STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED
Registered and Corporate Office
1, New Tank Street, Valluvar Kottam High Road, Nungambakkam,
Chennai - 600 034. ★ Phone : 044 - 28288800 ★ CIN : U66010TN2005PLC056649
Email : support@starhealth.in ★ Web : www.starhealth.in ★ IRDAI Regn. No. : 129

IndiaFirst Life Insurance Company Limited
Registered and Corporate Office
301, (B) Wing,The Qube, Infinity Park, Dindoshi - Film City Road, Malad (E),
Mumbai - 400 097, Web : www.indiafirstlife.com Email : customer.first@indiafirstlife.com
CIN: U66010MH2008PLC183679, IRDAI. Reg. No. 143,

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.

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Customer Information Sheet - STAR FIRST COMPREHENSIVE

Unique Identification No.: SHAHLIP18036V021718

TITLE		Description	Clause no. of the policy
What am I covered for Section (i)	a	In-patient Treatment- Covers hospitalisation expenses for period more than 24 hrs.	Section-1 (A,B,C)
	b	Emergency Ambulance- Minimum Rs. 2000/- per policy period, Maximum Rs. 5000/- based on the sum insured opted. In case of Air Ambulance, the per policy limit is 10% of the Sum Insured opted for. Air Ambulance is not available for the Sum Insured of Rupees five lakhs.	1-D
	c	Pre-Hospitalisation- Medical Expenses incurred up to 30 days prior to hospitalisation,	1-E
	d	Post-Hospitalisation- Medical Expenses incurred up to 60 days after discharge from the ho spital	1-F
	e	Outpatient consultation (other than dental and Ophthalmic treatment) Minimum Rs. 1,200/ - Maximum Rs.3,300/- based on the sum insured	1-G
	f	Domiciliary Hospitalisation treatment for a period exceeding three days	1-H
	g	Coverage for Delivery Minimum Rs.10000/- Maximum Rs.40000/- based on sum insured New Born Baby Minimum Rs.50,000/- maximum Rs.1,00,000/- based on sum insured	Section-2
	h	Outpatient dental and Ophthalmic treatment Minimum Rs. 5,000/ - Maximum Rs.10,000/- based on the sum insured	Section-3
	i	Cash benefit for each completed day of hospitalization minimum Rs.500/- maximum Rs.1500/- based on the sum insured.	Section-4
	j	Health Check up : Expenses incurred for health check up	Section-5
	k	Bariatric Surgery	Section-6
	l	Accidental Death and Permanent Total Disablement	Section 7
	m	Second Medical Opinion	Section 8
	n	Day Care Procedure	List Attached
	o	Restoration of Sum Insured : Automatic restoration of sum insured once during the currency of the policy period on exhaustion of the sum insured	Condition 12

TITLE	Description	Clause no. of the policy
Coverage for Section (ii) Major exclusions Section (i) for section 1 to section 6	**a** Pure life term insurance coverage	Section (ii)
	1. Any hospital admission primarily for investigation diagnostic purpose	3(11)
	2. Pregnancy, infertility	3(13)
	3. Treatment outside India	4(15)
	4. Circumcision, sex change surgery, cosmetic surgery & plastic surgery	3(6)
	5. Refractive error correction, hearing impairment correction, corrective & cosmetic dental surgeries	3(16) and 3(8)
	6. Substance abuse, self-inflicted injuries, STDs and HIV/AIDS	3(9) and 3(10)
	7. Hazardous sports, war, terrorism, civil war or breach of law	3(4) and 3(5)
	8. Any kind of service charge, surcharge, admission fees, registration fees levied by the hospital.	3(15)
	(Note: the above is a partial listing of the policy exclusions. Please refer to the policy clauses for the full listing)	
Major exclusions Section (i) for section 7	All Pre-existing Conditions	3(23)
	Intentional Self injury and use of intoxicating drugs /alcohol/ HIV or AIDS	3(25)
	War and nuclear perils	3(27)
	Engaging in Hazardous sports/ activites	3(31)
Waiting Period Section (i) (Section 1 to Section 6)	Initial waiting period: 30 days	3(2)
	Specific waiting period: 24 months 36 months for benefit under section 2 36 months for benefit under section 6 (Bariatric Surgery)	3(3) Section – 2 Section - 6
	Pre-existing diseases	3(1)
Payment basis (Section (i))	Reimbursement of covered expenses up to specified limits AND/OR	Section (i) (Section 1 to Section 6)
	Fixed amount on the occurrence of a covered event	Section (ii)
Loss Sharing Section (i)	In case of a claim, this policy requires you to share the following costs: Expenses exceeding the followings Sublimits 1. Room/ICU charges beyond 2. For the following specified diseases: 3. Deductible 4. Co-Payment	 Nil Nil Nil 4(6)
Renewal Condition (Section (i))	Lifelong renewal subject to payment of renewal premium	4 (8)
	Grace period of 30 days for renewing the policy is provided	
Renewal Benefit (Section (i))	Cost of Health Checkup.	Section - 5
	Bonus: Eligible for claim free year	4 (11)
Cancellation Section (i)	Policy can be cancelled on grounds of mi srepresentation, fraud, 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	4(14)

TITLE	Description	Clause no. of the policy
Claims for Section (i) and Section(ii)	For Cashless Service and For Reimbursement of claim	Section (i) (4 (4)) and Section (ii) (14)
Policy Servicing Grievances/ Complaints (Section i and ii)	Company Officials IRDAI/(IGMS/Call Centre): Ombudsman (Note: Please provide the contact details Toll free number/e-mail)	Common conditions no.8 and 12
Insured's Rights (Section i)	Free Look:	Common conditions no.1
	Implied renewability (except on certain specific grounds)	4 (8)
	Migration and Portability:	4 (16)
	Increase in SI during the Policy term	4(9)
	Turn Around Time (TAT) for issue of Pre - Auth and settlement of Reimbursement	4 (4)
Insured's Obligations for Section i and Section ii	Please disclose all pre -existing disease/s or condition/s before buying a policy. Non -disclosure may result in claim not being paid.	4 (10) (Section (i) and 10 (Section ii)
	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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STAR FIRST COMPREHENSIVE

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Section i – Health Insurance Coverage

The proposal and declaration given by the proposer and other documents if any 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 that if during the period stated in the Schedule of Benefits of Benefits 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, 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 at any **Nursing Home / Hospital** in India as an in-patient, the **Company** will pay to the **Insured Person** the amount of such expenses as are reasonably and necessarily incurred up-to the limits indicated but not exceeding the sum insured in any one period stated in the Schedule hereto.

1. Coverage

Section 1 Hospitalization

A) Room (Single Standard A/C room), Boarding and Nursing Expenses as provided by the Hospital / Nursing Home

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, Dialysis, Chemotherapy, Radiotherapy, cost of Pacemaker and similar expenses.

