Galaxy Top-up

Unique Identification No.: GHIHLIP25039V012425

I Preamble

Galaxy Health Insurance Company Limited has received a proposal and premium from the proposer. Upon its acceptance and realisation of premium, subject to terms and conditions set out in the policy, the company agrees to pay claims submitted by the insured in respect of hospitalisation and benefits covered under the policy.

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.

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

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

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   i. Having at least 5 in-patient beds.

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

"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 pre-authorization approved.

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

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

- **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.

"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.

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

i. Minimum 10 beds for multi-speciality and 5 beds for Single Speciality.
ii. 24 hours Medical Practitioner & Nursing Staffs.
iii. Medical Records Department (MRD).
iv. IT Solutions - Minimum System Requirements with internet facility.
v. Pollution Control Board Certificate or Any Government Registration certificate
vi. Operation Theatre with basic Requirements - Surgical Facility

- ICU (or) HDU is Mandatory - Surgical facility
- Ventilator is Mandatory, if the number of beds is >50
- C-ARM is Mandatory for Orthopaedic Speciality
- All other facilities required as per Clinical Establishment Act

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

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

a. Acute condition - Acute condition is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/Illness/ Injury which leads to full recovery.

b.Chronic condition - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:

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

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

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

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

"ICU (Intensive Care Unit) Charges" means the amount charged by a Hospital towards ICU expenses 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.

"Maternity expense" means

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation).
b. Expenses towards lawful medical termination of pregnancy during the Policy period.

"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:

- is required for the medical management of the illness or injury suffered by the insured
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity
- must have been prescribed by a medical practitioner
- 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.

"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

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

i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

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

"Pre-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 center 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 Definitions

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

"Any Room" any category room in a hospital

"Associated Medical Expenses" means medical expenses such as Professional fees, OT charges, Procedure charges, etc., which vary based on the room category occupied by the insured person whilst undergoing treatment in some of the hospitals. If Policy Holder chooses a higher room category above the eligibility defined in policy, then proportionate deduction will apply on the Associated Medical Expenses in addition to the difference in room rent. Such associated medical expenses do not include Cost of pharmacy, Consumables, Cost of implants,

medical devices, Cost of diagnostics and ICU charges. Hence Proportionate deduction will not be applicable on these items.

"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.

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

"Company/Insurer" means Galaxy Health Insurance Company Limited.

"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.

"Dependent Child" means a child (natural or legally adopted), who is unmarried, aged between 16 days and 25 years, financially dependent on the Insured and does not have his / her independent sources of income.

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

"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.
"Donor" means a person who gives an organ for use in another person.

"Durable Medical Equipment": Medical device means an article, instrument, apparatus or machine that is used in the treatment of illness or disease.

"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.

"Excess" Excess is the amount of admissible hospitalization expenses up to which the Company will not be liable to pay

"Family" includes Insured Person, Spouse, dependent children between 16 days and 25 years of age not exceeding 3 in number and Dependent Parent / Parents in law.

"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.

"Immediate Family" means spouse, dependent children and dependent parent(s) of the Insured.

"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/Annual/2 instalments / 4 instalments / 12 instalments 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.

"Limit of Indemnity" The maximum amount the insurer will pay under a policy during the policy year.

"Nanotechnology and Nanomedicine" Nanomedicine is the use of Nanotechnology in healthcare and medicine. It involves using nanomaterials and nanoparticles to deliver drugs to the specific parts of the body, diagnose diseases, and help in wound healing by regenerating tissues to help in wound healing. This technology enables more precise and effective treatment while minimizing side effects.

"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 the Company.

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

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

"Proportionate deductions" If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this policy, then the Insured Person shall bear a ratable proportion of the total Associated medical expenses (including surcharges or taxes thereon) called proportionate deductions

"Single Private A/C room" means a single occupancy air-conditioned room with attached wash room and a couch for the attendant. The room may have a television and/or a telephone. Such room must be the most economical of all accommodations available in that hospital as single occupancy. This does not include deluxe room or a suite

"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: Tirupati, Hyderabad including K V Ranga Reddy and Medchal Malkajgiri, Secunderabad, Vijayawada, Patna, Goa, Himachal Pradesh, Bengaluru, Thiruvananthapuram, Ernakulam, Bhopal, Indore, Pune, Nashik, Chennai, Lucknow and Kolkata.
Zone C: Rest of India.

