Policy Wording

Galaxy Guardian
Unique Identification No.: GHIHLIP25037V012425

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 preauthorization approved.

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

"Congenital Anomaly" refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
a. **Internal Congenital Anomaly** - Congenital Anomaly which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly.
b. **External Congenital Anomaly -** Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly.

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

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

"Day care Centre" means any institution established for day care treatment of Illness and / or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:
i. Has qualified nursing staff under its employment
ii. Has qualified medical practitioner/s in charge
iii. Has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

"Day Care treatment" means medical treatment, and / or surgical procedure which is:
i. Undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
ii. Which would have otherwise required a hospitalisation of more than 24 hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

"Domiciliary hospitalisation" means medical treatment for an Illness/Disease/Injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
i. The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii. The patient takes treatment at home on account of nonavailability of room in a hospital.

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

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

If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected. The same is applicable for both Indemnity and Benefit products.
Availability of insurance coverage during grace period: If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

"Hospital" A hospital means any institution established for in-patient care and day care treatment of Illness and/ or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:
i. Minimum 10 beds for multi-speciality and 5 beds for Single Speciality.
ii. 24 hours Medical Practitioner & Nursing Staffs.
iii. Medical Records Department (MRD).
iv. IT Solutions - Minimum System Requirements with internet facility.
v. Pollution Control Board Certificate or Any Government Registration certificate
vi. Operation Theatre with basic Requirements - Surgical Facility

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

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

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

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

b. Chronic condition - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:
1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests.
2. It needs ongoing or long-term control or relief of symptoms.
3. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. It continues 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:

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

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

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

"Newborn Baby" means baby born during the Policy Period and is aged upto 90 days.

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

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

"OPD treatment" means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

"Post-hospitalisation Medical Expenses" means Medical Expenses incurred during predefined number of days immediately after the Insured Person is discharged from the hospital provided that:
i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

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

"Pre-existing Disease" means any condition, ailment, injury or disease:
a. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
b. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy

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

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
b. 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 preexisting 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.

"Subrogation" means the right of the insurer to assume the rights of the Insured person to recover expenses paid out under the Policy that may be recovered from any other source.

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

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

Specific Definitions

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

"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.

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

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

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

"**Dependent Child**" means a child (natural or legally adopted), who is unmarried, aged between 5 months 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.

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

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

"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.

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

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

"Home" means the Insured Person's place of residence.

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

a) The Medical practitioner advice the Insured person to undergo treatment at home,

b) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment,
c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

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

"Instalment" means frequency of Premium amount paid through Single premium/ Quarterly / Half-yearly 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 Coverage" means Sum Insured plus Cumulative bonus earned wherever applicable.

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

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

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

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

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

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

"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

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

"Stroke" Any cerebrovascular incident producing permanent neurological sequelae.

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

III. COVERAGE

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

The coverage provided varies among plan offerings and only applies to the relevant covers opted by the insured person, as specified in the policy schedule and if during the period stated in the Policy Schedule the insured person

sustains bodily injury or contracts any disease or suffer from any illness requiring Hospitalisation and incurs expenses at any Nursing Home / Hospital in India as an In-patient, the Company will indemnify the Insured Person such expenses as are reasonably and necessarily incurred under the heads given below but not exceeding the Limit of Coverage stated in the Policy schedule.

1. Inpatient Treatment

a. Room rent inclusive of boarding, nursing charges, Residential/Duty Medical Officer charges during Hospitalisation as charged by the Hospital where the Insured Person availed medical treatment as per the table given below

Sum Insured (Rs.)	Limit per day
3,00,000	up to 1% of the Sum Insured
5,00,000	

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.

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

c. Anesthesia, Blood, Oxygen, Operation theatre charges, ICU charges, Surgical appliances, Medicines and Drugs, Diagnostic materials and X-ray, Diagnostic imaging modalities, investigation test, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses 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 as per the table given below in respect of the following are payable, provided that the hospitalisation claim is admissible.