D) Emergency ambulance charges up-to the limit stated in the schedule of Benefits 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 such Hospitalization claim is admissible as per the Policy.

Subject to the above terms, the Insured Person/s is/are eligible for reimbursement, expenses incurred towards the cost of air ambulance as per the schedule of Benefits, if availed on the advice of the treating Medical Practitioner / Hospital. Air ambulance is payable for only from the place of first occurrence of the illness / accident to the nearest appropriate hospital. Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s.

E) **Relevant Pre-Hospitalization** medical expenses incurred for a period up-to 30 days immediately prior to the date of Hospitalization on the disease / illness sustained following an admissible claim under the policy.

F) Post Hospitalization expenses incurred under the policy towards Consultant fees, Diagnostic charges, Medicines and Drugs wherever recommended by the Hospital / Medical Practitioner, where the treatment was taken, for 60 days after discharge from the hospital following an admissible claim. Provided however such expenses so incurred are in respect of ailment for which the insured person was hospitalized.

G) Expenses of Medical Consultations as an Out Patient incurred in a Network Hospital for other than Dental and Ophthalmic treatments, up to the limits mentioned in the schedule of benefits with a limit of Rs.300/- per consultation. Payment under this benefit G does not form part of Sum Insured, and payable while the policy is in force.

H) Domiciliary hospitalization treatments for a period exceeding three days

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 Pharingitis, Arthritis, Gout and Rheumatism. Pre-hospitalisation and Post-hospitalization expenses are not payable for this cover

Note: Expenses on Hospitalization are payable provided the hospitalization is for minimum period of 24 hours. However this time limit will not apply for the treatments / procedures mentioned in the list of Day Care treatments, taken in the Hospital / Nursing Home and the Insured are discharged on the same day.

Section 2 Delivery and New Born

A) Expenses for a Delivery including Delivery by Caesarean section (including pre-natal and post natal expenses) up-to the limits mentioned in the schedule per Delivery, subject to a maximum of 2 deliveries in the entire life time of the insured person are payable *while the policy is in force.*

B) Expenses up-to the limits mentioned in the Schedule of Benefits, incurred in a hospital/ nursing home on treatment of the New-born for any disease, illness (including any congenital disorders) or accidental injuries provided there is an admissible claim under A of Section-2 above and while the policy is in force.

C) Vaccination expenses up to Rs.1000/, for the new born baby until the new born baby completes one year and is added in the policy on renewal. Claim under this is admissible only if claim under A of Section-2 above has been admitted and *while the policy is in force.*

Special Conditions applicable for this Section

1) Benefit under this Section As subject to a waiting period of 36 months from the date of first commencement of this policy and continuous renewal thereof with the company. A waiting period of 24 months will apply afresh following a claim under "A" of Section-2 above.
2) Pre-hospitalisation and Post Hospitalization expenses and Hospital Cash Benefit are not applicable for this section.
3) This cover is available only when both Self and Spouse are Covered under this policy until the period when the benefit under this Section becomes payable. Claims under this section will not reduce the Sum Insured and will not impact the benefit under Section 5.

Section 3 Out-patient Dental and Ophthalmic Treatment

Expenses incurred on acute treatment to a natural tooth or teeth or the services and supplies provided by a licensed dentist, up to limits mentioned in the schedule of Benefits are payable.

Expenses incurred for the treatment of the eye or the services or supplies provided by a licensed ophthalmologist, hospital or other provider that are medically necessary to treat eye problem including cost of spectacles / contact lenses, not exceeding the limit for the coverage as mentioned in the Schedule of Benefits are payable.

The insured persons become eligible for this benefit after continuous coverage under this policy after every block of 3 years with the company and payable while the policy is in force.

Claims under this section will not reduce the Sum Insured *and will not impact the benefit under Section 5*

Section 4 Hospital Cash

Cash Benefit up to the limits mentioned in the Schedule of Benefits for each completed day of Hospitalization subject to a maximum of 7 days per occurrence is payable. Provided however there is an admissible claim under Section 1 of the policy.

This Benefit is available for a maximum of 120 days during the entire policy period.

This benefit is subject to an excess of first 24 hours of Hospitalization for each and every claim. Claims under this section will not reduce the Sum Insured.

Section 5 Health Check Up

Expenses incurred towards Cost of Medical Check-up up to the Limits indicated in the Schedule of Benefits is payable. The insured persons become eligible for these benefits after continuous coverage under this policy after every block of 3 claim-free years with the Company and payable while the policy is in force.

Where the policy is on a floater basis, if a claim is made under Section 1 (other than Section 1G) or under Section 6 by any of the insured persons the health check up benefits will not be available under the policy. However where the policy is on individual sum insured basis a claim made by one insured person will not affect the Health Check-up benefit to other insured persons covered.

Section 6 Bariatric Surgery

Expenses incurred on hospitalization for bariatric surgical procedure and its complications thereof are payable subject to a maximum of Rs.2,50,000/- during the policy period. This maximum limit of Rs.2,50,000/- is inclusive of pre-hospitalisation and post hospitalization expenses.

Special conditions:

1. This benefit is subject to a waiting period of 36 months from the date of first commencement of this policy and continuous renewal thereof with the Company.
2. The minimum age of the insured at the time of surgery should be above 18 years.
3. This benefit shall not apply where the surgery is performed for
   a) Reversible endocrine or other disorders that can cause obesity
   b) Current drug or alcohol abuse
   c) Uncontrolled, severe psychiatric illness
   d) Lack of comprehension of risks, benefits, expected outcome, alternatives and lifestyle changes required with bariatric surgery.
   e) Bariatric surgery performed for Cosmetic reasons
4. The indication for the procedure should be found appropriate by two qualified surgeons and the insured person shall obtain prior approval for cashless treatment from the Company.
5. To make a claim, the insured person should satisfy the following criteria as devised by NIH (National Institute of Health)
   a) The BMI should be greater than 40 or greater than 35 with co-morbidities (like Diabetes, High Blood Pressure etc.)
   b) Is unable to lose weight through traditional methods like diet and exercise.

Note: Claims under this section shall be processed only on cashless basis. The limit of cover provided under this section forms part of the sum insured.

Section 7 Accidental Death and Permanent Total Disablement

If at any time during the Period of Insurance, the Insured Person shall sustain any bodily injury resulting solely and directly from Accident caused by external, violent and visible means then the Company will pay as under:

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

Special Conditions:

1. If the Accident affects any physical or mental function, which was already impaired prior to the accident, a deduction as recommended by any Government Doctor not below the rank of a Civil Surgeon will be made in respect of this prior disablement.
2. In the event of Permanent Total Disablement, the Insured Person will be under obligation:
   a) To have himself/herself examined by doctors appointed by the Company / and the Company will pay the costs involved thereof.
   b) To authorize doctors providing treatments or giving expert opinion and any other authority to supply the Company any information that may be required. If the obligations are not met with due to whatsoever reason, the Company may be relieved of its liability to pay.
3. This Section As applicable for the person specifically mentioned in the Schedule.
4. The sum insured for this Section As equal to the sum insured opted for Health Section
5. Where a claim has been paid during the policy period the cover under this Section ceases until the expiry of the policy. Upon renewal the cover applies to the person specifically chosen again. However even if the sum insured under this Section As exhausted by way of claim, the coverage under health section will continue until expiry of the policy period.