III. COVERAGE

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

If during the period stated in the Policy Schedule the insured person sustains bodily injury through accident 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, in excess of the deductible but not exceeding the sum insured in aggregate in any one period stated in the Policy schedule.

1. **Inpatient Treatment**

a. Room rent (Single Private A/C room) inclusive of boarding, nursing charges, Residential/Duty Medical Officer charges during Hospitalisation as charged by the Hospital where the Insured Person availed medical treatment.

b. **Note:** Associated Medical expenses which vary based on the room occupied by the insured person will be considered in proportion to the room rent stated in the policy

schedule or actuals whichever is less. Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room rent.

c. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees.

d. Anesthesia, Blood, Oxygen, Operation theatre charges, ICU charges, Digital ICU, Surgical appliances, Medicines and Drugs, Diagnostic materials and X-ray, Diagnostic imaging modalities, investigation test, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses with regard to coronary stenting, medicines, Implants and other similar items. The Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping.

2. **Road Ambulance:** Expenses incurred towards road ambulance upto Rs.3,000/- per hospitalization is payable, subject to the following conditions, provided there is an admissible hospitalisation claim;
   i. For transportation of the insured person by private ambulance service to go to hospital when this is needed for medical reasons or
   ii. For transportation of the insured person by private ambulance service from one hospital to another hospital for better medical treatment or
   iii. For transportation of the insured person from the hospital where treatment is taken to their place of residence (if it is in same city) provided the requirement of an ambulance to the residence is certified by the medical practitioner.

3. **Air Ambulance:** Air ambulance expenses are payable subject to an admissible hospitalisation claim, the Insured Person(s) is/are eligible for reimbursement of expenses incurred towards the cost of air ambulance service upto 10% of sum insured per year, provided that
   a. It is for emergency care of the insured person which requires immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot be provided.
   b. Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency
   c. It is prescribed by a Medical Practitioner and is Medically Necessary.
   d. The insured person is in India and the treatment is in India only
   e. Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s.

Note: The Company will not cover the following expenses:

a) Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital
b) Any transportation or Air Ambulance expenses incurred outside the geographical territory of India.
c) Applicable for sum insured of Rs.15 Lakhs and above

4. **Pre- Hospitalisation Expenses:** Medical expenses incurred upto 60 days immediately before the insured person is hospitalised.

5. **Post Hospitalisation Expenses:** Medical expenses incurred upto 90 days immediately after the Insured Person is discharge from the hospital.

6. **Day Care Procedures/Treatment:** All day care Procedures/Treatment are covered up to sum insured

7. **Delivery Expenses**:

- Expenses for a Delivery including Normal Delivery or Caesarean section (Pre-natal and Postnatal expenses are also covered) up to 10% of Sum Insured or up to Maximum of Rs.50,000, whichever is less.
- **Antenatal Scan:** During pregnancy both 12th and 20th week of Antenatal scan are covered (Maximum 2 Scans per delivery) within the above mentioned delivery limit.

Note:

- Pre-hospitalisation and Post Hospitalisation expenses are not applicable for this cover.
- Both self and spouse should be covered under this policy for a minimum period of 2 years continuously without break either individual or floater sum insured (or) Insured Women alone should be covered under this policy for 4 years continuously without break.
- There is no waiting period for subsequent deliveries
- Maximum 2 deliveries are allowed in the lifetime

8. **AYUSH Treatment:** Medical expenses for Inpatient Hospitalisation incurred on treatment under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines in a AYUSH Hospital is payable up to the sum insured.
Note: Claims under Yoga and Naturopathy system of treatment will be payable subject to prior approval from the Company.

9. **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 as per the table given below (including Pre and Post hospitalisation expenses) during the policy year.

			Treatment type	Limit per policy year (Rs.)
I	Robotic Surgeries	a	Total Knee Replacement & Total Hip Replacement	Upto Sum Insured
		b	Radical Prostatectomy	
			Wipples Procedure	
			For treatment of Thoracic & Abdominal Malignancies	
			Complex Intra-Abdominal Surgeries	
		c	For treatment of Laryngeal & Pharyngeal Cancers	
			Staging Laparotomy (including the cost of instruments)	
			Cyto-reduction Surgeries	

