

CLASSIC GROUP HEALTH INSURANCE

Unique Identification No.: SHAHLGP21239V022021

A. PREAMBLE

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

B. DEFINITIONS

Standard Definitions

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

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

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

- i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

AYUSH Hospital: An AYUSH Hospital is a healthcare facility wherein medical/surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

- a. Central or State Government AYUSH Hospital; or
- b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
- c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

Break in policy means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or Grace Period.

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

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

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

- a) **Internal Congenital Anomaly:** Congenital anomaly which is not in the visible and accessible parts of the body
- b) **External Congenital Anomaly:** Congenital anomaly which is in the visible and accessible parts of the body

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

Day Care Centre: A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-

- i) has qualified nursing staff under its employment;
- ii) has qualified medical practitioner/s in charge;
- iii) has fully equipped operation theatre of its own where surgical procedures are carried out;
- iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Day Care Treatment: Day care treatment means medical treatment, and/or *surgical procedure* which is:
i. Undertaken under General or Local Anesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and

- ii. which would have otherwise required hospitalization of more than 24 hours

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

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

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

Provided the insurers shall offer coverage during the Grace Period, if the premium is paid in instalments during the policy period.

Hospital: A hospital means any institution established for *in-patient care* and *day care treatment* of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act **Or** complies with all minimum criteria as under:

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

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

- (a) **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
- (b) **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics;
 1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
 2. it needs ongoing or long-term control or relief of symptoms
 3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 4. it continues indefinitely
 5. it recurs or is likely to recur

Injury: Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

Inpatient Care Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

Intensive Care Unit: Intensive care unit means an identified section, ward or wing of a *hospital* which is under the constant supervision of a dedicated *medical practitioner(s)*, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

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

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

no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Medical Practitioner: Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which:

- i) is required for the medical management of the illness or injury suffered by the insured;
- ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- iii) must have been prescribed by a *medical practitioner*;
- iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for Pre-Existing Diseases and specific waiting periods from one health insurance policy to another with the same Insurer.

Network Provider: Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

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

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

- a) That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the Insurer
- or
- b) For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

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

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

Post-hospitalization Medical Expenses: Post-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

- i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
- ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

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

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

Specific waiting period: Specific waiting period means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

Surgery or Surgical Procedure: Surgery or Surgical Procedure means manual and / or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a *medical practitioner*.

Unproven/Experimental treatment: Unproven/Experimental treatment means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Specific Definitions

Attendant: Attendant means any person other than a relative of the Insured Person who is engaged for the sole purpose of attending to the Insured Person.

Associated medical expenses: Associated medical expenses means medical expenses such as Professional fees, OT charges, Procedure charges, etc., which vary based on the room category occupied by the insured person whilst undergoing treatment in some of the hospitals. If Policy Holder chooses a higher room category above the eligibility defined in policy, then proportionate deduction will apply on the Associated Medical Expenses in addition to the difference in room rent. Such associated medical expenses do not include Cost of pharmacy and consumables, Cost of implants and medical devices and Cost of diagnostics.

Company: Company means Star Health and Allied Insurance Company Limited

Day: Day means a period of 24 consecutive hours.

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

Group Administrator: Group Administrator means the proposer mentioned in the policy schedule

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

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

C. COVERAGE

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

That if during the period stated in the Schedule the **Insured Person/s** shall contract any disease or suffer from any **illness** or sustain bodily **injury** through **accident** and if such disease or injury shall require the Insured Person/s, upon the advice of a Physician/Medical Specialist /**Medical Practitioner** or of duly Qualified Surgeon to incur Hospitalization expenses during the period stated in the schedule for medical/surgical treatment at any

Nursing Home / Hospital in India as an in-patient, the Company will indemnify the Insured Person/s the amount of such expenses as are reasonably and necessarily incurred, up-to the limits mentioned in the schedule but not exceeding the **sum insured** in aggregate in any one period stated in the schedule hereto

