Policy Wording

Galaxy Marvel

UIN: GHIHLIP26042V012526

I Preamble

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

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

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

II Definitions

Standard Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

vi. Operation Theatre with basic Requirements - Surgical Facility

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

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

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

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

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

"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

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

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

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

"Aggregate Deductible" means the aggregate of admissible hospitalization expenses in a policy year up to which the Company is not liable. (Applicable for each year).

"Any Room" any category room in a hospital.

"Assisted Reproduction Treatment" means Intra Uterine Insemination (IUI), Intra-Cytoplasmic Sperm Injection (ICSI), In-Vitro Fertilization (IVF) and TESA / TESE (Testicular / Epididymal Sperm Aspiration / Extraction).

"Assisted Reproductive Technology (ART) Act" means the Assisted Reproductive Technology (Regulation) Act, 2021 and its amendments.

"Assisted Reproductive Technology clinic" means any premises equipped with requisite facilities and medical practitioners registered with the National Medical Commission for carrying out the procedures related to the assisted reproductive technology.

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

"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.

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

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

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

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

"Dependent Child" means a child (natural or legally adopted), who is unmarried, aged between 16 days and 30 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.

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

"Family" includes Insured Person, Spouse, dependent children between 16 days and 30 years of age not exceeding 3 in number and Dependent Parent / Parents in law.

"General Ward" is the basic (cheapest) category of hospital room with several beds, typically with more than three patient beds and is usually equipped with basic amenities such as beds, bedside tables, and shared bathroom facilities.

"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.

"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.

"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 instalment/4 instalment/12 instalment mode by the Policy Holder/ Insured.

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

"Limit of Coverage" means Sum Insured plus Bonus earned plus Enhanced Multiplier 3X or 10X (if opted) plus Automatic Restoration plus Advance Access (if opted).

"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 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.

"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.

"Shared Room" A basic category of Shared Room in a Hospital with / without air-conditioning with two or three patient beds.

"Single Private A/C room" means a single occupancy air-conditioned room with attached washroom 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 or a Suite room.

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

"**Still Birth**" means a baby born without signs of life.

Zones:

Zone A: Gujarat, Haryana, Rajasthan, Punjab, Chandigarh, NCR of Delhi, Mumbai, Thane, Ghaziabad and Noida.
Zone B: Hyderabad including K V Ranga Reddy and Medchal Malkajgiri, Secunderabad, Patna, Goa, Himachal Pradesh, Bengaluru, Thiruvananthapuram, Ernakulam, Bhopal, Indore, Pune, Nashik, Chennai, Lucknow and Kolkata.
Zone C: Rest of India.

Definition of Critical Illness:-

Standard Definition

1. **CANCER OF SPECIFIED SEVERITY:** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

   The following are excluded –

   i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

   ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. **MYOCARDIAL INFARCTION:** The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

A. Other acute Coronary Syndromes
B. Any type of angina pectoris
C. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. **OPEN CHEST CABG**

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
The following are excluded
Angioplasty and/or any other intra-arterial procedures are excluded:

4. **REPAIR / REPLACEMENT OF HEART VALVES:** The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves or Trans catheter aortic valve implantation (TAVI) under anesthesia, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve. The diagnosis of the valve abnormality must be supported by an echocardiography/ a cardiac catheterization and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques apart from TAVI (Trans catheter aortic valve implantation), including but not limited to, balloon valvotomy/valvuloplasty are excluded. "

5. **COMA OF SPECIFIED SEVERITY:** A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. **KIDNEY FAILURE REQUIRING REGULAR DIALYSIS:** End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. **STROKE RESULTING IN PERMANENT SYMPTOMS:** Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

   The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. **SURGERY FOR MAJOR ORGAN /BONE MARROW TRANSPLANT:** The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

   The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

9. **PERMANENT PARALYSIS OF LIMBS:** Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. **MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS:** Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective

evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded

12. BENIGN BRAIN TUMOR: Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord are excluded.

13. BLINDNESS: Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or ;
ii. the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

14. DEAFNESS: Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

15. END STAGE LUNG FAILURE: End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
iv. Dyspnea at rest.

16. **END STAGE LIVER FAILURE:** Permanent and irreversible failure of liver function that has resulted in all three of the following:
    i. Permanent jaundice; and
    ii. Ascites; and
    iii. Hepatic encephalopathy
    iv. Liver failure secondary to drug or alcohol abuse is excluded.

17. **LOSS OF SPEECH:** Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

18. **LOSS OF LIMBS:** The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

19. **MAJOR HEAD TRAUMA:** Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
    The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.
    The Activities of Daily Living are:
    i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
    ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
    iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
    iv. Mobility: the ability to move indoors from room to room on level surfaces;
    v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
    vi. Feeding: the ability to feed oneself once food has been prepared and made available. Spinal cord injury are excluded:

20. **PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION:** An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac

impairment.

The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. **MAJOR THIRD DEGREE BURNS:** There must be third-degree burns with scarring that cover at least 40% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 40% of the body surface area.

Specific Definition

22. **ALZHEIMER'S DISEASE** Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner.

    The following conditions are however not covered:

    a. non-organic diseases such as neurosis and psychiatric Illnesses;
    b. alcohol related brain damage; and
    c. any other type of irreversible organic disorder/dementia.

23. **CREUTZFELDT-JACOB DISEASE (CJD)** Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A Registered Doctor, who is a neurologist, must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.

24. **ENCEPHALITIS** Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Doctor who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks.

    Encephalitis caused by HIV infection is excluded.

25. **FULMINANT HEPATITIS** A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

    a. Rapid decreasing of liver size;
    b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
    c. Rapid deterioration of liver function tests;

d. Deepening jaundice; and
e. Hepatic encephalopathy.

Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

26. **MUSCULAR DYSTROPHY** A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a Registered Doctor who is a consultant neurologist. The condition must result in the inability of the Life Insured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" for a continuous period of at least 6 months.

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

27. **AORTA GRAFT SURGERY** The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

The following are exclude from this definition

a. Surgery performed using only minimally invasive or intra-arterial techniques.
b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

28. **SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS** A multi-system autoimmune disorder characterised by the development of autoantibodies directed against various self-antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a Registered Doctor specialising in Rheumatology and Immunology.

The WHO Classification of Lupus Nephritis:
Class I Minimal Change Lupus Glomerulonephritis
Class II Messangial Lupus Glomerulonephritis
Class III Focal Segmental Proliferative Lupus Glomerulonephritis
Class IV Diffuse Proliferative Lupus Glomerulonephritis
Class V Membranous Lupus Glomerulonephritis

29. **DISSECTING AORTIC ANEURYSM** A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a Registered Doctor who is a specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.

30. **INFECTIVE ENDOCARDITIS** Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:
    I. Positive result of the blood culture proving presence of the infectious organism(s);
    II. Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and
    III. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a Registered Doctor who is a cardiologist.

31. **SEVERE ULCERATIVE COLITIS** Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.
    All of the following criteria must be met:
    - the entire colon is affected, with severe bloody diarrhoea; and
    - the necessary treatment is total colectomy and ileostomy; and
    - the diagnosis must be based on histopathological features and confirmed by a Registered Doctor who is a specialist in gastroenterology.

32. **AMPUTATION OF FEET DUE TO COMPLICATIONS FROM DIABETES** Diabetic neuropathy and vasculitis resulting in the amputation of both feet at or above ankle as advised by a Registered Doctor who is a specialist as the only means to maintain life. Amputation of toe or toes, or any other causes for amputation shall not be covered.

33. **APALLIC SYNDROME** Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.

34. **APLASTIC ANEMIA** Chronic persistent bone marrow failure which results in anemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:
    - Blood product transfusion;
    - Marrow stimulating agents;
    - Immunosuppressive agents; or
    - Bone marrow transplantation.

    The diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:

a. Absolute neutrophil count of less than 500/mm^3 or less
b. Platelets count less than 20,000/mm^3 or less
c. Reticulocyte count of less than 20,000/mm^3 or less

Temporary or reversible Aplastic Anemia is excluded.

35. **BACTERIAL MENINGITIS:** Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:
    a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
    b. A consultant neurologist.

    Bacterial Meningitis in the presence of HIV infection is excluded.

36. **BRAIN SURGERY** The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are all excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Registered Doctor who is a qualified specialist.

37. **CHRONIC ADRENAL INSUFFICIENCY (ADDISON'S DISEASE)** An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a Registered Doctor who is a specialist in endocrinology through one of the following:
    - ACTH simulation tests;
    - insulin-induced hypoglycemia test;
    - plasma ACTH level measurement;
    - Plasma Renin Activity (PRA) level measurement.

    Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.

38. **CHRONIC RELAPSING PANCREATITIS** An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Registered Doctor who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterised by irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence.

    Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

39. **CROHN'S DISEASE** Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite

of optimal therapy, with all of the following having occurred:

I. Stricture formation causing intestinal obstruction requiring admission to hospital, and
II. Fistula formation between loops of bowel, and
III. At least one bowel segment resection.

The diagnosis must be made by a Registered Doctor who is a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.

40. **EISENMENGER'S SYNDROME** Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a Registered Doctor who is a specialist with echocardiography and cardiac catheterisation and supported by the following criteria:
    I. Mean pulmonary artery pressure > 40 mm Hg;
    II. Pulmonary vascular resistance > 3mm/L/min (Wood units); and
    III. Normal pulmonary wedge pressure < 15 mm Hg.

41. **HEMIPLEGIA** The total and permanent loss of the use of one side of the body through paralysis caused by illness or injury, except when such injury is self-inflicted.

42. **HIV DUE TO BLOOD TRANSFUSION AND OCCUPATIONALLY ACQUIRED** HIV Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:
    I. The blood transfusion was medically necessary or given as part of a medical treatment;
    II. The blood transfusion was received in India after the Policy Date, Date of endorsement or Date of reinstatement, whichever is the later;
    III. The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and
    IV. The Life Insured does not suffer from Thalassaemia Major or Haemophilia.

    Infection with the Human Immunodeficiency Virus (HIV) which resulted from an Accident occurring after the Policy Date, date of endorsement or date of reinstatement, whichever is the later whilst the Life Insured was carrying out the normal professional duties of his or her occupation in India, provided that all of the following are proven to the Company's satisfaction:
    I. Proof that the Accident involved a definite source of the HIV infected fluids;
    II. Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented Accident. This proof must include a negative HIV antibody test conducted within 5 days of the Accident; and
    III. HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

    This benefit is only payable when the occupation of the Life Insured is a Registered Doctor, housemen, medical student, registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in India. This benefit will not apply where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.

43. **LOSS OF INDEPENDENT EXISTENCE** Inability to perform at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months and leading to a permanent inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor.

    All psychiatric related causes are excluded.

    Activities of daily living:

    I. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
    II. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
    III. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
    IV. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
    V. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
    VI. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence.

44. **LOSS OF ONE LIMB AND ONE EYE** Total, permanent and irrecoverable loss of sight of one eye and loss by severance of one limb at or above the elbow or knee.

    The loss of sight of one eye must be clinically confirmed by a Registered Doctor who is an eye specialist, and must not be correctable by aides or surgical procedures.

45. **MEDULLARY CYSTIC DISEASE** Medullary Cystic Disease where the following criteria are met:
    - the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
    - clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
    - the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

    Isolated or benign kidney cysts are specifically excluded from this benefit.

46. **MYELOFIBROSIS** A disorder which can cause fibrous tissue to replace the normal bone marrow and **results** in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Life Insured requires a blood transfusion at least monthly. The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a Registered Doctor who is a specialist.

47. **OTHER SERIOUS CORONARY ARTERY DISEASE** Severe coronary artery disease in which at least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only (non-invasive diagnostic procedures excluded).

    For purposes of this definition, "major coronary artery" refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).

48. **PHEOCHROMOCYTOMA** Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.

    The Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.

49. **POLIOMYELITIS** The occurrence of Poliomyelitis where the following conditions are met:
    1. Poliovirus is identified as the cause,
    2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

50. **PROGRESSIVE SCLERODERMA** A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

    The following are excluded:
    - Localised scleroderma (linear scleroderma or morphea);
    - Eosinophilic fasciitis; and CREST syndrome.

51. **PROGRESSIVE SUPRANUCLEAR PALSY** Confirmed by a Registered Doctor who is a specialist in neurology of a definite diagnosis of progressive supranuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability.

52. **SEVERE RHEUMATOID ARTHRITIS** Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:
    - Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
    - Permanent inability to perform at least two (2) "Activities of Daily Living";
    - Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and
    - The foregoing conditions have been present for at least six (6) months.

53. **TERMINAL ILLNESS** The conclusive diagnosis of an illness, which in the opinion of a Registered Doctor who is an attending Consultant and agreed by our appointed Registered Doctor, life expectancy is no greater than twelve (12) months from the date of notification of claim, regardless of any treatment that might be undertaken.

54. **TUBERCULOSIS MENINGITIS** Meningitis caused by tubercle bacilli, resulting in permanent

neurological deficit. Such a diagnosis must be confirmed by a Registered Doctor who is a specialist in neurology.

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 policy 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.

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

1. **Inpatient Treatment**
   a. Room rent (Any room) inclusive of boarding, nursing charges, Residential/Duty Medical Officer charges during Hospitalisation as charged by the Hospital where the Insured Person availed medical treatment.

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

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

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

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

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

5. **Road Ambulance:** Expenses incurred towards ambulance charges for the following are payable, provided the hospitalization claim is admissible.
   i. for transportation of the insured person by private ambulance service to go to hospital when this is needed for medical reasons or
   ii. for transportation of the insured person by private ambulance service from one hospital to another hospital for better medical treatment or

iii. for transportation of the insured person from the hospital where treatment is taken to their place of residence (if it is in same city) provided the requirement of an ambulance to the residence is certified by the medical practitioner.

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

7. **Modern Treatment:** The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to sum insured (including Pre and Post hospitalisation expenses) during the policy year;

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

8. **Domiciliary Hospitalisation:** Coverage for medical treatment (Including AYUSH) for a period exceeding three days, for an illness/disease/injury, which in the normal course, would require care and treatment at a hospital but, on the advice of the attending Medical Practitioner, is taken whilst confined at home under any of the following circumstances.
   - The condition of the patient is such that he/she is not in a condition to be moved to a Hospital, or
   - The patient takes treatment at home on account of non-availability of room/bed in a hospital.

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

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

The below listed are covered

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

Note:

a. The Medical practitioner advises the Insured person to undergo treatment at home.
b. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment
c. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
d. Insured can avail ''Home Care Treatment'' service, if availed from the list of Network service provider given in the Company website ''www.galaxyhealth.com''
e. Exclusion No.1: Pre-Existing disease (Code Excl 01), Exclusion No.2: Specified disease (Code Excl 02), Exclusion No.3: Initial waiting period (Code Excl 03) are applicable and the above mentioned sub-limit will apply.

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

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

Conditions:

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 shall 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

11. Organ Transplantation Expenses: Hospitalisation medical expenses incurred to the Insured Person for inpatient organ transplantation treatment, including the harvesting of the donated organ will be covered upto sum insured subject to a waiting period of 24 months from the date of first inception of this policy with the Company.
Note : Organ transplant on the Insured Person shall satisfy the requirements of the Transplantation of Human Organs Act of 1994 and any amendments thereto.

12. Organ Donor Expenses

i. For Donor:

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

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

Note:

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

ii. For Insured:

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

a. The donation conforms to the Transplantation of Human Organs Act 1994 and any amendments thereafter and the organ is for the use of the Insured Person.
b. The organ transplant is certified in writing by a Medical Practitioner as Medically Necessary Treatment for the Insured Person.

c. A waiting period of 24 months from the date of first commencement of this policy.

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

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

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

Note:

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

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

a) **For one year policy term:** The coverage for newborn baby starts from day-1 after its birth till the expiry date of the policy year, as per the table given below subject to availability of the sum insured.

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

Sum Insured (Rs.)	Limit per policy year (Rs.)

5,00,000 /- to 25,00,000/-	**10% of sum insured or upto Rs.2,50,000/-, whichever is less**
1,00,00,000/- and 2,00,00,000/-	**10% of sum insured or upto Rs.5,00,000/- whichever is less**

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

Note:

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

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

Note:

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).

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

Conditions

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

17. Premium waiver:

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

Note:

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

b. For Voluntary organ donor:

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

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

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

Conditions

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

Illustration:

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

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

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

Note:

i. The customer should opt for either Bonus or No claim 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.)	5,00,000	
Family Size	2A	
Zone	A	
Self and Spouse Age	36 and 31	
Base Premium (Rs.)	11,854	A
Add: GST at 18% (Rs.)	2,134	B = A * 18
Total Premium (Rs.)	13,988	C = A+B
During Renewal, Insured enhanced sum Insured to Rs.10,00,000/- and opted No Claim discount		
Policy Type	Renewal	
Sum Insured Enhanced to (Rs.)	10,00,000	
Family Size	2A	
Zone	A	
Self and Spouse Age	37 and 32	
Base Premium (Rs.)	13427	D
Less: No Claims Discount at 4% (Rs.)	474	E = A*4%
Sub-total (Rs.)	12,953	F = D-E
Add: GST at 18% (Rs.)	2,332	G = F*18%
Total Premium (Rs.)	15,285	H = F+G

19. **NRI/OCI Benefit** – The Company will provide a discount of 15% on base cover premium to Non-Resident Indians / Overseas Citizens of India, provided that the Insured Person(s)-
    a. Provides declaration upon Policy Issuance and subsequent renewals that they are Non-Resident Indians / Overseas citizens of India based abroad in entirety for the Policy Year.
    b. Provides proof of overseas residence for the upcoming year upon each renewal to continue availing the discount
    c. Possesses and provides other relevant identity proof documents as mandated for Citizenship of India
    d. Has an Indian bank account for premium/claims payment.