		d	For all other Robotic procedures	
II	Immunotherapy – Monoclonal Antibody to be given as injection	a	For Cancer Treatment	
		b	Other than treatment of Cancer	
III	Stem Cell Therapy Hematopoietic stem cells for bone marrow transplant for haematological conditions	a	For Cancer Treatment	
		b	Other than treatment of Cancer	
IV	Intravitreal Injection	a	Allowed Maximum 3 injections per eye (6 injection both eyes) per policy period	
V	Deep Brain Stimulation	a	Upto sum insured	
VI	Other Modern Treatment	a	Balloon Sinuplasty	
		b	Bronchial Thermoplasty	
		c	IONM – (Intra Operative Neuro Monitoring)	
		d	Stereotactic Radio Surgeries	
		e	Vaporisation of Prostate	
		f	Oral Chemotherapy	
		g	Uterine Artery Embolization & High-Intensity Focussed Ultrasound	

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

Note:

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

11. **Bariatric Surgery:** Expenses incurred on hospitalisation including pre-hospitalisation and post hospitalisation for bariatric surgical procedure and its complications thereof are payable up to sum insured.

Conditions:

- This benefit is subject to a waiting period of 12 months from the date of first commencement of this policy and continuous renewal thereof with the Company
- The minimum age of the insured at the time of surgery should be above 18 years
- This benefit shall not apply where the surgery is performed for
  - Reversible endocrine or other disorders that can cause obesity

- Current drug or alcohol abuse
- Uncontrolled, severe psychiatric illness
- Lack of comprehension of risks, benefits, expected outcome, alternatives and lifestyle changes required with bariatric surgery
- Bariatric surgery performed for Cosmetic reasons

- The indication for the procedure should be found appropriate by two qualified surgeons and the insured person should obtain prior approval for cashless treatment from the Company.
- To make a claim, the insured person should satisfy the following criteria as devised by NIH (National Institute of Health)
  - The BMI should be greater than 40 or greater than 35 with co-morbidities (like Diabetes, High Blood Pressure etc.)
  - The insured person is unable to lose weight through traditional methods like diet and exercise

12. **Organ Transplantation Expenses:** Hospitalisation medical expenses incurred to the Insured Person for inpatient organ transplantation treatment, including the harvesting of the donated organ will be covered up to sum insured subject to a waiting period of 12 months from the date of first inception of this policy with the Company.

Note: Organ transplant on the Insured Person shall satisfy the requirements of the Transplantation of Human Organs Act of 1994 and any amendments thereto. Any other medical treatment for the donor is not covered.

13. **Consumables:** If there is an admissible claim under inpatient or day care under this policy, items listed in List I will be payable up to the sum insured. Further, the company covers admission/registration charges, record charges, and insurance processing charges up to the sum insured.

14. **Gala Fit - Pro Active Care (Wellness Engaging 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 Company have the wellness program available based on the age. One is for adults and dependent child above 18 years and other one is for children above 7 years to below 18 years of age. The following table shows the discount on premium available under the Wellness Program, applicable for both on Individual and Floater Plans.

Gala Fit - Pro-Active Care Discount (Wellness Engaging Program)	
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 be availed as per members in a floater policy

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

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

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

Gala Fit – Pro Active Care Program for Adults + Dependent child age from 18 years and above			
S No	**Activity - For Each Insured**	**Monthly coins**	**Yearly coins**
1	Enrolling in Wellness Program, in mobile application by individual mobile number with ID proof		10
2	Register under organ donation plan (share details)		10
3	Sleep pattern - Having minimum of 7 hours of sleep / day -monitored monthly basis	5 / month	60
4	Blood donation (maximum twice per year allowed) (10 coins*2)		20
5	Participation in physical activities • Wellness program (like Gym / Health club subscription) • Marathon, cycling, Trekking and similar activities, Indoor and outdoor sports	5 / activity) *(2/ month)	120
6	Target Steps count / per day (monitored monthly basis) **Recognise with Galaxy team certificate via E-mail** ▪ >5,000 ▪ >8,000	10 for 5000+ steps or 15 for 8000+ steps	180
7	Preventive check-up		