- A) Room, boarding, nursing expenses as provided by the Hospital / Nursing Home at 2% of the Sum Insured, subject to a maximum of Rs.5,000/- per day
- B) Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees.
- C) Anesthesia, blood, oxygen, operation theatre charges, ICU Charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent, similar expenses. With regard to coronary stenting, the company will pay such amount up to the extent of cost of bare metal stent/drug eluting cobalt-chromium stent/drug eluting stainless steel stent. In respect of medicines, Implants and such other similar items, the Company will pay up to the cost of alternate indigenous make.
- D) Emergency ambulance charges up-to a sum of Rs.750/- per hospitalization and overall limit of Rs.1,500/- per policy period for transportation of the insured person by private ambulance service when this is needed for medical reasons to go to hospital for treatment, provided however there is an admissible claim under the policy.
- E) Relevant Pre-Hospitalization medical expenses incurred for a period not exceeding 30 days prior to the date of hospitalization, for the disease/illness, injury sustained following an admissible claim under the policy.
- F) Post –Hospitalization expenses incurred up to 60 days after discharge from the hospital. The amount payable shall not exceed the sum equivalent to 7% of the hospitalization expenses subject to a maximum of Rs5000/- per hospitalization. For the purpose of calculation of the 7%, only nursing expenses, surgeon’s / consultants fees, diagnostic charges and cost of drugs and medicines will be taken
- G) **Coverage for Modern Treatment**
The expenses payable during the entire policy period for treatment of the following diseases/ conditions (either as a day care or as in-patient exceeding 24hrs of admission in the hospital) is limited to the amount mentioned in table below

| Sum Insured | Rs.1,50,000/- | Rs.2,00,000/- | Rs.3,00,000/- | Rs.4,00,000/- | Rs.5,00,000/- | Rs.10,00,000/- |
|--|---------------|---------------|---------------|---------------|---------------|----------------|
| Limit per person, per policy period for each diseases / Condition Rs. | | | | | | |
| Uterine artery Embolization and HIFU | 12500 | 25000 | 37500 | 100000 | 125000 | 150000 |
| Balloon Sinuplasty | 5000 | 10000 | 15000 | 40000 | 50000 | 100000 |
| Deep Brain Stimulation | 25000 | 50000 | 75000 | 200000 | 250000 | 300000 |
| Oral Chemotherapy* | 12500 | 25000 | 37500 | 100000 | 125000 | 200000 |
| Immunotherapy- Monoclonal Antibody to be given as injection | 25000 | 50000 | 75000 | 200000 | 250000 | 400000 |
| Intra Vitreal injections | 5000 | 10000 | 15000 | 40000 | 50000 | 75000 |
| Robotic surgeries | 25000 | 50000 | 75000 | 200000 | 250000 | 300000 |

| | | | | | | |
|--|--------------------------|-------|-------|--------|--------|--------|
| Stereotactic radio surgeries | 25000 | 50000 | 75000 | 175000 | 200000 | 225000 |
| Bronchical Thermoplasty | Up to Sum Insured | | | | | |
| Vaporisation of the prostate (Green laser treatment or holmium laser treatment) | | | | | | |
| IONM-(Intra Operative Neuro Monitoring) | | | | | | |
| Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions | 25000 | 50000 | 75000 | 200000 | 250000 | 300000 |

- H) **AYUSH Treatment:** Medical expenses for Inpatient Hospitalization incurred on treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines in a AYUSH Hospital is payable up to the sum insured.

Note: Yoga and Naturopathy systems of treatments are excluded from the scope of coverage under AYUSH treatment

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

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

- J) **Hospital Cash:** Cash Benefit of Rs 1,000/-for each completed day of hospitalization subject to a maximum of 7 days per occurrence and 14 days per policy period, is payable. Provided however there is a valid claim for hospitalization. For the purpose of cash benefit the days of admission and discharge will not be taken into account.

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

Note: Benefits given under H and I above are optional and effective only if specifically opted for and shown in the Policy Schedule.

Where Package rates are charged by the hospitals the Post-Hospitalization benefit will be calculated after taking the room, boarding and nursing charges at Rs 5000/- per day.

The expenses as above are payable only where the in-patient hospitalization is for a minimum period of 24 hours. However this time limit will not apply to the day-care treatments detailed elsewhere in the policy.

K) The expenses incurred on treatment of cataract are payable up-to the limits mentioned hereunder:

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

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

Company's liability in respect of all claims admitted during the period of insurance shall not exceed the sum insured per person mentioned in the schedule.