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

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

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

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

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

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

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

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

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

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

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

Gala Fit – Pro Active Care Program for Adults + Dependent child age 18 years and above			
S No	**Activity - For Each Insured**	**Monthly coins**	**Yearly coins**
1	Enrolling in Wellness Program, in mobile application by individual mobile number with ID proof		10
2	Register under organ donation plan (share details)		10
3	Sleep pattern - Having minimum of 7 hours of sleep / day -monitored monthly basis	5 / month	60
4	Blood donation (maximum twice per year allowed) (10 coins*2)		20
5	Participation in physical activities a) Wellness program (like Gym / Health club subscription) b) Marathon, cycling, Trekking and similar activities, Indoor and outdoor sports	5 / activity) *(2/ month)	120
6	Target Steps count / per day (monitored monthly basis) **Recognise with Galaxy team certificate via E-mail** ▪ >5,000 ▪ >8,000	10 for 5000+ steps Or 15 for 8000+ steps	180
7	Preventive check-up 1. ENT check-up (20 coins) 2. Eye check-up (including Glaucoma test for 40+years .members) (20 coins) 3. Dental check up with reports (10 coins)		50
8	Condition Management Program (CMP): (per policy period) – **To record BMI, general health checks up by physician (only 60 coins)** ▪ Member with Lifestyle disease – can provide once every four month (thrice a policy period) (3*60 coins) assessment records ▪ Wellness team analysis– if progression noted then coins credited		180
9	Only for members who have submitted wellness assistance last policy year. 1. Reduce in BMI from obese to normal compared to previous year reports (25 coins) 2. Sharing a success story (5 coins)		30
10	Submission of Vaccination - 100 Coins – HPV - 10 Coins - Other vaccine		100
11	Provide the standard medical test 1. Complete blood test with haemoglobin 2. Urine routine 3. USG abdomen 4. S.creatinine 5. ECG 6. HbA1C 7. Pulmonary function 9. Thyroid profile 10. Bone density 11. (HHH) serology test (20 Coins) 12. PSA (M) (20 Coins) 13. Mammogram test (F) (20 Coins)		220

	8. Cholesterol	14. PAP smear test (F) (20 Coins) 15. ECHO (20 Coins) 16. Cancer profile markers (20 Coins)		
12	Enrolling with video programs in Galaxy health app and successful completion of the program			20
	Total			1000

Additional benefits available in the wellness via app

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

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

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

The following list of activity for Dependent children

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

6	Interactive video program in Galaxy health app - *Two Programs minimum and maximum of 5 programs	20*5	100
	Total		1000

Additional benefits available in the wellness via app

- Domain for complete medical records of the members (Digital Vault)
- Access to health gadgets
- Water intake alarm
- Diet program including calories

Under s.no 6 (wellness program – in app) - attending Counselling / workshop for the following

- Emotional & Mental Health
- Child behaviour care
- Stress management
- Life balance management
- Drawing and Painting Competition
- Co-Curricular Activities Participation
- Participation in Quiz

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

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

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

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

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

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

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

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

Wellness for Kids

Three categories for children participating in the following categories

- Mental enrichment program
- Physical health activity
- 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 program in Galaxy health app	10	20
	Total	**420**	**505**
Note - cumulation of coins (420 + 505) /2 = 462 = 8% discount applicable during the renewal of the policy.			

S. No.	2A +1C model	50 years old (Male)	41 years old (Female)	9 years old (Kid)

1	Enrolling to Wellness Program	10	10	50
2	Register under organ donation plan	10	10	N/A
3	Sleep pattern	50	0	N/A
4	Blood donation	10	0	N/A
5	Participation in physical activities	120	0	210
6	Target Steps count	100	120	N/A
7	Preventive check-up	40	40	90
8	Condition Management Program (CMP)	60	180	N/A
9	Old participants	30	0	N/A
10	Submission of Vaccination certificate	10	0	50
11	Provide the standard medical test	100	100	N/A
12	Enrolling with program in Galaxy health app	20	0	60
13	Participation in mental enrichment program	N/A	N/A	120
	Total	**560**	**460**	**580**
Note - Cumulation of coins (560 + 460 + 580) /3 = 533 = 8% discount applicable during renewal of the policy.				

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

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

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

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

i. **Asthma** is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath.

ii. **Blood pressure (Hypertension)** is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.

iii. **Cholesterol (Hyperlipidaemia)** is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease.

iv. **Diabetes mellitus** is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages every organ in the body, which causes serious health consequences.

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

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

Note:

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

23. Delivery Expenses:

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

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

b) **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:

a) Maximum 2 deliveries are allowed in the lifetime.
b) Pre-hospitalisation and Post Hospitalisation expenses are not applicable for this cover.
c) 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.
d) There is no waiting period for subsequent deliveries

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

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

a) For the purpose of claiming under this benefit, inpatient treatment is not mandatory.
b) Automatic Restoration of Sum Insured shall not be applicable for this benefit.
c) 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.
d) Company will pay for one Assisted Reproduction Treatment cycle in a policy year

Sum Insured (Rs.)	Upto the Limit Per policy Year (Rs.)

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

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

25. **Enhanced Multiplier 3X or 10X :** If the Insured Person has opted for this optional cover, the Company will provide an additional cumulative Bonus of 100% of sum insured, irrespective of any claims in previous policy year maximum upto 3 times of sum insured or upto 10 times of sum insured(based on the plan opted), provided that the Policy has been continuously renewed with the Company.
Note:
    i. The bonus will be calculated on the expiring Sum Insured.
    ii. In case, the Insured Person opts out of this cover at the time of renewal, all the bonus accumulated under Enhanced Multiplier (3X or 10X) will be reduced to zero.
    iii. The customer can opt either Enhanced Multiplier (3X or 10X).

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

Conditions

- This benefit will be available for those purchased this policy up to the entry age of 50 years.
- No additional premium will be charged in the middle of the tenure in case of claims. At the time of renewal (in case of a claim), the premium will be charged as per the current age of the insured at renewal.

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

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

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

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

29. **High End Diagnostics:** The Company will indemnify the reasonable charges incurred for the following diagnostic tests only on OPD basis during the policy period, if required as part of a medically necessary treatment subject to the limit of Rs.25,000/- per policy year.
    1. Brain Perfusion imaging
    2. Computed Tomography (CT) guided Biopsy
    3. Computed Tomography (CT) Urography
    4. Digital Subtraction Angiography (DSA)
    5. Liver Biopsy
    6. Magnetic Resonance Cholangiography Scan
    7. Positron Emission Tomography– Computed Tomography (PET/CT)
    8. Positron emission tomography – Magnetic Resonance Imaging (PET/ MRI)

9. Renogram
10. Magnetic Resonance Imaging with Magnetic Resonance Venography and Magnetic Resonance Angiography

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

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

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

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

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

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

1. There must be an admissible claim under the policy for the condition, for which assisted living benefit is sought for.

2. The Medical condition should have resulted in loss of independent living requiring skilful assistance for performing daily tasks.
3. The Justification and need for Assisted living shall be certified by the treating Medical Practitioner.

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

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

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

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

List of Durable Medical Equipment Covered under this optional Cover:

a) CPAP/ BIPAP 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).

34. Compassionate Travel: In the event of the insured person being hospitalized for a life-threatening emergency at a place away from his usual place of residence as recorded in the policy, the Company

will reimburse the transportation expenses by air and train incurred upto Rs.25,000/- for one immediate family member and for travel towards the place where hospital is located.

Note :

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

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

    a) This benefit is subject to an excess of first 24 hours of Hospitalisation for every claim.
    b) Claims under this optional cover will not reduce the Sum Insured.
    c) Claims under this optional cover are valid only if the claim is admissible either under this policy or any other insurance policy.
    d) Claims only under this optional cover, without claims on the base cover will not affect the Premium Promise, Bonus/ No Claim discount/Enhanced Multiplier 3X or 10X.

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

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

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

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

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

Policy Wording

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

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

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

Exclusions for Tele Consultation Cover

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

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

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

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

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

recognized by the Government of India or accredited by the Quality Council of India/National Accreditation Board on Health.

