STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED
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MEDI CLASSIC INSURANCE POLICY (INDIVIDUAL)

Unique Identification No.: SHAHLIP23037V072223

PREAMBLE

The proposal, declaration and other documents if any given by the proposer shall be the basis of this Contract and is deemed to be incorporated herein.

I. DEFINITIONS

STANDARD DEFINITIONS

Accident: An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

Any one illness: Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

AYUSH Day Care Centre: 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: An 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.

Cashless facility: Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

Condition Precedent: Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Congenital Anomaly: Congenital Anomaly means a condition 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

b) External Congenital Anomaly: Congenital anomaly which is in the visible and accessible parts of the body

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

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

Day Care Centre: A 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 supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –

i) has qualified nursing staff under its employment;
ii) has qualified medical practitioner/s in charge;
iii) has 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: 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 hrs because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours

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

Dental Treatment: Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Disclosure to information norm: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Domiciliary Hospitalization: Domiciliary hospitalization 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

Grace Period: Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act **Or** complies with all minimum criteria as under:

i) has qualified nursing staff under its employment round the clock;
ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii) has qualified medical practitioner(s) in charge round the clock;
iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

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

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

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics;

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

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

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

Medical Expenses: 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: 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: "Migration" means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Network Provider: 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.

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

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

Notification of Claim: Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

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

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement
or
b) For which medical advice or treatment was recommended by, or received from, a Physician within 48 months Prior to the effective date of the policy issued by the insurer or its reinstatement

Pre-hospitalization Medical Expenses: Pre-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

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

Portability: "Portability" means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre- existing conditions and time bound exclusions, from one insurer to another insurer.

Post-hospitalization Medical Expenses: Post-hospitalization Medical Expenses means medical expenses incurred during pre-defined 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 hospitalization was required, and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

Qualified Nurse: 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: 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: 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: Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

Surgery or Surgical Procedure: 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 from suffering and prolongation of life, performed in a hospital or day care centre by a *medical practitioner.*

Unproven/Experimental treatment: 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

Associated medical expenses: 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 and consumables, Cost of implants and medical devices and Cost of diagnostics.

AYUSH Treatment: AYUSH Treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Basic Sum Insured: Basic Sum Insured means the sum insured opted for and for which the premium is paid.

Company: Company means Star Health and Allied Insurance Company Limited.

Dependent Child: Dependent Child means a child (natural or legally adopted) who is financially dependent and does not have his or her independent source of income and not over 25 years.

Diagnosis: Diagnosis means Diagnosis by a registered **medical practitioner**, supported by clinical, radiological and histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable, acceptable to the Company.

Family: Family means Self, Spouse, Dependent children.

Insured Person: Insured Person means the name/s of person/s shown in the schedule of the Policy.

Instalment: Instalment means Premium amount paid through Half-yearly mode by the Policy Holder / Insured.

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

Limit of Coverage: Limit of Coverage means Basic Sum Insured plus the Cumulative Bonus earned, wherever applicable.

Material fact: Material fact is one which would affect the judgment of a prudent insurer in deciding whether to accept the risk and if so, at what rate or premium and subject to what terms and conditions.

Policy Period: Policy Period means the period commencing from the Policy Period Start Date and Time; and ending at the Policy Period End Date and Time of the Policy, as specified in the Policy Schedule.

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

Psychiatric Disorders: Psychiatric Disorders means clinically significant psychological or behavioral syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behavior or an expected response to a stressful life event) as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the Insured Person in respect of whom a claim is lodged.

Psychosomatic Disorders: Psychosomatic Disorders means one or more psychological or behavioral problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person's risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the Insured Person in respect of whom a claim is lodged.

Zone 1: Zone 1 means Mumbai, Thane, Delhi (including Faridabad, Gurgaon, Ghaziabad and Noida), Ahmedabad, Baroda and Surat.

Zone 2: Zone 2 mean rest of India (other than those mentioned in Zone 1).

II. COVERAGE

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

That if during the period stated in the Schedule the insured person shall contract any disease or suffer from any illness or sustain bodily injury through accident and if such disease or injury shall require the insured Person/s, upon the advice of a **Medical Practitioner** to incur Hospitalization expenses for medical/surgical treatment at any **Hospital** in India as an **in-patient**, the **Company** will pay to the **Insured Person/s** the amount of such expenses as are **reasonably and necessarily** incurred up-to the limits stated in the schedule.

A. Room, boarding, nursing expenses as provided by the Hospital / Nursing Home as per the limits given below;

Basic Sum Insured Rs	Limits (Rs)
1,50,000/-	2% of Basic Sum Insured maximum of Rs.5,000/- per day
2,00,000/-	
3,00,000/-	
4,00,000/-	
5,00,000/-	
10,00,000/-	
15,00,000/-	

Note: Expenses relating to Associated Expenses will be considered in proportion to the eligible room rent/room category stated in the policy schedule or actuals whichever is less. Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room rent.

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

C. Anesthesia, Blood, Oxygen, Operation Theatre charges, ICU charges, Surgical Appliances, Medicines and Drugs, Diagnostic materials and X-ray, Diagnostic Imaging modalities, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, stent and such other similar expenses. With regard to coronary stenting, medicines, Implants and such other similar items the Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping.