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

Limit Per Hospitalisation (Rs)	Up to Rs.1,500/-
Limit Per Policy Period (Rs)	Up to Rs.3,000/-

3.Pre- Hospitalisation Expenses: Medical expenses incurred immediately before the insured person is hospitalized is not exceeding 30 days

4. Post Hospitalisation Expenses: Medical Expenses incurred in respect of the Insured Person immediately following the Insured Person's discharge from Hospital is not exceeding 60 days

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

6. Treatment of Cataract: Expenses incurred on treatment of Cataract is payable up to the limit as per the table given below:

Sum Insured (Rs.)	Limit per policy year (in Rs.)
3,00,000	Up to 25,000 /-
5,00,000	Up to 35,000 /-

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

7. Health Check-up: Expenses incurred towards cost of health check-up is payable up to the limits as per the table given below:

Sum Insured (Rs.)	Limit per policy year (Rs.)
3,00,000	Up to 750/-
5,00,000	Up to 1,000/-
Available at network hospital for every claim free year	

Note :

1. Any unutilized health check-up limit cannot be carried forward to the next Policy Year.
2. Payment under this cover will not have an impact on Cumulative Bonus / No Claim Discount.

8. Home Care Treatment

The Company will pay for expenses towards treatment availed by the Insured Person at home up to 10% of Sum Insured in a policy year. It is available only for the specified conditions mentioned below, which in normal course would require care and treatment at a hospital but is actually taken at home.

The below listed are covered

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

Note:

a. The Medical practitioner advises the Insured person to undergo treatment at home
b. There is a continuous active line of treatment with monitoring of health status by a medical practitioner for each day
   through the duration of the home care treatment
c. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained
d. Insured can avail ''Home Care Treatment'' service, if availed from the list of Network service provider given in the Company website ''www.galaxyhealth.com''
e. Exclusion No.1: Pre-Existing disease (Code Excl 01), Exclusion No.2: Specified disease (Code Excl 02), Exclusion No.3: Initial waiting period (Code Excl 03) are applicable and the above mentioned sub-limit will apply.
f. Insured claiming under this cover for Post CVA Care at Home after discharge, will not be eligible to claim under Rehabilitation and Pain Management for Stroke.

9. Rehabilitation and Pain Management: The company will pay the medical expenses up to Rs.25,000/- per policy year for Rehabilitation and Pain Management.

Rehabilitation: The company will pay the expenses for rehabilitation, if availed at authorized centres as an In-patient/Out-patient, and if there is an admissible claim for In-patient hospitalisation for an injury, disease or illness specified below.

1. Poly Trauma
2. Head injury
3. Diseases of the spine
4. Stroke

S. No.	Name of the covered Pain Management Treatment
1	Lumbar and cervical medial branch block with RF ablation for lumbar and cervical facet joint arthritis
2	Caudal epidural injection for Discogenic pain
3	Lumbar and cervical selective nerve root block for Lumbar and Cervical radicular pain
4	Caudal Neuroplasty for Failed back spine surgery
5	Stellate ganglion ablation for upper limb CRPS
6	Occipital nerve Pulsed RF lesioning for Migraines, Cluster headache and cervicogenic headaches
7	Lumbar sympathetic chain RF ablation for lower limb CRPS, diabetic periphery painful neuropathy and Ischaemic limb pain
8	Gasserian ganglion ablation for Trigeminal neuralgia
9	Intercostal nerve Ablation for post thoracotomy pain and Thoracic malignancy pain
10	Coeliac plexus ablation for upper gastrointestinal malignancies pain
11	Superior hypogastric plexus ablation for lower Gastro intestinal malignancies pain
12	Ganglion impar ablation for perineal cancer pain and coccydynia
13	Cooled RF ablation of genicular nerve for grade 1 and 2 osteoarthritis knee and hip
14	Suprascapular nerve RF ablation for rotator cuff partial tear and peri arthritis shoulder pain
15	Physiotherapy maximum 10 session will be allowed per policy period not exceeding Rs.10,000/- per policy period

Important Note:

