STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam,
Chennai - 600 034. ★ Phone : 044 - 28288800 ★ Email : support@starhealth.in
Website : www.starhealth.in ★ CIN : U66010TN2005PLC056649 ★ IRDAI Regn. No. : 129

Kind Attention : Policyholder

Please check whether the details given by you about the insured persons in the proposal form (a copy of which was provided at the time of issuance of cover for the first time) are incorporated correctly in the policy schedule. If you find any discrepancy, please inform us within 15 days from the date of receipt of the policy, failing which the details relating to the person/s covered would be taken as correct.

So also the coverage details may also be gone through and in the absence of any communication from you within 15 days from the date of receipt of this policy, it would be construed that the policy issued is correct and the claims if any arise under the policy will be dealt with based on proposal / policy details.

FOR LIST OF PREFERRED NETWORK HOSPITALS PLEASE VISIT WEBSITE : www.starhealth.in.

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Customer Information Sheet - FAMILY HEALTH OPTIMA INSURANCE PLAN

Unique Identification No . : IRDAI/HLT/SHAI/P-H/V.III/129/2017-18

TITLE		Description	Refer to Policy Clause No.
Coverage	a.	In-patient Treatment-Covers hospitalization expenses for period more than 24 hrs	1 (A,B,C)
	b.	Emergency Ambulance-Up to Rs. 750/-per hospitalization and Rs.1,500/-per policy period for utilizing ambulance service for transporting insured person to hospital in case of an emergency.	1 (D)
	c.	Air Ambulance: Per policy limits is up to 10% of the basic Sum Insured	1 (E)
	d.	Pre-Hospitalisation-Medical Expenses incurred up to 60 days prior to hospitalisation,	1 (F)
	e.	Post-Hospitalisation-Medical Expenses incurred up to 90 days after discharge from the hospital	1 (G)
	f.	Domiciliary Hospitalisation treatment for a period exceeding three days	1(H)
	g.	OrganDonor Expenses: This cover is subject to a limit of 10% of the Sum Insured or Rupees One lakh, whichever is less.	1 (I)
	h.	Cost of Health Checkup: Expenses incurred towards cost of health check-up subject to maximum of Rs.3,500/- for every claim free year	1 (J)
	i.	Hospitalization expenses for treatment of New Born Baby: The coverage for new born baby starts from the 16th day after its birth and is subject to a limit of 10% of the Sum Insured or Rupees Fifty thousand, whichever is less	1(K)
	j.	Emergency Domestic Medical Evacuation: The Company will reimburse reasonable and necessary expenses incurred towards transportation of the insured person from the treating hospital to another hospital for further treatment	1 (L)
	k.	Compassionate travel: The Company will reimburse the transportation expenses by air incurred upto Rs.5000/- for one immediate family member (other than the travel companion) for travel towards the place where hospital is located	1 (M)
	l.	Repatriation of Mortal remains: Following an admissible claim for hospitalisation under the policy, the Company shall reimburse up to Rs.5,000/- the cost of transportation of mortal remains of the insured person (including the cost of embalming and coffin charges) to the residence of the Insured as recorded in the policy	1 (N)

TITLE		Description	Refer to Policy Clause No.
Coverage	m.	**Treatment in Preferred Network Hospitals**: If the insured taken treatment in a hospital suggested by the Company, then the company will provide lump-sum payment calculated at 1% of Basic Sum Insured subject to a maximum of Rs.5,000/-	1 (O)
	n.	**Shared Accomodation:** If the Insured person occupies shared accommodation during in patient hospitalisation, then a lump sum payment as stated will be payable	1 (P)
	o.	**AYUSH Treatment:** Expenses incurred on treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines in a Government Hospital or in any institute recognized by the government and/or accredited by the Quality Council of India/National Accreditation Board on Health is payable up to the limits.	1 (Q)
	p.	**Second Medical Opinion:** The Insured Person is given the facility of obtaining a Medical Second Opinion from a Doctor in the Company's network of Medical Practitioners	1 (R)
	q.	**Assisted ReproductionTreatment:** The Company will reimburse medical expenses incurred on Assisted Reproduction Treatment **for** sub-fertility	1 (S)
	r.	**Automatic Restoration of Basic Sum Insured**: Automatic restoration of Basic sum insured three times during the currency of the policy period upon exhaustion of the limit of coverage	1 (T)
	s.	**Recharge Benefit**: If the limit of coverage under the policy is exhausted/ exceeded during the policy period, additional indemnity up to the limits would be provided once for the remaining policy period	1 (U)
	t.	**Additional Sum Insured for RTA (Road Traffic Accident)**: If the insured person meets with a Road Traffic Accident resulting in patient hospitalization, then the basic sum insured shall be increased by 25% subject to a maximum of Rs.5,00,000/-	1 (V)
Major Exclusions	I.	Any hospital admission primarily for investigation diagnostic purpose	4 (19)
	II.	Pregnancy, infertility (except to the extent provided under coverage 1 S)	4 (13), 4 (14)
	III.	Domicilary treatment, treatment outside India	5 (16)
	IV.	Circumcision, sex change surgery, cosmetic surgery and plastic surgery	4 (1), 4 (24) and 4 (25)
	V.	Refractive error correction, hearing impairment correction, corrective and cosmetic dental surgeries	4 (18) and 4 (4)
	VI.	Substance abuse, self-inflicted injuries, STDs and HIV/AIDS	4 (8) and 4 (12)
	VII.	Hazardous sports, war, terrorism, civil war or breach of law	4 (10)
	VIII.	Any kind of service charge, surcharge, admission fees, registration fees levied by the hospital.	4 (27)
		(Note: the above is a partial listing of the policy exclusions. Please refer to the policy clauses for the full listing)	
Waiting Period		Initial waiting period	3 (i)
		Specific waiting period	3 (ii)
		Pre-existing diseases	3 (iii)
Payment basis		Reimbursement of covered expenses up to specified limits	1 (A to S) and 1 (V)
		Fixed amount on the occurrence of a covered event	1 (O) and 1 (P)
Loss Sharing		In case of a claim, this policy requires you to share the following costs: Expenses exceeding the following Sublimits 1. Room/ICU charges beyond limits 2. For the following specified diseases: 3. Deductible 4. Co-payment	 1 (A) Nil Nil 5 (5)
Renewal Condition		Life long renewal subject to payment of renewal premium	5 (7)
		Grace period of 120 days for renewing the policy is provided	

