



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

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STAR HEALTH ASSURE INSURANCE POLICY

Unique Identification No.: SHAHLIP23131V022223

PREAMBLE

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

A. 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:

- Having qualified registered AYUSH Medical Practitioner(s) in charge;
- Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- 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:

- Central or State Government AYUSH Hospital; or
- Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
- 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:
 - Having at least 5 in-patient beds;
 - Having qualified AYUSH Medical Practitioner in charge round the clock;
 - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

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

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

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

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

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

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

Day Care Treatment: Day care treatment means medical treatment, and/or surgical procedure which is:

- Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
- 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

Deductible: Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

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

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

Domiciliary Hospitalization: Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

- 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

Emergency Care: Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

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

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

- has qualified nursing staff under its employment round the clock;
- 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;
- has qualified medical practitioner(s) in charge round the clock;
- 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;

Hospitalization: Hospitalization means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

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

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

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
- it continues indefinitely
- 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 intensivists 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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SPECIFIC DEFINITIONS

Advanced Medicine: Advanced Medicine means targeted therapy with Monoclonal antibodies such as NUCALA (Mepolizumab) which are Proven and are used to treat Chronic severe refractory asthma.

Associated medical expenses: Associated Medical Expenses means expenses that shall include the applicable nursing charges, Operation theatre charges, Professional fees of Medical Practitioner including Surgeon/ anaesthetist/ Physician/Specialist of the Hospital where the Insured Person has been admitted and treated and hence Proportionate deduction will be applicable on these items.

"Associated Medical Expenses" does not include cost of pharmacy and consumables, cost of implants and medical devices and cost of diagnostics, ICU charges and hence Proportionate deduction will not be applicable on these items.

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

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

Company / Insurer: Company / Insurer means Star Health and Allied Insurance Company Limited

Dependent Child: Dependent Child means a child (natural or legally adopted) who is financially dependent and does not have his / her independent sources of income and upto 17 years of age.

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

Diseases of Spine: Diseases of Spine includes injuries to the spine and/or Infections to the spine and/or a blocked blood supply and/or compression by a fractured bone and/or a tumour resulting in neurological sequelae.

Family: Family includes Insured Person, spouse, dependent children between 16 days to 17 years of age not exceeding 3 in number Dependent Parent and Dependent Parents in law.

Head Injury: If a person sustained traumatic injury to brain / skull with (or) without loss of consciousness

Home: Home means the Insured Person's place of residence

Home Care Treatment: Home Care Treatment means treatment availed by the Insured Person at home, which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

- The Medical practitioner advises the Insured person to undergo treatment at home
- There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment
- Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

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

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

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

Limit of Coverage: Limit of Coverage means Sum Insured plus Cumulative bonus earned wherever applicable

Poly trauma If a person sustained a two or more severe injuries/ fractures in two or more areas of the body.

Policy Period / Policy year: Policy period / Policy year means a year following the commencement date and its subsequent annual anniversary

Policy term: Policy term means the period between the commencement date and expiry date specified in the schedule

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

Rehabilitation: Rehabilitation is defined as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment".

Stroke: Any cerebrovascular incident producing permanent neurological sequelae

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

Zone

Zone A - Delhi including Faridabad, Gurgaon, Ghaziabad and Noida, Mumbai including Thane, Ahmedabad, Surat and Vadodara

Zone B - Pune including Nashik, Trivandrum, Ernakulam, Chennai, Bengaluru, Hyderabad, Secunderabad and Rest of Gujarat

Zone C - Rest of India

B. COVERAGE

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

If during the period stated in the Policy Schedule the **insured person** sustains bodily **injury** or contracts any **disease** or suffer from any **illness** requiring **Hospitalization** and incurs expenses at any **Nursing Home / Hospital** in India as an **In-patient**, the **Company** will indemnify the **Insured Person** such expenses as are **reasonably and necessarily** incurred under the heads given below but not exceeding the Limit of Coverage stated in the Policy schedule.

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

Sum Insured in lakhs (Rs.)	5	10/15/20/25	50/75/100/200
Room Rent Criteria	Up to 1% of Sum Insured per day	Any Room (Except suite or above category)	Any room

Note: Associated Medical expenses which vary based on the room occupied by the insured person will be considered in proportion to the room rent stated in the policy schedule or actuals whichever is less. Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room rent.

- Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees.
- Anesthesia, blood, oxygen, operation theatre charges, ICU charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses. With regard to coronary stenting, medicines, Implants and such other similar items the Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping.
- All day care treatments are covered.
- Coverage for Non-medical Items (Consumables):** If there is an admissible claim under inpatient / day care the policy, then Items as per List I will become payable
- Emergency Road ambulance:** Subject to an admissible hospitalization claim, road ambulance expenses incurred for the following are payable :-
 - for transportation of the insured person by private ambulance service to go to hospital when this is needed for medical reasons or
 - for transportation of the insured person by private ambulance service from one hospital to another hospital for better medical treatment or
 - for transportation of the insured person from the hospital where treatment is taken to their place of residence (if it is in same city) provided the requirement of an ambulance to the residence is certified by the medical practitioner.
- Air Ambulance:** Air ambulance expenses are payable subject to an admissible hospitalization claim, the Insured Person(s) is/are eligible for reimbursement of expenses incurred towards the cost of air ambulance service up to 10% of sum insured per policy year, provided that
 - It is for emergency care of the insured person which requires immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot be provided.
 - Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency
 - It is prescribed by a Medical Practitioner and is Medically Necessary;
 - The insured person is in India and the treatment is in India only
 - Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s.
- Pre-hospitalization Expenses:** Medical expenses incurred up to 60 days immediately before the insured person is hospitalized.
- Post Hospitalization Expenses:** Medical expenses incurred up to 180 days immediately after the insured person is discharged from the hospital.

- Domiciliary Hospitalization:** Coverage for medical treatment (Including AYUSH) for a period exceeding three days, for an illness/disease/injury, which in the normal course, would require care and treatment at a Hospital but, on the advice of the attending Medical Practitioner, is taken whilst confined at home under any of the following circumstances
 - The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
 - The patient takes treatment at home on account of non-availability of room in a hospital.

However, this benefit shall not cover Asthma, Bronchitis, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all types of Dysenteries including Gastro-enteritis, Diabetes Mellitus and Insipidus, Epilepsy, Hypertension, Influenza, Cough and Cold, all Psychiatric or Psychosomatic Disorders, Pyrexia of unknown origin for less than 10 days, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Arthritis, Gout and Rheumatism.

- Organ Donor Expenses** In patient hospitalization expenses incurred for organ transplantation from the Donor to the Recipient Insured Person are payable provided the claim for transplantation is payable. In addition, the expenses incurred by the Donor, (if any) for the complications that necessitate a Redo Surgery / ICU admission will be covered.

The coverage limit under this benefit is over and above the Limit of Coverage and upto the Sum Insured. **This additional Sum Insured can be utilized by the Donor and not by the Insured.**

- Health Checkup Assure:** Expenses incurred towards cost of health check-up up to the limits mentioned in the table given below for each policy year (irrespective of claim).