D. Ambulance charges up-to Rs. 750/- per hospitalization and overall limit of Rs.1,500/- per policy period for transportation of the insured person by private ambulance service when this is needed for medical reasons to go to hospital for treatment, provided there is an admissible claim under the policy

E. Pre-Hospitalization medical expenses incurred for a period not exceeding 30 days prior to the date of hospitalization, for the disease/illness, injury sustained following an admissible claim for hospitalization under the policy

F. Post Hospitalization medical expenses incurred for a period up to 60 days from the date of discharge from the hospital. The amount payable shall not exceed the sum equivalent to 7% of the hospitalization expenses subject to a maximum of Rs.5,000/- per hospitalisation. For the purpose of calculation of the 7%, only nursing expenses, surgeon's/consultants fees, diagnostic charges and cost of drugs and medicines will be taken

G. Expenses incurred towards Cost of Health checkup up to 1% of the average Basic Sum Insured of the eligible block subject to a maximum of Rs.5,000/- is payable. This benefit is available for Basic Sum Insured of Rs.2,00,000/- and above only. The insured person becomes eligible for this benefit subject to continuous coverage under this policy with the Company after every block of 4 claim free years and payable on renewal
Note: Payment under this benefit does not form part of the Basic Sum Insured.

H. The expenses incurred on treatment of cataract are payable up to the limits mentioned hereunder;

Basic Sum Insured (Rs.)	Limit for Cataract Surgery (Rs.)
Up to 2,00,000/-	12,000/- per person per policy period
3,00,000/- to 5,00,000/-	20,000/- per eye per person and not exceeding 30,000/- per person per policy period
10,00,000/- and 15,00,000/-	30,000/- per eye per person and not exceeding 40,000/- per person per policy period

I. **Psychiatric And Psychosomatic Disorder:** If the insured person is diagnosed with psychiatric or psychosomatic disorder for the first time and hospitalized for minimum period of 5 consecutive days under this policy, then the Company will pay hospitalization expenses up to Basic Sum Insured provided the insured person has been covered under this policy for a continuous period of 24 months without any break
Note: The treatment should be taken at Authorized Psychiatric hospital licensed by Mental Health Authority or any similar Authority of Central and State Government / Union Territory.

J. **Coverage for Modern Treatments:** The expenses payable during the entire policy period for the following treatment / procedures (either as a day care or as in-patient exceeding 24hrs of admission in the hospital) is limited to the amount mentioned in table below;

Sum Insured in Rs.	Uterine artery Embolization and HIFU,	Balloon Sinuplasty,	Deep Brain Stimulation	Oral Chemotheraphy* (Sublimits including Pre and Post Hospitalisation)	Immunotheraphy-Monoclonal Antibody to be given as injection	Intra Vitreal injections
	Limit per person per policy period for each treatment / procedure Rs.					
1,50,000/-	12,500/-	5,000/-	25,000/-	12,500/-	25,000/-	5,000/-
2,00,000/-	25,000/-	10,000/-	50,000/-	25,000/-	50,000/-	10,000/-
3,00,000/-	37,500/-	15,000/-	75,000/-	37,500/-	75,000/-	15,000/-
4,00,000/-	1,00,000/-	40,000/-	2,00,000/-	1,00,000/-	2,00,000/-	40,000/-
5,00,000/-	1,25,000/-	50,000/-	2,50,000/-	1,25,000/-	2,50,000/-	50,000/-
10,00,000/-	1,50,000/-	1,00,000/-	3,00,000/-	2,00,000/-	4,00,000/-	75,000/-
15,00,000/-	1,75,000/-	1,25,000/-	4,00,000/-	2,50,000/-	5,00,000/-	1,00,000/-

Sum Insured in Rs.	Robotic surgeries	Stereotactic radio surgeries	Bronchical Thermoplasty	Vaporisation of the prostate (Green laser treatment or holmium laser treatment)	IONM-(Intra Operative Neuro Monitoring)	Stem cell theraphy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
	Limit per person per policy period for each treatment / procedure Rs.					
1,50,000/-	25,000/-	25,000/-	Up to Sum Insured			25,000/-
2,00,000/-	50,000/-	50,000/-				50,000/-
3,00,000/-	75,000/-	75,000/-				75,000/-
4,00,000/-	2,00,000/-	1,75,000/-				2,00,000/-
5,00,000/-	2,50,000/-	2,00,000/-				2,50,000/-
10,00,000/-	3,00,000/-	2,25,000/-				3,00,000/-
15,00,000/-	4,00,000/-	2,50,000/-				4,00,000/-

*Sublimit all inclusive with or without hospitalization where ever hospitalization includes pre and post hospitalization.