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

Specific exclusions applicable for In-Clinic Consultation:

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

Section B. ii. Prescribed Pathology & Radiology

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

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

Note:

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

Specific exclusions applicable for Prescribed Pathology & Radiology Cover

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

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

S. No	Invasive Test Names	S. No	Invasive Test Names
1	Bronchoscopy guided biopsy	20	Hysteroscopy biopsy
2	Bronchoscopy	21	Incisional biopsy of breast
3	Colonoscopy Biopsy	22	Lumbar Puncture
4	Colonoscopy	23	Lymph node biopsy
5	Core biopsy of Breast	24	MRI Fusion Biopsy

6	Coronary Angiography	25	MRI guided breast biopsy
7	CSF biopsy	26	Office Hysteroscopy
8	CSF liquid biopsy	27	Oral biopsy
9	CT Angiography	28	Pleural Biopsy
10	CT guided biopsy of growth- Abdomen/ Chest/ Pelvic/ Paraspinal region	29	Pleural fluid cytology
11	CT guided bone biopsy	30	Pleuroscopic Biopsy
12	CT guided lung biopsy	31	Prostate needle biopsy
13	Cystoscopy	32	Tru-cut biopsy breast
14	Cystoscopy with bladder biopsy	33	Upper GI Endoscopic Biopsy
15	Diagnostic Laparoscopy	34	Upper GI Endoscopy
16	Endometrial Biopsy	35	Urethroscopy
17	ENT Endoscopic biopsy	36	USG guided biopsy of abdominal organs
18	Excision biopsy of any lump	37	USG guided biopsy of pelvic organs
19	Fine Needle Aspiration Cytology- FNAC	38	USG guided kidney biopsy

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

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

Note –

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

Exclusions for Doctor Prescribed Pharmacy Cover

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

Specific Conditions (Applicable for all Plans):

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

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

1. **Accidental Death of Insured Person**: If following an Accident that causes death of the Insured Person within12 Calendar months from the date of Accident, then the Company will pay an amount as compensation the Sum Insured mentioned in the Schedule
2. **Permanent Total Disablement of the Insured Person:** If following an Accident which caused permanent impairment of the Insured's mental or physical capabilities, then the Company will pay the benefits as provided in the "Table of Benefits – B1", depending upon the degree of disablement provided that:
   a) The disablement occurs within 12 Calendar months from the date of the Accident.
   b) The disablement is confirmed and claimed for, prior to the expiry of a period of 60 days since occurrence of the disablement.

Condition:

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

7. Where there is an admissible claim for Permanent Total Disability during the policy period, the health cover would continue until the expiry of the policy for all the insured persons covered including the person who has made a claim for Permanent Total Disability and renewal thereof.

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

Table – B2			
Physical function already impaired prior to accident			**Percentage Of Sum Insured Deducted**
1	Loss of all toes	All	20
	Loss of Great toe	both phalanges	5
	Loss of Great toe	one phalanx	2
	Other than Great, if more than		
	One toe lost, for each toe	For each toe	1
2	Loss of hearing both ears	Both ears	75
	Loss of hearing one ear	One ear	30
3	Loss of four fingers and thumbs of One hand		40
4	Loss of four fingers		35
	Loss of thumb both phalanges	Both phalanges	25
		One phalanx	10
5	Loss of index finger three phalanges	Three phalanges	10
	Two phalanges	Two phalanges	8
	One phalanx	One phalanx	4
6	Loss of middle finger	Three phalanges	6
		Two phalanges	4
		One phalanx	2
7	Loss of ring finger	Three phalanges	5
		Two phalanges	4
		One phalanx	2

8	Loss of little finger	Three phalanges	4
		Two phalanges	3
		One phalanx	2
9	Loss of metacarpals	First or second	3
		Additional (third fourth or fifth)	2
10	Any other Permanent partial disablement		Percentage as assessed by the Medical Board or by the government doctor

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

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

Sum Insured (Rs.)	Individual (Upto the limits per policy year (Rs.)	Floater (Upto the limits per policy year (Rs.)
5,00,000	1,500	2,500
7,50,000	2,000	5,000
10,00,000	2,000	5,000
15,00,000	4,000	8,000
20,00,000	5,000	10,000
25,00,000	5,000	10,000
1,00,00,000	8,000	15,000
2,00,00,000	12,000	20,000

Note :

1. Available at network hospital for every year (irrespective of claims) from first purchase of this policy.
2. Any unutilized health check-up limit cannot be carried forward to the next Policy Year. Payment under this cover will not reduce the sum insured and will not impact on Premium Promise /Bonus/No claim discount.
3. Payment of any claim under this coverage shall not be construed as a waiver of Company's right to repudiate any claim on grounds of non-disclosure of material fact or pre-existing disease, for hospitalization expenses under hospitalization provisions of the policy contract.

* **Health Check-up** means a routine physical or wellness check, is a comprehensive assessment of overall health of the insured including blood tests and other screenings. It helps detect potential health issues early, monitor chronic conditions, and ensures that the health of the insured is on track.

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

a. The treatment as applicable under In-patient treatment/Day care treatment / AYUSH treatment is to be taken in a hospital listed under the "Preferred Partner Network" available in our website www.galaxyhealth.com.

b. In case if the treatment is taken in a hospital which is outside "Preferred Partner Network" list, a co-payment of 15% will be applicable (over and above other co-payment, if any) on each and every claim (except in case of accident).

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

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

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

42. **Room Rent Modification**: The insured person has the option to modify the room type category to Single Private A/c room or Shared accommodation or General ward and can avail discount on premium.
If the Insured Person is admitted in a room category that is higher than the one that is opted in this policy, then the Insured Person shall bear a ratable proportion of the Associated medical expenses in the proportion of the difference between room rent of the entitled room category to the room rent actually occupied.
Note: Associated Medical expenses which vary based on the room occupied by the insured person will be considered in proportion to the room rent stated in the policy schedule or actuals whichever is less. Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room rent.

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

Note:

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

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

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

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

    Listed Treatments and Procedures are as follows.

    1. Neurological Diseases
    2. Heart Diseases
    3. Auto Immune Diseases
    4. Cancer (Including Chemotherapy / Radiotherapy)
    5. Medical Renal Diseases (Including Dialysis)
    6. Treatment of Breakage of Long Bones

Sum Insured (Rs.)	Individual Policy (Rs.) (Limits per Policy year)	Floater Policy (Rs.) (Limits per Policy year)
5,00,000	3,00,000	3,50,000
7,50,000	4,00,000	6,00,000
10,00,000	4,50,000	7,00,000
15,00,000	5,00,000	8,00,000
20,00,000	5,50,000	9,00,000
25,00,000	6,00,000	10,00,000
1,00,00,000	7,50,000	12,50,000
2,00,00,000	10,00,000	15,00,000

46. **Advance Access:** On payment of additional premium, for single premium payment of 5-year policy term, the sum insured of the subsequent policy year shall be made available for utilisation of admissible claim in the current policy year.
    Note:
    - The cover is applicable for admissible claim under base cover only.
    - This benefit would however be subject to all applicable limits, copayments, deductibles as per the policy.
    - This benefit can be utilised once during the policy term.
    - Upon utilisation of this optional cover, an unutilised sum insured, shall be carried forward to the subsequent policy year.

    Illustration:

Sum Insured per policy year – Rs.10 Lakhs

Policy term – 5 years

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

Note: Illustration for utilization of benefits is as follows;

a. Sum Insured
b. Bonus
c. Enhanced Multiplier 3X or 10 X (if opted)
d. Automatic Restoration
e. Advance Access (if opted)

Illustration for Utilisation of Benefits	
Scenario - 1	
Policy term	5 years
Sum Insured	5 Lakhs
Bonus	0
Enhanced Multiplier (3X opted)	0
Advance Access	5 lakhs
Total cover available	10 lakhs
Automatic Restore trigger on subsequent claim	

Scenario 1 - Fresh

	Claim 1		
Year 1	Claim amount	7 Lakhs	

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

Scenario – 2 (Renewal policy of Scenario – 1)