TITLE	Description	Refer to Policy Clause No.
Renewal Benefits	Bonus upto 100%	1 (W)
	Health Check up upto the limit mentioned in the table	1 (J)
Cancellation	Policy can be cancelled on grounds of misrepresentation, fraud, moral hazard, non disclosure of material fact as declared in proposal form / at the time of claim, or non-co-operation by the insured person, by sending the insured 30 days notice without refund of premium	5 (12)
Claims	For Cashless Service and for Reimbursement of claim	5 (3)
Policy Servicing Grievances/ Complaints	Company Officials IRDAI/(IGMS/Call Centre): Ombudsman	5 (18), 5 (20) and 5(21)
Insured's Rights	Free Look:	5 (11)
	Implied renewability (except on certain specific grounds)	5 (7)
	Migration and Portability	5 (14)
	Increase in SI during the Policy term	5 (10)
	Turn Around Time (TAT) for issue of Pre-Auth and settlement of Reimbursement	5 (2)
Insured's Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.	5 (12)
	Disclosure of Material Information during the policy period such as change in occupation	Not Applicable

LEGAL DISCLAIMER NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail

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FAMILY HEALTH OPTIMA INSURANCE PLAN

Unique Identification No . : IRDAI/HLT/SHAI/P-H/V.III/129/2017-18

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

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 duly Qualified Physician/Medical Specialist /**Medical Practitioner** or of duly **Qualified Surgeon** to incur Hospitalization expenses during the period stated in the schedule for medical/surgical treatment at any **Nursing Home / Hospital** in India as an **in-patient**, the Company will indemnify the **Insured Person/s** the amount of such expenses as are reasonably and necessarily incurred, up-to the limits mentioned and /or compensate to an extent as agreed but not exceeding the Limit of Coverage in aggregate in any one period stated in the schedule hereto.

1. Coverage

A. Room, Boarding, Nursing Expenses all inclusive as provided by the Hospital / Nursing Home as per the limits given below:-

Sum Insured Rs.	Limit Rs.
1,00,000/-	Up to 2,000/- per day
2,00,000/-	
3,00,000/-	Up to 5,000/- per day
4,00,000/-	
5,00,000/-	Single Standard A/C Room
10,00,000/-	
15,00,000/-	
20,00,000/-	
25,00,000/-	

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

C. Anesthesia, blood, oxygen, operation theatre 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 stent, the Company will pay such amount up to the extent of cost of bare metal stent/drug eluting cobalt-chromium stent/drug eluting stainless steel stent. In respect of medicines, Implants and such other similar items, the Company will pay up to the cost of alternate indigenous make.

Expenses relating to hospitalization will be considered in proportion to the eligible room rent stated in the policy or actual whichever is less.

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 the Hospital / Nursing Home and the Insured is discharged on the same day.

Expenses incurred on treatment of Cataract is subject to the limit as per the following table

Sum Insured Rs.	Limit per eye (in Rs.)	Limit per policy period (in Rs.)
1,00,000/-	Up to 12,000/- per eye, per policy period	
2,00,000/-		
3,00,000/-	Up to 25,000/-	Up to 35,000/-
4,00,000/-	Up to 30,000/-	Up to 45,000/-
5,00,000/-	Up to 40,000/-	Up to 60,000/-
10,00,000/-	Up to 50,000/-	Up to 75,000/-
15,00,000/-		
20,00,000/-		
25,00,000/-		

D. Emergency ambulance charges up-to a sum of 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 for hospitalization under the policy.

E. Air Ambulance charges up to 10% of the Basic Sum Insured during the entire policy period, provided that

1. It is for life threatening emergency health condition/s of the insured person which requires immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot provide.
2. Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency
3. It is prescribed by a Medical Practitioner and is Medically Necessary;
4. The insured person is in India and the treatment is in India only
5. Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s

Note: This benefit is available for sum insured options of Rs.5, 00,000/- and above only.

F. Relevant Pre-Hospitalization medical expenses incurred for a period not exceeding 60 days prior to the date of hospitalization, for the disease/illness, injury sustained following an admissible claim for hospitalization under the policy.