   At any point of time only one person will be eligible to be covered under this Section.
6. Any claim under health portion will not affect the Sum Insured under this section.
7. Where there is an admissible claim for Accidental Death during the policy period, the health cover will continue for the remaining insured persons.

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

   Where there is an admissible claim for Permanent Total Disability or Death during the policy period, the personal accident cover will be applicable for another person chosen at the time of renewal.
8. Geographical Scope : The cover under this section applies World Wide

Section 8 Option for 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. This is an optional benefit to the Insured Person. All the medical records provided by the Insured Person will be submitted to the Doctor chosen by him/her either online or through post/courier and the medical opinion will be made available directly to the Insured by the Doctor.

Subject to the following conditions :-

- This should be specifically requested for by the Insured Person
- This opinion is given without examining the patient, based only on the medical records submitted.
- 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.

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 includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was 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.

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

Capital Sum Insured means the sum insured available under Section 7 (Personal Accident)

Company means Star Health and Allied Insurance Company Limited

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

Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly: Congenital anomaly which is not in the visible and accessible parts of the body.

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

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

Day Care Centre means any institution established for day care treatment of illness and / or injuries or a medical 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 :-

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner/s in charge;
iii. has fully equipment 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 personal

Day Care Treatment means medical treatment and or surgical procedure which is: -

i. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
ii. Which would have otherwise required 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 means a child (natural or legally adopted) who is financially dependent and does not have his or her independent source of income and not over 25 years.

Diagnosis 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.

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

Domiciliary hospitalisation means 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 :

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

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

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

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

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.

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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and 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;

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

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 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.

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

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.

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

Note: Such facility must be separate and apart from surgical recovery room and from rooms' beds and wards customarily used for patient confinement.

Limit of Coverage means Basic Sum Insured plus the No Claim Bonus earned wherever applicable

Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Medical expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Medical Practitioner 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 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

Maternity expense shall include a) Medical treatment expenses traceable to child birth (including complicated deliveries and caesarean sections) incurred during Hospitalization b) expenses towards the lawful medical termination of pregnancy during the Policy Period.

Newborn baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

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.

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

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

Out-patient 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 medial practitioner. The insured is not admitted as a day care or in-patient

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 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

Post Hospitalization 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 incurred 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.

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

Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India

Reasonable and Customary charges. means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved

Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods

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

Single Standard A/C Room means an individual air-conditioned room with attached wash room. This room may have a television, telephone and a couch. This does not include deluxe room / suite or room with additional facilities other than those stated herein.

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.

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

3. 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:

Applicable for Sections 1 to 6

1. Pre Existing Diseases as defined in the policy until 48 consecutive months of continuous coverage has elapsed, since inception of the first policy with any Indian Insurer. However the limit of the Company's liability in respect of claim for Pre-existing Diseases shall be limited to the Sum Insured under first policy with any Indian Insurance Company.
2. Any disease contracted by the insured person during the first 30 days from the commencement date of the policy. This exclusion shall not apply in case of the insured person having been covered under any health insurance policy (Individual or Group Insurance policy) with any of the Indian Insurance companies for a continuous period of preceding 12 months without a break.
3. During the First two Years of continuous operation of insurance cover,
   a) The expenses for treatment of cataract, degenerative disc of vertebral diseases and prolapse of intervertebral disc (other than caused by accident), varicose veins and varicose ulcers, benign prostatic hypertrophy, deviated nasal septum, sinusitis Tonsillitis, Nasal polyps, Chronic Supparative Otitis Media and related disorders, hernia, hydrocele, fistula / fissure in ano and haemorrhoids congenital internal disease/defect (except to the extent provided under Section 2 for New Born)
   b) All treatments (conservative, interventional, open laparoscopic) for Hepatobilary Gall Bladder and Pancreatic stones and Genito-urinary calculi.
   c.) All treatments (conservative, interventional, open, and laparoscopic) for Uterine prolapse, Dysfunctional Uterine Bleeding, Fibroids, Pelvic Inflammatory Diseases, all diseases of fallopian tubes and ovaries,
   d.) Arthroscopic repair and removal [other than caused by an accident]

   If these are Pre-Existing at the time of proposal they will be covered subject to the waiting period mentioned in Exclusion 1 above

   The exclusion 3 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 Insurer for a continuous period of preceding 24 months without any break. The Claim for such illnesses/diseases/disabilities contracted /suffered if admitted will be processed as per the Sum Insured of immediately preceding 24 months policy only. Where there is a change in the sum insured in the following continuous policy year the lower of the sum insured will apply.
4. 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)
5. Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons /materials.
6. a) Circumcision unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident,

   b) Vaccination. However this exclusion will not apply where such expenses are for post –bite treatment, for medical treatment other than preventive treatments and to the extent provided for under Section 2 for New Born Child

   c) Inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery (other than as necessitated due to an accident or as a part of any illness).
7. Cost of spectacles and contact lens (in excess of what is specifically provided), hearing aids including cochlear implants, walkers, crutches wheel chairs and such other aids.
8. Dental treatment or surgery (in excess of what is specifically provided) unless necessitated due to accidental injuries and requiring hospitalization.
9. Convalescence, general debility, Run-down condition or rest cure, nutritional deficiency states, psychiatric , Psychosomatic disorders, Congenital external disease or defects or anomalies (except to the extent provided under Section 2 for New Born) sterility, venereal disease, intentional self injury and use of intoxicating drugs/alcohol.
10. 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 the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or

condition of a similar kind commonly referred to as 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.

11. Charges incurred at Hospital or Nursing Home primarily for Diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at hospital/nursing home.
12. Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Physician.
13. Treatment arising from or traceable to pregnancy, miscarriage, abortion or complications of any of these (other than ectopic pregnancy and to the extent covered under Section 2)
14. Naturopathy Treatment.
15. Hospital registration charges, admission charges, record charges telephone charges and such other charges.
16. Expenses incurred on Lasik Laser or Refractive Error Correction, treatment of Eye disorders requiring intra-vitreal injections.
17. Expenses incurred on weight control services including cosmetic procedures for treatment of obesity, medical treatment for weight control, treatment for metabolic, genetic and endocrine disorders except to the extent provided as per 'Coverage' under Section-6.
18. Expenses incurred on Non Allopathic treatment.
19. Expenses incurred on Enhanced External Counter Pulsation therapy and related therapies and Rotational Field Quantum Magnetic Resonance Therapy
20. Any specific time-bound or life time exclusions applied, specified and accepted by the insured
21. Other expenses as detailed in the policy.