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

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

	Sum insured	16.25 lakhs	5 laksh sum insured + 1.25 lakhs Bonus + 5 lakhs Enhanced Multiplier + 5 lakhs advance access
	Claim amount	13 Lakhs	
	Claim paid	13 lakhs	5 laksh sum insured + 1.25 lakhs Bonus + 5 lakhs Enhanced Multiplier utilised +1.75 advance access
	Available Balance sum insured	8.25 lakhs	100% of Restored sum insured trigger for subsequent claim.Hence, 5 lakhs restored sum insured + 3.25 Advance access
	Claim 2		
	Available Sum Insured	8.25 lakhs	Restored sum insured of 5 lakhs
	Claim amount	8 Lakhs	
	Claim paid	5 lakhs	(paid from 5 lakhs of restored sum insured)(as advance access can be utilised only once during the policy term)
	Available Balance sum insured	5 lakhs	(5 lakhs from restored sum insured)
Year 3	Claim 1		
	Available Sum Insured	9.50 lakhs	Sum Insured of 3.25 lakhs(advance access utilised in year 2) + 1.25 lakhs bonus +5 lakhs Enhanced Multiplier
	Claim amount	10 Lakhs	
	Claim paid	9.50 lakhs	Sum Insured of 3.25 lakhs + 1.25 lakhs bonus +5 lakhs Enhanced Multiplier
	Available Balance sum insured	5 lakhs	(5 lakhs from restored sum insured as the restoration is for unlimited number of times)
	Claim 2		
	Available Sum Insured	5 lakhs	Restored sum insured of 5 lakhs
	Claim amount	8 lakhs	
	Claim paid	5 lakhs	5 lakhs restored sum insured
	Available Balance sum insured	5 lakhs	Restored sum insured of 5 lakhs
Year 4	Available Sum Insured	11.25 lakhs	Sum insured of 5 lakhs + 1.25 lakhs bonus + 5 lakhs Enhanced Multiplier

List of Benefits which are part of sum Insured and in addition to Sum Insured			
S.No	**Coverage**	**Forming part of Sum Insured/In addition to Sum Insured**	**Impact on Bonus/No Claim Discount**
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, Digital ICU, Surgical appliances, Medicines and Drugs, Diagnostic materials and X-ray, Diagnostic imaging modalities, investigation test, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses with regard to coronary stenting, medicines, Implants and other similar items the Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping.	Forming part of Sum Insured	Impact
2	Day Care Procedures/Treatment	Forming part of Sum Insured	Impact
3	Pre Hospitalisation	Forming part of Sum Insured	Impact
4	Post Hospitalisation	Forming part of Sum Insured	Impact
5	Road Ambulance	Forming part of Sum Insured	Impact
6	AYUSH Treatment	Forming part of Sum Insured	Impact
7	Modern Treatment	Forming part of Sum Insured	Impact
8	Newborn Baby cover	Forming part of Sum Insured	Impact

			Policy Wording
9	Nanotechnology	Forming part of Sum Insured	Impact
10	Domiciliary Hospitalisation	Forming part of Sum Insured	Impact
11	Home Care Treatment	Forming part of Sum Insured	Impact
12	Bariatric Surgery	Forming part of Sum Insured	Impact
13	Automatic Restoration	In addition to Sum Insured	Not Applicable
14	a. Premium waiver for Critical Illness / Accidental Death b. Premium waiver for Voluntary organ donor	Not Applicable	Not Applicable
15	a. Bonus (or) b. No Claim Discount	In addition to Sum Insured Not Applicable	Not Applicable Not Applicable
16	Organ Transplantation Expenses	Forming part of Sum Insured	Impact
17	Organ Donor Expenses	Insured: Forming part of Sum Insured Donor: In addition to Sum Insured	Impact No Impact
18	E-Domestic Second Medical Opinion	Not Applicable	Not Applicable
19	NRI/OCI Benefit	Not Applicable	Not Applicable
20	Gala Fit - Pro-Active Care(Wellness Engaging Program)	Not Applicable	Not Applicable
Optional Covers			
21	Insta Care Cover from 31st Day	Forming part of Sum Insured	Impact
22	Enhanced Multiplier 3X or 10X	In addition to Sum Insured	Not Applicable
23	Premium Promise	Not Applicable	Not Applicable
24	Consumables	Forming part of Sum Insured	Impact
25	Partner Protect	Forming part of Sum Insured	Impact
26	Delivery Expenses	Forming part of Sum Insured	Impact
27	Assisted Reproduction Treatment	Forming part of Sum Insured	Impact
28	High End Diagnostics	In addition to Sum Insured	No Impact
29	Wealth for Health	Not Applicable	Not Applicable
30	Outpatient Benefit	In addition to Sum Insured	No Impact
31	Air Ambulance	Forming part of Sum Insured	Impact
32	Accidental Death and Permanent Total Disablement	In addition to Sum Insured	No Impact

33	Health Check-up	In addition to Sum Insured	No Impact
34	Assisted Living	Forming part of Sum Insured	Impact
35	Nursing at Home	Forming part of Sum Insured	Impact
36	Durable Medical Equipment/CAPD	Forming part of Sum Insured	Impact
37	Compassionate Travel	In addition to Sum Insured	No Impact
38	Preferred Partner Network	Not Applicable	Not Applicable
39	Reduction in Pre-Existing Diseases (PED) waiting period	Forming part of Sum Insured	Impact
40	Reduction in Specific Disease Waiting Period	Forming part of Sum Insured	Impact
41	Room Rent Modification	Forming part of Sum Insured	Impact
42	Voluntary Aggregate Deductible	Not Applicable	Not Applicable
43	Voluntary Co-payment	Not Applicable	Not Applicable
44	Sub-limits on the Specific Diseases/Treatments	Forming part of Sum Insured	Impact
45	Hospital Cash	In addition to Sum Insured	No Impact
46	Advance Access	In addition to Sum Insured	Impact

IV. EXCLUSIONS: (Applicable for Neo Plan and Prime Plan)

A. Standard Exclusions

1. **Pre-Existing Diseases - Code- Excl 01:**
   A. **Applicable for Neo Plan:** Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.

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

   B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   C. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
   D. **Applicable for Neo Plan**: Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

2. **Specified disease/procedure waiting period – Code Excl 02**

A. Expenses related to the treatment of the listed conditions: surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
C. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
D. The waiting period for listed conditions shall apply even if contracted after the policy inception or declared and accepted without a specific exclusion.
E. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
F. List of specific diseases/procedures
    1. Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, Diseases related to Thyroid, Benign diseases of the breast.
    2. Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal Tunnel Syndrome, Trigger Finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology.
    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 - [except for Newborn Coverage (14)].

Note: Waiting period for the following benefits are as follows

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

b. Assisted Reproduction Treatment (Optional Cover): A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person

c. **Newborn Baby Cover:** If insured women is covered under this policy for a continuous period of 12 months without break or if the insured women submit 12th and 20th week of ante natal scan at the time of pregnancy.

d. **Organ Transplantation Expenses:** A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person.

e. **Organ Donor Expenses**: A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person.

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

g. **Hospital Cash (Optional Cover):** The above-mentioned specified disease/procedure waiting period – **Code Excl 02** is applicable.

3. **30-day waiting period – Code Excl 03**
   a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months
   c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4. **Investigation & Evaluation – Code Excl 04**
   a. Expenses related to any admission, primarily for diagnostics and evaluation purposes only are excluded.
   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

6. **Obesity/ Weight Control (except to the extent covered under Coverage 10)– Code Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions
   i. Surgery to be conducted is upon the advice of the Doctor
   ii. The surgery/Procedure conducted should be supported by clinical protocols
   iii. The member must be 18 years of age or older and
   iv. Body Mass Index (BMI)
      1. greater than or equal to 40 or
      2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         a. Obesity-related cardiomyopathy
         b. Coronary heart disease

c. Severe Sleep Apnea
d. Uncontrolled Type2 Diabetes

7. **Change-of-Gender treatments – Code Excl 07:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
8. **Cosmetic or plastic Surgery – Code Excl 08:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
9. **Hazardous or Adventure sports – Code Excl 09:** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
10. **Breach of law – Code Excl 10:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
11. **Excluded Providers– Code Excl 11:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
12. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof **– Code Excl 12**
13. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons – **Code Excl 13**
14. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure **– Code Excl 14**
15. **Refractive Error – Code Excl 15** Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 diopters.
16. **Unproven Treatments – Code Excl 16:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
17. **Sterility and Infertility (Except to the extent covered under Coverage 24) – Code Excl 17:** Expenses related to sterility and infertility. This includes.
    a. Any type of contraception, sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational Surrogacy
    d. Reversal of sterilization
18. **Maternity – Code Excl 18 (Except to the extent covered under Coverage 23)**

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

B. Specific Exclusions

19. Circumcision (unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident), Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA **-Code- Excl 19**
20. Congenital External Condition / Defects / Anomalies **-Code- Excl 20**
21. Convalescence, general debility, run-down condition, Nutritional deficiency states **-Code- Excl 21**
22. Intentional self -injury**-Code- Excl 22**
23. Injury/disease caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) **-Code- Excl 24**
24. Injury or disease caused by or contributed to by nuclear weapons/ materials **-Code- Excl 25**
25. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion **-Code- Excl 26.**
26. Unconventional, Untested, Experimental therapies **-Code- Excl 27**
27. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy **-Code- Excl 28**
28. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalisation warranted. **- Code- Excl 29**
29. All treatment/Interventions for Erectile Dysfunctions - **Code- Excl 30**
30. Inoculation or Vaccination (except for post–bite treatment and for medical treatment for therapeutic reasons) **-Code- Excl 31**
31. Cost of spectacles and contact lens, hearing aids, Cochlear implants and procedures, walkers and crutches, wheel chairs, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis, infusion pump and such other similar aids. **-Code- Excl 35 (Except to the extent covered under Optional cover "Durable Medical Equipment/CAPD")**
32. Any hospitalisation which are not medically necessary / does not warrant hospitalisation**-Code- Excl 36**
33. Other Excluded Expenses as detailed in the website www.galaxyhealth.com (**Except to the extent covered under Coverage 28)** - **Code Excl 37**
34. Existing disease/s, disclosed by the insured and mentioned in the policy schedule under permanent exclusion (based on insured's consent), for specified ICD codes **-Code- Excl 38**
35. Expenses for venereal disease or any sexually transmitted disease except HIV/AIDS.