G. Post Hospitalization medical expenses incurred for a period of 90 days from the date of discharge from the hospital towards Consultant fees, Diagnostic charges, Medicines and Drugs wherever recommended by the Hospital / Medical Practitioner, 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.

H. Domiciliary Hospitalization: Coverage for medical treatment 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

1. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

2. 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.

Pre-hospitalization and Post-hospitalization expenses are not payable for this benefit.

I. Organ Donor Expenses for organ transplantation where the insured person is the recipient are payable provided the claim for transplantation is payable and subject to the availability of the sum insured. Donor screening expenses and post-donation complications of the donor are not payable. This cover is subject to a limit of 10% of the Sum Insured or Rupees One lakh, whichever is less.

J. Cost of Health Checkup: Expenses incurred towards cost of health check-up up to the limits mentioned in the table given below for every claim free year provided the health checkup is done at network hospitals and the policy is in force. Payment under this benefit does not form part of the sum insured and will not impact the Bonus.

If a claim is made by any of the insured persons, the health check up benefits will not be available under the policy.

Note: Payment of expenses towards cost of health check up will not prejudice the company's right to deal with a claim in case of non disclosure of material fact and / or Pre-Existing Diseases in terms of the policy.

Sum Insured Rs.	Limit Per Policy Period (Rs.)
1,00,000/-	Not Available
2,00,000/-	
3,00,000/-	Up to 750/-
4,00,000/-	Up to 1,000/-
5,00,000/-	Up to 1,500/-
10,00,000/-	Up to 2,000/-
15,00,000/-	Up to 2,500/-
20,00,000/-	Up to 3,000/-
25,00,000/-	Up to 3,500/-

K. 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 Sum Insured or Rupees Fifty thousand, whichever is less, subject to the availability of the sum insured, provided the mother is insured under the policy for a continuous period of 12 months without break.

Note: 1. 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.

2. Waiting periods as stated under 3(i) shall not apply for the New Born Baby
3. All other terms, conditions and exclusions shall apply for the New Born Baby

L. Emergency Domestic Medical Evacuation: Subject to limits mentioned in the table given below, the Company will reimburse reasonable and necessary expenses incurred towards transportation of the insured person from the hospital where the insured person is currently undergoing treatment to another hospital for further treatment provided :

a. The medical condition of the Insured Person is a life threatening emergency,

b. Further treatment facilities are not available in the current hospital

c. The Medical Evacuation is recommended by the treating Medical Practitioner.

d. Claim for Hospitalization is admissible under the policy.

Sum Insured Rs.	Limit per hospitalization
Up to 4,00,000/-	Up to Rs.5,000/-
5,00,000/- to 15,00,000/-	Up to Rs.7,500/-
20,00,000/- and 25,00,000/-	Up to Rs.10,000/-

Note: Payment under this benefit does not form part of the sum insured but will impact the Bonus.

M. 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 incurred up to Rs. 5000/- for one immediate family member (other than the travel companion) for travel towards the place where hospital is located, provided the claim for hospitalization is admissible under the policy.

Note: This benefit is available for sum insured options of Rs.10,00,000/- and above only. Payment under this benefit does not form part of the sum insured but will impact the Bonus.

N. Repatriation of Mortal Remains: Following an admissible claim for hospitalization under the policy, the Company shall reimburse up to Rs.5,000/- per policy period towards the cost of repatriation of mortal remains of the insured person (including the cost of embalming and coffin charges) to the residence of the Insured as recorded in the policy. Payment under this benefit does not form part of the sum insured but will impact the Bonus.

O. Treatment in Preferred Network Hospitals: In the event of a medical contingency requiring hospitalization, if the insured seeks advice from the Company, the Company may suggest an appropriate hospital from the network for treatment. Where the insured accepts the same and undergoes treatment in the suggested hospital, an amount calculated at 1% of Basic Sum Insured subject to a maximum of Rs.5,000/- per policy period is payable as lump sum.

Note:
1. This benefit is applicable for Basic Sum Insured of Rs.3, 00,000/- and above only.
2. This benefit is payable only if there is an admissible claim for hospitalization under the policy.
3. This benefit shall be paid if a hospital is a part of the list as on date of admission
4. Payment under this benefit does not form part of the sum insured but will impact the Bonus
5. The Company shall not be responsible for the quality of the treatment in the Preferred Network Facility
6. **FOR LIST OF PREFERRED NETWORK HOSPITALS PLEASE VISIT WEBSITE : www.starhealth.in.**

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

Sum Insured Rs.	Limit per day Rs.
1,00,000/-	Not Payable
2,00,000/-	
3,00,000/-	800/- per day
4,00,000/-	
5,00,000/-	
10,00,000/-	
15,00,000/-	
20,00,000/-	1,000/- per day
25,00,000/-	

Note:
i) This benefit is applicable for Basic Sum Insured of Rs. 3,00,000/- and above only.
ii) This benefit is payable only if there is an admissible claim for hospitalization under the policy
iii) This benefit will not be applicable where the sanction is on package rates
iv) Insured stay in Intensive Care Unit or High Dependency Units / wards will not be counted for this purpose
v) Payment under this benefit does not form part of the sum insured but will impact the Bonus

