudal epidural injection for Discogenic pain
3	Lumbar and cervical selective nerve root block for Lumbar and Cervical radicular pain
4	Caudal Neuroplasty for Failed back spine surgery
5	Stellate ganglion ablation for upper limb CRPS
6	Occipital nerve Pulsed RF lesioning for Migraines, Cluster headache and cervicogenic headaches
7	Lumbar sympathetic chain RF ablation for lower limb CRPS, diabetic periphery painful neuropathy and Ischaemic limb pain
8	Gasserian ganglion ablation for Trigeminal neuralgia
9	Intercostal nerve Ablation for post thoracotomy pain and Thoracic malignancy pain
10	Coeliac plexus ablation for upper gastrointestinal malignancies pain
11	Superior hypogastric plexus ablation for lower Gastro intestinal malignancies pain
12	Ganglion impar ablation for perineal cancer pain and coccydynia
13	Cooled RF ablation of genicular nerve for grade 1 and 2 osteoarthritis knee and hip
14	Suprascapular nerve RF ablation for rotator cuff partial tear and peri arthritis shoulder pain
15	Physiotherapy maximum 10 session will be allowed per policy period

Important Note:

- Rehabilitation and/or Pain management treatment can be taken only at the Authorized centres mentioned in the company website – www.galaxyhealth.com
- Insured claiming under this cover for Stroke, will not be eligible to claim under Home Care Treatment for Post CVA Care at Home after discharge.

B. Hospice Care: The Company will pay medical expenses up to 10% of Sum Insured, once in lifetime for each Insured person for Hospice care availed at Networked facility, which is mentioned in the Company website www.galaxyhealth.com.

Note :

- Available after a waiting period of 12 months from the inception of this policy.
- The admissibility of claim under Hospice Care is based on the decision of the medical panel by the company will be final.
- If any balance limit is available, the same cannot be carried forward.

17. Recovery and Enrichment Care:

A. 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 Limit per policy year (Rs.)	Floater Limit per policy year (Rs.)
5,00,000	10,000	15,000
10,00,000	20,000	30,000
15,00,000	30,000	45,000
20,00,000	40,000	60,000
25,00,000	50,000	75,000

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: -

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

B. Nursing at Home: The company will pay the expenses incurred, up to the limits mentioned in the table below post Hospitalisation 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 Limit per policy year (Rs.)	Floater Limit per policy year (Rs.)
5,00,000	3,500	5,000
10,00,000	8,000	10,000
15,00,000	10,000	12,500
20,00,000	12,500	15,000
25,00,000	15,000	20,000

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

18. Modification of Co-payment: The insured person has option to reduce / increase the co-payment under base cover and can avail loading / discount on the premium as per the table given below. In case Co-payment modification is opted as mentioned in the Policy Schedule, the Insured Person will be liable to bear the specified Co-payment percentage of admissible claim amount of each and every claim amount.

Modification of Co-payment	Discount / loading percentage on premium
Decrease of Co-payment (from 25% to 20%)	5% Loading on premium
Increase of Co-payment (from 25% to 30%)	5% Discount on premium

Note: Modification of Co-payment, if chosen by the Insured Person(s) shall be applicable on Base Covers except Gala Fit-Pro Active Care (Engaging Wellness Program).

List of Benefits which are part of sum Insured and in addition to Sum Insured		
S.No	Coverage	Forming part of Sum Insured/In addition to Sum Insured
1	Room rent inclusive of boarding, nursing charges, Residential/Duty Medical Officer charges, ICU charges including Digital ICU, Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees, 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.	Forming part of Sum Insured

List of Benefits which are part of sum Insured and in addition to Sum Insured		
S.No	Coverage	Forming part of Sum Insured/In addition to Sum Insured
2	Other Medical expenses	Forming part of Sum Insured
3	Road Ambulance	
4	Pre & Post Hospitalisation	
5	Day Care Procedures	
6	Cataract (per member)	
7	Modern Treatments	
8	AYUSH Treatment	
9	Second Medical Opinion (Domestic)	Not Applicable
10	Repatriation of mortal remains	In addition to Sum Insured
11	Home Care Treatment	Forming part of Sum Insured
12	Gala Fit Proactive care (Engaging Wellness Program)	Not Applicable
13	Sub-limits on the Major Diseases/ Surgeries and All other Major surgeries	Forming part of Sum Insured
14	Consumables	Forming part of Sum Insured
15	Deductible	Not Applicable
16	Supportive Care a. Rehabilitation and Pain Management b. Hospice Care	Forming part of Sum Insured
17	Recovery and Enrichment Care a. Assisted Living b. Nursing at Home	Forming part of Sum Insured
18	Modification of Co-payment	Not Applicable

IV. EXCLUSIONS

A. Standard Exclusions

1. Pre-Existing Diseases - Code- Excl 01:

- A. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with insurer
- B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- C. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- D. Coverage under the policy after the expiry of 12 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 the 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.
 - 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, Spermatocele, 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

Note: Waiting period for the following benefit is as follows

- a. **Hospice care (Optional cover 16 B):** A waiting period of 12 months from the date of first inception of this policy with the Company.
- 3. **30-day waiting period – Code Excl 03 (Not Applicable for Accidents)**
 - 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

- 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 (except to the extent covered under Optional Cover 16 (A)) 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 – 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**

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 – 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**

- 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**

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**

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 Optional Cover 14**)-**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. Dental Implants however are not payable.