	• ENT check-up (20 coins) • Eye check-up (20 coins) (including Glaucoma test for 40+years members) • Dental check up with reports (10 coins)			50
8	Condition Management Program (CMP): (per policy period) – **To record BMI, general health check-ups by physician (only 60 coins)** ▪ Member with Lifestyle disease – can provide once every four-month (thrice a policy period) (3*60 coins) assessment records ▪ Wellness team analysis– if progression noted then coins credited			180
9	Only for members who have submitted wellness assistance in the last policy year. • Reduce in BMI from obese to normal compared to previous year reports (25 coins) • Sharing a success story (5 coins)			30
10	Submission of Vaccination			
	- 100 Coins – HPV	- 10 Coins - Other vaccine		100
11	Provide the standard medical test			220
	• Complete blood test with haemoglobin • Urine routine • USG abdomen • S.creatinine • ECG • HbA1C • Pulmonary function • Cholesterol	• Thyroid profile • Bone density • (HHH) serology test (20 Coins) • PSA (M) (20 Coins) • Mammogram test (F) (20 Coins) • PAP smear test (F) (20 Coins) • ECHO (20 Coins) • Cancer profile markers (20 Coins)		
12	Enrolling with video program in Galaxy health app and successful completion of the program			20
	Total			1000

Additional benefits available in the wellness via app

- Domain for complete medical records of the members (Digital Vault)
- Access to health gadgets
- Water intake alarm
- Diet program including calories
- Location detectors for blood bank, hospital (with label for network and non-network), Rehabilitation centre, Pharmacy, diagnostic centre, physiotherapy centre and clinics

Under s.no 12 (wellness program – in app) - attending Counselling / workshop for the following

- Pregnancy
- Postpartum condition
- Emotional & Mental Health
- Menopausal syndrome
- Stress management
- Life balance management

The following list of activities for Dependent children

Gala Fit – Pro Active Care Integrated Health Program for Dependent children above 7 years to below 18 years of age			
S. No.	**Activity**	**Monthly coins**	**Yearly coins**
1	Avail coins for Enrolling in Wellness Program, by parent's mobile number & Dependent Children photo proof		50
2	Submission of Vaccination ▪ As per Indian government vaccination chart (50 Coins) ▪ Preventive vaccines as per medical board suggestions (20 Coins)		70
3	**Engaging in mental enrichment program** ▪ Singing / dancing program / Story telling / drawing	(10 / activity) *(2 / month)	240
4	**Engaging in physical activities** ▪ Indoor and outdoor sports, Swimming, Trekking and similar activities. ▪ Sharing certificate of participating in sports	(15 / activity) * (2/ month)	360
5	Preventive check • ENT check-up (50 Coins) • Eye check-up (50 Coins) • Dental check up with reports once in every Six month (40*2 coins)	50 50 40*2	180
6	Interactive video program in Galaxy health app - *Two Programs minimum and maximum of 5 programs	20*5	100
	Total		1000

Additional benefits available in the wellness via app
- Domain for complete medical records of the members (Digital Vault)
- Access to health gadgets
- Water intake alarm
- Diet program including calories

Under s.no 6 (wellness program – in app) - attending Counselling / workshop for the following
- Emotional & Mental Health
- Child behaviour care
- Stress management
- Life balance management
- Drawing and Painting Competition
- Co-Curricular Activities Participation
- Participation in Quiz

Enrolling to Wellness Program

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

Register under organ donation plan

Organ donation involves a person to donate their organs for transplantation to someone in need. This registration of voluntary organ donation for Nobel cause is acknowledged by us. Once

registered with a standard organ donor bank, the insured can share their registration details and upload the certificate to earn wellness coins.

Sleep pattern

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

Blood donation

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

Participation in physical activities

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

Target Steps count

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

Preventive check-up

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

Condition Management Program (CMP)

This is categorised as basic plan and chronic disease management plan

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

For the chronic disease management plan.

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

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

Example 1: -
If a member is suffering from uncontrolled hypertension, they must provide the first consultation paper, along with the requested investigations suggested by the treating doctor, during the first month of the current policy period (e.g., April). These records should be uploaded to the system.

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

The Company will evaluate the uploaded documents to assess any progression or reduction in the member's health condition. If there is a noted improvement, the insured will be awarded coins. Additionally, the medical team will review the consultation papers to check for any progression in the insured's condition. If no progression is noted, they will guide the insured to subscribe to certain wellness programs.

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

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

Submission of Vaccination certificate
There are two types of coins provided under this activity. The coins given under this activity is once a lifetime.
One under adult activity and other one under children above 7 years of age to below 18 years of age.