D. EXCLUSIONS

Standard Exclusions

1. Pre-Existing Diseases – Code Excl 01

- Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then for the same would be reduced to the extent of prior coverage.
- Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

- Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- List of specific diseases/procedures
 - Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye (other than retinal detachment), Diseases of ENT, Diseases related to Thyroid, Benign diseases of the breast.
 - Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal

Tunnel Syndrome, Trigger Finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology

3. All treatments (Conservative, Operative treatment) and all types of intervention for Diseases related to Tendon, Ligament, Fascia, Bones and Joint Including Arthroscopy and Arthroplasty / Joint Replacement [other than caused by accident].
 4. All types of treatment for Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system, Prolapse of Intervertebral Disc (other than caused by accident),
 5. All treatments (conservative, interventional, laparoscopic and open) related to Hepato-pancreato-biliary diseases including Gall bladder and Pancreatic calculi. All types of management for Kidney and Genitourinary tract calculi.
 6. All types of Hernia,
 7. Desmoid Tumor, Umbilical Granuloma, Umbilical Sinus, Umbilical Fistula,
 8. All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Cervix, Uterus, Fallopian tubes, Ovaries, Uterine Bleeding, Pelvic Inflammatory Diseases
 9. All Diseases of Prostate, Stricture Urethra, all Obstructive Uropathies,
 10. Benign Tumours of Epididymis, Spermatocele, Varicocele, Hydrocele,
 11. Fistula, Fissure in Ano, Hemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence
 12. Varicose veins and Varicose ulcers
 13. All types of transplant and related surgeries.
 14. Congenital Internal disease / defect.
- 3. 30-day waiting period – Code Excl 03**
- A. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered
 - B. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months
 - C. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently
- 4. Investigation & Evaluation – Code Excl 04**
- A. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
 - B. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded
- 5. Rest Cure, rehabilitation and respite care – Code Excl 05:** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
- i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons
 - ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs
- 6. Obesity/ Weight Control – Code Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions;

- A. Surgery to be conducted is upon the advice of the Doctor
 - B. The surgery/Procedure conducted should be supported by clinical protocols
 - C. The member has to be 18 years of age or older and
 - D. Body Mass Index (BMI);
 1. greater than or equal to 40 or
 2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - a. Obesity-related cardiomyopathy
 - b. Coronary heart disease
 - c. Severe Sleep Apnea
 - d. Uncontrolled Type2 Diabetes
7. **Change-of-Gender treatments – Code Excl 07:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
 8. **Cosmetic or plastic Surgery – Code Excl 08:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
 9. **Hazardous or Adventure sports – Code Excl 09:** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
 10. **Breach of law – Code Excl 10:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
 11. **Excluded Providers – Code Excl 11:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
 12. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof – **Code Excl 12**
 13. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons – **Code Excl 13**
 14. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure – **Code Excl 14**
 15. **Refractive Error – Code Excl 15:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
 16. **Unproven Treatments – Code Excl 16:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
 17. **Sterility and Infertility – Code Excl 17:** Expenses related to sterility and infertility. This includes;

- a. Any type of contraception, sterilization
- b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- c. Gestational Surrogacy
- d. Reversal of sterilization

18. Maternity – Code Excl 18

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

Specific Exclusions

19. Circumcision (unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident), Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA - **Code- Excl 19**
20. Congenital External Condition / Defects / Anomalies – **Code Excl 20.**
21. Convalescence, general debility, run-down condition or rest cure, Nutritional deficiency states.- **Code Excl 21.**
22. Intentional self injury - **Code- Excl 22.**
23. Venereal Disease and Sexually Transmitted Diseases (Other than HIV) - **Code- Excl 23.**
24. Injury/disease caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) - **Code- Excl 24.**
25. Injury or disease caused by or contributed to by nuclear weapons/materials - **Code- Excl 25.**
26. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion – **Code Excl 26.**
27. Unconventional, Untested, Experimental therapies - **Code Excl 27**
28. Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy.- **Code- Excl 28.**
29. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalization warranted.-**Code- Excl 29.**
30. All treatment for Priapism and erectile dysfunctions, -**Code- Excl 30.**
31. Inoculation or Vaccination (except for post-bite treatment and for medical treatment for therapeutic reasons)-**Code- Excl31.**
32. Dental treatment or surgery unless necessitated due to accidental injuries and requiring hospitalization. (Dental implants are not payable)-**Code- Excl32.**
33. Medical and / or surgical treatment of Sleep apnea, treatment for genetic and endocrine disorders.- **Code- Excl33.**
34. Hospital registration charges, admission charges, record charges, telephone charges and such other charges-**Code- Excl34**