V. CONDITIONS

Standard Conditions

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

2.Claim Settlement

A. **Condition Precedent to Admission of Liability:** The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

B. For Cashless Treatment:

- a. Call the 24 hour help-line for assistance – 18002030007. Senior Citizens may call at 18002030007.
- b. Inform the ID number for easy reference
- c. On admission in the hospital, produce the ID Card issued by the Company at the Hospital Helpdesk.
- d. Obtain the Pre-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk. (Insurers shall also provide pre-authorization to the policyholder through Digital mode).
- e. The Treating Doctor will complete the hospitalisation/ treatment information, and the hospital will fill up expected cost of treatment. This form is submitted to the Company.
- f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.

- g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits.
- h. In case of emergency hospitalisation information to be given within 24 hours after hospitalisation
- i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.galaxyhealth.com or contact the nearest branch. KYC (Identity proof with Address) of the proposer, as per AML Guidelines.

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

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

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

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

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

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

- i. Duly filled in claim forms with treating doctor signature.
- ii. Pre/Post Hospitalisation investigations and treatment papers.
- iii. All investigations reports including Radiological films (Xray, CT scan, MRI and USG) and Biopsy during hospitalisation.
- iv. Discharge Summary from the hospital
- v. Cash receipts from hospital, chemists
- vi. Cash receipts and reports for tests done
- vii. Receipts from doctors, surgeons, anaesthetist
- viii. Certificate from the attending doctor regarding the diagnosis.
- ix. KYC (Identity proof with Address) of the proposer, as per AML Guidelines
- x. Copy of PAN Card
- xi. NEFT documents of the proposer 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. Documents for Supportive Care (Assisted Living and Nursing at Home-Optional cover 17 A and 17 B)

1. Discharge summary
2. Certificate from treating doctor on diagnosis

3. Cash receipts for the payment to assistant / Nursing in charge

Note:

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

3. Provision for Penal Interest

- i) The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
- ii) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
- v) "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

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

5. Multiple Policies:

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

6. Fraud: If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his

agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true.
- b) the active concealment of a fact by the insured person having knowledge or belief of the fact.
- c) any other act fitted to deceive and
- d) any such act or omission as the law specially declares to be fraudulent.

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. Cancellation

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

Note: Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

- ii. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8. Migration:

In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

9. Portability:

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

10. Renewal of Health Insurance policy:

- a. A health insurance policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or

misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate.

- b. An Insurer shall not deny the renewal on the ground that the policyholder had made a claim (s) in the preceding policy years.
- c. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
- d. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- e. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
- f. Coverage is not available during the grace period.
- g. No loading shall apply on renewals based on individual claims experience

11. 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.

12. 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.

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

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

- v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vi. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

14. 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.

15. 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.

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

Website: www.galaxyhealth.com

Toll free : 18002030007

Senior Citizens may call at 18002030007

E-mail: gro@galaxyhealth.com

Phone No. : 044 - 4001 7238

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

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the Grievance redressal officer (GRO) at corporate office - 044 - 4001 7238

For updated details of grievance officer, kindly refer the link
<https://www.galaxyhealth.com/grievance-redressal>

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per insurance Ombudsman Rules 2017. For the details of Insurance Ombudsman, please visit: <https://cioins.co.in/Complaint/Online>

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

17. Nomination:

- a. The policyholder shall give his nomination for the purpose of payment of claims. In the event of death of the

policyholder, the claim proceeds will be paid to the nominee.

- b. Nomination can be changed any time during the term of the policy.

Specific Conditions

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

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

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

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

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

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

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

24. 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.

25. Policy disputes: Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

26. 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.**

27. 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.

28. Important Note

- a) Where the policy is issued on floater basis, The Sum Insured and other related benefits floats amongst the insured members.

- b) The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws
- c) The terms conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each relevant insured person. Failure to comply with may result in the claim being denied.

- d) The attention of the policy holder is drawn to the company website www.galaxyhealth.com for anti-fraud policy of the company for necessary compliance by all stake holders.

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

List of Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District
AHMEDABAD: Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Near S.V. College, Tilak Marg, Relief Road, Ahmedabad – 380 001, Gujarat. Tel.: 079 - 25501201/02 • oio.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU: Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 • Email: oio.bengaluru@cioins.co.in	Karnataka.
BHOPAL: Office of the Insurance Ombudsman, LIC of India Zonal Office Bldg, 1st floor, "Jeevan Shikha", South Wing, 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 / 2769200 • Email: oio.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR: Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 / 2596455 / 2596429 / 2596003 Email: oio.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH: Office Of The Insurance Ombudsman, LIC of India Office Bldg, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 / 2773101 / 2990938 / 2706196 / 2707468 / 2772101 / 2990942 Email: oio.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonapat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh& Chandigarh.
CHENNAI: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 • Email: oio.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI : Office of the Insurance Ombudsman, 2/2 A, 1st Floor, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992 • Email: oio.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.
GUWAHATI: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Pan Bazar, S.S. Road, Guwahati – 781001. Tel.: 0361 - 2632204 / 2631307 / 2732937 / 2632205 • Email: oio.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: oio.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR: Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Road, Ambedkar Circle, Jaipur - 302 005. Tel.: 0141 - 2740363 • Email: oio.jaipur@cioins.co.in	Rajasthan.