Applicable for Section 7

22. Any claim relating to events occurring before the commencement of the cover or otherwise outside the Period of Insurance.
23. Any injuries/conditions which are Pre-existing conditions
24. Any claim arising out of Accidents that the Insured Person has caused
    a) intentionally or
    b) by committing a crime / involved in it or
    c) as a result of / in a state of drunkenness or addiction (drugs, alcohol).
25. Any claim arising out of mental disorder, suicide or attempted suicide self inflicted injuries, or sexually transmitted conditions, anxiety, stress, depression, venereal disease or any loss directly or indirectly attributable to HIV (Human Immunodeficiency Virus) and / or any HIV related illness including AIDS (Acquired Immunodeficiency Syndrome), insanity and / or any mutant derivative or variations thereof howsoever caused.
26. 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.
27. 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.
28. 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.
29. Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:
    a. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self sustaining process of nuclear fission) of nuclear fuel.
    b. Nuclear weapons material
    c. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
    d. Nuclear, chemical and biological terrorism
30. 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.
31. Participation in Hazardous Sport / Hazardous Activities
32. Persons who are physically and mentally challenged, unless specifically agreed and endorsed in the policy.
33. 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.
34. Any payment in case of more than one claim under the policy during the period of insurance by which the maximum liability of the Company in that period would exceed the amount specified in the Schedule
35. Any other claim after a claim has been admitted by the Company and becomes payable for Death or Permanent Total Disablement, as mentioned in Table.
36. Any claim arising out of an accident related to pregnancy or childbirth, infirmity, whether directly or indirectly.
37. Any claim for Death or Permanent Total Disablement of the Insured Person from self-endangerment unless in self-defense or to save life.

4. 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, 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.
2. Upon the happening of any event, which may give rise to a claim under this policy, notice with full particulars shall be sent to the Company within 24 hours from the date of occurrence of the event.
3. Claim must be filed within 15 days from the date of discharge from the Hospital.

   Note: Condition 2 and 3 are precedent to admission of liability under the policy. However the company may examine and relax the time limits mentioned in condition nos. 2 and 3 depending upon the merits of the Case.

   Post hospitalization bills are to be submitted within 15 days after completion of 60 days from the date of discharge from hospital
4. The Insured Person 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

   Documents to be submitted in support of claim are –

   For Reimbursement Claim

   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, anesthetist
   g. Certificate from the attending doctor regarding the diagnosis.

   Note: Claim towards Bariatric Surgery under Section-6 will not be processed on Reimbursement Basis.

   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-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk.
   e. The Treating Doctor will complete the hospitalisation/ treatment information and the hospital will fill up expected cost of treatment.
   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 possible reimbursement.

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

   Prescriptions and receipts for Pre and Post-Hospitalization

   Claims of Out Patient Consultations / treatments will be settled on a reimbursement basis on production of cash receipts.

   For Accidental Death Claims:-

   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)

For Permanent Total Disablement Claims:

Certificate from Government doctor confirming the disability and its percentage

Note:

1. The Company authorized doctor may examine the insured if required
2. The Company reserves the right to call for additional documents wherever required

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.

5. 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.
6. **Co-payment:** This policy is subject to co-payment of 10% of each and every claim amount for fresh as well as renewal policies for insured persons whose age at the time of proposing this insurance policy is above 60 years. Co-payment is applicable only for Section 1A to F
7. If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier. This is applicable for claims falling under Section 1 only.
8. **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 or non cooperation of the insured. A grace period of 30 days from the date of expiry of the policy is available for renewal. If renewal is made within this 30 days period the continuity of benefits will be allowed. However the actual period of cover will start only from the date of payment of premium. In other words no protection is available between the policy expiry date and the date of payment of premium for renewal.

   If the policy is to be renewed or ported from other Indian Insurance Company for enhanced sum insured, such enhanced sum insured will not be available for an illness, disease, injury already contracted under the preceding policy periods. Further, for illness / disease / sickness already contracted, the sum insured will be restricted to that policy sum insured when the signs or symptoms was diagnosed or received medical advice / treatment.

   In the event of this policy being withdrawn / modified with revised terms and/or premium with the prior approval of the Competent Authority, the insured will be intimated three months in advance and accommodated in any other equivalent health insurance policy offered by the Company, if requested for by the Insured Person, at the relevant point of time.

   Following an admissible claim under Section-7 the coverage under Personal Accident insurance upon renewal will be applicable for the person to be chosen by the Proposer at the time of renewal, subject to other terms, conditions contained herein
9. **Enhancement of sum insured at the time of renewal**

   The sum insured can be enhanced at the time of renewal or at the time of porting and the same may be allowed at the discretion of the Company.

   Where the sum insured is enhanced, the amount of such additional sum insured and the amount of cumulative bonus earned on such additional sum insured shall be subject to the following terms:

   a. Medical test will be done at the Company's cost
   b. Waiting period as under shall apply afresh from the date of such enhancement:
      i) First 30 days as under Exclusion No. 2
      ii) 24 months with continuous coverage without break (with grace period) in respect of diseases / treatments falling under exclusion No.3
      iii) 48 months of continuous coverage without break (with grace period) in respect of Pre-Existing diseases as defined under Exclusion No.1
      iv) 48 months of continuous coverage without break (with grace period) in respect of diseases / conditions for which the insured was diagnosed / hospitalized in the preceding 2 policy periods.
10. 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.
11. **Bonus (Applicable for Section 1 other than 1G**) Where the sum insured under the policy is Rs.5,00,000/-, the insured person would be entitled to the benefit of bonus calculated at 50% of the basic sum insured under this policy following a claim free year up to a maximum of 100%. In case a claim is made during the policy period, the bonus will be reduced by 50% in the following year. If there is a claim in the succeeding year also the bonus will become zero. The basic sum insured will however not be reduced.

    Where the sum insured under the policy is Rs.7,50,000/- or Rs.10,00,000/- or Rs.15,00,000/- or Rs.20,00,000/- or Rs.25,00,000/-, the insured person would be entitled to the benefit of bonus calculated at 100% of the basic sum insured under this policy following a claim free year. In case a claim is made during the policy period, the bonus will become zero in the following year. The maximum allowable bonus is 100%.

    Note: The bonus will be offered on that part of the sum insured that is continuously renewed. Such bonus will be available only upon timely renewal of the policy without break or upon renewal within the grace period allowed. The bonus is not cumulative. If the Insured opts to reduce

the basic Sum Insured at a subsequent renewal, the limit of indemnity by way of such Bonus shall not exceed such reduced sum insured.