Sum Insured (Rs.)	Limit Upto (Rs.)	
	Individual	Floater
5,00,000	1,500	2,500
10,00,000	2,000	5,000
15,00,000	4,000	8,000
20,00,000	5,000	10,000
25,00,000	5,000	10,000
50,00,000	5,000	10,000
75,00,000	8,000	15,000
1,00,00,000	8,000	15,000
2,00,00,000	8,000	15,000

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

- Home care treatment:** Payable up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year, for treatment availed by the Insured Person at home, only for the specified conditions mentioned below, which in normal course would require care and treatment at a hospital but is actually taken at home provided that:
 - The Medical practitioner advises the Insured person to undergo treatment at home
 - There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment
 - Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained
 - Insured can avail "Home Care Treatment" service on cashless / reimbursement basis, if availed from the list of our Network service providers given in our website "www.starhealth.in"

List of Conditions covered under Home care treatment

- Fever and Infectious diseases which can be managed as Inpatient
- Uncomplicated Urinary tract infections but needing Parenteral Antibiotics
- Asthma and COPD -Mild Exacerbations needing Home Nebulization
- Acute Gastritis/Gastroenteritis
- I.V. Chemotherapy [Where advised by the doctor]
- Palliative Cancer care requiring medical assistance
- Acute Vertigo
- Diabetic foot and Cellulitis
- IVDP [Cervical and Lumbar disc diseases]
- Major Surgeries/Arthroplasties needing IV Antibiotics Post Discharge
- Care for Brain and Spinal Injury Cases Post Discharge
- Post CVA Care at Home after Discharge
- Chronic Severe Refractory Asthma (by Advanced Medicine)
- Delivery Expenses:** Expenses for a Delivery including Delivery by Caesarean section (including pre-natal and postnatal expenses) up-to 10% of the Sum Insured is payable, subject to the following:-
 - Benefit under this section is subject to a waiting period of 24 months from the date of first commencement of Star Health Assure Insurance policy and its continuous renewal thereof with the Company.
 - There is no waiting period for subsequent deliveries

- ii. This cover is available only when
- Both self and spouse are covered under this policy for a continuous period of 24 months under Individual or floater sum insured.
- iii. Pre-hospitalisation and Post Hospitalization expenses are not applicable for this section.

15. In Utero Fetal Surgery/Intervention: The Company will pay the expenses incurred for In Utero Fetal Surgeries and Procedures mentioned below after the waiting period of 24 months from the date of inception of this policy:

Note: The above mentioned waiting period will not apply for treatment related to congenital Internal disease / defects for the Unborn.

Types of in utero-surgeries covered

- Open Fetal Surgery
- Fetendo Fetal Surgery
- Fetal Image-Guided Surgery (FIGS-IT)
- EXIT procedure

Types of in utero-surgeries/procedures covered

TYPE OF INTERVENTION	DESCRIPTION	SURGERIES
OPEN SURGERY	Hysterotomy	CPAM - Lobectomy
		SCT - Resection
		MMC - Repair
		Cervical Teratoma - Resection EXIT
		Tracheal occlusion
		Neck tumors
		CDH (EXIT to ECMO)
FETENDO	Fetoscopic Surgery	Balloon Occlusion of Trachea (for CDH)
		Laser Ablation of Vessels (for TTTS)
		Cord Ligation/Division
		Cystoscopic Ablation Valves (Urinary Obstruction)
		Amniotic Bands Release
FIGS	Fetal Image Guided Surgery	Amnioreduction/Infusion
		Fetal Blood Sampling
		RFA Anomalous Twins
		Vesico/Pleuro Amniotic Shunts
		Balloon Dilation Aortic Stenosis
EXIT procedure	Planned Specialized Delivery	CHAOS
		Removal of the CDH
		Tracheal Occlusion Balloon
		Pulmonary Sequestration
		CCAM

List of procedures covered under in utero-surgeries:

- Amniotic band syndrome
- Bronchopulmonary sequestration of the lung
- Congenital cystic adenomatoid malformation (CCAM) of the lung
- Congenital diaphragmatic hernia (CDH)
- Congenital high airway obstruction syndrome (CHAOS)
- Fetalanemia
- Lower urinary tract obstruction (LUTO)
- Mediastinalteratoma
- Neck mass
- Sacroccygealteratoma (SCT)
- Spina bifida (myelomeningocele)
- Twin reversed arterial perfusion (TRAP) sequence
- Twin-twin transfusion syndrome (TTTS)

16. Assisted Reproduction Treatment: The Company will reimburse medical expenses incurred on Assisted Reproduction Treatment as per the table mentioned below, for sub-fertility subject to:

- A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person.
- Company will pay for one Assisted Reproduction Treatment cycle in a policy year.
- For the purpose of claiming under this benefit, in-patient treatment is not mandatory.

Sum Insured (Rs.) in lakhs	Limit of Liability in a policy year (Rs.)
5,00,000/-	1,00,000
10,00,000/-, 15,00,000/-, 20,00,000/-, 25,00,000/-	2,00,000
50,00,000/-, 75,00,000/-, 1,00,00,000/-, 2,00,00,000/-	4,00,000

Special Exclusions

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

- Pre and Post treatment expenses
- Sub-fertility services that are deemed to be unproven, experimental or investigational
- Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.
- Reversal of voluntary sterilization
- Treatment undergone for second or subsequent pregnancies except where the child from the first delivery / previous deliveries is/are not alive at the time of treatment
- Payment for services rendered to a surrogate
- Costs associated with cryopreservation and storage of sperm, eggs and embryos
- Selective termination of an embryo.
- Services done at unrecognized centre
- Surgery / procedures that enhances fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery/procedures

17. Hospitalization expenses for treatment of New Born Baby: Expenses up-to the limit mentioned in the below given table incurred in a hospital/ nursing home on treatment of the New born for any disease, illness (including any congenital disorders) or accidental injuries are payable from Day 1 of its birth till the expiry date of the policy.

Special Conditions applicable for this section

- This cover is available only If Delivery Expenses Claim is paid under this policy or if Mother is covered under this policy for a continuous period of 12 months without break
- Intimation about the birth of the New Born should be given to the company and the coverage will be given to the New Born from the first day of its birth.
- Exclusion no.1 (Code-Excl 01), Exclusion no.2 (Code-Excl 02), Exclusion no.3 (Code-Excl 03) and Exclusion no.20 (Code-Excl 20) as stated under this policy shall not apply for the New Born baby cover.
- In the subsequent years, the New Born Baby will be covered up to the Sum Insured (without any underwriting and the entry age criteria), if the policy holder opts the coverage for New Born and pays the premium.
- Enhancement of sum insured is subject to underwriters approval

Sum Insured in Lakhs (Rs.)	Limit Per Policy Period (Rs.)
5,00,000/-, 10,00,000/-, 15,00,000/-, 20,00,000/-, 25,00,000/-	2,00,000
50,00,000/-, 75,00,000/-, 1,00,00,000/-, 2,00,00,000/-	4,00,000

Note: The above mentioned sub-limits will not apply for treatment related to congenital Internal disease / defects for the new born.

