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DIABETES SAFE INSURANCE POLICY

Unique Identification No.: SHAHLIP23081V082223

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 (APPLICABLE FOR PLAN A AND PLAN B)

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.

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

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

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.

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.

Kidney Failure Requiring Regular Dialysis: End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

Medical Advice: Medical Advice means any consultation or advice from a Medical Practitioner including the issuance 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.

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.

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

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.

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.

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.

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.

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

Insured Person: Insured Person means the persons named in the schedule of the Policy.

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

In-Patient: 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.

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.

Networked Facility: Networked Facility means hospitals, day care centers, clinics, diagnostic centers that the Company has mutually agreed with to provide medical services.

Nuclear, Chemical and Biological Terrorism: Nuclear, Chemical and Biological Terrorism shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear. "Chemical" agent shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property. "Biological" agent shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

Single Standard A/c room: 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.

II. COVERAGE

In consideration of the premium paid and subject to the terms and conditions as set out in the Schedule with all its Parts the Company by this Policy agrees as under:

a. Section 1 (Applicable for Plan A and Plan B)

If during the policy period stated in the schedule, the **Insured Person** shall develop any complications of Diabetes Mellitus and if such complications shall require the Insured Person, upon the advice of the duly Qualified **Medical Practitioner,** to incur hospitalization expenses for medical/surgical treatment at **Nursing Home / Hospital** in India as an **inpatient,** the Company will pay the amount of such expenses as are **reasonably and necessarily** incurred as would fall under different heads as stated hereto up-to the limits mentioned but not exceeding the sum insured in aggregate as stated in the schedule hereto;

A. Room (Single Standard A/C room), Boarding and Nursing Expenses
B. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees
C. Anaesthesia, Blood, Oxygen and Operation Theatre charges, ICU Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and diagnostic imaging modalities, X-ray and stent. 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. Emergency ambulance charges up-to a sum of Rs. 2000/- 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 however there is an admissible claim under this section
E. Relevant **Pre Hospitalization** medical expenses incurred for a period not exceeding 30 days prior to the date of Hospitalisation, on the disease/illness contracted following an admissible claim under the policy
F. **Post Hospitalization** expenses incurred up to 60 days after 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 hospitalization provided such expenses so incurred are in respect of ailment for which the insured person was hospitalized. 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

b. Special conditions applicable for Section 1

Plan A	Plan B
1. Donor expenses for kidney 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	1. Donor expenses for kidney 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

Plan A	Plan B
2. Expenses incurred on dialysis **(inclusive of AV fistula /graft creation charges)** are payable up-to Rs.1,000/- per sitting commencing from the policy year in which Chronic Kidney disease occurs and payable for up to 24 consecutive months provided the policy is in force	2. Expenses incurred on dialysis **(inclusive of AV fistula /graft creation charges)** are payable up-to Rs.1,000/- per sitting commencing from the policy year in which Chronic Kidney disease occurs and payable for up to 24 consecutive months provided the policy is in force
3. Cost of artificial limbs following amputation is payable up-to 10% of Sum Insured provided the claim for such amputation is admissible under the policy	3. Cost of artificial limbs following amputation is payable up-to 10% of Sum Insured provided the claim for such amputation is admissible under the policy
4. Claims directly or indirectly relating to Cardio Vascular System, Renal System, Diseases of eye, Foot Ulcer, Diabetic Peripheral Vascular Diseases and other complications of diabetes are eligible to be payable under Section 1 only, except where specifically provided for	4. Claims directly or indirectly relating to any Cardio Vascular System, Renal System, Diseases of eye, Foot Ulcer and other complications of diabetes are eligible to be payable under Section 1 only, except where specifically provided for The expenses payable in respect of diseases relating to Cardio Vascular System is limited to the amount mentioned there against
	Sl. No. / Sum Insured (Rs.) / Limit of the Company's Liability per policy period (Rs.) 1 / 3,00,000/- / 2,00,000/- 2 / 4,00,000/- / 2,50,000/- 3 / 5,00,000/- / 3,00,000/- 4 / 10,00,000/- / 4,00,000/-
5. Claim for cataract surgery is payable under Section 2 only	5. Claim for cataract surgery is payable under Section 2 only
6. The expenses as above are payable only where the in-patient hospitalization is for a minimum period of 24 hours. However this time limit will not apply to the day-care treatments / procedures, where treatment is taken in the Hospital / Nursing Home and the Insured is discharged on the same day	6. The expenses as above are payable only where the in-patient hospitalization is for a minimum period of 24 hours. However this time limit will not apply to the day-care treatments / procedures, where treatment is taken in the Hospital / Nursing Home and the Insured is discharged on the same day
7. **Important Note: Expenses relating to Associated Medical 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.**	7. **Important Note: Expenses relating to Associated Medical 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.**