K. **Cumulative Bonus**: The insured person will be eligible for Cumulative bonus calculated at 5% of the basic sum insured for every claim free year subject to a maximum of 25%

Special Conditions

1. The Cumulative bonus will be calculated on the expiring Basic Sum Insured or on the renewed Basic Sum Insured whichever is less
2. If the insured opts to reduce the Basic Sum Insured at the subsequent renewal, the limit of indemnity by way of such Cumulative bonus shall not exceed such reduced basic sum insured
3. **In the event of a claim resulting in;**
   a. Partial utilization of Basic Sum Insured, such cumulative bonus so granted will be reduced at the same rate at which it has accrued
   b. Full utilization of Basic Sum Insured and nil utilization of cumulative bonus accrued, such cumulative bonus so granted will be reduced at the same rate at which it has accrued
   c. Full utilization of Basic Sum Insured and partial utilization of cumulative bonus accrued, the cumulative bonus granted on renewal will be the balance cumulative bonus available and will be reduced at the same rate at which it has accrued
   d. Full utilization of Basic Sum Insured and full utilization of cumulative bonus accrued, the cumulative bonus granted on renewal will be "nil" or "zero"

L. **Automatic Restoration of Basic Sum Insured**: There shall be automatic restoration of the Basic Sum Insured by 200%, once during the policy period, immediately upon exhaustion of the limit of coverage which has been defined.
It is made clear that such restored Basic Sum Insured can be utilized only for illness / disease unrelated to the illness / diseases for which claim/s was / were made. The restored Basic Sum Insured cannot be carried forward. This benefit is not available for Modern Treatment

M. **Non Allopathic Treatment / AYUSH:** In patient Hospitalizations Expenses incurred for treatment of diseases / illness / accidental injuries by system of medicines other than allopathic is payable up to 25% of the Basic Sum Insured subject to a maximum of Rs.25,000/- during entire policy period

III. OPTIONAL COVERS

1. **Gold Plan**
   A. Room, boarding, nursing expenses as provided by the Hospital / Nursing Home as per the limits given below;

Basic Sum Insured (Rs.)	Limit (Rs.)
3,00,000/-	Up to 5000/- per day
4,00,000/-	
5,00,000/-	Private Single A/c Room
10,00,000/-	
15,00,000/-	
20,00,000/-	
25,00,000/-	

Note: Expenses relating to Associated Expenses will be considered in proportion to the eligible room rent/room category stated in the policy schedule or actuals whichever is less. Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room rent

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

C. Anesthesia, Blood, Oxygen, Operation Theatre charges, ICU charges, Surgical Appliances, Medicines and Drugs, Diagnostic materials and X-ray, Diagnostic Imaging modalities, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, stent and such other similar expenses. With regard to coronary stenting, medicines, Implants and such other similar items the Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping.

D. Ambulance charges up-to Rs. 2,000/- per hospitalization for transportation of the insured person by private ambulance service when this is needed for medical reasons to go to hospital for treatment, provided there is an admissible claim under the policy

E. Pre-Hospitalization medical expenses incurred for a period not exceeding 30 days prior to the date of hospitalization, for the disease/illness, injury sustained following an admissible claim for hospitalization under the policy

F. Post Hospitalization medical expenses incurred for a period up to 60 days from the date of discharge from the hospital wherever recommended by the Medical Practitioner / Hospital, where the treatment was taken, following an admissible claim for hospitalization provided however such expenses so incurred are in respect of ailment for which the insured person was hospitalized

G. Expenses incurred towards Cost of Health check-up;

Basic Sum Insured (Rs.)	Limit (Rs.)
3,00,000/- to 5,00,000/-	Up to 1,500/- for every claim free year
10,00,000/- and 15,00,000/-	Up to 2,500/- for every claim free year
20,00,000/- and 25,00,000/-	Up to 5,000/- for every claim free year

Note:
1. This benefit is payable on renewal and when the renewed policy is in force.
2. Payment under this benefit does not form part of the Basic Sum Insured.

H. The expenses incurred on treatment of cataract are payable up to the limits mentioned hereunder;

Basic Sum Insured (Rs.)	Limit for Cataract Surgery (Rs.)
3,00,000/- to 5,00,000/-	30,000/- per eye and not exceeding 40,000/- per person per policy period
10,00,000/- and 15,00,000/-	40,000/- per eye and not exceeding 50,000/- per person per policy period
20,00,000/- and 25,00,000/-	45,000/- per eye and not exceeding 60,000/- per person per policy period

I. **Psychiatric And Psychosomatic Disorder:** If the insured person is diagnosed with psychiatric or psychosomatic disorder for the first time and hospitalized for minimum period of 5 consecutive days under this policy, then the Company will pay hospitalization expenses up to Basic Sum Insured provided the insured person has been covered under this policy for a continuous period of 24 months without any break
Note: The treatment should be taken at Authorized Psychiatric hospital licensed by Mental Health Authority or any similar Authority of Central and State Government / Union Territory.