18. Treatment for Chronic Severe Refractory Asthma: In-patient hospitalization / Day Care treatment / Home Care Treatment/ Out-patient treatment expenses incurred for treatment of Chronic Severe Refractory Asthma by Advanced Medicine, if recommended by the treating Medical practitioner (Pulmonologist) is payable up to 10% of sum insured not exceeding Rs.5 lakhs per policy period.

19. Compassionate travel: In the event of the insured person being hospitalized for a life threatening emergency at a place away from his usual place of residence as recorded in the policy, the Company will reimburse the transportation expenses by air incurred upto Rs.10,000/- for one immediate family member(other than the travel companion) for travel towards the place where hospital is located, provided the claim for hospitalization is admissible under the policy.

20. Repatriation of Mortal Remains Following an admissible claim for hospitalization under the policy, the Company shall reimburse up to Rs.15,000/- in a policy year towards the cost of repatriation of mortal remains of the insured person (including the cost of embalming and coffin charges) to the residence of the Insured as recorded in the policy.

21. Treatment in Valuable service providers network: In the event of hospitalization in valuable service provider network, an amount calculated at 1% of Sum Insured subject to a maximum of Rs.5,000/- per policy period is payable as lump sum.

Note

- This benefit is payable only if there is an admissible claim for hospitalization under the policy.
- This benefit shall be paid if a hospital is a part of the Valuable service provider network list as on date of admission
- Payment under this benefit does not form part of the sum insured
- The Company shall not be responsible for the quality of the treatment in the Valuable Service Providers Network.
- FOR THE LIST OF VALUABLE SERVICE PROVIDERS NETWORK PLEASE VISIT OUR COMPANY WEBSITE www.starhealth.in**

22. Shared accommodation: If the Insured person occupies, a shared accommodation during in-patient hospitalization, then amount of Rs.1,000/- per day will be payable for each continuous and completed period of 24 hours of stay in such shared accommodation.

Note

- This benefit is payable only if there is an admissible claim for hospitalization under the policy

- ii) This benefit will not be applicable where the sanction is on package rates
 iii) Insured stay in Intensive Care Unit or High Dependency Units / wards will not be counted for this purpose

23. 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

- i. Yoga and Naturopathy systems of treatments are excluded from the scope of coverage under AYUSH treatment

24. Second Medical Opinion: The Insured Person can obtain a Second Medical Opinion from a Doctor in the Company's network of Medical Practitioners. All the medical records provided by the Insured Person will be submitted to the Doctor chosen by him/her online and the medical opinion will be made available directly to the Insured by the Doctor. To utilize this benefit, all medical records should be forwarded to the mail-id e_medicalopinion@starhealth.in or through Post/Courier.

Special Conditions:-

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

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

25. Coverage for Modern Treatment: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital upto sum insured (including Pre and Post hospitalization expenses) during the policy period;

- Uterine artery Embolization and HIFU
- Balloon Sinuplasty
- Deep Brain Stimulation
- Oral Chemotherapy
- Immunotherapy- Monoclonal Antibody to be given as injection
- Intra Vitreal injections
- Robotic surgeries
- Stereotactic radio surgeries
- Bronchical Thermoplasty
- Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- IONM-(Intra Operative Neuro Monitoring)
- Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions

26. Cumulative Bonus: The insured person will be eligible for Cumulative bonus calculated at 25% of sum insured for each claim free year and maximum up to 100% of the sum insured

Special Conditions

- The Cumulative bonus will be calculated on the expiring Sum Insured
- If the insured opts to reduce the Sum Insured at the subsequent renewal, the limit of indemnity by way of such Cumulative bonus shall not exceed such reduced sum insured
- In the event of a claim resulting in;
 - Partial utilization of Sum Insured, such cumulative bonus so granted will not be reduced
 - Full utilization of Sum Insured and nil utilization of cumulative bonus accrued, such cumulative bonus so granted will not be reduced
 - Full utilization of Sum Insured and partial utilization of cumulative bonus accrued, the cumulative bonus granted on renewal will be the balance cumulative bonus available and will be reduced at the same rate at which it has accrued
 - Full utilization of Sum Insured and full utilization of cumulative bonus accrued, the cumulative bonus on renewal will be "nil"

27. Automatic Restoration of Sum Insured: The policy provides automatic restoration of sum insured subject to the following condition;

- Sum Insured will be restored unlimited number of times and maximum up to 100% each time, which can be utilized for a subsequent hospitalization.
- The restoration will trigger immediately upon partial/ full utilization of the sum insured, which can be utilized for a subsequent hospitalization.
- On partial utilization of the Sum Insured, it will be restored up to extent of utilization.
- On full utilization of the Sum Insured, it will be restored to 100%.
- The Restored Sum Insured can be used for all claims including for modern treatment, but for a subsequent hospitalization.
- The maximum payable amount for a single claim under restoration benefit shall not be more than the Sum Insured.

Unlimited Restoration – illustration

If there are 2 insured members with Sum Insured of 10 Lacs each, lets understand how restoration benefit will apply to each under different circumstances.

		Insured 1	Insured 2
Sum Insured		Rs.10,00,000	Rs.10,00,000
	No Claim Bonus (NCB)	0	Rs.5,00,000
	Total Available amount	Rs.10,00,000	Rs.15,00,000 (Sum Insured 10 Lac + NCB 5 Lac)
1st Claim	1st Claim	Rs.5,00,000	Rs.5,00,000
	Claim paid amount	Rs.5,00,000	Rs.5,00,000
	Will the restoration kick in?	Rs.5,00,000 (Restored Sum Insured)	Rs.5,00,000 (Restored Sum Insured)
	Yes, Why - Since there is partial utilization of Sum Insured.	Rs.5,00,000 (Restored Sum Insured)	Rs.5,00,000 (Restored Sum Insured)
Available amount for next claim		Rs.10,00,000 (Restored SI 5Lac + Balance SI 5Lac)	Rs.15,00,000 (Restored SI 5Lac + Balance SI 5Lac+ NCB 5L)
2nd Claim	2nd Claim (For Same / different illness)	Rs.15,00,000	Rs.15,00,000
	Claim paid amount	Rs.10,00,000	Rs.15,00,000
	Will the restoration kick in?	Rs.10,00,000 (Restored Sum Insured)	Rs.10,00,000 (Restored Sum Insured)
	Yes, Why - Since there is full utilization of Sum Insured.	Rs.10,00,000 (Restored Sum Insured)	Rs.10,00,000 (Restored Sum Insured)
Available amount for next claim		Rs.10,00,000 (SI is Restored up to 100%)	Rs.10,00,000 (SI is Restored up to 100%)
3rd Claim	3rd Claim (For Same / different illness)	Rs.11,00,000	Rs.11,00,000
	Claim paid amount	Rs.10,00,000	Rs.10,00,000
	Will the restoration kick in?	Rs.10,00,000 (Restored Sum Insured)	Rs.10,00,000 (Restored Sum Insured)
	Yes, Why - Since there is full utilization of Sum Insured.	Rs.10,00,000 (Restored Sum Insured)	Rs.10,00,000 (Restored Sum Insured)

28. Rehabilitation and Pain Management: The company will pay the medical expenses for Rehabilitation and Pain Management up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less, per policy year.