KOCHI: Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Ernakulam, Kochi - 682 011. Tel.: 0484 – 2358759 / 2358734 / 2358336 • Email: oio.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 • Email: oio.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW: Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 • Email: oio.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 • Email: oio.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
NOIDA : Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Noida-201301, Dist: Gautam Buddh Nagar, Uttar Pradesh. Tel.: 0120-2514252 / 2514253 / 4027589 • Email: oio.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA: Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 / 22547067 • Email: oio.patna@cioins.co.in	Bihar, Jharkhand
PUNE: Office of the Insurance Ombudsman, Jeevan Darshan- Jeevan Darshan LIC of India Office Bldg, 3rd Floor, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 • Email: oio.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
THANE : Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasant Rao Naik Mahamarg, Thane (West), Thane – 400604 Tel: 022- 20812868 / 20812869 • Email: oio.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.
For the details of Insurance Ombudsman, please visit: https://cioins.co.in/Complaint/Online	

List I - Items (Covered under Optional Cover no. 14)

SI No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)

SI No	Item
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS

SI No	Item
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOTWEAR

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

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

SI No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTHPASTE
13	TOOTHBRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX

SI No	Item
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

SI No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHIELD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER

SI No	Item
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV - Items that are to be subsumed into costs of treatment

SI No	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE/SPIRIT/ DISINFECTANTS ETC

SI No	Item
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Schedule of Benefits

S.No.	Sum Insured (Rs. in Lakhs)	Individual and Floater: 5 / 10 / 15 / 20 / 25
1	Room, Boarding, Nursing Expenses all-inclusive as provided by the Hospital / Nursing Home as per the limits	2% of Sum Insured maximum up to Rs.10,000/- per day
2	ICU including Digital ICU	3% of Sum Insured not exceeding Rs.20,000/- per day
3	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees	Covered upto 35% of sum insured
4	Other Medical expenses	Covered upto 60% of sum insured
5	Road Ambulance	Covered up to Rs.2500/- per hospitalisation, Rs.5000/- per policy year
6	Day Care Procedures	All day care procedures are covered.
7	Pre & Post Hospitalisation	30 days with sublimit of Rs.10,000/-
8	Cataract (per member)	Rs. 35 ,000/- Per eye and Rs. 50,000/- per policy year
9	Modern Treatments	Covered upto 50% of sum insured
10	AYUSH Treatment	Covered up to Sum insured
11	Second Medical Opinion (Domestic)	Covered
12	Repatriation of Mortal Remains	Rs.15,000/- per policy year
13	Home Care treatment	5% of sum insured or upto Rs.1,00,000/- whichever is less
14	Gala Fit – Pro Active Care (Engaging Wellness Program)	Premium discount available up to 10% at the time of renewal
15	Sub-limits on the Major Diseases/Surgeries and All other Major Surgeries	The expenses incurred on the listed disease/conditions are payable upto the amount specified.
16	Co-payment	25% for all claims

Schedule of Benefits					
S.No.	Sum Insured (Rs. in Lakhs)	Individual and Floater: 5 / 10 / 15 / 20 / 25			
	Optional Covers				
17	Consumables	Available			
18	Voluntary Aggregate Deductible	Rs.25,000/-, Rs.50,000/-, Rs. 1,00,000/-			
19	Supportive Care: A. Rehabilitation and Pain Management (limit per policy year) B. Hospice Care	A. Rehabilitation and Pain Management			
		Individual		Floater	
		Sl in lakhs (Rs.)	Limit (Rs.)	Sl in lakhs (Rs.)	Limit (Rs.)
		5/10	25,000	5/10	30,000
		15/20/25	50,000	15/20/25	60,000
		B. Hospice Care: 10% of Sum Insured			
20	Recovery and Enrichment Care: (limit per policy year) A. Assisted Living B. Nursing at Home	A. Assisted Living			
		Sum Insured (Rs.)	Individual (Rs.)	Floater (Rs.)	
		5,00,000	10,000	15,000	
		10,00,000	20,000	30,000	
		15,00,000	30,000	45,000	
		20,00,000	40,000	60,000	
		25,00,000	50,000	75,000	
		B. Nursing at Home			
		Sum Insured (Rs.)	Individual (Rs.)	Floater (Rs.)	
		5,00,000	3,500	5,000	
		10,00,000	8,000	10,000	
		15,00,000	10,000	12,500	
		20,00,000	12,500	15,000	
		25,00,000	15,000	20,000	
		21	Modification of Co-payment	Decrease of Co-pay - From 25% to 20% Increase of Co-pay - From 25% to 30%	



GALAXY HEALTH INSURANCE COMPANY LIMITED

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

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