Q. AYUSH Treatment: Expenses incurred on treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines in a Government Hospital or in any institute recognized by the government and / or accredited by the Quality Council of India / National Accreditation Board on Health is payable up to the limits given below:

Sum Insured Rs.	Limit per policy period Rs.
1,00,000/-	Up to 10,000/-
2,00,000/-	
3,00,000/-	
4,00,000/-	
5,00,000/- to 15,00,000/-	Up to 15,000/-
20,00,000/- and 25,00,000/-	Up to 20,000/-

Note: Payment under this benefit forms part of the sum insured and will impact the Bonus

R. Second Medical Opinion: The Insured Person can obtain a Medical Second Opinion from a Doctor in the Company's network of Medical Practitioners. All the medical records provided by the Insured Person will be submitted to the Doctor chosen by him/her 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 "e_medicalopinion@starhealth.in."

Special Conditions:-

- This should be specifically requested for by the Insured Person
- This opinion is given based only on the medical records submitted without examining the patient,
- The second opinion should be only for medical reasons and not for medico-legal purposes.
- Any liability due to any errors or omission or consequences of any action taken in reliance of the second opinion provided by the Medical Practitioner is outside the scope of this policy.
- Utilizing this facility alone will not amount to making a claim

Note: Medical Records / Documents submitted for utilizing this facility will not prejudice the Company's right to reject a claim in terms of policy.

S. Assisted Reproduction Treatment: The Company will reimburse medical expenses incurred on Assisted Reproduction Treatment, where indicated, for sub-fertility subject to:

1. A waiting period of 36 months from the date of first inception of this policy with the Company for the insured person. The maximum liability of the Company for such treatment shall be limited to Rs.1,00,000/- for Sum Insured of Rs.5,00,000/- and Rs.2,00,000/- for Sum Insured of Rs.10,00,000/- and above for every block of 36 months and payable on renewal
2. For the purpose of claiming under this benefit, in- patient treatment is not mandatory.
3. Automatic Restoration of Basic Sum Insured, Recharge Benefit shall not be applicable for this benefit.

Note: To be eligible for this benefit both husband and spouse should stay insured continuously without break under this policy for every block. This coverage is available only for sum insured options of Rs. 5,00,000/- and above

Special 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:

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

T. Automatic Restoration of Basic Sum Insured (Applicable for A to I, K, Q): There shall be automatic restoration of the Basic Sum Insured immediately upon exhaustion of the **limit of coverage**, which has been defined, during the policy period.

Such Automatic Restoration is available 3 times at 100% each time, during the policy period. Each restoration will operate only after the exhaustion of the earlier one.

It is made clear that such restored Sum Insured can be utilized only for illness / disease unrelated to the illness / diseases for which claim/s was / were made. The unutilized restored sum insured cannot be carried forward.

Note: Automatic Restoration of Basic Sum Insured is available only for sum insured options of Rs.3,00,000/- and above.

U. Recharge Benefit (Applicable for A to I, K, Q): If the limit of coverage under the policy is exhausted/ exceeded during the policy period, additional indemnity up to the limits stated in the table given below would be provided once for the remaining policy period. Such additional indemnity can be utilized even for the same hospitalization or for the treatment of diseases / illness / injury / for which claim was paid / payable under the policy. The unutilized Recharge amount cannot be carried forward.

Sum Insured (Rs.)	Limit Rs.
1,00,000/-	Not Available
2,00,000/-	
3,00,000/-	75,000/-
4,00,000/-	1,00,000/-
5,00,000/-	1,50,000/-
10,00,000/-	
15,00,000/-	
20,00,000/-	
25,00,000/-	

V. Additional 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 25% subject to a maximum of Rs.5,00,000/- and subject to the following:

1. 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.
2. The additional sum insured shall be available only once during the policy period.
3. The additional sum insured shall be available after exhaustion of the **limit of coverage.**
4. The additional sum insured can be utilized only for the particular hospitalization following the Road Traffic Accident
5. Automatic Restoration of Basic Sum Insured and Recharge Benefit shall not apply for this benefit
6. This benefit shall not be applicable for day care treatment
7. The unutilized balance cannot be carried forward for the remaining policy period or for renewal
8. Claim under this benefit will impact the Bonus

W. Bonus (Applicable for A to I, L TO Q, S and V) In respect of a claim free year of Insurance, for the Basic Sum Insured options Rs.3,00,000/- and above, the insured would be entitled to benefit of bonus of 25% of the expiring Basic Sum Insured in the second year and additional 10% of the expiring Basic sum Insured for the subsequent years. The maximum allowable bonus shall not exceed 100%

The Bonus will be calculated on the expiring sum insured or on the renewed sum insured whichever is less. Bonus will be given on that part of sum insured which is continuously renewed. 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.

Bonus shall be available only upon timely renewal without break or upon renewal within the grace period allowed.

In the event of a claim, such bonus so granted will be reduced at the same rate at which it has accrued. However the Basic sum insured, will not be reduced.

2. Definitions

Accident/Accidental means sudden, unforeseen and involuntary event caused by external, visible and violent means.

Any one Illness means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment has been taken. Occurrence of the same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy.