Rehabilitation: The company will pay the expenses for rehabilitation, if availed at authorized centres as an In-patient/Out-patient, and if there is an admissible claim for In-patient hospitalization for an injury, disease or illness specified below.

- Poly Trauma
- Head injury
- Diseases of the spine
- Stroke

Pain Management treatment

S.No.	Name of the covered pain management treatment	Sub-limits (Per Policy year) (Rs.)	
	Sum Insured (Rs in Lac)	5 / 10 / 15 / 20	25 & Above
1	Lumbar and cervical medial branch block with RF ablation for lumbar and cervical facet joint arthritis	65,000/-	75,000/-
2	Caudal epidural injection for Discogenic pain	40,000/-	50,000/-
3	Lumbar and cervical selective nerve root block for Lumbar and Cervical radicular pain	50,000/-	60,000/-
4	Caudal Neuroplasty for Failed back spine surgery	85,000/-	1,00,000/-
5	Stellate ganglion ablation for upper limb CRPS	65,000/-	75,000/-
6	Occipital nerve Pulsed RF lesioning for Migraines, Cluster headache and cervicogenic headaches	65,000/-	75,000/-
7	Lumbar sympathetic chain RF ablation for lower limb CRPS, diabetic periphery painful neuropathy and Ischaemic limb pain	65,000/-	75,000/-
8	Gasserian ganglion ablation for Trigeminal neuralgia	65,000/-	75,000/-
9	Intercostal nerve Ablation for post thoracotomy pain and Thoracic malignancy pain	65,000/-	75,000/-
10	Coeliac plexus ablation for upper gastrointestinal malignancies pain	65,000/-	75,000/-

S.No.	Name of the covered pain management treatment	Sub-limits (Per Policy year) (Rs.)	
	Sum Insured (Rs in Lac)	5 / 10 / 15 / 20	25 & Above
11	Superior hypogastric plexus ablation for lower Gastro intestinal malignancies pain	65,000/-	75,000/-
12	Ganglion impar ablation for perineal cancer pain and coccydynia	65,000/-	75,000/-
13	Cooled RF ablation of genicular nerve for grade 1 and 2 osteoarthritis knee and hip	1,00,000/-	1,25,000/-
14	Suprascapular nerve RF ablation for rotator cuff partial tear and peri arthritis shoulder pain	65,000/-	75,000/-

Important Note:

(i) Rehabilitation and/or Pain management treatment can be taken only at the Authorized centres mentioned in the website – www.starhealth.in

29. Star Wellness Program: This program intends to promote, incentivize and to reward the Insured Persons' healthy life style through various wellness activities. The wellness activities as mentioned below are designed to help the Insured person to earn wellness reward points which will be tracked and monitored by the Company. The wellness points earned by the Insured Person(s) under the wellness program, can be utilized to get discount in premium.

This Wellness Program is enabled and administered online through Star Wellness Platform through Star Health customer mobile app "Star Power" and through "Star Health Customer Portal (digital platform)".

Note: The Wellness Activities mentioned in the table below (from Serial Number 1 to 5) are applicable for the Insured person(s) aged 18 years and above only.

The following table shows the discount on premium available under the Wellness Program;

Wellness Points Earned	Discount in Premium
200 to 350	4%
351 to 600	10%
601 to 750	14%
751 to 1000	20%

*In case of floater policy the weightage is given as per the following table

Family Size	Weightage
Self, Spouse	1:1
Self, Spouse and Dependent Children (up to 17 years)	1:1:0:0:0
Self, Spouse and Dependent Children (18 years and above)	2:2:1:1:1

Note: In case of two year policy, total number of wellness points earned in two year period will be divided by two.

*Please refer the Illustrations to understand the calculation of discount in premium, weightage and the calculation.

The wellness services and activities are categorized as below

Sr.No.	Activity	Maximum number of Wellness Points that can be earned under each activity in a policy year
1.	Manage and Track Health	
	a) Online Health Risk Assessment (HRA)	50
	b) Preventive Risk Assessment	200
2.	Affinity to Wellness	
	a) Participating in Walkathon, Marathon, Cyclothon and similar activities	100
	b) Membership in a health club (for 1 year or more)	100
3.	Stay Active - If the Insured member achieves the step count target on mobile app	200
4.	a) Weight Management Program (for the Insured who is Overweight/ Obese)	100
	b) Sharing Insured Fitness Success Story through adoption of Star Wellness Program (for the Insured who is not Overweight/ Obese)	50
5.	a) Chronic Condition Management Program (for the Insured who is suffering from Chronic Condition/s - Diabetes, Hypertension, Cardiovascular Disease or Asthma)	250
	b) On Completion of De-Stress & Mind Body Healing Program (for the Insured who is not suffering from Chronic Condition/s - Diabetes, Hypertension, Cardiovascular Disease or Asthma)	125

Sr.No.	Activity	Maximum number of Wellness Points that can be earned under each activity in a policy year
Additional Wellness Services		
6.	Star Tele-health services	
7.	Medical Concierge Services	
8.	Digital Health Vault	
9.	Wellness Content	
10.	Post-Operative Care	
11.	Discounts from Network Providers	

1. **Manage and Track Health**

a) **Completion of Health Risk Assessment (HRA):** The Health Risk Assessment (HRA) questionnaire is an online tool for evaluation of health and quality of life of the Insured. It helps the Insured to introspect his/ her personal lifestyle. The Insured can log into his/her account on the website www.starhealth.in and complete the HRA questionnaire. The Insured can undertake this once per policy year.

On Completion of online HRA questionnaire, the Insured earns 50 wellness points.

Note: To get the wellness points mentioned under HRA, the Insured has to complete the entire HRA within one month from the time he/she started HRA Activity.

b) **Preventive Risk Assessment:** The Insured can also earn wellness points by undergoing diagnostic / preventive tests during the policy year. These tests should include the four mandatory tests mentioned below. Insured can take these tests at any diagnostic centre at Insured's own expenses.

- If all the results of the submitted test reports are within the normal range, Insured earns 200 wellness points.
- If the result of any one test is not within the normal range as specified in the lab report, Insured earns 150 wellness points.
- If two or more test results are not within the normal range, Insured earns 100 wellness points only.

Note: These tests reports should be submitted together and within 30 days from the date of undergoing such Health Check-Up.

List of mandatory tests under Preventive Risk Assessment

1. Complete Haemogram Test
2. Blood Sugar (Fasting Blood Sugar (FBS) + Postprandial (PP) [or] HbA1c)
3. Lipid profile (Total cholesterol, HDL, LDL, Triglycerides, Total Cholesterol / HDL Cholesterol Ratio)
4. Serum Creatinine

2. **Affinity towards wellness:** Insured earns wellness points for undertaking any of the fitness and health related activities as given below

List of Fitness Initiatives and Wellness points

	Initiative	Wellness Points
a.	Participating in Walkathon, Marathon, Cyclothon and similar activities	100
	- On submission of BIB Number along with the details of the entry ticket taken to participate in the event.	
b.	Membership in a health club (for 1 year or more) - In a Gym / Yoga Centre / Zumba Classes / Aerobic Exercise/ Sports Club/ Pilates Classes/ Swimming / Tai Chi/ Martial Arts / Gymnastics/ Dance Classes	100

Note: In case if Insured is not a member of any health club, he/she should join into club within 3 months from the date of the policy risk commencement date. Insured person should submit the health club membership.