Claim under Coverage 1(G) will not affect the No Claim Bonus.

12. **Automatic Restoration of Sum Insured (Applicable for Section 1 Only)**

    There shall be automatic restoration of the Basic Sum Insured by 100% immediately upon exhaustion of the limit of coverage, once during the policy period

    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.

    Such restoration will be available for section 1 other than Section 1G.

13. **Automatic Termination**:

    The Health Insurance cover shall terminate immediately on the death of the Insured Person. This also means that in case of family floater policy, cover for the other surviving members of the family will continue, subject to other terms of the policy.

    In case of a claim being paid under Section-7 of this policy, this Personal Accident cover ceases for the remaining period of the policy.

14. **Cancellation:** The Company may cancel this policy on grounds of misrepresentation, fraud, moral hazard, non disclosure of material fact or non-co-operation by the insured person, by sending the Insured 30 days notice by registered letter at the Insured person's last known address and no refund of premium will be made.

    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	1/3rd of the annual premium
Up to three Months	½ of the annual premium
Up to six months	3/4th of the annual premium
Exceeding six months	full annual premium

15. All claims under this policy shall be payable in Indian currency. All medical / surgical treatments under this policy shall have to be taken in India.
16. **Portability:** This policy is portable for Health benefits only and not applicable for Life Insurance benefit. If the insured is desirous of porting this policy to another Insurer towards renewal, application in the appropriate form should be made to the Company atleast before 45 days from the date when the renewal is due.

    Where the outcome of acceptance of portability is still waiting from the new insurer on the date of renewal,the existing policy will be extended on the request of the Insured person, for a period not less than one month on pro rata premium. Such extended cover will be cancelled only on the written request by the Insured Person, subject to a minimum pro rata premium for one month. If the Insured Person requests in writing to continue the policy with the Company without porting, it will be allowed by charging the regular premium with the same terms as per the expiringpolicy. In case of a claim made by the Insured person and admitted by the Company during such extension, the policy will be extended for the remaining period by charging the regular premium. Portability is not possible during the policy period. For details contact "portability@starhealth.in" or call Telephone No +91-044-28288869
17. **Relief under Section 80-D:** Insured Person is eligible for relief under Section 80-D of the Income Tax Act in respect of the amount paid by any mode other than cash.
18. In case the policy is issued on floater basis, the sum insured under the policy floats among the insured persons. The specified waiting periods shall be individually applicable to each insured person from date of induction of such insured person into this contract of insurance for the first time for such floater benefits and not be construed in common from the date of commencement of the policy of insurance for the first time itself. This condition is not applicable for Section 7
19. 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.

20. **Policy Dispute**: 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**.**
21. **Notice:** 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. Toll Free Fax No.: 1800 425 5522, Toll Free No.: 1800 425 2255 / 1800 102 4477, E-Mail : support@starhealth.in.
22. **Important Note:** 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.

    The attention of the policy holder is drawn to our website www.starhealth.in www.starhealth.in for anti fraud policy of the Company for necessary compliance by all stake holders.

Schedule of Benefits

Section 1 D	
Sum Insured (Rs)	**Limit per policy period by road ambulance (Up-to) (Rs)**
500000/-	2,000/-
750000/-	3,000/-
1000000/-	3,500/-
1500000/-	4,000/-
2000000/-	4,500/-
2500000/-	5,000/-
In case of Air Ambulance, the limit per pdicy period is up to 10% of the Sum Insured. However, this is not available for Sum Insured option of Rupees Five Lakhs.	

Out-Patient Consultation Section 1-G	
Sum Insured Rs	**Limit for Out Patient consultation per policy period for other than Dental and O phthalmic Treatments (up to Rs.)**
5,00,000/-	1200/-
7,50,000/-	1500/-
10,00,000/-	2100/-
15,00,000/-	2400/-
20,00,000/-	3000/-
25,00,000/-	3300/-
Limit of per consultation is Rs.300/-	

Section 2 Delivery and New Born			
Sum Insured Rs	**Limit for Delivery**		**Limit of Company's liability for New Born Cover Rs**
	Normal Delivery Rs.	**Delivery by Caesarean Section Rs.**	
5,00,000/-	10000/-	15000/-	50000/-
7,50,000/-	20000/-	40000/-	100000/-
10,00,000/-	25000/-	40000/-	100000/-
15,00,000/-	25000/-	40000/-	100000/-
20,00,000/-	25000/-	40000/-	100000/-
5,00,000/-	25000/-	40000/-	100000/-

Section 3 Out-patient Dental and Ophthalmic Treatment	
Sum Insured Rs	**Limit for Out Patient Dental and Ophthalmic Treatments for each block of 3 continuous years (up to Rs.)**
5,00,000/-	5000/-
7,50,000/-	5000/-
10,00,000/-	10000/-
15,00,000/-	10000/-
20,00,000/-	10000/-
25,00,000/-	10000/-

Section 4 Hospital Cash	
Sum Insured Rs	**Hospital Cash Benefit - Limit of Company's liability per day (Rs)**
5,00,000/-	500/-
7,50,000/-	750/-
10,00,000/-	750/-
15,00,000/-	1000/-
20,00,000/-	1000/-
25,00,000/-	1500/-

Section 5 Health Check Up	
Sum insured (Rs)	**Limit (Up to Rs)**
5,00,000/-	5000/-
7,50,000/-	7500/-
10,00,000/-	7500/-
15,00,000/-	12000/-
20,00,000/-	12000/-
25,00,000/-	12000/-

Section 7 Accidental Death and Permanent Total Disablement	
Benefits	**Percentage of the Sum Insured**
1. Death	100%
2. Permanent Total Disablement	100%
Total and irrevocable loss* of	
(i) Sight of both eyes	100%
(ii) Physical separation of two entire hands	100%
(iii) Physical separation of two entire foot	100%
(iv) One entire hand and one entire foot	100%
(v) Sight of one eye and loss of one hand	100%
(vi) Sight of one eye and loss of one entire foot	100%
(vii) Use of two hands	100%
(viii) Use of two foot	100%
(ix) Use of one hand and one foot	100%
(x) Sight of one eye and use of one hand	100%
(xi) Sight of one eye and use of one foot	100%

Section (ii) : Pure Term-Life Insurance Coverage

IndiaFirst Life Insurance Company Limited (herein after called "the Company") having received a proposal and declaration with the statements contained and referred to hereunder, and the first premium from the proposer/life assured named in the schedule hereunder, and the said proposal and declaration and the statements thereto having been agreed to by the proposer/Life Assured and the company as basis of this assurance, do by this policy agree, in consideration and subject to the due receipt of premiums on the days stipulated in the schedule annexed, to pay the Sum Assured under this policy, to the person/s to whom the same is payable as per the schedule, on submitting that the said sum becomes payable as set out in the schedule, together with the proof of the claimant's right to the policy moneys, and acceptable proof of age of the policy holder, if age is not admitted earlier. Further, it is hereby declared that this policy of insurance shall be subject to the conditions and privileges printed in the policy document and that the following schedule and any endorsement placed by the Company shall be deemed part of the policy.