35. Cochlear implants and procedure related hospitalization expenses .Cost of spectacles and contact lens, hearing aids, walkers and crutches, wheel chairs, Nutritional Supplements, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis [CAPD], infusion pump and such other similar aids-**Code- Excl 35.**
36. Any hospitalizations which are not Medically Necessary-**Code- Excl 36.**
37. Other excluded expenses as detailed in the website www.starhealth.in- **Code- Excl 37**
38. Existing disease/s, disclosed by the insured and mentioned in the policy schedule under Permanent Exclusion (based on insured's consent) -**Code- Excl 38**
39. Naturopathy Treatment **Code- Excl 40**

E. CONDITIONS

Standard Conditions

1. **Disclosure of Information:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policy holder.
 2. **Claim Settlement**
 - A. **Condition Precedent to Admission of Liability:** The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.
 - B. **Documents for Cashless Treatment:**
 - a. For assistance call 24 hours help-line 044-69006900 or Toll Free No. 1800 425 2255, Senior Citizens may call at 044-40020888
 - b. Inform the ID number for easy reference
 - c. On admission in the hospital, produce the ID Card issued by the Company at the Hospital Helpdesk
 - d. Obtain the Pre-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk.
 - e. The Treating Doctor will complete the hospitalisation/ treatment information and the hospital will fill up expected cost of treatment. This form is submitted to the Company
 - f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.
 - g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits.
 - h. In case of emergency hospitalization information to be given within 24 hours after hospitalization
 - i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.starhealth.in or contact the nearest branch or refer to the list of Networked Hospitals provided with the policy document.
 - j. KYC (Identity proof with Address) of the proposer, as per AML Guidelines
- In non-network hospitals payment must be made up-front and then reimbursement will be effected on submission of documents.

Note: The Company reserves the right to call for additional documents wherever required.

Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person can go ahead with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

C. For Reimbursement claims: Time limit for submission of

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

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

Note: Conditions C and D are precedent to admission of liability under the policy. However the Company will examine and relax the time limit mentioned in these conditions depending upon the merits of the case.

E. Documents to be submitted for Reimbursement: The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

- a. Duly completed claim form, and
- b. Pre Admission investigations and treatment papers.
- c. Discharge Summary from the hospital
- d. Cash receipts from hospital, chemists
- e. Cash receipts and reports for tests done
- f. Receipts from doctors, surgeons, anesthetist
- g. Certificate from the attending doctor regarding the diagnosis.
- h. KYC (Identity proof with Address) of the proposer, as per AML Guidelines.
- i. NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code
- j. CKYC No. of the proposer

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

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

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

4. Multiple Policies

- i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy
- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted.

- Then the insurer shall independently settle the claim subject to the terms and conditions of this policy
- iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount
 - iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

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

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

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

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

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

6. **Cancellation:**

i. The Policy Holder may cancel his Policy anytime during the term by giving 7 days written notice. In such an event, The Company shall

a. refund proportionate premium for unexpired Policy period, for policy term upto one year and there is no claim (s) made during the Policy period.

b. refund premium for the unexpired Policy period, in respect of policies with policy term more than 1 year and risk coverage for such Policy years has not commenced.

ii. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 Days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Note: In case of long term policies the refund will be given after adjusting the long term discount availed by the insured/ policyholder.

7. **Renewal of policy:** The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.

1. Renewal shall not be denied on the ground that the insured person had made a claim or claims in

the preceding policy years.

2. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
3. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
4. Coverage is not available during the grace period.
5. In the event of the group policy being discontinued or not renewed or when the members of the group leave the group on account of resignation/retirement/termination or otherwise, the following provision shall apply.
 - a. The insured person/s covered under this group policy will be granted cover under Indemnity based Individual Health Policy. In respect of persons who have been covered continuously for a period of one year under this group policy with the Company, exclusion Code Excl – 03 shall be waived.
 - b. In respect of persons who have been covered continuously for a period of two years under this group policy with the Company, exclusions Code Excl-03 and Code Excl-02 shall be waived
 - c. In respect of persons who have been covered continuously for a period of three years under this group policy with the Company, exclusions Code Excl-03, Code Excl-02 and Code Excl-01 shall be waived.