Assisted Reproduction Treatment means intrauterine insemination (IUI), Intra-Cytoplasmic Sperm Injection (ICSI), In-Vitro Fertilisation(IVF) and TESA / TESE (Testicular / Epididymal Sperm Aspiration / Extraction)

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

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

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

Company means Star Health and Allied Insurance Company Limited

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

Co-payment is a cost-sharing requirement under a health insurance policy that provides that the insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

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

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

Day Care Centre means any institution established for day care treatment of illness and/or injuries or a medical set up within 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

- has qualified nursing staff under its employment;
- has qualified medical practitioner(s) in charge;
- has fully equipped operation theatre of its own where surgical procedures are carried out;
- 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:

a. Undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement and

b. Which would have otherwise required a 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 means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Dependent Child to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

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

Disclosure to information norm: The Policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of mis representation, mis-description or non-disclosure of any material fact.

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 whilst confined at home under any of the following circumstances:

a. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

b. The patient takes treatment at home on account of non-availability of room in a hospital.

Family includes Insured Person, spouse, dependent children between 16 days and 25 years of age

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 / Nursing Home 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:

a. Has qualified nursing staff under its employment round the clock;

b. 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;

c. Has qualified medical practitioner(s) in charge round the clock.

d. Has a fully equipped operation theatre of its own where surgical procedures are carried out;

e. Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

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.

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.

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.

ICU 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

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 - Accute 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

Insured Person means the name/s of persons shown in the schedule of the Policy who are covered under this policy, for whom the insurance is proposed, appropriate premium is paid.

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 Basic Sum Insured plus the No Claim Bonus earned wherever applicable.

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 is 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 there by entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

Medically Necessary treatment is defined as any treatment, tests, medication, or stay in *hospital* or part of a stay in hospital which

- Is required for the medical management of the illness or injury suffered by the insured;
- Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- Must have been prescribed by a medical practitioner;
- Must conform to the professional standards widely accepted in international medical practice or by the medical community In India

Network Hospital 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 means baby born during the policy period and is aged above 15 days

Non Network Hospital means any hospital, day care center or other provider that is not part of the network.

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

Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

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

a. Such medical expenses are incurred for the same condition for which the insured person's hospitalization was required and

b. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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:

a. Such medical expenses are for the same condition for which the insured person's hospitalization was required and

b. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

Portability means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre existing condition and time bound exclusions, from one insurer to another or from one plan to another plan of the same insurer

Qualified Nurse is 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.

Shared accommodation means a room with two or more patient beds in a Network Hospital.

Single Standard 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 a deluxe room or a suite

Sum Insured wherever it appears shall mean Basic Sum Insured only, except otherwise expressed.

Surgery/Surgical Operation 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 means treatment, including drug Experimental therapy, which is not based on established medical practice in India, treatment experimental or unproven.

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

Zone 1a: Chennai, Bangalore, Pune, Nasik, Ernakulam, Trivandrum and Rest of Gujarat.

Zone 2: Coimbatore, Indore City, and Rest of Kerala.

Zone 3: Rest of India

3. Waiting periods

i. Any disease contracted by the insured person during the first 30 days from the commencement date of the policy.

This waiting period shall not apply in case of the insured person having been covered under any health insurance policy (Individual policy) with any of the Indian General Insurance companies / health insurance companies for a continuous period of preceding 12 months without a break.

ii. A waiting period of 24 consecutive months of continuous coverage from the inception of this policy will apply to the following specified ailments / illness / diseases:-

a) Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, Diseases related to Thyroid, Prolapse of Intervertebral Disc (other than caused by accident), Varicose veins and Varicose ulcers, Desmoid Tumor, Umbilical Granuloma, Umbilical Sinus, Umbilical Fistula, all Diseases of Prostate, Stricture Urethra, all Obstructive Uropathies, all types of Hernia, Benign Tumours of Epididymis, Spermatocele, Varicocele, Hydrocele, Fistula, Fissure in Ano, Hemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence and Congenital Internal disease / defect

b) 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.

c) All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Cervix, Uterus, Fallopian tubes, Ovaries(other than due to cancer), Uterine Bleeding, Pelvic Inflammatory Diseases and Benign diseases of the breast.

d) 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].

e) All types of treatment for Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system

f) Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal Tunnel Syndrome, Trigger Finger, Lipoma , Neurofibroma, Fibroadenoma, Ganglion and similar pathology

g) All types of transplant and related surgeries.

This waiting period shall not however apply in the case of the Insured person/s having been covered under any Individual health insurance scheme with any of the Indian General/ Health Insurer for a continuous period of preceding 24 months without any break.

If these are pre-existing at the time of proposal they will be covered subject to waiting period **iii** below

iii. Pre Existing Diseases as defined in the policy until 48 consecutive months of continuous coverage have elapsed, since inception of the first policy with any Indian General/ Health Insurer.

The waiting period i, ii and iii above are subject to Portability regulations.