36. Dental Treatment, Diagnostics, Dental Procedures or Surgery of any kind unless requiring Hospitalisation as a result of accidental Injury.

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

1. Any claim relating to events occurring before the commencement of the cover or otherwise outside the Period of Insurance.

2. Any injuries/conditions which are Pre-existing conditions.

3. Any claim arising out of Accidents that the Insured Person has caused.
   i. intentionally or
   ii. by committing a crime / involved in it or
   iii. as a result of / in a state of drunkenness or addiction (drugs, alcohol)

4. Insured Person engaging in Air Travel unless he/she flies as a fare-paying passenger on an aircraft properly licensed to carry passengers. For the purpose of this exclusion Air Travel means being in or on or boarding an aircraft for the purpose of flying therein or alighting there from.

5. Accidents that are results of war and warlike occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, seizure capture arrest restraints detainments of all kings princes and people of whatever nation, condition or quality whatsoever.

6. Participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

7. Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from.
   a. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self sustaining process of nuclear fission) of nuclear fuel
   b. Nuclear weapons material
   c. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof
   d. Nuclear, chemical and biological terrorism

8. Any claim arising out of sporting activities in so far as they involve the training or participation in competitions of professional or semi-professional sports persons.

9. Participation in Hazardous Sport / Hazardous Activities.

10. Persons who are physically challenge unless specifically agreed and endorsed in the policy.

11. Any loss arising out of the Insured Person's actual or attempted commission of or wilful participation in an illegal act or any violation or attempted violation of the law.

12. Any payment in case of more than one claim under the policy during the period of insurance by which the maximum liability of the Company in that period would exceed the amount specified in the Schedule.

13. Any other claim after a claim has been admitted by the Company and becomes payable for Death and Permanent Total Disablement as mentioned in the table.

14. Any claim arising out of an accident related to pregnancy or childbirth, infirmity, whether directly or indirectly.

15. Any claim for Death or Permanent Total Disablement of the Insured Person from self-endangerment unless in self-defence or to save human life.

V. CONDITIONS: (Applicable for Neo and Prime Plan)

Standard Conditions

1. **Disclosure of Information:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policy holder.
2. **Claim Settlement**
   - A. **Condition Precedent to Admission of Liability**: The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy
   - B. **For Cashless Treatment:**
     - a. Call the 24 hour help-line for assistance – 18002030007.Senior Citizens may call at 18002030007
     - b. Inform the ID number for easy reference
     - c. On admission in the hospital, produce the ID Card issued by the Company at the Hospital Helpdesk
     - d. Obtain the Pre-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk. (Insurers shall also provide pre-authorization to the policyholder through Digital mode).
     - e. The Treating Doctor will complete the hospitalisation/ treatment information, and the hospital will fill up expected cost of treatment. This form is submitted to the Company
     - f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.
     - g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits.

h. In case of emergency hospitalisation information to be given within 24 hours after hospitalisation

i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.galaxyhealth.com or contact the nearest branch. KYC (Identity proof with Address) of the proposer, as per AML Guidelines.

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

Note: The Company reserves the right to call for additional documents wherever required. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person can go ahead with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

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

Sl.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 180 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 of the proposer viz., Customer name, Bank Account No., Name of the Bank, IFSC code
xii. CKYC No. of the proposer (if available)
xiii. Legal heir/succession certificate, wherever applicable

F. **For Accidental Death Claims (Optional cover 37):**
i. Claim Intimation
ii. Claim Form duly filled and signed

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

G. **For Permanent Total Disablement Claims**:

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

H. **For Outpatient Benefit (Optional Cover 36):**

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

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

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

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

A. Tele-Consultation Cover Service Delivery Process:

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

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

In-Clinic consultation Service Delivery process

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

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

B. Prescribed Investigations Cover – Pathology & Radiology Service Delivery Process

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

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

l) Similarly, in case the estimated amount is higher than the actual test amount, voucher will be generated for balance amount and will be deducted from Insured's benefit amount

C. Prescribed Pharmacy Cover

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

a) Start by downloading the Galaxy Wellness app.
b) Sign-up using the registered mobile number.
c) Add policy details in the "Manage policy" section.
d) Under my "Active Plans", select the purchased product/Plan.
e) Select Prescribed Pharmacy benefit option.
f) Choose "Order medicine by uploading prescription" option.
g) Upload prescription.
h) The Insured Person will receive call to confirm the medicines and payment details.
i) The payment for the Insured Person order will be deducted from the benefit amount available in the Insured Person prescribed pharmacy benefit.
j) Any additional amount (if any) needs to be paid by customer either on our application or via cash on delivery
k) The Insured Person will receive the medicines at the Insured Person doorstep delivered by our pharmacy partner.

- **Documents to be submitted for reimbursement (Outpatient Benefit)**:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

a) Duly completed claim form, and
b) Certificate from the attending doctor regarding the diagnosis
c) Prescription of the treating doctor
d) Receipt from the treating doctor / hospital / Physiotherapist
e) Receipt from Pharmacy / chemists
f) Receipts and reports for tests done
g) KYC (Identity proof with Address) of the proposer, as per AML Guidelines
h) NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code
i) CKYC No. of the proposer (if available)

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

The bills or receipts produced should be within the policy period

I. **High End Diagnostics (Optional Cover 29)**:

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

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

1. Discharge summary

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

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

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

L. **Compassionate Travel (Optional Cover 34):**

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

Note:

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

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) 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. **Multiple Policies:**

a) Indemnity Policies:

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

b) Benefit based Policies:

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

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, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.

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

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

12. **Moratorium Period:** After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments and deductibles as per the policy contract.

13. **Premium Payment in Instalments:** If the insured person has opted for Payment of Premium on an instalment basis i.e. 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 effected.

15. **Free Look Period**: The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
    The insured person shall be allowed free look period of 30 days from date of receipt of the policy document whether electronically or otherwise to review the terms and conditions of the policy, and to return the same if not acceptable.

    If the insured has not incurred any claim during the Free Look Period, the insured shall be entitled to
    i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
    ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
    iii. where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

16. **Redressal of Grievance:** In case of any grievance the insured person may contact the Company through
    Website : www.galaxyhealth.com

Toll free : 18002030007
Senior Citizens may call at 18002030007

E-mail : gro@galaxyhealth.com

Phone No. : 044 - 4001 7238

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

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 sublimits, automatic restoration benefit (if applicable) is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year / 3rd years / 4th year / 5th year cannot be utilized in the 1st year itself except Advance Access (if opted). 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, bonus, Enhanced Multiplier (if opted) 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. **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.

30. **Midterm Inclusion:** Midterm inclusion of Newly Married Spouse, legally adopted child and New Born baby is Permissible on payment of proportionate premium subject to the following:
    i. The cover for newborn commences from 16th day of its birth.
    ii. Waiting periods as stated in the policy will be applicable from the date of inclusion of such newly married spouse, newborn baby, legally adopted child.
    iii. Such midterm inclusion will be subject to underwriter's approval.

List of Insurance Ombudsman

Office Details	**Jurisdiction of Office Union Territory, District**
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Near S.V. College, Tilak Marg, Relief Road, Ahmedabad – 380 001, Gujurat. Tel.: 079 - 25501201/02 Email: oio.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: oio.bengaluru@cioins.co.in	Karnataka.
BHOPAL	Madhya Pradesh , Chhattisgarh.