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

10. Newborn Baby cover: Hospitalisation expenses for treatment of newborn is covered up to 10% of the mothers sum insured (including for twins/ triplets/ quadruplets) incurred in a hospital/ nursing home for any disease, illness or accidental injuries are payable as follows.
Waiting Period: Provided the mother is insured under the policy for a continuous period of 12 months without break in this policy

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

Note:

1. Intimation about the birth of the Newborn Baby should be given to the company and policy must be endorsed for this cover to commence.
2. Exclusion no. 3 initial waiting period (Code Excl 03) as stated under this policy shall not apply for the Newborn Baby
3. All other terms, conditions and exclusions shall apply for the Newborn Baby.
4. The Exclusion No.1: Pre-Existing disease (Code Excl 01), Exclusion No.2: Specified disease (Code Excl 02), and the above-mentioned sub-limit will not apply for treatment related to Congenital Internal disease/defects for the newborn.

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

Sum Insured (Rs.)	Limit Per Policy Year (Rs.)
3,00,000	Up to 90,000/-
5,00,000	Up to 1,50,000/-

Conditions:

a) This benefit is subject to a waiting period of 24 months from the date of first commencement of this policy

and continuous renewal thereof with the Company

b) The minimum age of the insured at the time of surgery should be above 18 years

c) This benefit shall not apply where the surgery is performed for
   i. Reversible endocrine or other disorders that can cause obesity
   ii. Current drug or alcohol abuse
   iii. Uncontrolled, severe psychiatric illness
   iv. Lack of comprehension of risks, benefits, expected outcome, alternatives and lifestyle changes required with bariatric surgery
   v. Bariatric surgery performed for Cosmetic reasons

d) 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.

e) To make a claim, the insured person should satisfy the following criteria as devised by NIH (National Institute of Health)
   i. The BMI should be greater than 40 or greater than 35 with co-morbidities (like Diabetes, High Blood Pressure etc.)
   ii. The insured person is unable to lose weight through traditional methods like diet and exercise

12. 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	**Up to the limit per policy year (Rs.)**
I	Robotic Surgeries	a	Total Knee Replacement & Total Hip Replacement	Maximum up to Rs.4,00,000/- or up to sum insured whichever is less, (Including the Costs of Implants)
		b	Radical Prostatectomy	Up to sum insured
			Wipples Procedure	
			For treatment of Thoracic & Abdominal Malignancies	
			Complex Intra-Abdominal Surgeries	
		c	For treatment of Laryngeal & Pharyngeal Cancers	Up to sum insured
			Staging Laparotomy (including the cost of instruments)	
			Cyto-reduction Surgeries	
		d	For all other Robotic procedures	Up to 30% sum insured
II	Immunotherapy – Monoclonal Antibody to be given as injection	a	For Cancer Treatment	Up to sum insured
		b	Other than treatment of Cancer	Up to 30% sum insured
III	Stem Cell Therapy Hematopoietic stem cells for bone marrow transplant for haematological conditions	a	For Cancer Treatment	Up to sum insured
		b	Other than treatment of Cancer	Up to 30% sum insured
IV	Intravitreal Injection	a	Allowed Maximum 2 injections per eye (4 injection both eyes) per policy period	Up to 30% sum insured
V	Deep Brain Stimulation	a	Up to sum insured	
VI	Other Modern Treatments	a	Balloon Sinuplasty	Up to 30% sum insured
		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	

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

14. Organ Transplantation Expenses: Hospitalisation medical expenses incurred to the Insured Person for inpatient organ transplantation treatment, including the harvesting of the donated organ will be covered upto sum insured subject to a waiting period of 36 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.

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

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

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

16. Outpatient Consultation:
Expenses of Medical Consultations as an Outpatient incurred in a Network Hospital is payable up to the limits mentioned in the below table of benefits with a limit of Rs.750/- per consultation. Payment under this section does not form part of Sum Insured, and payable while the policy is in force.