Under Adult
If the Insured Person submit the vaccine certificate as per the suggested list of vaccine guided by the Indian Ministry of Health. Coins will be awarded to acknowledge participation, with the coins varying based on the type of vaccine administered. For example, if the Insured Person receives the HPV vaccine (a three-stage vaccine), 100 coins will be given. While if, insured person administrated with Hepatitis B vaccine or any other list of vaccine guided by the Indian Ministry of Health, then 10 coins will be rewarded.

For the other type of coins provided in children wellness plan.
The Company urge all parents and guardians to ensure their children participate in this vaccination program. Please administer the recommended vaccines, as advised by the Ministry

of Health, to the Insured Person children and provide an updated list of completed vaccinations. In line with current medical advancements, if a physician recommends any additional preventive vaccines and the Insured Person child has received them, the Company will acknowledge those as well. As a token of appreciation for completing this activity, the Company will distribute coins.

Provide the standard medical test

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

Enrolling with program in Galaxy health app

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

Wellness for children

Three categories for children participating in the following categories

- Mental enrichment program
- Physical health activity
- Community interactive activities

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

Mental enrichment program

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

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

Physical health activity

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

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

Community interactive activities

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

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

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

Important Note:

- Member must download the application within 30 days from the inception date of the policy.
- The investigation requested and OPD consultation and preventive health check-up must be made from registered diagnostic laboratories and physician
- The Participants in the Interactive program must complete the program, to get the monthly coin
- The app based pre recordings must be seen without skipping the videos
- To get coins, for monthly basis, minimum 25 days in a month must be achieved the target step count.
- If the member completes 20 days can avail partial coins for that month.
- The uploaded certificates and reports are validated and then only the coins are added.
- The reward coins are not carried forward to next year (for annual renewal of policy).
- The wellness coins are not transferable to other members in the policy.

Terms and conditions under wellness activity

- Any information provided by the Insured in this regard shall be kept confidential.
- There will not be any cash redemption against the wellness reward points.
- Insured should notify and submit relevant documents, reports, receipts etc for various wellness activities within one month of undertaking such activity/test.
- For services that are provided through empanelled service provider, Galaxy Health is only acting as a facilitator; hence would not be liable for any incremental costs or the services.

- Insured should consult his/her doctor before availing/taking the medical advice/services. The decision to utilize these advice/services is solely at Insured person's discretion.
- The Company reserve the right to remove the wellness reward points if found to be achieved in unfair manner.
- Galaxy Health, its group entities, or affiliates, their respective directors, officers, employees, agents, vendors, are not responsible or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which a Member claims to have suffered, sustained or incurred, by way of and / or on account of the Wellness Program.
- Services offered are subject to guidelines issued by IRDAI from time to time.

Illustration of benefits two models proposed

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

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

S. No.	2A +1C model	50 years old (Male)	41 years old (Female)	9 years old (Kid)
1	Enrolling to Wellness Program	10	10	50
2	Register under organ donation plan	10	10	N/A
3	Sleep pattern	50	0	N/A
4	Blood donation	10	0	N/A
5	Participation in physical activities	120	0	210
6	Target Steps count	100	120	N/A

7	Preventive check-up	40	40	90
8	Condition Management Program (CMP)	60	180	N/A
9	Old participants	30	0	N/A
10	Submission of Vaccination certificate	10	0	50
11	Provide the standard medical test	100	100	N/A
12	Enrolling with video program in Galaxy health app	20	0	60
13	Participation in mental enrichment program	N/A	N/A	120
	Total	**560**	**460**	**580**
Note - Cumulation of coins (560 + 460 + 580) /3 = 533 = 4% discount applicable during renewal of the policy.				

Optional covers: (On payment of Additional Premium)

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

Conditions

- This benefit will be available for those purchased this policy up to the entry age of 50 years.
- No additional premium will be charged in the middle of the tenure in case of claims. At the time of renewal (in case of a claim), the premium will be charged as per the current age of the insured at renewal.
- In case of multi tenure policies, the premium for the entire tenure will be charged as per the entry age.
- **Floater Plan:** During the renewal of this policy, If the insured adds a member to the floater plan, then the premium will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.
- **Individual Plan:** During the renewal of this policy, If the insured adds a member to an individual plan and convert it into a Floater plan, then the premium will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.
- If the eldest member is no longer part of the Floater plan, then the Floater premium will be calculated as per the original entry age of the eldest member amongst the remaining members during the renewal of this policy and lock the premium at that age, till a claim is paid.
- If a floater plan, splits into multiple policies, then the Company will carry forward the locked age at which the floater policies were taken by individuals in the policies carried forward, till a claim is paid.