Annexure A - Plan Schedule

I. Plan details

Company Name:	IndiaFirst Life Insurance Company Limited
Product Name:	IndiaFirst Life Plan (Traditional Non-Participating Pure Protection Term Plan)
UIN:	[143N007V02]
Plan No.:	
Proposal Form No.:	
Plan Commencement Date:	DD|MM|YY
Risk Commencement Date:	DD|MM|YY
Expiry Date:	DD|MM|YY

II. Policyholder and Life Assured's Details

Policyholder's Name:	
Date of Birth:	DD|MM|YY
Relationship with the Life Assured:	
Policyholder's Address:	
Telephone No./ Mobile No:	
Email:	
Life Assured's Name:	
Date of Birth:	DD|MM|YY
Client ID:	Age:
Gender:	Age admitted: Yes/ No
Life Assured's Address:	
Telephone No./ Mobile No.:	
Email:	

III. Nominee (as per Section 39 of the Insurance Act, as amended by Insurance Laws (Amendment) Act, 2015) Details

Name:	
Date of Birth:	DD|MM|YY
Appointee's Name*:	

*If any of the Nominees is a minor, then, the Appointee will be the person named as the Appointee in the Proposal Form and will be entitled to receive the death benefit from us for and on behalf of the Nominee.

IV. Premium and Benefit Details

Sum Assured:	Plan Term:
Premium Frequency: Regular Premium/ Single Premium	Premium Paying Term:
Regular Premium Payment Mode: Annual/ Six Monthly/ Monthly	Regular Premium Due Dates: DD|MM|YY
Due Date for Payment of Last Regular Premium: DD|MM|YY	Premium (in INR):
Extra Premium (in INR):	Service Tax (in INR): Education Cess:

Note: ON EXAMINATION OF THIS PLAN, if you notice any mistake, then, you may contact us for correction of the same.
The Premium payable under this Plan may differ on the basis of the Extra Premiums, if any, the Premium payment mode chosen by you and the applicable Modal Factor.
Please read the terms and conditions of this Plan carefully to understand the terms referred to in this Plan Schedule.

2. Definitions

We have listed below a few words, terms and phrases which have been used in this Plan along with their meaning for your easy reference.

Word	Meaning
Age	Age of the Life Assured or the Nominee as at the last birthday on the Plan Commencement Date and on any subsequent Plan Anniversary.
Annexure	Any Annexure, endorsement attached to this Plan as changed/ modified and issued by us from time to time.
Appointee	The person nominated/ chosen by you to receive the proceeds or the benefits under this Plan, if the Age of the Nominee is less than 18 (Eighteen) years.
Expiry Date	The date on which the Plan Term expires and the Plan terminates.
Extra Premium	An additional amount you may have to pay, depending on our board approved underwriting policy. This is determined on the basis of information provided by you in the Proposal Form or on the basis of any other information submitted to us or through the Life Assured's medical examination. For example: We may charge an Extra Premium in case of a Life Assured who is a smoker.
Grace Period	An additional period of 30 (Thirty) days from the due date for payment of Premium for yearly Premium payment mode.
Income Tax Act	Income Tax Act, 1961.
Insurance Act	Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.
Life Assured	The person on whose life this Plan has been issued by us.
Nominee	The person nominated/ chosen by you as Nominee in accordance with Section 5, who is entitled to receive the death benefit.
Plan	This IndiaFirst Life Plan which includes this Plan wording (as may be changed/ modified by us subject to prior approval of the Regulatory Authority, from time to time), the Proposal Form, Annexures, the Plan Schedule, any tables, information and documents which form a part of this Plan. This Plan includes the entire contract of insurance between you and us.
Plan Anniversary	The annual anniversary of the Plan Commencement Date. Example: If the Plan Commencement Date is December 18, 2013, then, every December 18 will be the Plan Anniversary thereafter.
Plan Commencement Date	The date on which this Plan is issued by us. This is specified in the Plan Schedule.
Plan Schedule	The schedule attached to this Plan as Annexure A and if we have issued a revised Plan Schedule, then, such revised Plan Schedule.
Plan Term	The period which starts on the Plan Commencement Date and ends on the Expiry Date. This is specified in the Plan Schedule.
Plan Year	A period of 12 (Twelve) consecutive months starting from the Plan Commencement Date and ending on the day immediately preceding its annual anniversary and each subsequent period of 12 (Twelve) consecutive months thereafter during the Plan Term. Example: If the Plan Commencement Date is December 18, 2013, then, the first Plan Year will be December 18, 2013 to December 17, 2014.
Premium	An amount that you pay us as Regular Premiums for securing the benefits under this Plan. The Premium payable under this Plan includes Extra Premiums (if any) and excludes any taxes, cesses or levies (if any). This is specified in the Plan Schedule.
Premium Paying Term	The time period during which you need to pay your Premiums regularly to us for securing the benefits under this Plan. Your Premium Paying Term is specified in the Plan Schedule.
Proposal Form	The Proposal Form completed and submitted by you based on which we have issued this Plan.
Risk Commencement Date	The date on which the insurance coverage starts under this Plan. This is specified in the Plan Schedule.
Regular Premium	The amount which is payable by you during Premium Paying Term at regular intervals as specified in the Plan Schedule.

Word	Meaning
Regulatory Authority	The Insurance Regulatory and Development Authority of India or such other authority or authorities, as may be designated/ appointed under the applicable laws and regulations as having the authority to oversee and regulate life insurance business in India.
Sum Assured	The guaranteed amount payable on the Life As sured's death during the Plan Term provided we have received the due Premiums and this Plan is in force. The Sum Assured is specified in the Plan Schedule.
Surrender	Termination or cancellation of this Plan prior to the Expiry Date.
We or us or our or Insurer or Company	IndiaFirst Life Insurance Company Limited
You or your or Policyholder or Proposer	The person named as the Policyholder in the Plan Schedule, who has taken this Plan from us. You may or may not be the Life Assured under this Plan.

3. Payment of premium:

3.1. Under this Plan, you have an option to pay your Premiums as a Regular Premiums.

3.2. Regular Premiums can be paid to us as a yearly payment mode. The Premiums should be paid on or before the due dates to avoid any lapsation.

4. Missing your Premium

4.1. You are provided a Grace Period in case you miss paying your Regular Premium on the due dates. All your Plan benefits continue during the Grace Period.

4.2. In case of the Life Assured's death during the Grace Period, we will pay the death benefit only after deducting the unpaid due Regular Premiums till such date.