3. **Stay Active:** Insured earns wellness points on achieving the step count target on star mobile application as mentioned below

Average number of steps per day in a policy year	Wellness Points
- If the average number of steps per day in a policy year are between - 5000 and 7999	100
- If the average number of steps per day in a policy year are between - 8000 and 9999	150
- If the average number of steps per day in a policy year are - 10000 and above	200

Note

- First month and last month in each policy year will not be taken into consideration for calculation of average number of steps per day under Stay Active.
- The mobile app must be downloaded within 30 days of the policy risk start date to avail this benefit.
- The average step count completed by an Insured member would be tracked on star wellness mobile application.

4. *Weight Management Program*

- a) This Program will help the Insured persons with Over Weight and Obesity to manage their Body Mass Index (BMI) through the empanelled wellness experts who will guide the Insured in losing excess weight and maintain their BMI.
- On acceptance of the Weight Management Program, Insured earns 50 wellness points.
 - An additional 50 wellness points will be awarded in case if the results are achieved and maintained as mentioned below

Sr.No.	Name of the Ailment	Values to be submitted	Criteria to get the Wellness points
1.	Obesity (If BMI is above 29)	Height & Weight (to calculate BMI)	Achieving and maintaining the BMI between 18 and 29
2.	Overweight (If BMI is between 25 and 29)	Height & Weight (to calculate BMI)	Reducing BMI by two points and maintaining the same BMI in the policy year
- Values (for BMI) shall be submitted for every 2 months (up to 5 times in each policy year)			

- b) In case if the Insured is not Overweight / Obese, the Insured can submit his/her Fitness Success Story through adoption of Star Wellness Activities with us. On submission of the Fitness Success Story through adoption of Star Wellness Activities, Insured earns 50 wellness points.

5. *Chronic Condition Management Program*

- a) This Program will help the Insured suffering from Diabetes, Hypertension, Cardiovascular Disease or Asthma to track their health through the empanelled wellness experts who will guide the insured in maintaining/improving the health condition.
- On acceptance of the Chronic Condition Management Program, Insured earns 100 wellness points.
 - The Insured has to submit the test result values for every 3 months maximum up to 3 times in a policy year.
 - If the test result values are within +/- 10% range of the values given below, for at least 2 times in a policy year, an additional 150 wellness points will be awarded.
 - These tests reports to be submitted within 1 month from the date of undergoing the Health Check-Up

Sr.No.	Name of the Ailment	Test to be submitted	Values Criteria to get the additional Wellness points
1.	Diabetes (Insured can submit either HbA1c test value (or) Fasting Blood Sugar (FBS) Range and Postprandial test value)	HbA1c	£ 6.5
		Fasting Blood Sugar (FBS) Range and Postprandial test value	100 to 125 mg/dl below 160 mg/dl
2.	Hypertension	Measured with - BP apparatus	Systolic Range - 110 to 140 mmHg Diastolic Range - 70 to 90 mmHg
3.	Cardiovascular Disease	LDL Cholesterol and Total Cholesterol / HDL Cholesterol Ratio	100 to 159 mg/dl £ 4.0
4.	Asthma	PFT (Pulmonary Function Test)	FEV1 (PFC) is 75% or more FEV1/ FVC is 70% or more

- b) In case if the Insured is not suffering from Chronic Condition/s (Diabetes, Hypertension, Cardiovascular Disease or Asthma) he/she can opt for "De-Stress & Mind Body Healing Program". This program helps the Insured to reduce stress caused due to internal (self-generated) & external factors and increases the ability to handle stress.

- On acceptance of De-stress & Mind Body Healing Program Insured earns 50 wellness points.
- On completion of De-stress & Mind Body Healing Program Insured earns an additional 75 wellness points.

Note: This is a 10 weeks program which insured needs to complete without any break.

6. *Star Tele-health Services:* Insured can consult with the In-house Medical Practitioners between 8.00 am and 10.00 pm, who can help the Insured by providing Medical advice, Second Medical Opinion and consultation on Diet & Nutrition through Voice Call, Video Call & Online Chat provided in our Mobile App "Talk to Star" and for Consultation by Telephone (between 8.00 am to 10.00 pm) Insured can call to the phone number - 7676 905 905

7. *Medical Concierge Services:* The Insured can also contact Star Health to avail the following services - Emergency assistance information such as nearest ambulance / hospital / blood bank etc.

8. *Digital Health Vault:* A secured Personal Health records system for Insured to store/access and share health data with trusted recipients. Using this portal, Insured can store their health documents (prescriptions, lab reports, discharge summaries etc.), track health data add family members.

9. *Wellness Content:* The wellness portal provides rich collection of health articles, blogs, tips and other health and wellness content. The contents have been written by experts drawn from various fields. Insured will benefit from having one single and reliable source for learning about various health aspects and incorporating positive health changes.

10. *Post Operative Care:* It is done through follow up phone calls (primarily for surgical cases) for resolving their medical queries.

11. *Discounts from Network Providers:* The Insured can avail discounts on the services offered by our network providers which will be displayed in our website.

Terms and conditions under wellness activity

- Any information provided by the Insured in this regard shall be kept confidential.
- There will not be any cash redemption against the wellness reward points.
- Insured should notify and submit relevant documents, reports, receipts etc for various wellness activities within 1 month of undertaking such activity/test.
- For services that are provided through empanelled service provider, Star Health is only acting as a facilitator; hence would not be liable for any incremental costs or the services.
- All medical services are being provided by empanelled health care service provider. We ensure full due diligence before empanelment. However Insured should consult his/her doctor before availing/taking the medical advices/services. The decision to utilize these advices/services is solely at Insured person's discretion.
- We reserve the right to remove the wellness reward points if found to be achieved in unfair manner.
- Star Health, its group entities, or affiliates, their respective directors, officers, employees, agents, vendors, are not responsible or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which a Member claims to have suffered, sustained or incurred, by way of and / or on account of the Wellness Program.
- Services offered are subject to guidelines issued by IRDAI from time to time.

ILLUSTRATION OF BENEFITS

Lets look how the Insured can avail discount on premium through the "Star Wellness Program"

Scenario: A 50 year old Individual Suresh and his wife Lakshmi along with their two dependent children (aged below 18 yrs) buy a **Star Health Assure Insurance Policy** with Sum Insured 20 Lacs, let's understand how they can earn **Wellness Points** under the Floater Policy. Suresh has declared that he is suffering from Diabetes & Hypertension. Suresh has declared his Body Mass Index (BMI) as 30 & Lakshmi has declared her BMI as 25

Suresh and Lakshmi enrolled under the Star wellness program and completed the following **wellness activities**.