- Once insured crosses the age of 55 years irrespective of claim, premium will be charged as per Insured's current age and the Company will continue to charge as per the age at renewal.
- In the event of price change due to product revision, the premium will be charged based on the original age slab of the revised product.

16. **Room Rent Enhancement:** Room rent including boarding, nursing charges, Residential/Duty Medical Officer charges during Hospitalisation as charged by the Hospital. The Insured Person has option to choose **Any Room by paying an additional premium at time of purchasing of the policy or during renewal.**

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

List of Durable Medical Equipment Covered under this optional Cover:

a) CPAP Machine
b) Ventilator
c) Wheelchair
d) Prosthetic device
e) Suction Machine
f) Commode Chairs
g) Infusion pump
h) Continuous Passive motion devices in case of Knee Replacement
i) Oxygen concentrator

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

S.No	Coverage	List of Benefits which are part of sum insured and in addition to Sum Insured
1	Room rent	Forming part of Sum Insured
2	Road Ambulance	Forming part of Sum Insured
3	Air Ambulance	Forming part of Sum Insured
4	Pre Hospitalisation and Post Hospitalization expenses	Forming part of Sum Insured
5	Day Care Procedures / treatment	Forming part of Sum Insured
6	Delivery Expenses	Forming part of Sum Insured
7	AYUSH Treatment	Forming part of Sum Insured
8	Modern Treatment	Forming part of Sum Insured
9	Nanotechnology	Forming part of Sum Insured
10	Bariatric Surgery	Forming part of Sum Insured
11	Organ Transplantation Expenses	Forming part of Sum Insured
12	Gala Fit – Pro Active Care (wellness engaging program)	Not Applicable

13	Consumables	Forming part of Sum Insured
14	Premium promise	Not Applicable
15	Room Rent Enhancement	Forming part of Sum Insured
16	Durable Medical Equipment/CAPD	Forming part of Sum Insured

Note:

1. Expenses on Hospitalization for minimum period of 24 hours only are admissible. However this time limit will not apply for the day care treatments / procedures, where treatment is taken in the Hospital / Nursing Home and the Insured is discharged on the same day.
2. The Company's liability will begin only when the aggregate of the hospitalization expenses admissible under this policy during this policy period exceed the Deductible limit. The amount payable shall be the amount in excess of the deductible limit, however not exceeding the Sum Insured for the policy period.
3. For the purpose of calculating the aggregate deductible limit, the pre-hospitalization and post-hospitalization expenses will not be taken into account.

IV EXCLUSIONS

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 12 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 benefits are as follows

a. **Delivery Expenses:** Both self and spouse are covered under this policy for a period of 2 years continuously without break either under Individual or floater sum insured (or) if insured women alone covered under this policy for 4 years continuously without break.

b. **Organ Transplantation Expenses:** A waiting period of 12 months from the date of the first inception of this policy with the Company for the insured person

c. **Bariatric Surgery:** 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, are excluded

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

5. **Rest Cure, rehabilitation and respite care – Code Excl 05:** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons
   b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

6. **Obesity/ Weight Control (except to the extent covered under Coverage 11)– 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 members 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 (Except to the extent covered under Coverage 7)**
    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

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** (Except to the extent covered under Optional cover "Durable Medical Equipment/CAPD")

32. Any hospitalisation which are not medically necessary / does not warrant hospitalisation**- Code-Excl 36**

33. Other Excluded Expenses as detailed in the website www.galaxyhealth.com - **Code Excl 37** (Except to the extent covered under Coverage 13)

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.

V.CONDITIONS

Standard Conditions

1. **Disclosure of Information:** The policy shall be void and all premiums 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 or refer to the list of Networked Hospitals provided with the policy document. KYC (Identity proof with Address) of the proposer, as per AML Guidelines.
In non-network hospitals payment must be made up-front and then reimbursement will be effected on submission of documents.
Note: The Company reserves the right to call for additional documents wherever required.
Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person can go ahead with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

C. **For Reimbursement claims**: Time limit for submission of necessary claim documents for

S.no	**Type of Claim**	**Prescribed time limit**
1	Reimbursement of hospitalisation, day care and pre-hospitalisation expenses	Claim must be filed within 15 days from the date of discharge from the Hospital.
2	Reimbursement of Post hospitalisation	within 15 days after completion of 90 days from the date of discharge from hospital

D. **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.

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

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

Note:

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

3. Provision for Penal Interest

i) The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document
ii) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate

iii) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. ln such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document

iv) ln 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. **Claims in respect of multiple Policies held by policyholders:**
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:** lf 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.