Sum Insured	Limit Per Policy Year (Rs.)
3,00,000	Up to 2,000/-
5,00,000	Up to 3,000/-

Note: Settling any claim under this section does not imply that the Company waives its right to deny any claim due to non-disclosure of important information or pre-existing conditions, as per the hospitalization terms of the policy contract.

17. A. Cumulative Bonus: The Company will provide a Cumulative Bonus at 10% of the Sum Insured at the end of every claim free year subject to a maximum of 50 %, if the policy is continuously renewed with the company.
Conditions

1. The Cumulative bonus will be calculated on the expiring Sum Insured.
2. If the insured opts to reduce the sum insured at the subsequent renewal, the limit of indemnity by way of such Bonus shall not exceed such reduced sum insured.
3. In the event of a claim, such bonus so granted will be reduced at the same rate at which it has accrued.

17. B. No Claim Discount (in lieu of Cumulative Bonus)**:** Policy is eligible for no claim discount in lieu of no claim bonus as per the given below,

Sum Insured	Discount in Premium
3,00,000	3%
5,00,000	2%

Note:

i. The customer should opt for either cumulative bonus or No claims discount during the first purchase of this policy and the same will be maintained throughout the lifetime.

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

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

Policy Type	Fresh	
Sum Insured (Rs.)	3,00,000	
Self and Age	36	
Base Premium (Rs.)	6,208	A
Add: GST at 18% (Rs.)	1,117	B = A * 18
Total Premium (Rs.)	7,325	C = A+B
During Renewal, Insured enhanced sum Insured to Rs.5,00,000/- and opted No Claim discount		
Policy Type	Renewal	
Sum Insured Enhanced to (Rs.)	5,00,000	
Self and Age	37	
Base Premium (Rs.)	7,431	D
Less: No Claims Discount at 4% (Rs.)	124	E = A*2%
Sub-total (Rs.)	7,307	F = D-E
Add: GST at 18% (Rs.)	1,315	G = F*18%
Total Premium (Rs.)	8,622	H = F+G

18 Co-payment: Each and every claim under the Policy shall be subject to a co-payment of 10% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

S. No.	Schedule of Benefits	Forming part of Sum Insured / In addition to Sum Insured
1	Room rent including boarding, nursing charges, Residential /Duty Medical Officer charges, Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees, Anesthesia, Blood, Oxygen, Operation theatre charges, ICU charges, Surgical appliances, Medicines and Drugs, Diagnostic materials and X-ray, Diagnostic imaging modalities, investigation test, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses with regard to coronary stenting, medicines, Implants and other similar items the Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping	Forming part of Sum Insured
2	Road Ambulance	Forming part of Sum Insured
3	Pre-Hospitalisation	Forming part of Sum Insured
4	Post Hospitalisation	Forming part of Sum Insured
5	Day Care Procedures	Forming part of Sum Insured
6	Cataract	Forming part of Sum Insured
7	Health Check-Up	In addition to Sum Insured
8	Home Care Treatment	Forming part of Sum Insured
9	Rehabilitation and Pain Management	Forming part of Sum Insured
10	Newborn Baby Cover	Forming part of Sum Insured
11	Bariatric Surgery	Forming part of Sum Insured

12	Modern Treatments	Forming part of Sum Insured
13	AYUSH	Forming part of Sum Insured
14	Organ Transplantation	Forming part of Sum Insured
15	Domiciliary Hospitalisation	Forming part of Sum Insured
16	Outpatient Consultation	In addition to Sum Insured
17.A	Cumulative Bonus	In addition to Sum Insured
17.B	No Claim Discount	Not Applicable

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 36 months of continuous coverage after the date of inception of the first policy with insurer
   - B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   - C. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
   - D. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer, applicable for 1 year / 2 year / 3 year term plans.

2. **Specified disease/procedure waiting period – Code Excl 02**
   Expenses related to the treatment of the listed conditions: surgeries/treatments shall be excluded until the expiry of 24 months, provided 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. Applicable for 1 year / 2 year / 3 year term plans.
   - A. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   - B. 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.
   - C. The waiting period for listed conditions shall apply even if contracted after the policy inception or declared and accepted without a specific exclusion.
   - D. 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.
   - E. 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. Congenital Internal disease / defect - [except for Newborn Coverage (10)].