8. Withdrawal of policy

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

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

10. Redressal of Grievance: In case of any grievance the insured person may contact the Company through
Website : www.starhealth.in

E-mail : grievances@starhealth.in, gro@starhealth.in

Ph. No. : 044-69006900 | Toll Free No. 1800 425 2255

Senior Citizens may call at 044-69007500

Courier : 4th Floor, Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai- 600014

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

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

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

If Insured person is not satisfied with the redressal of grievance through above methods, the insured

person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017, as amended from time to time.

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

11. **Migration:** In case of migration of one policy to another with the same insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.
12. **Nomination:** The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

Specific Conditions

13. The Insured Person/s shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim.
14. All claims under this policy shall be payable in Indian currency.
15. The premium payable under this policy shall be payable in advance. No receipt of premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance of fulfillment of the terms, provision, conditions and endorsements of this policy by the Insured Person/s, in so far as they relate to anything to be done or complied with by the Insured Person/s, shall be a condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions, and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of the Company. Any medical practitioner authorized by the company shall be allowed to examine the **Insured Person/s** in case of any alleged injury or diseases requiring hospitalization when and as often as the same may reasonably be required on behalf of the Company at the Company's cost.
16. **Notices** :Any notice, direction or instruction given under this policy shall be in writing and delivered by hand, post or email to Star Health and Allied Insurance Company Limited, No.1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai 600034. Customer Care No. 044-69006900 or Toll Free No. 1800 425 2255, e-mail: support@starhealth.in
Notice and instructions will be deemed served 7 days after posting or **immediately** upon receipt in the case of hand delivery or e-mail.
17. **Territorial Limit** : All medical/surgical treatments under this policy shall have to be taken in India.
18. **Automatic Termination:** The insurance under this policy with respect to each relevant insured person policy shall terminate immediately on the earlier of the following events:
 - ✓ Upon the death of the Insured Person.
 - ✓ Upon exhaustion of the sum insured
19. **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.
20. **Arbitration:** The parties to the contract may mutually agree and enter into a separate Arbitration Agreement

to settle any and all disputes in relation to this policy. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.”

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

22. IMPORTANT NOTE:

- a) The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws
- b) 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 with may result in the claim being denied.
- c) Settlement of claims under the Policy are subject to the provisions of Anti- Money Laundering / Counter Financing of Terrorism (AML / CFT) policy of the Company. For further details, please visit our website www.starhealth.in
- d) The attention of the policy holder is drawn to our website www.starhealth.in for anti fraud policy of the Company for necessary compliance by all stake holders.

23. Role of Group Administrator / Proposer

The Group administrator shall play a facilitative role between the Insurer and the Insured Person. Such role includes

- (i) Furnish to the Company detailed list of Insured Person/s for preparation of ID cards
- (ii) Distribute ID cards received from the Company
- (iii) To facilitate Insured Person / s in availing cashless facility (iv) To make payment of premium on or before the stipulated time.

24. Package Charges: The Company’s liability in respect of package charges will be restricted to 80% of such amount. (Package charges refer to charges that are not advertised in the Schedule of the hospital).

25. Group Discount depending on the size of the Group is as per scales below;

| No of members in the Group | % Of discount on premium (excluding Add-on cover premium and Service Tax) |
|----------------------------|---|
| Up-to 500 persons | Nil |
| 501-1000 | 2.5% |
| 1001-3000 | 5.0% |
| 3001-7000 | 7.5% |
| 7001-10000 | 10.0% |
| > 10000 | 12.0% |

Note: The Group Discount is allowable only to Groups where the claims experience is less than 80%. The Group Discount will be allowed only on the Basic premium and not on the premium in respect of Add-on covers. The discount is not cumulative. The applicable scale of discount is to be reckoned in accordance with the group size at the inception of the policy.

Increase / decrease in the Group size following additions/deletions will not alter Group discount. Inclusions of persons into the Group can be made on payment of additional premium on pro-rata basis.