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

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, 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, nondisclosure, misrepresentation and 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. Annually or Half Yearly or Quarterly or Monthly or two or four or twelve instalments as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. The grace period of 15 days (where premium is paid on a monthly instalments) and 30 days (where premium is paid in quarterly/half yearly/annual/2/4/12 instalments) is available on the premium due date, to pay the premium. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.
ii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, Waiting Periods for Pre-Existing Diseases, Moratorium Period etc.) accrued under the policy shall be protected. The same is applicable for both Indemnity and Benefit products.
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 affected.

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 – 600035.

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

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

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

If insured person is not satisfied with the redressal of grievance through one of 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 – 600035, 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 for more than 1st year, the Sum Insured including aggregate deductible limit, is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year or 3rd years cannot be utilized in the 1st year itself. 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 policy year

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

c) 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

d) 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.

e) 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. Special conditions: The proposer has the option to migrate to any Indemnity Health Insurance policy without the Aggregate Deductible limit at the beginning of the 6th year or during any successive renewal of this policy, with continuity of benefits for the average sum insured over the past 5 years, provided that

a. All insured persons must have been covered before the age of 50 years and continuously renewed without a break with the company
b. No claims has been made in the immediately preceding 5 years.
c. Once the option is exercised, this policy will not be renewed further.

30. 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 – 600035, 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, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.

Office Details	Jurisdiction of Office Union Territory, District)
BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh , Chhattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar – 751 009. Tel.: 0674 - 2596461 /2596455/2596003 Fax: 0674 – 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh& Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504/46013992 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

Office Details	Jurisdiction of Office Union Territory, District)
Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	
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 Fax: 040 - 23376599 Email: bimalokpal.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 Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.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: bimalokpal.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 / 3500613 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, 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,

Office Details	Jurisdiction of Office Union Territory, District)
	Azamgarh, Kushinagar, Gor khpur, 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: bimalokpal.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, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, 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 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district,Palghar District, Raigad district & Mumbai Metropolitan Region
THANE Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane - 400604 Email: bimalokpal.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."

Office Details	Jurisdiction of Office Union Territory, District)
For the details of Insurance Ombudsman, please visit: https://cioins.co.in/Complaint/Online	

List I — Items (This cover is available as inbuilt)

S. No	Item		S No	Item
1	Abdominal Binder		35	Laundry Charges
2	Ambulance		36	Leggings
3	Ambulance Collar		37	Lumbo Sacral Belt
4	Ambulance Equipment		38	Mask
5	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]		39	Medical Certificate
6	Armsling		40	Medical Records
7	Attendant Charges		41	Mineral Water
8	Baby Food		42	Mortuary Charges
9	Baby Utilities Charges		43	Nebulisation Kit
10	Beauty Services		44	Nebulizer Kit
11	Belts/ Braces		45	Nimbus Bed Or Water Or Air Bed Charges
12	Birth Certificate		46	Ounce Glass
13	Blood Grouping And Cross Matching Of Donors Samples		47	Oxygen Cylinder (For Usage Outside The Hospital)
14	Buds		48	Oxygen Mask
15	Carry Bags		49	Pan Can
16	Certificate Charges		50	Pelvic Traction Belt
17	Cervical Collar		51	Photocopies Charges
18	Cold Pack/Hot Pack		52	Private Nurses Charges- Special Nursing Charges
19	Conveyance Charges		53	Sanitary Pad
20	Courier Charges		54	Service Charges Where Nursing Charge Also Charged
21	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical) Pharmaceuticals Payable)		55	Slings
22	Crepe Bandage		56	Spacer
23	Diabetic Footwear		57	Spirometre
24	Diaper Of Any Type		58	Splint
25	ECG Electrodes		59	Steam Inhaler
26	Email / Internet Charges		60	Sugar Free Tablets
27	Extra Diet Of Patient (Other Than That Which Forms Part Of Bed Charge)		61	Surcharges
28	Eyelet Collar		62	Telephone Charges