Note: Waiting period for the following benefits are as follows

a. **Organ Transplantation:** A waiting period of 36 months from the date of first inception of this policy with the Company for the insured person for all types of transplant and related surgeries including Stem Cell transplant.

b. **Bariatric Surgery:** A waiting period of 24 months from the date of first inception of this policy with the Company.

c. **New born cover:** A waiting period of 12 months from the date of first inception for the mother in this policy with the Company

3. **30-day waiting period – Code Excl 03 (Not Applicable for Accidents)**
   a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months
   c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently
4. **Investigation & Evaluation – Code Excl 04**
   a. Expenses related to any admission, primarily for diagnostics and evaluation purposes only are excluded
   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded
5. **Rest Cure, rehabilitation (except to the extent covered under Coverage 9) 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**
    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

A. <u>Specific Exclusions</u>

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. Inoculation or Vaccination (except for post–bite treatment and for medical treatment for therapeutic reasons) **-Code- Excl 31**

30. Any payment in case of more than one claim under the policy during the period of insurance by which the maximum liability of the Company in that period would exceed the amount specified in the Schedule **Excl 34**
31. Cost of spectacles and contact lens, hearing aids, Cochlear implants and procedures, walkers and crutches, wheelchairs, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis, infusion pump and such other similar aids. **-Code- Excl 35**
32. Any hospitalisation which are not medically necessary / does not warrant hospitalisation**-Code-Excl 36**
33. Other Excluded Expenses as detailed in the website www.galaxyhealth.com - **Code Excl 37**
34. Existing disease/s, disclosed by the insured and mentioned in the policy schedule under permanent exclusion (based on insured's consent), for specified ICD codes **-Code- Excl 38**
35. All treatment/Interventions for Erectile Dysfunctions
36. Expenses for venereal disease or any sexually transmitted disease except HIV/AIDS
37. 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 premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policy holder.

2. **Claim Settlement**
   A. **Condition Precedent to Admission of Liability**: The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy
   B. **For Cashless Treatment:**
      a. Call the 24 hour help-line for assistance – 18002030007.Senior Citizens may call at 18002030007
      b. Inform the ID number for easy reference
      c. On admission in the hospital, produce the ID Card issued by the Company at the Hospital Helpdesk
      d. Obtain the Pre-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk. (Insurers shall also provide pre-authorization to the policyholder through Digital mode).
      e. The Treating Doctor will complete the hospitalisation/ treatment information, and the hospital will fill up expected cost of treatment. This form is submitted to the Company
      f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.
      g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits.
      h. In case of emergency hospitalisation information to be given within 24 hours after hospitalisation
      i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.galaxyhealth.com or contact the nearest branch 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 60 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

For Outpatient Consultation:

i. 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;
ii. Duly completed claim form, and
iii. Certificate from the attending doctor regarding the diagnosis
iv. Prescription of the treating doctor
v. Receipt from the treating doctor / hospital / Physiotherapist
vi. KYC (Identity proof with Address) of the proposer, as per AML Guidelines
vii. NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code
viii. CKYC No. of the proposer (if available)

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.
iv. In case of Accidents and emergency treatments, insured person can claim for Outpatient consultation expenses in non-network hospitals also.

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) ln 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) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim

v) "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

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

5. **Claims in respect of multiple Policies held by policyholders:**
a) Indemnity Policies:
A policyholder can file for claim settlement as per his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer. In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

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

7. **Cancellation**
i. The policyholder may cancel his/her policy at any time during the term, by giving 7 day's 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, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.