Office Details	Jurisdiction of Office Union Territory, District
Office of the Insurance Ombudsman, LIC of India Zonal Office Bldg, 1st floor, "Jeevan Shikha", South Wing 60-B,Hoshangabad Road, Opp. Gayatri Mandir Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 / 2769200 Email: oio.bhopal@cioins.co.in	
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar – 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: oio.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH Office Of The Insurance Ombudsman, LIC of India Office Bldg, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 / 2773101 / 2990938 / 2706196 / 2707468 / 2772101 / 2990942 Email: oio.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh& Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: oio.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A,1st Floor, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992 Email: oio.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, 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. Pan Bazar , S.S. Road, Guwahati – 781001. Tel.: 0361 - 2632204 / 2631307 / 2732937 / 2632205 Email: oio.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 Email: oio.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Road, Ambedkar Circle, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: oio.jaipur@cioins.co.in	Rajasthan.
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Ernakulam, Kochi - 682 011. Tel.: 0484 – 2358759 / 2358734 / 2358336 Email: oio.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: oio.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road,	**Districts of Uttar Pradesh** : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur,

Office Details	Jurisdiction of Office Union Territory, District
Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 Email: oio.lucknow@cioins.co.in	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: oio.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N, S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Noida-201301, Dist: Gautam Buddh Nagar, Uttar Pradesh. Tel.: 0120-2514252 / 2514253 / 4027589 Email: oio.noida@cioins.co.in	State of Uttarkhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 / 22547067 Email: oio.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan- Jeevan Darshan LIC of India Office Bldg, 3rd Floor, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: oio.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region

Office Details	Jurisdiction of Office Union Territory, District
THANE Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane – 400604 Tel: 022- 20812868 / 20812869 Email: oio.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.
For the details of Insurance Ombudsman, please visit: https://cioins.co.in/Complaint/Online	

Annexure - I
List I — Items

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES

21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOTWEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)

2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTHPASTE
13	TOOTHBRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES

7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRIT/ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

List of Critical Illness - Annexure – II

S No	Critical Illness List
1	Cancer of Specified Severity
2	Myocardial Infarction

3	Open Chest CABG
4	Repair /Replacement of Heart Valves
5	Coma of Specified Severity
6	Kidney Failure Requiring Regular Dialysis
7	Stroke Resulting in Permanent Symptoms
8	Surgery for Major Organ /Bone Marrow Transplant
9	Permanent Paralysis of Limbs
10	Motor Neuron Disease with Permanent Symptoms
11	Multiple Sclerosis with Persisting Symptoms
12	Benign Brain Tumor
13	Blindness
14	Deafness
15	End Stage Lung Failure
16	End Stage Liver Failure
17	Loss of Speech
18	Loss of Limbs
19	Major Head Trauma
20	Primary (Idiopathic) Pulmonary Hypertension
21	Major Third degree Burns
22	Alzheimer's Disease
23	Creutzfeldt-Jacob Disease (CJD)
24	Encephalitis
25	Fulminant Hepatitis
26	Muscular Dystrophy
27	Aorta Graft Surgery
28	Systemic Lupus Erythematosus with Lupus Nephritis
29	Dissecting Aortic Aneurysm
30	Infective Endocarditis
31	Severe Ulcerative Colitis
32	Amputation of Feet due to Complications from Diabetes
33	Apallic Syndrome
34	Aplastic Anemia
35	Bacterial Meningitis
36	Brain Surgery
37	Chronic Adrenal Insufficiency (Addison's Disease)
38	Chronic Relapsing Pancreatitis
39	Crohn's Disease
40	Eisenmenger's Syndrome
41	Hemiplegia
42	HIV Due to Blood Transfusion and Occupationally Acquired HIV
43	Loss of Independent Existence

44	Loss of One Limb and One Eye
45	Medullary Cystic Disease
46	Myelofibrosis
47	Other Serious Coronary Artery Disease
48	Pheochromocytoma
49	Poliomyelitis
50	Progressive Scleroderma
51	Progressive Supranuclear Palsy
52	Severe Rheumatoid Arthritis
53	Terminal illness
54	Tuberculosis Meningitis

Schedule of Benefits (Applicable for Neo and Prime Plan)

S.No	Sum Insured (Rs. in Lakhs)	5	7.5	10	15	20	25	100	200
1	Room rent (Per day)	Any Room							
2	Day Care Procedures/Treatment	All day care procedures/treatments are covered							
3	Pre Hospitalisation	Covered upto 90 Days							
4	Post Hospitalisation	Covered upto 180 Days							
5	Road Ambulance	Covered up to Sum Insured							
6	AYUSH Treatment	Covered up to Sum Insured							
7	Modern Treatment	Covered up to Sum Insured							
8	Domiciliary Hospitalisation	Covered up to Sum Insured							
9	Home Care Treatment	Covered upto 10% of Sum Insured or upto Rs.5,00,000/- whichever is less in a policy year.							
10	Bariatric Surgery	Rs.3,00,000/-				Rs.6,00,000/-			Rs.7,00,000/-
11	Organ Transplantation Expenses	Covered up to Sum Insured							
12	Organ Donor Expenses	**For Insured:** Covered up to Sum Insured, If the insured donates an organ **For Donor**: The expenses incurred by the Donor, (if any) for the complications that necessitate a Redo Surgery / ICU admission will be covered.							
13	E-Domestic Second Medical Opinion	Covered up to Sum Insured							
14	Newborn Baby cover	10% of sum insured or upto Rs.2,50,000/- whichever is less						10% of sum insured or upto Rs.5,00,000/- whichever is less	
15	Nanotechnology	Covered up to 25% of Sum Insured							

16	**Automatic Restoration**	Covered upto 100% of Sum insured each time for unlimited number of times, for any illness/disease/injury. This reset can be utilized for a subsequent hospitalisation for same illness or different illness including modern treatment and accidents.							
17.a	**Premium waiver For Critical Illness/ Accidental Death**	1 year premium will be waived for the next policy year during renewal. (If insured is diagnosed with specified critical illness or dies due to an accident)							
b	**Premium waiver for Voluntary organ donor**	This benefit gives a 2-year premium waiver on the renewal policy of an insured person who donates organs							
18.a	**Bonus**	100% of sum insured if no claims are made in the previous policy year. If there is a claim in the previous policy year, then bonus of 25% of sum insured only will be provided.							
		(OR)							
b	**No Claim Discount**	4%	4%	2%	1%	1%	1%	1%	1%
19	**NRI/OCI Benefit**	The Company will provide a discount of 15% on base cover premium to Non-Resident Indians / Overseas Citizens of India if this cover has been opted							
20	**Gala Fit - Pro-Active Care**	Discount in premium available up to 20% on renewal.							
Optional Cover (on payment of additional premium / discount on premium)									
21	**Insta Care Cover from 31st Day**	Pre-existing Disease(s) related to Asthma, Blood Pressure, Cholesterol and diabetes mellitus are covered from 31st day.							
22	**Partner Protect**	Waiting periods served by insured can be carried forward to the spouse if added in the policy (if spouse entry age is up to 35 years)							
23	**Delivery Expenses**	Normal: Rs.25,000/- Caesarean: Rs.50,000/-	Normal: Rs.50,000/- Caesarean: Rs.1,00,000/-			Normal: Rs. 1,00,000/- Caesarean: Rs. 2,00,000/-			
24	**Assisted Reproduction Treatment**	Rs.1,00,000/-				Rs.2,00,000/-			
25	**Enhanced Multiplier 3X or 10 X**	The Company will provide an additional cumulative Bonus of 100% of sum insured irrespective of any claims in previous policy year maximum upto 3 times of sum insured or 10 times of sum insured based on plan opted.							
26	**Premium Promise (applicable as an inbuilt cover under Prime Plan)**	Premium remains same until claims made or Upto 55 years whichever is earlier							
27	**Wealth for Health**	If there is no claim for a block of 5 consecutive policy years, then the Company shall refund the 1st policy year premium of base cover, provided the policy is renewed continuously.							
28	**Consumables (applicable as an inbuilt cover under Prime Plan)**	68 Consumables + Admission, Record and Insurance Processing charges are covered.							
29	**High End Diagnostics**	Specific tests for medically necessary treatment subject to the limit of Rs.25,000/- per policy year.							
30	**Air Ambulance**	Covered up to 10% of Sum Insured							
31	**Assisted Living**	Any Disease /Condition resulting in loss of independent living and requiring trained skilful assistance.							
		Individual: Rs.10,000/ Floater: Rs.15,000/-	Individual: Rs.15,000/ Floater: Rs.25,000/-	Individual: Rs.20,000/ Floater: Rs.30,000/-	Individual: Rs.25,000/ Floater: Rs.40,000/-	Individual: Rs.30,000/ Floater: Rs.50,000/-	Individual: Rs.35,000/ Floater: Rs.60,000/-	Individual: Rs.50,000/ Floater: Rs.75,000/-	Individual: Rs.75,000/- Floater: Rs.1,00,000/-