Sr. No	Name of the wellness activity taken up during the policy year	Wellness Points Earned by Suresh	Wellness Points Earned by Lakshmi
1.	Completed Online Health Risk Assessment (HRA)	50	50
2.	Submitted Health Check-Up Report	200	200
3.	Participation in Marathon	100	0
4.	Attended to Gym	100	100
5.	Achieved 10,000 average number of steps per day during the policy year	200	200
6.	Suresh accepted the Weight management program and reached 27 BMI Lakshmi accepted the Weight management program and reached 23 BMI	100	100
7.	Suresh Managed Diabetes & Hypertension through Chronic Condition Management Program; Lakshmi has completed De-stress & Mind Body Healing Program	250	125
Total Number of Wellness Points earned		1000	775
No of wellness points based upon weightage - 1:1		500 (1000X1/2)	388 (775X1/2)

Total Number of Wellness Points earned by Suresh and Lakshmi = 888 (500+388)
Based on the no of Wellness Points earned, Suresh & Lakshmi are eligible to get 20% discount on renewal premium

30. *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 person whose age at the time of entry is 61 years and above.

- 31. Optional Cover to choose deductible:** If the insured person chooses any of the following deductible, the Company will provide a discount on premium as per the table given below;

Sum Insured	Aggregate Deductible Option	Discount Offered
Up to Rs. 20 lakhs	Rs. 50,000/-	45%
	Rs. 1,00,000/-	55%
Above Rs. 20 lakhs	Rs. 50,000/-	35%
	Rs. 1,00,000/-	50%

Note: This deductible is applicable for every policy year (on Aggregate basis)

Illustration of deductible

If an Insured with 10 Lac Sum Insured opted for an aggregate deductible of Rs.50,000 in a year, lets understand how this deductible will be applied

First Policy Year

Sum Insured	Rs. 10,00,000/- (Opted Deductible is Rs. 50,000/-)
What does opting a deductible mean	Coverage will start once the Insured incurs single / multiple claims that add up to the deductible amount in a policy year
1st Claim (Injury due to Accident)	Rs. 50,000/- (Not paid by us as it is within Deductible limit)
Balance Sum Insured	Rs. 10,00,000/-
2nd Claim (Dengue fever)	Rs. 65,000/- (Payable as the deductible limit of Rs. 50,000/- is already exhausted in the policy year)
Balance Sum Insured	Rs. 9,35,000/-
3rd Claim (Bacterial Gastroenteritis)	Rs. 55,000/- (Payable as the deductible limit of Rs. 50,000/- is already exhausted in the policy year)
Balance Sum Insured	Rs. 8,80,000/-

List of Benefits which are part of sum insured and in addition to sum insured

Sl.No.	Coverage	Forming Part of Sum Insured / In addition to Sum Insured
1	Room Rent , Boarding, Nursing Expenses, Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees, Anesthesia, Blood, Oxygen, Operation theatre charges, ICU charges, Surgical appliances, Medicines and Drugs, Diagnostic materials and X-ray, Diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses.	Forming Part of Sum Insured
2	All day care treatments	Forming Part of Sum Insured
3	Coverage for Non-medical items (Consumables)	Forming Part of Sum Insured
4	Emergency Road ambulance	Forming Part of Sum Insured
5	Air Ambulance	Forming Part of Sum Insured
6	Pre-hospitalization Expenses	Forming Part of Sum Insured
7	Post Hospitalization Expenses	Forming Part of Sum Insured
8	Domiciliary Hospitalisation	Forming Part of Sum Insured
9	Organ Donor Expenses	Forming Part of Sum Insured
10	Complications necessitating Redo surgery or ICU admission for the Organ donor	In addition to Sum Insured
11	Health Check Up Assure	In addition to Sum Insured
12	Home care treatment	Forming Part of Sum Insured
13	Delivery Expenses	Forming Part of Sum Insured
14	In Utero Fetal Surgery/Intervention	Forming Part of Sum Insured
15	Assisted Reproduction Treatment	Forming Part of Sum Insured
16	Hospitalisation expenses for Treatment of New Born Baby	Forming Part of Sum Insured
17	Compassionate Travel	In addition to Sum Insured
18	Repatriation of Mortal Remains	In addition to Sum Insured
19	Treatment in Valuable Service Providers Network	In addition to Sum Insured
20	Shared Accommodation	In addition to Sum Insured

List of Benefits which are part of sum insured and in addition to sum insured

Sl.No.	Coverage	Forming Part of Sum Insured / In addition to Sum Insured
21	AYUSH Treatment	Forming Part of Sum Insured
22	Coverage for Modern Treatment	Forming Part of Sum Insured
23	Automatic Restoration of Sum Insured:	In addition to Sum Insured
24	Treatment for Chronic Severe Refractory Asthma	Forming Part of Sum Insured
25	Rehabilitation and Pain Management	Forming Part of Sum Insured

C. EXCLUSIONS

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

STANDARD EXCLUSIONS

1. Pre-Existing Diseases - Code Excl 01

- A. **Applicable for 3 year policy term:** Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 30 months of continuous coverage after the date of inception of the first policy with insurer.

If the insured chooses for 1 year or 2 year policy term

Applicable for 1 year and 2 year policy term: 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

- B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- C. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- D. **Applicable for 3 year policy term:** Coverage under the policy after the expiry of 30 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.
- Applicable for 1 year and 2 year policy term:** 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

- A. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- C. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
- D. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- E. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- F. List of specific diseases/procedures
1. Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, Diseases related to Thyroid, Benign diseases of the breast.
 2. Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal Tunnel Syndrome, Trigger Finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology
 3. All treatments (Conservative, Operative treatment) and all types of intervention for Diseases related to Tendon, Ligament, Fascia, Bones and Joint Including Arthroscopy and Arthroplasty / Joint Replacement [other than caused by accident].
 4. All types of treatment for Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system, Prolapse of Intervertebral Disc (other than caused by accident),
 5. All treatments (conservative, interventional, laparoscopic and open) related to Hepato-pancreato-biliary diseases including Gall bladder and Pancreatic calculi. All types of management for Kidney calculi 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 - [except for Unborn in Coverage (15) and New Born in Coverage (17)]