J. **Coverage for Modern Treatments:** The expenses payable during the entire policy period for the following treatment / procedures (either as a day care or as in-patient exceeding 24hrs of admission in the hospital) is limited to the amount mentioned in table below;

Sum Insured in Rs.	Uterine artery Embolization and HIFU,	Balloon Sinuplasty,	Deep Brain Stimulation	Oral Chemotheraphy* (Sublimits including Pre and Post Hospitalisation)	Immunotheraphy-Monoclonal Antibody to be given as injection	Intra Vitreal injections
	Limit per person per policy period for each treatment / procedure Rs.					
3,00,000/-	75,000/-	30,000/-	1,50,000/-	75,000/-	1,50,000/-	30,000/-
4,00,000/-	1,00,000/-	40,000/-	2,00,000/-	1,00,000/-	2,00,000/-	40,000/-
5,00,000/-	1,25,000/-	50,000/-	2,50,000/-	1,25,000/-	2,50,000/-	50,000/-
10,00,000/-	1,50,000/-	1,00,000/-	3,00,000/-	2,00,000/-	4,00,000/-	75,000/-
15,00,000/-	1,75,000/-	1,25,000/-	4,00,000/-	2,50,000/-	5,00,000/-	1,00,000/-
20,00,000/-	2,00,000/-	1,50,000/-	4,50,000/-	2,75,000/-	5,50,000/-	1,25,000/-
25,00,000/-	2,00,000/-	1,50,000/-	5,00,000/-	3,00,000/-	6,00,000/-	1,50,000/-

Sum Insured in Rs.	Robotic surgeries	Stereotactic radio surgeries	Bronchical Thermoplasty	Vaporisation of the prostate (Green laser treatment or holmium laser treatment)	IONM-(Intra Operative Neuro Monitoring)	Stem cell theraphy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
	Limit per person per policy period for each treatment / procedure Rs.					
3,00,000/-	1,50,000/-	1,50,000/-	Up to Sum Insured			1,50,000/-
4,00,000/-	2,00,000/-	1,75,000/-				2,00,000/-
5,00,000/-	2,50,000/-	2,00,000/-				2,50,000/-
10,00,000/-	3,00,000/-	2,25,000/-				3,00,000/-
15,00,000/-	4,00,000/-	2,50,000/-				4,00,000/-
20,00,000/-	4,50,000/-	2,75,000/-				4,50,000/-
25,00,000/-	5,00,000/-	3,00,000/-				5,00,000/-

*Sublimit all inclusive with or without hospitalization where ever hospitalization includes pre and post hospitalization.

K. **Cumulative Bonus** In respect of a claim free year, the insured person will be eligible for Cumulative bonus calculated 25% of basic sum insured in the second year and additional 20% of the basic sum insured for each subsequent years subject to a maximum of 100% overall

Special Conditions

1. The Cumulative bonus will be calculated on the expiring Basic Sum Insured or on the renewed Basic Sum Insured whichever is less
2. If the insured opts to reduce the Basic Sum Insured at the subsequent renewal, the limit of indemnity by way of such Cumulative bonus shall not exceed such reduced basic sum insured
3. **In the event of a claim resulting in;**
   a. Partial utilization of Basic Sum Insured, such cumulative bonus so granted will be reduced at the same rate at which it has accrued
   b. Full utilization of Basic Sum Insured and nil utilization of cumulative bonus accrued, such cumulative bonus so granted will be reduced at the same rate at which it has accrued
   c. Full utilization of Basic Sum Insured and partial utilization of cumulative bonus accrued, the cumulative bonus granted on renewal will be the balance cumulative bonus available and will be reduced at the same rate at which it has accrued
   d. Full utilization of Basic Sum Insured and full utilization of cumulative bonus accrued, the cumulative bonus granted on renewal will be "nil" or "zero"

L. **Automatic Restoration of Basic Sum Insured**: There shall be automatic restoration of the Basic Sum Insured by 200% once during the policy period, immediately upon exhaustion of the limit of coverage which has been defined.
It is made clear that such restored Basic Sum Insured can be utilized only for illness / disease unrelated to the illness / diseases for which claim/s was / were made. The restored Basic Sum Insured cannot be carried forward. This benefit is not available for Modern Treatment

M. **Super Restoration:** If the limit of coverage under this policy is exhausted during the policy period, an additional Basic Sum Insured of 100% would be provided once, for the remaining policy period for the subsequent hospitalization. This additional basic sum insured can be utilized even for illness / disease for which claim/s was / were made. The unutilized additional Basic Sum Insured cannot be carried forward. This benefit is not available for Modern Treatment

N. **Domiciliary hospitalization treatments for a period exceeding three days:** 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 removed to a Hospital, or
- ✓ The patient takes treatment at home on account of non-availability of room in a hospital

However, this benefit shall not cover Asthma, Bronchitis, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all types of Dysenteries including Gastro-enteritis, 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.

O. **Organ Donor Expenses:** In patient hospitalization expenses incurred for organ transplantation from the Donor to the recipient insured person are payable provided the claim for transplantation is payable. Donor screening expenses and post-donation complications of the donor are not payable

P. **Shared accommodation:** If the Insured person occupies, a shared accommodation in a networked hospital during in-patient hospitalization, then amount as per the table given below will be payable for each continuous and completed period of 24 hours of stay, provided the hospitalization exceeds 48 hours in such shared accommodation

Basic Sum Insured (Rs.)	Limit (Rs.)
3,00,000/-, 4,00,000/- 5,00,000/-	500/- per day subject to maximum of 3,000/- per hospitalization
10,00,000/-, 15,00,000/- 20,00,000/- and 25,00,000/-	1,000/- per day subject to maximum of 6,000/- per hospitalization

Note:

- This benefit is payable only if there is an admissible claim for hospitalization under the policy
- Insured person's stay in Intensive Care Unit or High Dependency Units / wards will not be counted for this purpose
- Payment under this benefit does not form part of the Basic sum insured but will impact the Cumulative bonus
- Date of admission and date of discharge will not be counted for this purpose

Q. **Additional Basic Sum Insured for Road Traffic Accident (RTA):** If the insured person meets with a Road Traffic Accident resulting in in-patient hospitalization, then the Basic Sum Insured shall be increased by 50% subject to the following;

- It is evidenced that the insured person was wearing helmet and was either riding or travelling as pillion rider in a two wheeler at the time of accident as evidenced by Police record and Hospital record
- The additional Basic Sum Insured shall be available only once during the policy period
- The additional Basic Sum Insured shall be available after exhaustion of the limit of coverage
- The additional Basic Sum Insured can be utilized only for that particular hospitalization following the Road Traffic Accident
- Automatic Restoration of Basic Sum Insured and Super restoration shall not apply for this benefit
- This benefit shall not be applicable for day care treatment
- The unutilized balance cannot be carried forward for the remaining policy period or for renewal
- Claim under this benefit will impact the Cumulative bonus

R. **Hospitalization expenses for treatment of New Born Baby:** The coverage for New Born Baby starts from the **16th day** after its birth till the expiry date of the policy and is subject to a limit of 10% of the Basic Sum Insured or Rupees Fifty thousand, whichever is less, subject to the availability of the Basic Sum Insured, provided the mother has been insured under the policy for a continuous period of 12 months without break.

Note:

- Intimation about the birth of the New Born Baby should be given to the company and policy has to be endorsed for this cover to commence
- Exclusion No 3 (**Code Excl 03**) shall not apply for the New Born Baby
- All other terms, conditions and exclusions shall apply for the New Born Baby

S. **Non Allopathic Treatment / AYUSH:** In patient Hospitalizations Expenses incurred for treatment of diseases / illness / accidental injuries by system of medicines other than allopathic is payable up to 25% of the Basic Sum Insured subject to a maximum of Rs.25,000/- during entire policy period.

2. **Patient Care:** The Company will pay the cost of engaging one attendant at the residence of the insured person immediately after discharge from the hospital provided the same is recommended by the attending physician. Such expenses are payable up-to Rs.400/- for each completed day up-to 5 days per occurrence and 14 days per policy period. No payment will be made for the first day.

   This benefit is applicable only for insured persons above 60 years of age and becomes payable only upon a valid claim for hospitalization.

3. **Hospital Cash:** The Company will pay a Cash Benefit of Rs.1,000/- for each completed day of hospitalization subject to a maximum of 7 days per hospitalization and 14 days per policy period, provided, however there is a valid claim for hospitalization. For the purpose of this optional cover, the days of admission and discharge will not be taken into account.

   No claim under this head shall lie with the Company where the admission is for physiotherapy and/or any epidemic.

   Note: Patient Care and Hospital Cash are available on payment of additional premium under Gold Plan also.

   Important Note : Applicable for II Coverage and Optional Covers

   1. Where Gold Plan is opted, in the event of a claim, the benefits under Gold Pan only shall be applicable
   2. Company's liability in respect of all claims admitted during the period of insurance shall not exceed the Limit of Coverage per person mentioned in the schedule
   3. Expenses relating to hospitalization will be considered in proportion to the eligible room category stated in the policy or actual whichever is less
   4. All day care procedures are covered under this policy
   5. Expenses on Hospitalization for a minimum period of 24 hours only are admissible. However this time limit will not apply for the day care treatments / procedures, where treatment is taken In Hospital/Nursing Home and the Insured is discharged on the same day
   6. **Co-payment (Not Applicable for Patient Care and Hospital Cash):** This policy is subject to co-payment of 10% of each and every claim amount, for fresh as well as for the policies subsequently renewed for insured persons whose age at the time of entry in to this policy is 61 years and above. This co-payment will not apply for those insured persons who have entered the policy before attaining 61 years of age and renew the policy continuously without any break

IV. EXCLUSIONS

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

STANDARD EXCLUSIONS

1. **Pre-Existing Diseases - Code Excl 01**
   A. Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 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 for the same would be reduced to the extent of prior coverage
   D. Coverage under the policy after the expiry of 48 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 following 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 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(other than retinal detachment), 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 Gall bladder and Pancreatic calculi. All types of management for Kidney and Genitourinary tract calculi
      6. All types of Hernia
      7. Desmoid Tumor, 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, Hemorrhoids, 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

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:
   1. 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
   2. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

6. **Obesity / Weight Control - Code Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions;
   A. Surgery to be conducted is upon the advice of the Doctor
   B. The surgery/Procedure conducted should be supported by clinical protocols
   C. The member has to be 18 years of age or older and
   D. 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 hospitalization claim or day care procedure **- Code Excl 14**

15. **Refractive Error - Code Excl 15:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

16. **Unproven Treatments - Code Excl 16:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. **Sterility and Infertility - Code Excl 17:** Expenses related to sterility and infertility. This includes;
   a. Any type of contraception, sterilization
   b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   c. Gestational Surrogacy
   d. Reversal of sterilization

18. **Maternity - Code Excl 18**
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy
   b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