<table>
<tr><td>32</td><td>Nursing at Home</td><td>Individual: Rs.3,000/ Floater: Rs.5,000/-</td><td>Individual: Rs. 5,000/ Floater: Rs.7,500/-</td><td>Individual: Rs.7,500/ Floater: Rs.10,000/-</td><td>Individual: Rs.10,000/ Floater: Rs.12,500/-</td><td>Individual: Rs. 12,500/- Floater: Rs. 15,000/-</td><td>Individual: Rs.15,000/ Floater:Rs. 20,000/-</td><td>Individual: Rs.20,000/ Floater:Rs. 25,000/-</td><td>Individual: Rs. 25,000/ Floater: Rs.30,000/-</td></tr>
<tr><td>33</td><td>Durable Medical Equipment/CAPD</td><td colspan="8">Covered up to 10% of sum insured or Rs. 1 Lakh whichever is less will be payable during the policy year</td></tr>
<tr><td>34</td><td>Compassionate Travel</td><td colspan="8">The Company will reimburse the transportation expenses by air and train incurred upto Rs.25,000/- for one immediate family member and for travel towards the place where hospital is located.</td></tr>
<tr><td>35</td><td>Hospital Cash</td><td colspan="8">On payment of additional premium, Subject to an admissible Hospitalisation claim, Cash Benefit of Rs.1,000/- for each completed day of Hospitalisation for a maximum of 10 days per policy year is payable.</td></tr>
<tr><td>36</td><td>Outpatient Benefit</td><td colspan="8">
Individual:
<table>
<tr><th>Benefits</th><th>Silver</th><th>Gold</th><th>Platinum</th><th>Diamond</th></tr>
<tr><td>Section A. Tele-consultation</td><td>Unlimited - GP + Specialists</td><td>Unlimited - GP + Specialists</td><td>Unlimited - GP + Specialists</td><td>Unlimited - GP + Specialists</td></tr>
<tr><td>Section B.
i. In-clinic Doctor Consultations
ii. Prescribed Pathology & Radiology</td><td>Rs.5,000/-</td><td>Rs.7,500/-</td><td>Rs. 10,000/-</td><td>Rs.10,000/-</td></tr>
<tr><td>Section C Prescribed Pharmacy</td><td>Not Covered</td><td>Not Covered</td><td>Not Covered</td><td>Rs.2,000/-</td></tr>
</table>
Floater:
<table>
<tr><th>Benefits</th><th>Silver</th><th>Gold</th><th>Platinum</th><th>Diamond</th></tr>
<tr><td>Section A. Tele-consultation</td><td>Unlimited - GP + Specialists</td><td>Unlimited - GP + Specialists</td><td>Unlimited - GP + Specialists</td><td>Unlimited - GP + Specialists</td></tr>
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<tr><td>Section C. Prescribed Pharmacy</td><td>Not Covered</td><td>Not Covered</td><td>Not Covered</td><td>Rs.3,000/-</td></tr>
</table>
</td></tr>
<tr><td>37</td><td>Accidental Death and Permanent Total Disablement</td><td colspan="8">Covered</td></tr>
<tr><td>38</td><td>Health Check-up</td><td>Individual: Rs.1,500/ Floater: Rs.2,500/-</td><td>Individual: Rs. 2,000/ Floater: Rs.5,000/-</td><td>Individual: Rs.4,000/ Floater: Rs.8,000/-</td><td>Individual: Rs.5,000/ Floater: Rs.10,000/-</td><td>Individual: Rs.8,000/ Floater: Rs.15,000/-</td><td>Individual: Rs.12,000/ Floater: Rs.20,000/-</td></tr>
<tr><td>39</td><td>Preferred Partner Network</td><td colspan="8">Discount on premium up to 15% available if insured opted to take treatment at preferred partner network hospitals.</td></tr>
<tr><td>40</td><td>a.Reduction in Pre-Existing Diseases (PED) waiting period (Applicable for Neo Plan)</td><td colspan="8">On payment of additional premium the Insured Person has the option to opt for reduction of waiting period in respect of Pre-Existing Diseases from 36 months to 12 months or 24 months. This optional cover cannot be opted during mid-term of the policy/at the time of renewal/at the time of portability.</td></tr>
<tr><td></td><td>b. Reduction in Pre-Existing Diseases (PED) waiting</td><td colspan="8">On payment of additional premium the Insured Person has the option to opt for reduction of waiting period in respect of Pre-Existing Diseases from 24 months to 12 months. This optional cover cannot be opted during mid-term of the policy/at the time of renewal/at the time of portability.</td></tr>
</table>

<table>
<tr><td></td><td>period (Applicable for Prime Plan)</td><td></td></tr>
<tr><td>41</td><td>Reduction in Specific Disease Waiting Period</td><td>On payment of additional premium the Insured Person has the option to opt for reduction of waiting period in respect of Specific Diseases waiting period from 24 months to 12 months. This optional cover cannot be opted during mid-term of the policy/at the time of renewal/at the time of portability.</td></tr>
<tr><td>42</td><td>Room Rent Modification</td><td>
<table>
<tr><th>Room Category</th><th>% discount in the premium</th></tr>
<tr><td>Single Private A/c room</td><td>5%</td></tr>
<tr><td>Shared Accommodation</td><td>10%</td></tr>
<tr><td>General Ward</td><td>15%</td></tr>
</table>
</td></tr>
<tr><td>43</td><td>Voluntary Aggregate Deductible</td><td>The insured person has option to choose Voluntary Aggregate deductible and can avail discount on premium.
<table>
<tr><th></th><th colspan="9">Percentage of Discount</th></tr>
<tr><th>Deductible/ Sum Insured (Rs.in Lakhs)</th><th>Rs.10,000</th><th>Rs.25,000</th><th>Rs.50,000</th><th>Rs.1,00,000</th><th>Rs.2,00,000</th><th>Rs.3,00,000</th><th>Rs.4,00,000</th><th>Rs.5,00,000</th><th>Rs.10,00,000</th></tr>
<tr><td>5</td><td>6%</td><td>15%</td><td>27%</td><td>43%</td><td>55%</td><td>70%</td><td>75%</td><td>78%</td><td>79%</td></tr>
<tr><td>7.5</td><td>5%</td><td>13%</td><td>24%</td><td>40%</td><td>53%</td><td>66%</td><td>70%</td><td>71%</td><td>76%</td></tr>
<tr><td>10</td><td>5%</td><td>12%</td><td>22%</td><td>36%</td><td>48%</td><td>60%</td><td>63%</td><td>64%</td><td>72%</td></tr>
<tr><td>15</td><td>4%</td><td>11%</td><td>20%</td><td>32%</td><td>43%</td><td>54%</td><td>58%</td><td>60%</td><td>68%</td></tr>
<tr><td>20</td><td>4%</td><td>10%</td><td>18%</td><td>29%</td><td>40%</td><td>51%</td><td>54%</td><td>57%</td><td>67%</td></tr>
<tr><td>25</td><td>4%</td><td>9%</td><td>17%</td><td>28%</td><td>39%</td><td>49%</td><td>53%</td><td>56%</td><td>66%</td></tr>
<tr><td>100</td><td>3%</td><td>7%</td><td>14%</td><td>23%</td><td>31%</td><td>40%</td><td>43%</td><td>46%</td><td>56%</td></tr>
<tr><td>200</td><td>2%</td><td>6%</td><td>12%</td><td>19%</td><td>26%</td><td>33%</td><td>35%</td><td>37%</td><td>44%</td></tr>
</table>
</td></tr>
<tr><td>44</td><td>Voluntary Co-payment</td><td>The Insured Person will be liable to bear the specified Co-payment percentage (over and above other co-pay, if any) of admissible claim amount of each and every claim amount.
(10% / 20% / 30% / 40% / 50%)</td></tr>
<tr><td>45</td><td>Sub-limits on the Specific Diseases/Treatments</td><td>If the insured chooses this optional cover, then there shall be sub-limits on listed treatments and procedures upto the amount specified.
<table>
<tr><td>Individual: 3,00,000/- Floater: 3,50,000/-</td><td>Individual: 4,00,000/- Floater: 6,00,000/-</td><td>Individual: 4,50,000/- Floater: 7,00,000/-</td><td>Individual: 5,00,000/- Floater: 8,00,000/-</td><td>Individual: 5,50,000/- Floater: 9,00,000/-</td><td>Individual: 6,00,000/- Floater: 10,00,000/-</td><td>Individual: 7,50,000/- Floater: 12,50,000/-</td><td>Individual: 10,00,000/- Floater: 15,00,000/-</td></tr>
</table>
</td></tr>
<tr><td>46</td><td>Advance Access</td><td>The insured can utilise subsequent year sum insured in the current year policy itself. This cover is applicable for 5 year policy term only.</td></tr>
</table>