4. 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:

1. Circumcision, Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA
2. Inoculation or Vaccination (except for post–bite treatment and for medical treatment for therapeutic reasons)
3. Congenital External Condition / Defects / Anomalies
4. Dental treatment or surgery unless necessitated due to accidental injuries and requiring hospitalization. (Dental implants are not payable)
5. Convalescence, general debility, run-down condition or rest cure, nutritional deficiency states.
6. Psychiatric, mental and behavioral disorders.
7. Intentional self injury
8. Use of intoxicating substances, substance abuse, drugs / alcohol, smoking and tobacco chewing
9. Venereal Disease and Sexually Transmitted Diseases,
10. Injury/disease directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not)
11. Injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials

12. All expenses arising out of any condition directly or indirectly caused due to or associated with Human T-cell Lympho Trophic Virus type III (HTLV-III) or Lymphadenopathy Associated Virus (LAV) or HIV / AIDS. It is however made clear that such of those who are positive for HIV (Human Immuno Deficiency Virus) would be entitled for expenses incurred for treatment, other than for opportunistic infections and for treatment of HIV/AIDS, provided at the time of first commencement of insurance under this policy, their CD4 count is not less than 350.
13. Treatment arising from or traceable to pregnancy, childbirth, family planning, miscarriage, abortion and complications of any of these (other than ectopic pregnancy).
14. Treatment for Sub-Fertility, Assisted Conception and or other related complications of the same except to the extent covered under 1 S.
15. Expenses incurred on weight control services including surgical procedures such as Bariatric Surgery and /or medical treatment of obesity.
16. Medical and / or surgical treatment of Sleep apnea, treatment for genetic and endocrine disorders.
17. Expenses incurred on High Intensity Focused Ultra Sound, Uterine Fibroid Embolisation, Balloon Sinoplasty, Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Deep Brain Stimulation, 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 exclusion no17.
18. Expenses incurred on Lasik Laser or other procedures Refractive Error Correction and its complications, all treatment for disorders of eye requiring intra-vitreal injections.
19. Charges incurred on diagnostics that are not consistent with the treatment for which the insured is admitted in the hospital / nursing home. Admission primarily for diagnostic purpose with no positive existence of sickness / disease / ailment / injury and no further treatment is indicated.
20. Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Physician of the hospital where the insured underwent treatment.
21. Unconventional, Untested, Unproven, Experimental therapies.
22. Stem cell Therapy, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy.
23. Oral Chemotherapy, Immuno therapy and Biologicals, except when administered as an in-patient, when clinically indicated and hospitalization warranted.
24. All types of Cosmetic, Aesthetic treatment of any description, all treatment for erectile dysfunctions, Change of Sex.
25. Plastic surgery (other than as necessitated due to an accident or as a part of any illness),
26. Cost of spectacles and contact lens, hearing aids, walkers and crutches, wheel chairs, Nutritional Supplements, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis [CAPD], infusion pump and such other similar aids, Cochlear implants and procedure related hospitalization expenses
27. Hospital registration charges, admission charges, record charges, telephone charges and such other charges
28. Other excluded expenses as detailed under "Other Excluded Expenses"

5. CONDITIONS

1. The premium payable 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.

   Organ transplant on the Insured Person shall satisfy the requirements of the Transplantation of Human Organs Act of 1994 and any amendments thereto.
2. Upon hospitalization, notice with full particulars shall be sent to the Company within 24 hours from the time / date of occurrence of the event.

   Claim must be filed within 15 days from the date of discharge from the Hospital Post hospitalization bills are to be submitted within 15 days after completion of 90 days from the date of discharge from hospital.

   Note: This is condition 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.
3. 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.

   For Cashless Treatment

   a. Call the 24 hour help-line for assistance - 1800-425-2255 / 1800-102-4477
   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-authorization Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk.
   e. The Treating Doctor will complete the hospitalization / treatment information and the hospital will fill up expected cost of treatment.

f. This form is submitted to the Company

g. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.

h. 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.

i. In case of emergency hospitalization information to be given within 24 hours after hospitalization

j. Cashless facility can be availed only in networked Hospitals

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 permissible reimbursement.

In non-network hospitals payment must be made up-front by Insured / Insured Person and then reimbursement will be effected on submission of documents upon its admissibility.

For Reimbursement Claims:

a. Duly completed claim form, and

b. Pre Admission investigations and treatment papers.

c. Discharge Summary from the hospital in original

d. Cash receipts from hospital, chemists

e. Cash receipts and reports for tests done

f. Receipts from doctors, surgeons, anaesthetist

g. Certificate from the attending doctor regarding the diagnosis.

h. First Information Report in-case of Road Traffic Accident

i. Copy of PAN card

In case of delay in payment of any claim that has been admitted as payable under the Policy terms and conditions, beyond the time period as prescribed under IRDA (Protection of Policyholders Regulation), 2002, the Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is approved by the Company. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.

4. Any medical practitioner authorized by the company shall be allowed to examine the **Insured Person/s** 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 the Company's cost.

5. **Co-payment (Applicable for A to H and Q):** This policy is subject to co-payment of 20% of each and every claim amount for fresh as well as renewal policies for insured persons whose age at the time of entry is above 60 years

6. The Company shall not be liable to make any payment under the policy in respect of any claim if information furnished at the time of proposal is found to be incorrect or false or such claim is in any manner fraudulent or supported by any fraudulent means or device, misrepresentation whether by the Insured Person or by any other person acting on his behalf.

7. **Renewal**: The policy will be renewed except on grounds of misrepresentation / Non-disclosure of material fact as declared in the proposal form and at the time of claim, fraud committed / moral hazard non cooperation of the insured.