Refund for deletion of persons from the Group can be made on pro-rata basis subject to there being “No claim” in respect of such persons.

26. Customer Service: If at any time the Insured Person requires any clarification or assistance, the insured may contact "Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai- 600014", during normal business hours.

27. Excluded Hospitals (providers): Insured can refer the company website using the following link to the list of excluded hospitals. <https://www.starhealth.in/lookup/hospital/#excluded-hospital>

List of Ombudsman

| Office Details | Jurisdiction of Office Union Territory, District) |
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| <p>AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in</p> | Gujarat, Dadra & Nagar Haveli, Daman and Diu. |
| <p>BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in</p> | Karnataka. |
| <p>BHOPAL Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in</p> | Madhya Pradesh, Chhattisgarh. |
| <p>BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in</p> | Odisha. |
| <p>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 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in</p> | Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh. |
| <p>CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018.</p> | Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry). |

| Office Details | Jurisdiction of Office Union Territory, District) |
|--|---|
| Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in | |
| DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in | Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh. |
| KOCHI Office of the Insurance Ombudsman, 10 th Floor, Jeevan Prakash, LIC Building, Opp.to Maharaja's College, M. G. Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in | Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry. |
| GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in | Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura. |
| HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in | Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry. |
| JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in | Rajasthan. |
| KOLKATA Office of the Insurance Ombudsman, | West Bengal, Sikkim, Andaman & Nicobar Islands. |

| Office Details | Jurisdiction of Office Union Territory, District) |
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| <p>Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in</p> | |
| <p>LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 – 4002082/ 3500613 Email: bimalokpal.lucknow@cioins.co.in</p> | <p>Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, 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.</p> |
| <p>MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022-69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in</p> | <p>Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).</p> |
| <p>NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in</p> | <p>State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.</p> |
| <p>PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in</p> | <p>Bihar, Jharkhand.</p> |
| <p>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.: 020-24471175 Email: bimalokpal.pune@cioins.co.in</p> | <p>Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).</p> |

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| Office Details | Jurisdiction of Office Union Territory, District) |
| For the details of Insurance Ombudsman please visit: https://cioins.co.in/Complaint/Online | |

Items that are to be subsumed into Room Charges

| SI No | ITEM |
|-------|---|
| 1 | BABY CHARGES (UNLESS SPECIFIED / INDICATED) |
| 2 | HAND WASH |
| 3 | SHOE COVER |
| 4 | CAPS |
| 5 | CRADLE CHARGES |
| 6 | COMB |
| 7 | EAU-DE-COLOGNE / ROOM FRESHNERS |
| 8 | FOOT COVER |
| 9 | GOWN |
| 10 | SLIPPERS |
| 11 | TISSUE PAPER |
| 12 | TOOTH PASTE |
| 13 | TOOTH BRUSH |
| 14 | BED PAN |
| 15 | FACE MASK |
| 16 | FLEXI MASK |
| 17 | HAND HOLDER |
| 18 | SPUTUM CUP |
| 19 | DISINFECTANT LOTIONS |
| 20 | LUXURY TAX |
| 21 | HVAC |
| 22 | HOUSE KEEPING CHARGES |
| 23 | AIR CONDITIONER CHARGES |
| 24 | IM IV INJECTION CHARGES |
| 25 | CLEAN SHEET |
| 26 | BLANKET / WARMER BLANKET |

| | |
|----|---|
| 27 | ADMISSION KIT |
| 28 | DIABETIC CHART CHARGES |
| 29 | DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES |
| 30 | DISCHARGE PROCEDURE CHARGES |
| 31 | DAILY CHART CHARGES |
| 32 | ENTRANCE PASS / VISITORS PASS CHARGES |
| 33 | EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE |
| 34 | FILE OPENING CHARGES |
| 35 | INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED) |
| 36 | PATIENT IDENTIFICATION BAND / NAME TAG |
| 37 | PULSEOXYMETER CHARGES |

Items that are to be subsumed into Procedure Charges

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

| | |
|----|----------------------------|
| 19 | COTTON BANDAGE |
| 20 | SURGICAL TAPE |
| 21 | APRON |
| 22 | TORNIQUET |
| 23 | ORTHOBUNDLE, GYNAEC BUNDLE |

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