SPECIFIC EXCLUSIONS

19. Circumcision (unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident), Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA **- Code Excl 19**

20. Congenital External Condition / Defects / Anomalies **- Code Excl 20**

21. Convalescence, general debility, run-down condition, Nutritional deficiency states **- Code Excl 21**

22. Intentional self -injury **- Code Excl 22**

23. Injury/disease caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) **- Code Excl 24**

24. Injury or disease caused by or contributed to by nuclear weapons / materials **- Code Excl 25**

25. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion **- Code Excl 26**

26. Unconventional, Untested, Experimental therapies **- Code Excl 27**

27. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy **- Code Excl 28**

28. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalization warranted **- Code Excl 29**

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

30. Hospital registration charges, admission charges, record charges, telephone charges and such other charges **- Code Excl 34**

31. Cost of spectacles and contact lens, hearing aids, Cochlear implants and procedures, walkers and crutches, wheel chairs, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis, infusion pump and such other similar aids **- Code Excl 35**

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

33. Other Excluded Expenses as detailed in the website www.starhealth.in **- Code Excl 37**

34. Existing disease/s, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), for specified ICD codes **- Code Excl 38**

V. CONDITIONS

STANDARD CONDITIONS

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

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. **Documents for Cashless Treatment**
      a. For assistance call 24 hours help-line 044-69006900 or Toll Free No. 1800 425 2255. Senior Citizens may call at 044-40020888
      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
      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 hospitalization information to be given within 24 hours after hospitalization
      i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.starhealth.in or contact the nearest branch
      h. 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;

Sl.No.	Type of Claim	Prescribed time limit
1	Reimbursement of hospitalization, day care and pre hospitalization expenses	Claim must be filed within 15 days from the date of discharge from the Hospital
2	Reimbursement of Post hospitalization	within 15 days after completion of 60 days from the date of discharge from hospital

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

Note: Conditions C and D are precedent to admission of liability under the policy. However 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 and submitted within the prescribed time limit;

a. Duly completed claim form, and
b. Pre Admission investigations and treatment papers
c. Discharge Summary from the hospital
d. Cash receipts from hospital, chemists
e. Cash receipts and reports for tests done
f. Receipts from doctors, surgeons, anesthetist
g. Certificate from the attending doctor regarding the diagnosis
h. KYC (Identity proof with Address) of the proposer, as per AML Guidelines

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

Note: For assistance call 24 hours help-line 044-69006900 or Toll Free No. 1800 425 2255. Senior Citizens may call at 044-40020888

3. Provision for Penal Interest

i) The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document

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

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

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

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

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

5. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

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

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

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

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

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

7. Cancellation

i. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below;

Cancellation table applicable for Policy Term 1 Year without installment option	
Period on risk	**Rate of premium to be retained**
Up to 1 mth	25% of the policy premium
Exceeding 1 mth up to 3 mths	37.5% of the policy premium
Exceeding 3 mths up to 6 mths	60% of the policy premium
Exceeding 6 mths up to 9 mths	80% of the policy premium
Exceeding 9 mths	100% of the policy premium
Cancellation table applicable for installment option of Half-yearly premium payment for Policy Term 1 Year	
Period on risk	**Rate of premium to be retained**
Up to 1 Mth	50% of the total premium received
Exceeding 1 mth up to 4 mths	90% of the total premium received
Exceeding 4 mths up to 6 mths	100% of the total premium received
Exceeding 6 mths up to 7 mths	65% of the total premium received
Exceeding 7 mths up to 10 mths	87.5% of the total premium received
Exceeding 10 mths	100% of the total premium received
Cancellation table applicable for Policy Term 2 Year without installment option	
Period on risk	**Rate of premium to be retained**
Up to 1 Mth	22.5% of the policy premium
Exceeding 1 mth up to 3 mths	27.5% of the policy premium
Exceeding 3 mths up to 6 mths	37.5% of the policy premium
Exceeding 6 mths up to 9 mths	50% of the policy premium
Exceeding 9 mths up to 12 mths	60% of the policy premium
Exceeding 12 mths up to 15 mths	70% of the policy premium
Exceeding 15 mths up to 18 mths	80% of the policy premium
Exceeding 18 mths up to 21 mths	90% of the policy premium
Exceeding 21 mths	100% of the policy premium
Cancellation table applicable for installment option of Half-yearly premium payment for Policy Term 2 Year	
Period on risk	**Rate of premium to be retained**
Up to 1 Mth	43% of the total premium received
Exceeding 1 mth up to 4 mths	63.5% of the total premium received
Exceeding 4 mths up to 6 mths	77% of the total premium received
Exceeding 6 mths up to 7 mths	42% of the total premium received
Exceeding 7 mths up to 10 mths	52% of the total premium received
Exceeding 10 mths up to 13 mths	62.5% of the total premium received
Exceeding 13 mths up to 16 mths	72.5% of the total premium received
Exceeding 16 mths up to 19 mths	83% of the total premium received
Exceeding 19 mths up to 22 mths	93% of the total premium received
Exceeding 22 mths	100% of the total premium received
Cancellation table applicable for Policy Term 3 Year without installment option	
Period on risk	**Rate of premium to be retained**
Up to 1 Mth	20% of the policy premium
Exceeding 1 mth up to 3 mths	25% of the policy premium
Exceeding 3 mths up to 6 mths	32.5% of the policy premium
Exceeding 6 mths up to 9 mths	37.5% of the policy premium
Exceeding 9 mths up to 12 mths	45% of the policy premium
Exceeding 12 mths up to 15 mths	52.5% of the policy premium
Exceeding 15 mths up to 18 mths	60% of the policy premium
Exceeding 18 mths up to 21 mths	65% of the policy premium
Exceeding 21 mths up to 24 mths	72.5% of the policy premium
Exceeding 24 mths up to 27 mths	80% of the policy premium
Exceeding 27 mths up to 30 mths	87.5% of the policy premium
Exceeding 30 mths up to 33 mths	92.5% of the policy premium
Exceeding 33 mths	100% of the policy premium