Note: (Applicable for Plan A and Plan B): Only complications of Diabetes that are declared by the insured and accepted by the company shall be considered as covered under Section 1.

c. Section 2 (Applicable for Plan A and Plan B)

If during the period stated in the Schedule the insured person, upon the advice of a duly Qualified Physician / Medical Specialist / **Medical Practitioner** or of duly **Qualified Surgeon** to incur Hospitalization expenses for medical/surgical treatment for any disease/illness/sickness (Other than those falling under Section 1 above), accidental injuries at any **Nursing Home / 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 indicated but not exceeding sum insured in aggregate as stated in the schedule hereto;

A. Room (Single Standard A/C room), Boarding and Nursing Expenses

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

C. Anaesthesia, Blood, Oxygen and Operation Theatre charges, ICU charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and diagnostic imaging modalities and X-ray. 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. Relevant **Pre Hospitalization** medical expenses incurred for a period not exceeding 30 days prior to the date of Hospitalisation, on the disease/illness contracted following an admissible claim under the policy

E. Emergency ambulance charges up-to a sum of Rs. 2000/- 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 however there is an admissible claim under this section

F. **Post Hospitalization** expenses incurred up to 60 days after 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 hospitalization provided such expenses so incurred are in respect of ailment for which the insured person was hospitalized. 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

d. Special conditions applicable for Section 2 (Applicable for Plan A and Plan B);

1. 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
2. The expenses incurred on treatment of cataract are limited to;

Sum Insured Rs.	Limit Rs.
3,00,000/- 4,00,000/- and 5,00,000/-	20,000/- per eye per hospitalisation and 30,000/- for the entire policy period.
10,00,000/-	30,000/- per eye per hospitalisation and 40,000/- for the entire policy period

3. **Expenses relating to Associated Medical 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.**

e. Section 3 - Outpatient Expenses;

The Company will pay the amount of such expenses as are reasonably and necessarily incurred at any **Networked Facility** in India herein defined as an Out-patient Treatment, provided policy is in force;

a. The Cost of Fasting and Post Prandial and HbA1C tests - once every six months – upto Rs.750/- per event upto Rs.1500/- per policy period

b. Other expenses like medical consultation, other diagnostics, medicines and drugs upto the limits given below per policy period

Note: Payment of any claim under this section shall not be construed as a waiver of Company's right to repudiate any claim on grounds of non disclosure of material fact or pre-existing disease, for hospitalization expenses under hospitalization provisions of the policy contract.

Applicable for Plan A				
Individual				
Sum Insured Rs.	3,00,000	4,00,000	5,00,000	10,00,000
Limit of OP Benefit Rs.	1,000/-	2,500/-	3,500/-	5,500/-
Floater				
Sum Insured Rs.	3,00,000	4,00,000	5,00,000	10,00,000
Limit of OP Benefit Rs.	2,000/-	3,500/-	5,500/-	7,500/-
Applicable for Plan B				
Individual				
Sum Insured Rs.	3,00,000	4,00,000	5,00,000	10,00,000
Limit of OP Benefit Rs.	500/-	2,000/-	3,000/-	5,000/-
Floater				
Sum Insured Rs.	3,00,000	4,00,000	5,00,000	10,00,000
Limit of OP Benefit Rs.	1,500/-	3,000/-	5,000/-	7,000/-

This benefit forms part of Sum Insured.

f. Section 4 - Coverage for Modern Treatments: The expenses payable during the entire policy period for the following treatment / procedure (either as a day care or as an in-patient exceeding 24hrs of admission in the hospital) is limited to the amount mentioned in table below;