5. Reviving your Lapsed Plan

5.1. You may revive the lapsed Plan within 2 (Two) years from the due date of first unpaid Regular Premium but before the Expiry Date by:

- submitting a written request for revival of the lapsed Plan;
- paying all unpaid due Premiums without interest; and
- providing a declaration of good health and undergoing a medical examination, if needed. You will have to bear the cost of medical examinations, if any.

5.2. A lapsed Plan will only be revived along with all its benefits when we issue a written endorsement to you in accordance with our board approved underwriting policy.

5.3. The Plan will terminate and you will not be entitled to receive any benefits, if the lapsed Plan is not revived till the expiry of the revival period.

6. Nomination

6.1. Appointing a Nominee to receive the Death Benefit

The death benefit will be payable to the person nominated as Nominee by you in accordance with Section 39 of the Insurance Act, as amended by Insurance Laws (Amendment) Act, 2015

6.2. If the Nominee is a minor

If the Nominee is a minor, then, you need to appoint an Appointee to receive and hold the death benefits for the benefit of the Nominee until the Nominee attains the Age of 18 (Eighteen) years.

6.3. Making/ Changing a Nomination

You can also nominate a person or change a nomination at any time during the Plan Term and while this Plan is in force, by submitting a written request to us. The nomination or change in nomination will become effective only after it is recorded by us in accordance with Section 39 of the Insurance Act, as amended by Insurance Laws (Amendment) Act, 2015

6.4. Our Liability in a Nomination

In accepting or recording a nomination or a change of nomination, we do not accept any responsibility or express any opinion as to its validity or legality.

7. Assignment

7.1. Assignment of the Plan

You may assign this Plan by making an endorsement on the Plan itself or through a separate instrument in accordance with Section 38 of the Insurance Act, as amended by Insurance Laws (Amendment) Act, 2015. In either case, you should submit a written request to us for registration of the assignment.

Any assignment made by you under this Plan will become effective only after it is recorded by us.

Any assignment will automatically cancel any nomination made by you except in case of any assignment made by you in our favour, in

accordance with Section 39 of the Insurance Act, as amended by Insurance Laws (Amendment) Act, 2015.

Assignment is not permitted, if this Plan has been procured under the Married Women's Property Act, 1874.

7.2. Our Liability in an Assignment

In accepting or recording an assignment, we do not accept any responsibility or express any opinion as to its validity or legality.

8. Death Benefit Claim not Admitted under this Plan

8.1. You are not entitled to receive death benefits under this Plan, if the Life Assured, whether sane or insane, commits suicide within 12 (Twelve) months from the Plan Commencement Date. In such a case, we will pay 80% (Eighty percent) of the total Premiums received by us and this Plan will terminate.

8.2. You are not entitled to receive death benefits under this Plan, if the Life Assured, whether sane or insane, commits suicide within 12 (Twelve) months after revival of the Plan. In such a case, we will pay higher of 80% (Eighty percent) of the total Premiums or Surrender Value, if any and this Plan will terminate.

9. Loan

Under this plan, you are not entitled to receive any loans.

10. Plan Ceases/ Ends/ Terminates

10.1. This Plan will cease immediately and automatically on the happening of the earliest of any of the following:

- on the date of payment of the Sum Assured upon the death of the Life Assured; or
- on the date of intimation of rejection of claim by us; or
- on the date of Surrender of this Plan; or
- on the Expiry Date; or
- on the date of receipt of free look request ; or
- on the expiry of the revival period provided we have not received the due unpaid Regular Premiums along with interest from you till the expiry of such period.

11. Disclosures

11.1. Misrepresentation/Fraudulent Disclosures

Fraud, Misrepresentation and forfeiture would be dealt with in accordance with provisions of Sec 45 of the Insurance Act 1938, as amended from time to time

Section 45 of Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015:

- No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later.
- A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival, of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based.
- Notwithstanding anything contained in sub-section (2), no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer: Provided that in case of fraud, the onus of disproving lies upon the beneficiaries, in case the policyholder is not alive.
- A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision to repudiate the policy of life insurance is based: Provided further that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation.
- Nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.

11.2. Section 41 of the Insurance Act,1938 as amended by Insurance Laws (Amendment) Act, 2015:

No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.

Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-Section A at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bonafide insurance agent employed by the insurer.

Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees

12. Death Benefit

The Sum Assured is payable on the Life Assured's death on or after the Risk Commencement Date but before the Expiry Date.

Subject to Sections 10, 13 and 14, the aforesaid death benefit will become payable to the Nominee/ Appointee/ legal heir (as applicable) as specified in Section 13.1 provided this Plan is in force and we have received the due Premiums.

13. Surrender Benefit

13.1. No surrender benefit is payable under this plan.

14. Payments of Benefits

14.1. The death benefit under this Plan will be payable to the Nominee/ the Appointee/ legal heirs/ assignee/ person as directed by a court of competent jurisdiction.

14.2. All benefits including the Sum Assured and other sums, if any, under this Plan will only be paid in India and in Indian Rupees.

14.3. Upon payment of the proceeds or the Sum Assured to a person specified in Section 13.1, the same will constitute a good, valid and sufficient discharge of our liability under this Plan.

15. Making a Claim

15.1. Steps involved in making a claim

In order to process a claim under this Plan, we will need a written intimation about the claim, upon the death of the Life Assured during the Plan Term. This is the first step towards processing your claim. The written intimation should also be accompanied with all the required documents as mentioned below:

- Proof of Age of the Life Assured, if the Age of the Life Assured has not been admitted by us
- Claimant's statement and claim intimation report
- Death certificate issued by the local health and medical authority (only in case of death of the Life Assured)
- Copies of First Information Report, post mortem report, duly attested by the police (only in case of unnatural death of the Life Assured including accidental death etc.)
- Hospitalization documents including discharge summary, all investigation reports (only in case the Life Assured was treated for any illness related to the cause of death)
- Original Plan document
- A copy of photo-identity proof of the claimant and documents establishing the rights of claimant (e.g. driving license, PAN card, passport, Voter ID card etc.)
- Any other document or information that we may need for validating the claim and to process the claim

16. Right to Revise/ Delete/ Alter the Terms and Conditions of this Plan

16.1. We may revise, delete and/ or alter any of the terms and conditions of this Plan subject to receipt of the prior approval of the Regulatory Authority. We will intimate you by sending a prior written notice of 30 (Thirty) days, before revising, deleting and/or altering any of the terms and conditions of this Plan.

17. Loss of Plan Document

17.1. You should submit a written intimation about the loss of the Plan document and the reason for the loss. We will issue you a duplicate Plan document if we are satisfied that the original Plan document is lost or misplaced. The original Plan document immediately and automatically ceases to have any validity upon issue of the duplicate Plan document.