Cancellation table applicable for installment option of Half-yearly premium payment for Policy Term 3 Year	
Period on risk	**Rate of premium to be retained**
Up to 1 Mth	40.5% of the total premium received
Exceeding 1 mth up to 4 mths	54% of the total premium received
Exceeding 4 mths up to 6 mths	63.5% of the total premium received
Exceeding 6 mths up to 7 mths	34% of the total premium received
Exceeding 7 mths up to 10 mths	41% of the total premium received
Exceeding 10 mths up to 15 mths	52% of the total premium received
Exceeding 15 mths up to 21 mths	66% of the total premium received
Exceeding 21 mths up to 27 mths	79.5% of the total premium received
Exceeding 27 mths up to 33 mths	93% of the total premium received
Exceeding 33 mths	100% of the total premium received

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

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

8. **Migration:** The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the Policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

9. **Portability:** The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

10. **Renewal of Policy:** The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person;
    1. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal
    2. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years
    3. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period
    4. 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
    5. Coverage is not available during the grace period
    6. 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 eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from 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, deductibles as per the policy contract.

13. **Premium Payment in Instalments:** If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)
    i. Grace Period of 7 days would be given to pay the instalment premium due for the policy.
    ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
    iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
    iv. No interest will be charged If the instalment premium is not paid on due date.
    v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
    vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
    vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

    Note: In case of policy cancellation due to non-payment of the instalment within grace period, Company will refund the premium as per the cancellation table.

14. **Possibility of Revision of Terms of the Policy Including the Premium Rates:** The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. 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 fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

    If the insured has not made 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:** Incase of any grievance the insured person may contact the Company through

    Website : www.starhealth.in
    E-mail : gro@starhealth.in, grievances@starhealth.in
    Ph. No. : 044-69006900 | Toll Free No. 1800 425 2255
    Senior Citizens may call at 044-69007500
    Courier : 4th Floor, Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai- 600014

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

    If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at 044-43664600.

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

    If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

17. **Nomination:** The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under 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 fulfillment 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 condition 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 Hospitalization 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 shall be in writing and delivered by hand, post, or facsimile/email to Star Health and Allied Insurance Company Limited, No.1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai 600034. Customer Care No. 044-69006900 or Toll Free No. 1800 425 2255, e-mail: support@starhealth.in.

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

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

24. **Automatic Expiry**

    Applicable for II Coverage: The insurance under this policy with respect to each relevant Insured Person shall expire immediately on the earlier of the following events;

    - ✓ Upon the death of the Insured Person
    - ✓ Upon exhaustion of Limit of Coverage Plus Restored Basic Sum Insured wherever applicable

    Applicable for Gold Plan: The insurance under this policy with respect to each relevant Insured Person shall expire immediately on the earlier of the following events;

    - ✓ Upon the death of the Insured Person
    - ✓ Upon exhaustion of Limit of Coverage Plus Restored Basic Sum Insured wherever applicable
    - ✓ Upon exhaustion of Limit of Coverage Plus Restored Basic Sum Insured Plus Super Restored Basic Sum Insured, wherever applicable

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. **Arbitration:** If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

    It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

    It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

    It is also further expressly agreed and declared that if the Company shall disclaim liability to the Insured for any claim hereunder and such claim shall not, within three years from the date of such disclaimer have been made the subject matter of a suit in a Court of Law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

27. **Revision of Basic Sum Insured:** Reduction or enhancement of Basic 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. Where the basic sum insured is enhanced, the amount of such additional basic sum insured including the respective sublimits shall be subject to the following terms;

    Exclusions as under shall apply afresh from the date of such enhancement for the increase in the Basic Sum Insured, that is, the difference between the expiring policy Basic Sum Insured and the increased current Basic Sum Insured.

    a) First 30 days as per exclusion **- Code Excl 03**
    b) 24 months with continuous coverage without break (with grace period) in respect of diseases / treatments for ailments / illness / diseases as per exclusion **- Code Excl 02**
    c) 48 months of continuous coverage without break (with grace period) in respect of Pre-Existing diseases as per exclusion **- Code Excl 01**
    d) 48 months of continuous coverage without break (with grace period) for diseases / conditions diagnosed / treated irrespective of whether any claim is made or not in the immediately preceding three policy periods

    The above applies to each relevant insured person

28. **Relief under Section 80-D:** Insured Person is eligible for relief under Section 80-D of the IT Act in respect of the premium paid by any mode other than cash.