Sum Insured Rs.	3,00,000/-	4,00,000/-	5,00,000/-	10,00,000/-
Treatment / Procedure	Sum Insured on Individual Basis: Limit per person, per policy period for each treatment / procedure Sum Insured on Floater Basis: Limit per policy period for each treatment / procedure Rs.			
Uterine artery Embolization and HIFU	37,500/-	1,00,000/–	1,25,000/-	1,50,000/-
Balloon Sinuplasty	15,000/-	40,000/-	50,000/-	1,00,000/-
Deep Brain Stimulation	75,000/-	2,00,000/-	2,50,000/-	3,00,000/-
Oral Chemotherapy*	37,500/-	1,00,000/-	1,25,000/-	2,00,000/-
Immunotherapy-Monoclonal Antibody to be given as injection	75,000/-	2,00,000/-	2,50,000/-	4,00,000/-
Intra Vitreal injections	15,000/-	40,000/-	50,000/-	75,000/-
Robotic surgeries	75,000/-	2,00,000/-	2,50,000/-	3,00,000/-
Stereotactic radio surgeries	75,000/-	1,75,000/-	2,00,000/-	2,25,000/-
Bronchical Thermoplasty	Up to Sum Insured			
Vaporisation of the prostate (Green laser treatment or holmium laser treatment)				
IONM-(Intra Operative Neuro Monitoring)				
Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions	75,000/-	2,00,000/-	2,50,000/-	3,00,000/-

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

g. Section 5 - Personal Accident (Applicable for Plan A and Plan B): If at any time during the Period of Insurance, the Insured Person shall sustain any bodily injury resulting solely and directly from an Accident caused by external, violent and visible means and if such accident causes death of the Insured Person within 12 Calendar months from the date of Accident, then the Company will pay an amount as compensation the Sum Insured mentioned in the Schedule.

Note

1. Geographical Scope: The insurance cover under this Section applies Worldwide
2. This Section is applicable for the person specifically mentioned in the Schedule
3. At any point of time only one person will be eligible to be covered under this Section
4. The sum insured for this Section is equal to the sum insured opted for Section 1 / 2
5. Any claim under Section 1/2/3/4 will not affect the Sum Insured under this section

III. 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 Applicable for Section 2 and Section 4 under Plan A and Plan B - 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 waiting period 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

Applicable for Section 1 under Plan B

A. Expenses related to the treatment of following listed systems shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident

B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase

C. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion

D. List of Systems: Cardio Vascular System, Renal System, Diseases of eye, Diabetic Peripheral Vascular Diseases and Foot Ulcer

Applicable for Section 2 and Section 4 under Plan A and Plan B

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;

a. Cataract and diseases of the Anterior and Posterior Chamber of the Eye, Retinal detachment, Glaucoma, Diseases of ENT, Diseases related to Thyroid, Prolapse of intervertebral disc (other than caused by accident), Varicose veins and Varicose ulcers, all Diseases of Prostrate, Stricture Urethra, all Obstructive Uropathies, benign prostatic hypertrophy, stapedectomy, all types of Hernia, Epididymal Cyst, Benign Tumours of Epididymis, Spermatocele, Varicocoel, Hydrocele, Fistula / Fissure in ano, Hemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence, and Congenital Internal disease / defect

b. Desmoid Tumour of anterior abdominal wall, Gall Bladder and Pancreatic diseases and All treatments (conservative, interventional, laparoscopic and open) for Hepato pancreato biliary diseases including gall bladder and pancreatic calculi. All types of management for kidney calculi and genitourinary tract calculi

c. All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Uterus, Fallopian Tubes, Cervix and Ovaries, Uterine Bleeding, Pelvic Inflammatory Diseases, Benign breast diseases, Umbilical Sinus, Umbilical Fistula

d. Conservative, operative treatment of all types of intervention for diseases related to tendon, ligament, Fascia, bones and joint including Arthroscopy and Arthroplasty [other than caused by accident]

e. 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, Carpel Tunnel Syndrome, Trigger Finger, lipoma, neurofibroma, ganglion and similar pathology

g. Any transplant and related surgery

3. 30-day waiting period - Code Excl 03

Applicable for Section 1 under Plan B;

1. 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
2. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
3. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

Applicable for Section 2 and Section 4 under Plan A and Plan B;

1. 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
2. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
3. 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 similar therapies **- Code Excl 26**
26. Unconventional, Untested, Experimental therapies **- Code Excl 27**
27. Artificial Pancreas, 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**
35. Expenses incurred for treatment of diseases/illness/accidental injuries by systems of medicine other than allopathy **- Code Excl 39**