   A grace period up to 120 days from the date of expiry of the policy is available for renewal. If renewal is made within this 120 days period, the continuity of benefits with reference waiting periods stated will be available. Any Disease/illness contracted or injury sustained during the grace period will be deemed as Pre existing and will be subject to waiting period as stated under 3 iii.

   Note: 1. The actual period of cover will start only from the date of receipt of premium.
   2. Renewal premium is subject to change with prior approval from Regulator

8. **Modification of the terms of the policy:** The Company reserves the right to modify the policy terms and conditions or modify the premium of the policy with the prior approval of the Competent Authority. In such an event the insured will be intimated three months in advance.

9. **Withdrawal of the policy:** The Company reserves the right to withdraw the product with prior approval of the Competent Authority. In such an event the insured will be intimated three months in advance and the insured shall have the option to choose to be covered by an equivalent or similar policy offered by the Company.

10. **Enhancement of sum insured:** The sum insured can be enhanced at the time of renewal of this policy subject to no claim being lodged or paid under this policy; both the acceptance for enhancement and the amount of enhancement will be at the discretion of the Company. Where the sum insured is enhanced, the amount of such additional sum insured (including the respective sublimit) shall be subject to the following terms

    A Waiting period as under shall apply afresh from the date of such enhancement for the increase in the sum insured, that is, the difference between the expiring policy sum insured and the increased current sum insured.

    1. First 30 days as under Waiting period 3-i
    2. 24 months with continuous coverage without break (with grace period) in respect of diseases / treatments falling under waiting period 3-ii a to 3-ii h
    3. 48 months of continuous coverage without break (with grace period) in respect of Pre-Existing diseases.

4. 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

11. **Free Look Period**: A free look period of 15 days from the date of receipt of the policy is available to the insured to review the terms and conditions of the policy. In case the insured is not satisfied with the terms and conditions, the insured may seek cancellation of the policy and in such an event the Company shall allow refund of premium paid after adjusting the cost of pre-medical screening, stamp duty charges and proportionate risk premium for the period concerned provided no claim has been made until such cancellation.

Free look period is not applicable at the time of renewal of the policy

12. **Cancellation**: The Company may cancel this policy on grounds of misrepresentation, fraud, moral hazard, non disclosure of material fact as declared in the proposal form and/or claim form at the time of claim and non co-operation of the insured by sending the Insured 30 days notice by registered letter at the Insured person's last known address. No refund of premium will be made except where the cancellation is on the grounds of non co-operation of the insured, in which case the refund of premium will be on pro-rata basis. The insured may at any time cancel this policy and in such event the Company shall allow refund after retaining premium at Company's short Period rate only (table given below) provided no claim has occurred up to the date of cancellation

PERIOD ON RISK	RATE OF PREMIUM TO BE RETAINED
Up to one month	25% of the annual premium
Exceeding one month up to 3 months	40% of the annual premium
Exceeding 3 months up to 6 months	60% of the annual premium
Exceeding 6 months up to 9 months	80% of the annual premium
Exceeding 9 months	Full annual premium

13. **Automatic Termination**: The insurance under this policy with respect to each relevant insured person policy shall terminate 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 under the policy
14. **Portability:** This policy is portable. If the insured is desirous of porting this policy, application in the appropriate form should be made to the Company at least 45 days before but not earlier than 60 days from the date when the renewal is due. For details contact "portability@starhealth.in" or call Telephone No: 044-28288869
15. **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
16. All claims under this policy shall be payable in Indian currency. All investigations/treatments under this policy shall have to be taken in India.
17. **Important Note**
    a) The Sum Insured floats amongst the insured members.
    b) The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears.
    c) The terms, conditions, waiting periods 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 may result in the claim being denied.
    d) Settlement of claims under the Policy is subject to the provisions of Anti- Money Laundering / Counter Financing of Terrorism (AML / CFT) policy of the Company. For further details, please visit our website www.starhealth.in
    e) 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.

18. **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.

19. **Notices**: 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, ValluvarKottam High Road, Nungambakkam, Chennai - 600034. Toll Free Fax No.: 1800-425-5522, Toll Free No.:1800-425-2255 / 1800-102-4477, 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.

20. **Customer Service:** If at any time the Insured Person requires any clarification or assistance, the insured may contact the offices of the Company at the address specified, during normal business hours

21. **Grievances:** In case the Insured Person is aggrieved in any way, the insured may contact the Company at the specified address, during normal business hours.

    Grievance Department, Star Health and Allied Insurance Company Limited, No 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600034. or Call 044-28288821 during normal business hours. or Send e-mail to grievances@starhealth.in. Senior Citizens may Call 044-28288897.

    In the event of the following grievances:

    a. any partial or total repudiation of claims by the Company;
    b. any dispute in regard to premium paid or payable in terms of the policy;
    c. any dispute on the legal construction of the policies in so far as such disputes relate to claims;
    d. delay in settlement of claims;
    e. non-issuance of any insurance document to customer after receipt of the premium;

    The insured person may approach the Insurance Ombudsman at the address given below, within whose jurisdiction the branch or office of Star Health and Allied Insurance Company Limited are located.