29	Food Charges (Other Than Patient's Diet Provided By Hospital)		63	Television Charges
30	Gloves		64	Thermometer
31	Guest Services		65	Trolly Cover
32	Kidney Tray		66	Urometer, Urine Jug
33	Knee Braces (Long/ Short/ Hinged)		67	Vasofix Safety
34	Knee Immobilizer/Shoulder Immobilizer		68	Walking Aids Charges

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

S No	Item	S No	Item
1	Admission Kit	20	Flexi Mask
2	Air Conditioner Charges	21	Foot Cover
3	Baby Charges (Unless Specified/Indicated)	22	Gown
4	Bed Pan	23	Hand Holder
5	Blanket/Warmer Blanket	24	Hand Wash
6	Caps	25	House Keeping Charges
7	Clean Sheet	26	HVAC
8	Comb	27	IM IV Injection Charges
9	Cradle Charges	28	Incidental Expenses / Misc. Charges (Not Explained)
10	Daily Chart Charges	29	Luxury Tax
11	Diabetic Chart Charges	30	Patient Identification Band / Name Tag
12	Discharge Procedure Charges	31	Pulseoxymeter Charges
13	Disinfectant Lotions	32	Shoe Cover
14	Documentation Charges / Administrative Expenses	33	Slippers
15	Eau-De-Cologne / Room Freshners	34	Sputum Cup
16	Entrance Pass / Visitors Pass Charges	35	Tissue Paper
17	Expenses Related To Prescription On Discharge	36	Toothbrush
18	Face Mask	37	Toothpaste
19	File Opening Charges		

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

S No.	Item	S No.	Item
1	Apron	13	Gause Soft
2	Arthroscopy And Endoscopy Instruments	14	Gauze
3	Boyles Apparatus Charges	15	Hair Removal Cream
4	Camera Cover	16	Microscope Cover
5	Cotton	17	Orthobundle, Gynaec Bundle
6	Cotton Bandage	18	Surgical Blades, Harmonic scalpel, Shaver

7	Disposables Razors Charges (For Site Preparations)	19	Surgical Drill
8	DVD, CD Charges	20	Surgical Tape
9	Eye Drape	21	Torniquet
10	Eye Kit	22	Ward And Theatre Booking Charges
11	Eye Pad	23	X-Ray Film
12	Eye Shield		

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

S No.	Item	S No.	Item
1	Admission/Registration Charges	10	Hydrogen Peroxide\Spirit/ Disinfectants Etc
2	Alcohol Swabes	11	Infusion Pump— Cost
3	Antiseptic Mouthwash	12	Lozenges
4	Bipap Machine	13	Mouth Paint
5	Blood Reservation Charges And Ante Natal Booking Charges	14	Nutrition Planning Charges - Dietician Charges- Diet Charges
6	CPAP/ CAPD	15	Scrub Solution/Sterillium
7	Glucometer & Strips	16	Urine Bag
8	HIV Kit	17	Urine Container
9	Hospitalisation For Evaluation/ Diagnostic Purpose	18	Vaccination Charges

Schedule of Benefits										
S. No	**Sum Insured (Rs. in Lakhs)**	**5**	**10**	**15**	**20**	**25**	**50**	**75**	**100**	**200**
1	Room rent (Per day)	Single Private A/c Room								
2	Road Ambulance	Up to Rs.3,000 per hospitalisation								
3	Air Ambulance	Not applicable	Covered up to 10% of sum insured							

4	Pre hospitalisation Expenses	60 days
5	Post Hospitalization Expenses	90 days
6	Day Care Procedures	All day care procedures are covered
7	Delivery Expenses	10% of sum insured or of Rs 50,000, (including Caesarean & Normal delivery)
8	AYUSH Treatment	Covered up to Sum Insured
9	Modern Treatment	Covered up to sum insured
10	Nanotechnology	Covered up to 25% of sum insured
11	Bariatric Surgery	Covered up to sum insured
12	Organ Transplantation Expenses	Covered (Actuals) if insured is recipient
13	Consumables	Covered
14	Gala Fit - Pro Active Care (Wellness Engaging Program)	Premium Discount up to 10% on renewal premium
	Optional Covers (On payment of additional premium)	
15	Premium Promise	Premium remains same until claim is made or up to 55 years whichever is less
16	Room Rent Enhancement	Insured has an option to modify the room rent eligibility to any room
17	Durable Medical Equipment/CAPD	Covered up to 10% of sum insured or Rs 1 Lakh whichever is less