10. **Renewal of Health Insurance policy:**
   a. A health insurance policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate.
   b. An Insurer shall not deny the renewal on the ground that the policyholder had made a claim (s) in the preceding policy years.
   c. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
   d. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
   e. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
   f. Coverage is not available during the grace period.
   g. No loading shall apply on renewals based on individual claims experience

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

12. **Moratorium Period:** After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud, 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. Single premium, Half Yearly or Quarterly 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 30 days (where premium is paid in single/ quarterly/half yearly instalments) is available on the premium due date, to pay the premium. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

ii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, Waiting Periods for Pre-Existing Diseases, Moratorium Period etc.) accrued under the policy shall be protected. 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. ln case of instalment premium due not received within the grace period, the policy will get cancelled.
v. ln the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vi. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

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

15. **Free Look Period**: The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of 30 days from date of receipt of the policy document whether electronically or otherwise to review the terms and conditions of the policy, and to return the same if not acceptable.

lf 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.

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

lf lnsured 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

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

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

17. **Nomination:**

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

Specific Conditions

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

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

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

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

22. Notice and Communication: Any notice, direction or instruction given under this Policy by the policy holder / claimant shall be in writing and delivered by hand, post or / email to Galaxy Health Insurance Company Limited, Prestige Polygon – 12th Top Floor (P), No. 471, Anna Salai, Nandanam, Chennai – 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 and Limit of Coverage.

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.**

28. 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.

29. Important Note

a) Where the policy is issued for more than 1st year, the Sum Insured including sublimit benefit (if applicable) is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year or 3rd years 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) The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws

c) The terms conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each relevant insured person. Failure to comply with may result in the claim being denied.

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

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.
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).

Office Details	Jurisdiction of Office Union Territory, District)
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, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 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.

Office Details	Jurisdiction of Office Union Territory, District)
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, 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	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
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	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.
For the details of Insurance Ombudsman, please visit: https://cioins.co.in/Complaint/Online	

List I — Consumable Items

Sl No	Item		Sl 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

Sl No	Item 2	Sl No	Item 2
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

Sl No.	Item 3	Sl No.	Item 3
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, HARMONICSCALPEL, 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 SHEILD		

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

Sl No.	Item	Sl 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 EQUIPMENTS	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

Table of Benefits

S. No.	Schedule of Benefits	Sum Insured Rs.3 Lakhs	Sum Insured Rs.5 Lakhs
1.A	Room, Boarding, Nursing Expenses all-inclusive as	1% of Sum Insured	1% of Sum Insured

	provided by the Hospital / Nursing Home as per the limits		
1.B	ICU Room	Actuals	Actuals
2	Road Ambulance	Covered up to Rs.1,500/- per hospitalisation, Rs.3,000/- per policy year	Covered up to Rs.1,500/- per hospitalisation, Rs.3,000/- per policy year
3	Pre Hospitalisation	30 days	30 days
4	Post Hospitalisation	60 days	60 days
5	Day Care Procedures	All day care procedures are covered.	All day care procedures are covered.
6	Cataract	Rs.25,000/-	Rs.35,000/-
7	Health Check-Up	Rs.750/-	Rs.1,000/-
8	Home Care Treatment	Up to 10% of Sum Insured	Up to 10% of Sum Insured
9	Rehabilitation and Pain Management	Up to Rs.25,000/- per policy period	Up to Rs.25,000/- per policy period
10	Newborn Baby Cover	Up to 10% of Sum Insured	Up to 10% of Sum Insured
11	Bariatric Surgery	Up to Rs.90,000/-	Up to Rs.1,50,000/-
12	Modern Treatments	Sublimit applicable	Sublimit applicable
13	AYUSH	Actuals	Actuals
14	Organ Transplantation	Covered up to the Sum Insured- For Insured	Covered up to the Sum Insured- For Insured
15	Domiciliary Hospitalisation	Covered up to the Sum Insured	Covered up to the Sum Insured
16	Outpatient Consultation	Rs.2,000/-	Rs.3,000/-
17.a	Cumulative Bonus (or) No Claim Discount	10% of the Sum Insured for every claim free year subject to maximum of 50 %	10% of the Sum Insured for every claim free year subject to maximum of 50 %
17.b		3% on the premium	2% on the premium
18	Co-payment	10% of every admissible claim amount	10% of every admissible claim amount