17.2. You agree to indemnify us and hold us free and harmless from any costs, expenses, claims, awards or judgments arising out of or in relation to the original Plan document.

18. Electronic Transactions

18.1. You or the Life Assured will always adhere to and comply with all our terms and conditions in relation to electronic transactions and any electronic transaction effected by you or the Life Assured, as the case may be, will constitute a legally binding and valid transaction.

18.2. Such electronic transactions will include any transactions effected by you through internet, teleservice operations, short messaging services, electronic data interchange, call centres, or by means of electronic automated machines or through other means of telecommunications, established by us or on our behalf for and in relation to this Plan or our other products and services.

19. Force Majeure

19.1. If due to any act of God or State, strike, lock out, legislation or restriction by any government or any other authority or any other circumstances which are beyond our control, which restricts performance of our obligations under this Plan, then, this Plan will be wholly or partially suspended during the continuance of such force majeure conditions.

19.2. Once the force majeure conditions ceases to exist, then, we will resume our obligations under this Plan for such period during which the force majeure conditions existed.

20. Issuance of Notices

20.1. We also have the discretion to issue either individual notices to you or to publish general notices on our website www.indiafirstlife.com in relation to this Plan and/or for services in relation to the same.

21. Governing Law and Jurisdiction

21.1. All claims, disputes or differences arising under or in connection with this Plan will be governed by and construed in accordance with Indian laws and shall be subject to the jurisdiction of the Indian Courts.

22. Taxes

22.1. We will deduct the applicable taxes in accordance with the applicable provisions of Indian tax laws. Any Premium and benefit payable under this Plan is subject to applicable taxes, levies, cess, etc. which shall always be paid by you. You are liable to pay all applicable taxes, levies, cess etc. as levied by the Government/ statutory authorities from time to time.

22.2. You should consult your tax advisor for understanding the tax benefits and liabilities under this Plan. We do not accept any responsibility or express any opinion as to the validity or legality of tax benefits or liabilities as may be applicable to you.

Common conditions applicable to both Section 1 and Section 2

1. Cooling off Period (Free Look Period) :

If the policyholder disagree with the 'Terms and conditions' of the policy, the policy can be cancelled within 15 days from the date of receipt of the policy. In case Policyholder has bought this plan through distance marketing mode, he/she may cancel the Plan within 30 days from the date of receipt of the policy. However, the company reserves the right to deduct medical examination fees, cancellation fee*, stamp duty charges for issue of the policy and proportionate risk premium for the period concerned.

* Cancellation fee is not applicable for Pure Term Life Insurance Coverage

2. Liability to settle claims :

The liability to settle health insurance claim under section 1 vests with Star Health and Allied Insurance Company Limited and the liability to settle pure term life insurance claim under Section 2 vests with IndiaFirst Life Insurance Company Limited.

3. Withdrawal of tie-up :

The tie-up between Star Health and Allied Insurance Company Ltd. and IndiaFirst Life Insurance Company Ltd may be withdrawn at any time with the prior approval of the Regulator. The insured will be intimated 90 days in advance about the withdrawal of tie-up. In such an event all policies issued will continue until renewal. Upon expiry the insured has the option of continuing with either of the Sections with the respective insurers. In so far as Health section is concerned the continuity of benefits with reference to waiting periods stated will be available.

4. 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.

5. Legal / Quasi legal disputes :

The legal / quasi legal disputes, if any, shall be dealt with the respective insurers for respective benefits.

6. Discontinuance of insurance :

The Insured has the option to continue with either section of the policy discontinuing the other section during the policy term. The continuation of benefits as provided under each section would be available.

7. Premium payment options :

Premium shall be paid annually.

8. Policy servicing facility :

Star Health and Allied Insurance Company Limited will be the nodal point for policy servicing. Any queries relating to the coverage under the policy shall be obtained through the following Toll Free Numbers **1800 425 2255 and 1800 102 4477**

9. Claim Servicing :

Health Insurance claim payable under Section 1 will be serviced and settled by Star Health and Allied Insurance Company Limited and Pure Term life cover payable under Section 2 will be serviced and settled by IndiaFirst Life Insurance.

10. 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.

11. 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, Valluvar Kottam 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

12. 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 grievance@starhealth.in Senior Citizens may call: (044) 28288897

In case the Insured Person is aggrieved in any way, the Insured may contact the Company and Company at the specified address, during normal business hours.

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 branches or offices of Star Health and Allied Insurance Company Limited and IndiaFirst Life Insurance

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 -23230858 Email:bimalokpal.delhi@gbic.co.in	Delhi.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781 001 (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 - 226001. 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.

1. Important Note :

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.

For all purposes under the scope of this policy, "Company" under Section 1 means Star Health and Allied Insurance Company Limited and "Company" under Section 2 means IndiaFirst Life Insurance Company Limtied.

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	ESSENTIAL AND MAY BE PAID SPECIFICALLY FOR CASES WHO HAVE UNDERGONE 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-DE-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 BY HOSPITAL)	NOT PAYABLE
29	FOOT COVER	NOT PAYABLE
30	GOWN	NOT PAYABLE
31	LEGGINGS	ESSENTIAL IN BARIATRIC AND VARICOSE VEIN SURGERY AND SHOULD BE CONSIDERED FOR THESE CONDITIONS WHERE SURGERY ITSELF IS PAYABLE.
32	LAUNDRY CHARGES	NOT PAYABLE
33	MINERAL WATER	NOT PAYABLE
34	OIL CHARGES	NOT PAYABLE
35	SANITARY 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 PAYABLE
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 SHOULD BE CONSIDERED
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	NOT PAYABLE
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	NOT PAYABLE
66	PSYCHIATRIC & 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 PAYABLE
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 EXTENT PROVIDED UNDER EXCLUSION NO.10
74	STEM CELL IMPLANTATION/ SURGERY and Storage	NOT PAYABLE EXCEPT BONE

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 & 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(SERVICE 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 & 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 PAYABLE
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	CONVENYANCE 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 CHARGES	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 I DENTIFICATION BAND / NAME TAG	NOT PAYABLE
127	WASHING CHARGES	NOT PAYABLE
128	MEDICINE 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	COMMODE	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	SPIROMETRE	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	ESSENTIAL AND SHOULD BE PAID SPECIFICALLY FOR CASES WHO HAVE UNDERGONE 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
152	AMBULANCE COLLAR	NOT PAYABLE
153	AMBULANCE EQUIPMENT	NOT PAYABLE
154	MICROSHEILD	NOT PAYABLE
155	ABDOMINAL BINDER	ESSENTIAL AND SHOULD BE PAID 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	MAY BE 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 CHANGE 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 GEL	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	SHOULD BE 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	ESSENTIAL FOR CASE LIKE CABG ETC, WHERE IT SHOULD BE PAID