29. **Important Note**

    a) Where the policy is issued for more than 1 year, the Basic Sum Insured including sublimits, cumulative bonus (if applicable), automatic restoration benefit (if applicable), super restoration benefit (if applicable) is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year or 3rd year cannot be utilized in the 1st year itself. The terms, conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each policy year
    b) The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws
    c) The terms, conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each relevant insured person. Failure to comply with may result in the claim being denied
    d) The attention of the policy holder is drawn to our website www.starhealth.in for anti fraud policy of the company for necessary compliance by all stake holders

30. **Special conditions applicable to Family Package Plan (available only under II Coverage)**

    a) Family means the Insured Person, insured spouse and insured dependent children not exceeding two in numbers
    b) This plan is applicable for Basic Sum Insured of Rs.2,00,000/- and Rs.3,00,000/- only
    c) Plan is applicable for Age band of 5 months to 45 years
    d) The Basic Sum Insured is to be equally apportioned among all the persons insured
    e) Each family member is covered up-to his/her limit only
    f) No transfer of unutilized balance Basic Sum Insured to other insured persons is permissible
    g) Health check-up benefit will be calculated on the policy Basic Sum Insured and equally divided among all the insured persons
    h) Where any insured member has made a claim then he/she would not be eligible for his/her share of Health check-up benefit. However the other insured members can avail the health check-up benefit up-to their respective share
    i) The automatic restoration of Basic Sum Insured facility is not applicable for this Plan

31. **Customer Service:** If at any time the Insured Person requires any clarification or assistance, the insured may contact No. 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai 600034, during normal business hours.

STAR Personal & Caring | Health Insurance

The Health Insurance Specialist

List of Insurance Ombudsman

AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in **JURISDICTION:** Gujarat, Dadra & Nagar Haveli, Daman and Diu.	**BENGALURU** Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in **JURISDICTION:** Karnataka.	**BHOPAL** Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in **JURISDICTION:** Madhya Pradesh Chattisgarh.	**BHUBANESWAR** Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in **JURISDICTION:** Odisha.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in **JURISDICTION:** Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.	**CHENNAI** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai - 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in **JURISDICTION:** Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).	**DELHI** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in **JURISDICTION:** Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	**ERNAKULAM** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in **JURISDICTION:** Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in **JURISDICTION:** Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**HYDERABAD** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in **JURISDICTION:** Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.	**JAIPUR** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in **JURISDICTION:** Rajasthan.	**KOLKATA** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in **JURISDICTION:** West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in **JURISDICTION:** Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, 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.: 69038821/23/24/25/26/27/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in **JURISDICTION:** Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).	**NOIDA** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in **JURISDICTION:** State of Uttarakhand 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 Email: bimalokpal.patna@cioins.co.in **JURISDICTION:** Bihar, Jharkhand. **PUNE** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in **JURISDICTION:** Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Kindly refer our website, for future updates in Ombudsman address

ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES

SI.NO.	ITEM	SI.NO.	ITEM	SI.NO.	ITEM
1	BABY CHARGES (UNLESS SPECIFIED / INDICATED)	13	TOOTH BRUSH	25	CLEAN SHEET
2	HAND WASH	14	BED PAN	26	BLANKET / WARMER BLANKET
3	SHOE COVER	15	FACE MASK	27	ADMISSION KIT
4	CAPS	16	FLEXI MASK	28	DIABETIC CHART CHARGES
5	CRADLE CHARGES	17	HAND HOLDER	29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
6	COMB	18	SPUTUM CUP	30	DISCHARGE PROCEDURE CHARGES
7	EAU-DE-COLOGNE / ROOM FRESHNERS	19	DISINFECTANT LOTIONS	31	DAILY CHART CHARGES
8	FOOT COVER	20	LUXURY TAX	32	ENTRANCE PASS / VISITORS PASS CHARGES
9	GOWN	21	HVAC	33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
10	SLIPPERS	22	HOUSE KEEPING CHARGES	34	FILE OPENING CHARGES
11	TISSUE PAPER	23	AIR CONDITIONER CHARGES	35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
12	TOOTH PASTE	24	IM IV INJECTION CHARGES	36	PATIENT IDENTIFICATION BAND / NAME TAG
				37	PULSEOXYMETER CHARGES

ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES

SI.NO.	ITEM	SI.NO.	ITEM	SI.NO.	ITEM
1	HAIR REMOVAL CREAM	9	WARD AND THEATRE BOOKING CHARGES	17	BOYLES APPARATUS CHARGES
2	DISPOSABLES RAZORS CHARGES (FOR SITE PREPARATIONS)	10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	18	COTTON
3	EYE PAD	11	MICROSCOPE COVER	19	COTTON BANDAGE
4	EYE SHEILD	12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER	20	SURGICAL TAPE
5	CAMERA COVER	13	SURGICAL DRILL	21	APRON
6	DVD, CD CHARGES	14	EYE KIT	22	TORNIQUET
7	GAUSE SOFT	15	EYE DRAPE	23	ORTHOBUNDLE, GYNAEC BUNDLE
8	GAUZE	16	X-RAY FILM		

ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT

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