LIST OF OMBUDSMAN

OFFICE DETAILS	JURISDICTION
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@gbic.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase,Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email:bimalokpal.bengaluru@gbic.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 -2769203 Email:bimalokpal.bhopal@gbic.co.in	Madhya Pradesh, Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park,Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 -2596429 Email:bimalokpal.bhubaneswar@gbic.co.in	Orissa.
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 Fax: 0172 -2708274 Email:bimalokpal.chandigarh@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet,CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 -24333664 Email:bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 -23230858Email:bimalokpal.delhi@gbic.co.in	Delhi.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road,Guwahati –781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 -2732937 Email:bimalokpal.guwahati@gbic.co.in	Assam,Meghalaya,Manipur,Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool,Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 -23376599 Email:bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh,Telangana, Yanam and part of Territory of Pondicherry.

LIST OF OMBUDSMAN

OFFICE DETAILS	JURISDICTION
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg,Jaipur - 302 005. Tel.: 0141 -2740363 Email:Bimalokpal.jaipur@gbic.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road,Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 -2359336 Email:bimalokpal.ernakulam@gbic.co.in	Kerala,Lakshadweep,Mahe- a part of Pondicherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue,KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 -22124341 Email:bimalokpal.kolkata@gbic.co.in	West Bengal,Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 -2231310 Email:bimalokpal.lucknow@gbic.co.in	Districts of Uttar Pradesh : Laitpur, 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.: 022 -26106552 / 26106960 Fax: 022 -26106052 Email:bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar,U.P-201301. Tel.: 0120 - 2514250 / 2514252 / 2514253 Email:bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur,
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006. Tel.: 0612-2680952 Email:bimalokpal.patna@gbic.co.in	Bihar,Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email:bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thaneexcl uding Mumbai Metropolitan Region.

Sl. No.	Other Excluded Expenses	
	TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS	
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Payable for surgery of thoracic or lumbar spine
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED B HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Payable for Varicose Veins surgeries if Varicose veins surgery is payable
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SAN ITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable

41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payab le
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures payable
	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Not Payable
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Not Payable
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Not Payable
62	HORMONE REPLACEMENT THERAPY	Not Payable
63	HOME VISIT CHARGES	Not Payable
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Payable
65	OBESITY (INCLUDING MORBID OB ESITY) TREATMENT IF EXCLUDED IN POLICY	Not Payable
66	PSYCHIATRIC and PSYCHOSOMATIC DISORDERS	Not Payable
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Not Payable
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Not Payable
69	DONOR SCREENING CHARGES	Not Paya ble
70	ADMISSION/REGISTRATION CHARGES	Not Payable
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Not Payable
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not Payable, except to the extend provided under exclusion No.12
74	STEM CELL IMPLANTATION/ SURGERY and Storage	Not Payable except Bone Marrow ransplantation where covered by policy. Stem cell storage not payable

	ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY and ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not separately.
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT charges, not separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	Antiseptic or disinfectant lotions	Not Payable-Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable-Part of Dressing Charges
88	COTTON	Not Payable-Part of Dressing Charges
89	COTTON BANDAGE	Not Payable-Part of Dressing Charges
90	MICROPORE / SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable-Part of Hospital Services/Disposable linen to be part of OT/ICU charges
93	TORNIQUET	Not Payable(servic e is charged by hospitals, consumables cannot be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
	ELEMENTS OF ROOM CHARGE	
96	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION and AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of room charge not payable separately
102	ATTENDANT CHARGES	Not Payable Part of Room Charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payab le
104	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET	Not payable part of room charges

	ADMINISTRATIVE OR NON-MEDICAL CHARGES	
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONV ENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARG ES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTAINANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDI CINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
	EXTERNAL DURABLE DEVICES	
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMM ODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not Payable
135	INFUSION PUMP – COST	Device not Payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES	Device not Payable
138	SPACER	Not Payable
139	SPIROMET RE	Device not Payable
140	SPO2 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBO SACRAL BELT	Payable for surgery of lumbar spine.

150	LUMBO SACRAL BELT	Payable for surgery of lumbar spine.
151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs.200/day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Payable in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
156	BETADINE \ HYDROGEN PEROXIDE \ SPIRIT DISINFECTANTS ETC	Payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES	Post hospitalization nursing charges not payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES -DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable-Sugar free variants of admissible medicines are not excluded
160	CREAMS POWDERS LOTIONS (TOILETERIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)	Payable when prescribed
161	Digestion gels	Payable when prescribed
162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU, For longer stay in ICU, may require a chan ge and at least one set every second day must be payable.
163	GLOVES	Sterilized Gloves payable/unsterilized gloves not payable
164	HIV KIT	Payable - payable pre operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during hospitalization is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GE L	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not payable/Post Bite Vaccination payable
	PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
173	AHD	Not Payable-Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable-Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable-Part of Hospital's internal Cost

	OTHERS	
176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT,ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not Payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not Payable
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not Payable pre hospitalization or post hospitalization/ Reports and Charts required/Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	Payable-Ambulance from home to hospital or interhospital shifts is payable/RTA as specific requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable-maximum of 3 in 48 hrs and then 1 in 24 hrs
197	URINE BAG	Payable where medically necessary till a reasonable cost-maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Payable for case like CABG etc

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