Note: Exclusion nos. 15, 17, 18, 29, 31 and 35 are not applicable for Section 3

Exclusions applicable for Section 5

1. Any claim relating to events occurring before the commencement of the cover or otherwise outside the Period of Insurance **- Code-Sec 5-Excl 01**
2. **Code-Sec 5-Excl 02** Any claim arising out of Accident of the Insured Person from;
   a. Intentional self injury / suicide or attempted suicide or
   b. Whilst under the influence of intoxicating liquor or drugs or
   c. Self endangerment unless in self defense or to save human life
3. Any claim arising out of suicide or attempted suicide self inflicted injuries, or sexually transmitted conditions, anxiety, stress, depression, venereal disease (Other than HIV) **- Code-Sec 5-Excl 03**
4. Insured Person engaging in Air Travel unless he/she flies as a fare-paying passenger on an aircraft properly licensed to carry passengers. For the purpose of this exclusion Air Travel means being in or on or boarding an aircraft for the purpose of flying therein or alighting there from **- Code-Sec 5- Excl 04**
5. Accidents that are results of war and warlike occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, seizure capture arrest restraints detainments of all kings princes and people of whatever nation, condition or quality whatsoever **- Code-Sec 5- Excl 05**
6. Participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority **- Code-Sec5- Excl 06**
7. Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from **- Code-Sec5- Excl 07**
   a. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self sustaining process of nuclear fission) of nuclear fuel
   b. Nuclear weapons material
   c. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof
   d. Nuclear, chemical and biological terrorism
8. Any claim arising out of sporting activities in so far as they involve the training or participation in competitions of professional or semi-professional sports persons **- Code-Sec5-Excl 08**
9. Participation in Hazardous Sport / Hazardous Activities **- Code-Sec5-Excl 09**
10. Persons who are physically challenged, unless specifically agreed and endorsed in the policy **- Code-Sec5-Excl 10**
11. Any loss arising out of the Insured Person's actual or attempted commission of or willful, participation in an illegal act or any violation or attempted violation of the law **- Code-Sec5- Excl 11**
12. Any claim arising out of an accident related to pregnancy or childbirth, infirmity, whether directly or indirectly **- Code-Sec5-Excl 12**

IV. 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. **For Cashless Treatment (Section 1, Section 2 and Section 4);**
   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-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 should be 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
   k. KYC (Identity proof with Address) of the proposer, as per AML Guidelines

   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

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 permissible 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 any event, which may give rise to a valid claim under this policy, notice with full particulars shall be sent to the Company prior to hospitalisation and in any case not later than 24 hours from the time of Hospitalisation

Condition C and D are precedent to admission of liability under the policy. However the company may examine and relax the time limits mentioned in condition C and D 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. Copy of PAN card
   i. 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

F. **Claims of Out Patient Consultations / treatments (Section 3) will be settled on a reimbursement basis on production of cash receipts**

G. **For Section 5**

For Accidental Death Claims:- Claim Form
   a. Death Certificate
   b. Post-mortem Certificate, if conducted
   c. FIR (wherever required)
   d. Police Investigation report (wherever required)
   e. Viscera Sample Report (wherever required)
   f. Forensic Science Laboratory report (wherever required)
   g. Legal Heir Certificate
   h. Succession Certificate (wherever required)
   i. KYC (Identity proof with Address) of the proposer, as per AML Guidelines

Note
- The Company reserves the right to call for additional documents wherever required.
- 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 (Applicable for Section 1,2, 3 and 4)
   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

Applicable for Section 5: In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar polices.

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	57.5% 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	47.5% 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	85% 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	12.5% of the policy premium
Exceeding 1 mth up to 3 mths	20% of the policy premium
Exceeding 3 mths up to 6 mths	30% of the policy premium
Exceeding 6 mths up to 9 mths	40% of the policy premium
Exceeding 9 mths up to 12 mths	50% 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	24% of the total premium received
Exceeding 1 mth up to 4 mths	44.5% of the total premium received
Exceeding 4 mths up to 6 mths	58.5% of the total premium received
Exceeding 6 mths up to 7 mths	32.5% of the total premium received
Exceeding 7 mths up to 10 mths	43% of the total premium received
Exceeding 10 mths up to 12 mths	50% of the total premium received
Exceeding 12 mths up to 16 mths	72.5% of the total premium received
Exceeding 16 mths up to 19 mths	82.5% 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	7.5% of the policy premium
Exceeding 1 mth up to 3 mths	12.5% of the policy premium
Exceeding 3 mths up to 6 mths	20% of the policy premium
Exceeding 6 mths up to 9 mths	27.5% of the policy premium
Exceeding 9 mths up to 12 mths	32.5% of the policy premium
Exceeding 12 mths up to 15 mths	45% of the policy premium
Exceeding 15 mths up to 18 mths	52.5% of the policy premium
Exceeding 18 mths up to 21 mths	60% of the policy premium
Exceeding 21 mths up to 24 mths	67.5% of the policy premium
Exceeding 24 mths up to 27 mths	80% of the policy premium
Exceeding 27 mths up to 30 mths	85% 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	16% of the total premium received
Exceeding 1 mth up to 4 mths	30% of the total premium received
Exceeding 4 mths up to 6 mths	39% of the total premium received
Exceeding 6 mths up to 7 mths	22% of the total premium received
Exceeding 7 mths up to 10 mths	28.5% of the total premium received
Exceeding 10 mths up to 12 mths	33.5% of the total premium received
Exceeding 12 mths up to 15 mths	46% of the total premium received
Exceeding 15 mths up to 21 mths	60% of the total premium received
Exceeding 21 mths up to 24 mths	66.5% of the total premium received
Exceeding 24 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 (Applicable only for Section 2 and Section 4):** 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 (Applicable only for Section 2 and Section 4):** 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.
- If Instalment facility is opted for 2 year and 3 year term policies, the full premium applicable for 2 year or 3 year terms should be paid half yearly within the expiry of the first year.

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 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 and fulfillment of the terms, provision, conditions and endorsements of this policy by the Insured Person, in so far as they relate to anything to be done or complied with by the Insured Person, 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. **Notices 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 medical/surgical treatments under this policy shall have to be taken in India.

24. **Automatic Expiry of the Policy:** 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: This also means that in case of family floater policy, the cover for the surviving members of the family will continue, subject to other terms of the policy
- ✓ Upon exhaustion of Basic Sum Insured under the policy as a whole

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.

27. **Revision of Sum Insured:** Reduction or enhancement of sum insured is permissible only at the time of renewal.

Enhancement of sum insured is 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 sublimits shall be subject to the following terms

Exclusion given below 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;

i. First 30 days exclusion as under **- Code Excl 03**

ii. 24 months with continuous coverage without break (with grace period) in respect of diseases / treatments falling under exclusion **- Code Excl 02**

iii. 48 months of continuous coverage without break (with grace period) in respect of Pre-Existing diseases as under exclusion **- Code Excl 01**

iv. 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 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) Where the insured person has opted for floater policy, the sum insured floats amongst the insured members

c) The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws

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

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

30. **Automatic Restoration of Sum Insured (Applicable only for Section 2 under Plan A and Plan B)**

There shall be automatic restoration of the Basic Sum Insured by 100% immediately upon exhaustion of the basic sum insured, once during the policy period.

It is made clear that such restored Sum Insured can be utilized only for illness /disease/treatment unrelated to the illness /diseases/treatment for which claim/s was /were made.

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.

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

Benefit Illustration in respect of Policies offered on Individual and Family Floater Basis - Plan A

Age of the Members insured (in yrs)	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, (if any)	Premium After Discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount, (if any)	Premium After Discount (Rs.)	Sum Insured (Rs.)
Illustration - 1										
64	37,205	5,00,000	37,205	Nil	37,205	5,00,000	67,618	15,798	51,820	5,00,000
58	30,413	5,00,000	30,413		30,413	5,00,000				
Total Premium for all members of the family is **Rs.67,618/-**, when each member is covered separately. Sum insured available for each individual is **Rs.5,00,000/-**			Total Premium for all members of the family is **Rs.67,618/-**, when they are covered under a single policy. Sum insured available for each family member is **Rs.5,00,000/-**				Total Premium when policy is opted on floater basis is **Rs.51,820/-**, Sum insured of **Rs.5,00,000/-** is available for the entire family **(2A)**			
Illustration - 2										
47	22,983	5,00,000	22,983	Nil	22,983	5,00,000	43,216	11,039	32,177	5,00,000
44	20,233	5,00,000	20,233		20,233	5,00,000				
Total Premium for all members of the family is **Rs.43,216/-**, when each member is covered separately. Sum insured available for each individual is **Rs.5,00,000/-**			Total Premium for all members of the family is **Rs.43,216/-**, when they are covered under a single policy. Sum insured available for each family member is **Rs.5,00,000/-**				Total Premium when policy is opted on floater basis is **Rs.32,177/-** Sum insured of **5,00,000/-** is available for the entire family **(2A)**			

Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.

A - Adult

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

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

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