Note: Waiting period for the following benefits are as follows

- a. **Delivery Expenses Cover:** Benefit under this section is subject to a waiting period of 24 months from the date of first commencement of Star Health Assure Insurance policy and its continuous renewal thereof with the Company
 - b. **In Utero Fetal Surgery / Intervention:** The Company will pay the expenses incurred for In Utero Fetal Surgeries and Procedures mentioned below after the waiting period of 24 months from the date of inception of this policy
Note: The above mentioned waiting period will not apply for treatment related to congenital Internal disease / defects for the Unborn.
 - c. **Assisted Reproduction Treatment:** A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person
 - d. **New Born Baby Cover:** This cover is available only If Delivery Expenses Claim is paid under this policy or if Mother is covered under this policy for a continuous period of 12 months without break
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 (except to the extent covered under Coverage 28) 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 eyesight due to refractive error less than 7.5 dioptres.
16. **Unproven Treatments - Code Excl 16:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
17. **Sterility and Infertility (except to the extent covered under Coverage 16) - 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 (except to the extent covered under Coverage 14)**
 - i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - ii. 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(except to the extent covered under Coverage 17) - **Code Excl 20**
21. Convalescence, general debility, run-down condition, Nutritional deficiency states - **Code Excl 21**
22. Intentional self-injury - **Code Excl 22**
23. Injury/disease caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) - **Code Excl 24**
24. Injury or disease caused by or contributed to by nuclear weapons/ materials - **Code Excl 25**
25. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion - **Code Excl 26**
26. Unconventional, Untested, Experimental therapies - **Code Excl 27**
27. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy - **Code Excl 28**
28. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalization warranted - **Code Excl 29**
29. Inoculation or Vaccination (except for post-bite treatment and for medical treatment for therapeutic reasons) - **Code Excl 31**
30. Cost of spectacles and contact lens, hearing aids, Cochlear implants and procedures, walkers and crutches, wheel chairs, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis, infusion pump and such other similar aids - **Code Excl 35**
31. Any hospitalization which are not medically necessary / does not warrant hospitalization - **Code Excl 36**
32. Existing disease/s, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), for specified ICD codes - **Code Excl 38**

D. CONDITIONS

STANDARD CONDITIONS

1. **Disclosure of Information:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
2. **Claim Settlement**
 - A. **Condition Precedent to Admission of Liability:** The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy
 - B. **For Cashless Treatment**
 - 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 180 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

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

3. Provision for Penal Interest

- i) The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document
- ii) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate
- iii) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document
- iv) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim
- v) "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

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

5. Multiple Policies

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

- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy
- iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount
- iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

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

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

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

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

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

7. Cancellation

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

Cancellation table applicable for Policy Term 1 Year without installment option

Period on risk	Rate of premium to be retained
Up to one mth	22.5% of the policy premium
Exceeding one mth up to 3 mths	37.5% of the policy premium
Exceeding 3 mths up to 6 mths	57.5% of the policy premium
Exceeding 6 mths up to 9 mths	80% of the policy premium
Exceeding 9 mths	Full of the policy premium

Cancellation table applicable for Policy Term 1 Year with installment option of Half-yearly premium payment frequency

Period on risk	Rate of premium to be retained
Up to 1 Mth	45% of the total premium received
Exceeding one mth up to 4 mths	87.5% of the total premium received
Exceeding 4 mths up to 6 mths	100% of the total premium received
Exceeding 6 mths up to 7 mths	65% of the total premium received
Exceeding 7 mths up to 10 mths	85% of the total premium received
Exceeding 10 mths	100% of the total premium received

Cancellation table applicable for Policy Term 1 Year with installment option of Quarterly premium payment frequency

Period on risk	Rate of premium to be retained
Up to 1 Mth	87.5% of the total premium received
Exceeding one mth up to 3 mths	100% of the total premium received
Exceeding 3 mths up to 4 mths	87.5% of the total premium received
Exceeding 4 mths up to 6 mths	100% of the total premium received
Exceeding 6 mths up to 7 mths	85% of the total premium received
Exceeding 7 mths up to 9 mths	100% of the total premium received
Exceeding 9 mths up to 10 mths	85% of the total premium received
Exceeding 10 mths	100% of the total premium received

Cancellation table applicable for Policy Term 2 Year

Period on risk	Rate of premium to be retained
Up to 1 Mth	17.5% of the policy premium
Exceeding one mth up to 3 mths	25% of the policy premium
Exceeding 3 mths up to 6 mths	37.5% of the policy premium
Exceeding 6 mths up to 9 mths	47.5% of the policy premium
Exceeding 9 mths up to 12 mths	57.5% of the policy premium
Exceeding 12 mths up to 15 mths	67.5% of the policy premium
Exceeding 15 mths up to 18 mths	80% of the policy premium
Exceeding 18 mths up to 21 mths	90% of the policy premium
Exceeding 21 mths	Full of the policy premium

Cancellation table applicable for Policy Term 3 Year

Period on risk	Rate of premium to be retained
Up to 1 Mth	17.5% of the policy premium
Exceeding one mth up to 3 mths	22.5% of the policy premium
Exceeding 3 mths up to 6 mths	30% of the policy premium
Exceeding 6 mths up to 9 mths	37.5% of the policy premium
Exceeding 9 mths up to 12 mths	42.5% of the policy premium
Exceeding 12 mths up to 15 mths	50% of the policy premium
Exceeding 15 mths up to 18 mths	57.5% of the policy premium
Exceeding 18 mths up to 21 mths	65% of the policy premium
Exceeding 21 mths up to 24 mths	72.5% of the policy premium
Exceeding 24 mths up to 27 mths	80% of the policy premium
Exceeding 27 mths up to 30 mths	85% of the policy premium
Exceeding 30 mths up to 33 mths	92.5% of the policy premium
Exceeding 33 mths	Full of the policy premium

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

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

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

For Detailed Guidelines on migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

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

For Detailed Guidelines on portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

10. **Renewal of policy:** The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.
 - i) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
 - ii) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
 - iii) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
 - iv) 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.
 - v) Coverage is not available during the grace period.
 - vi) No loading shall apply on renewals based on individual claims experience

11. Withdrawal of policy

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

12. **Moratorium Period:** After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

13. **Premium Payment in Instalments:** If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly or Quarterly or as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

- i. Grace Period of 7 days would be given to pay the instalment premium due for the policy.
- ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
- iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
- iv. No interest will be charged if the instalment premium is not paid on due date.
- v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

14. **Possibility of Revision of Terms of the Policy Including the Premium Rates:** The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

15. **Free Look Period:** The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

16. **Redressal of Grievance:** In case of any grievance the insured person may contact the Company through

Website : www.starhealth.in

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

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

Senior Citizens may call at 044-69007500

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

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

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

For updated details of grievance officer, kindly refer the link

<https://www.starhealth.in/grievance-redressal>

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

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

17. **Nomination:** The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

SPECIFIC CONDITIONS

18. The Insured Person/s shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim.
19. All claims under this policy shall be payable in Indian currency
20. The premium under this policy shall be payable in advance. No receipt of premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance of fulfillment of the terms, provision, conditions and endorsements of this policy by the Insured Person/s, in so far as they relate to anything to be done or complied with by the Insured Person/s, shall be a condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions, and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of the Company.
21. Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged injury or diseases requiring Hospitalization when and as often as the same may reasonably be required on behalf of the Company at Company's cost.
22. **Notice and communication:** Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile/email to Star Health and Allied Insurance Company Limited, No.1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai 600034. Customer Care No. 044-69006900 or Toll Free No. 1800 425 2255, e-mail: support@starhealth.in
Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.
23. **Territorial Limit :** All investigations/treatments under this policy shall have to be taken in India.
24. **Automatic Termination:** The insurance under this policy with respect to each relevant Insured Person policy shall expire immediately on the earlier of the following events
- ✓ Upon the death of the Insured Person This means that, the cover for the surviving members of the family will continue, subject to other terms of the policy.
 - ✓ Upon exhaustion of the Sum Insured, Limit of Coverage, Limit of Coverage plus Restore Sum Insured.
25. **Policy disputes:** Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.
26. **Arbitration:** If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single

arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

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

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

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

27. **Revision of Sum Insured:** Reduction or enhancement of Sum Insured is permissible only at the time of renewal. The acceptance for enhancement and the amount of enhancement will be at the discretion of the Company and subject to **Exclusion Code Excl 01, Exclusion Code Excl 02 and Exclusion Code Excl 03.**
28. **Relief under Section 80-D:** Insured Person is eligible for relief under Section 80-D of the IT Act in respect of the premium paid by any mode other than cash
29. **Important Note**
- a) Where the policy is issued for more than 1 year, the Sum Insured including sublimits, automatic restoration benefit (if applicable), is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year or 3rd year cannot be utilized in the 1st year itself. The terms, conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each policy year
 - b) Where the policy is issued on floater basis, the Sum Insured, cumulative bonus and other related benefits floats amongst the insured members
 - c) The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws
 - d) The terms, conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each relevant insured person. Failure to comply with may result in the claim being denied
 - e) The attention of the policy holder is drawn to our website www.starhealth.in for anti fraud policy of the company for necessary compliance by all stake holders
30. **Customer Service:** If at any time the Insured Person requires any clarification or assistance, the insured may contact No.1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai 600034, during normal business hours.

The Health Insurance Specialist



**Health
Insurance**

The Health Insurance Specialist

List of Insurance Ombudsman

<p>AHMEDABAD</p> <p>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> <p>JURISDICTION: Gujarat, Dadra & Nagar Haveli, Daman and Diu.</p>	<p>BENGALURU</p> <p>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> <p>JURISDICTION: Karnataka.</p>	<p>BHOPAL</p> <p>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> <p>JURISDICTION: Madhya Pradesh Chattisgarh.</p>	<p>BHUBANESWAR</p> <p>Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in</p> <p>JURISDICTION: Odisha.</p>
<p>CHANDIGARH</p> <p>Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in</p> <p>JURISDICTION: Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.</p>	<p>CHENNAI</p> <p>Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in</p> <p>JURISDICTION: Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).</p>	<p>DELHI</p> <p>Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in</p> <p>JURISDICTION: Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.</p>	<p>ERNAKULAM</p> <p>Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in</p> <p>JURISDICTION: Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.</p>
<p>GUWAHATI</p> <p>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</p> <p>JURISDICTION: Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.</p>	<p>HYDERABAD</p> <p>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</p> <p>JURISDICTION: Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.</p>	<p>JAIPUR</p> <p>Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in</p> <p>JURISDICTION: Rajasthan.</p>	<p>KOLKATA</p> <p>Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in</p> <p>JURISDICTION: West Bengal, Sikkim, Andaman & Nicobar Islands.</p>
<p>LUCKNOW</p> <p>Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in</p> <p>JURISDICTION: 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, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.</p>	<p>MUMBAI</p> <p>Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in</p> <p>JURISDICTION: Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).</p>	<p>NOIDA</p> <p>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>JURISDICTION: State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, 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</p> <p>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>JURISDICTION: Bihar, Jharkhand.</p>
			<p>PUNE</p> <p>Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in</p> <p>JURISDICTION: Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).</p>

Kindly refer our website, for future updates in Ombudsman address

LIST I — ITEMS FOR WHICH COVERAGE IS AVAILABLE IN THE POLICY

SI.NO.	ITEM	SI.NO.	ITEM	SI.NO.	ITEM
1	BABY FOOD	24	ATTENDANT CHARGES	47	LUMBO SACRAL BELT
2	BABY UTILITIES CHARGES	25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	48	NIMBUS BED OR WATER OR AIR BED CHARGES
3	BEAUTY SERVICES	26	BIRTH CERTIFICATE	49	AMBULANCE COLLAR
4	BELTS/ BRACES	27	CERTIFICATE CHARGES	50	AMBULANCE EQUIPMENT
5	BUDS	28	COURIER CHARGES	51	ABDOMINAL BINDER
6	COLD PACK/HOT PACK	29	CONVEYANCE CHARGES	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
7	CARRY BAGS	30	MEDICAL CERTIFICATE	53	SUGAR FREE Tablets
8	EMAIL / INTERNET CHARGES	31	MEDICAL RECORDS	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
9	FOOD CHARGES(OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	32	PHOTOCOPIES CHARGES	55	ECG ELECTRODES
10	LEGGINGS	33	MORTUARY CHARGES	56	GLOVES
11	LAUNDRY CHARGES	34	WALKING AIDS CHARGES	57	NEBULISATION KIT
12	MINERAL WATER	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
13	SANITARY PAD	36	SPACER	59	KIDNEY TRAY
14	TELEPHONE CHARGES	37	SPIROMETRE	60	MASK
15	GUEST SERVICES	38	NEBULIZER KIT	61	OUNCE GLASS
16	CREPE BANDAGE	39	STEAM INHALER	62	OXYGEN MASK
17	DIAPER OF ANY TYPE	40	ARMSLING	63	PELVIC TRACTION BELT
18	EYELET COLLAR	41	THERMOMETER	64	PAN CAN
19	SLINGS	42	CERVICAL COLLAR	65	TROLLEY COVER
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	43	SPLINT	66	UROMETER, URINE JUG
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	44	DIABETIC FOOT WEAR	67	AMBULANCE
22	TELEVISION CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)	68	VASOFIX SAFETY
23	SURCHARGES	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER		

ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES

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

ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES

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

ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT

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

SCHEDULE OF BENEFITS

S.No	Sum Insured (INR)	5 lacs	10 lacs	15 lacs	20 lacs	25 lacs	50 lacs	75 lacs	1 Crore	2 Crore
1	Room, Boarding and Nursing charges	Up to 1% of Sum Insured per day	Any Room (Except suite or above category)	Any Room (Except suite or above category)	Any Room (Except suite or above category)	Any Room (Except suite or above category)	Any room	Any room	Any room	Any room
2	ICU/Operation Theatre Charges	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
3	Road Ambulance Charges (per policy period)	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
4	Air Ambulance (per policy year)	up to 10% of sum insured	up to 10% of sum insured	up to 10% of sum insured	up to 10% of sum insured	up to 10% of sum insured	up to 10% of sum insured	up to 10% of sum insured	up to 10% of sum insured	up to 10% of sum insured
5	Pre Hospitalisation Expenses incurred	Up to 60 days	Up to 60 days	Up to 60 days	Up to 60 days	Up to 60 days	Up to 60 days	Up to 60 days	Up to 60 days	Up to 60 days
6	Post Hospitalisation Expenses incurred	Up to 180 days	Up to 180 days	Up to 180 days	Up to 180 days	Up to 180 days	Up to 180 days	Up to 180 days	Up to 180 days	Up to 180 days
7	Domiciliary Hospitalization	Coverage for medical treatment (Including AYUSH) for a period exceeding three days	Coverage for medical treatment (Including AYUSH) for a period exceeding three days	Coverage for medical treatment (Including AYUSH) for a period exceeding three days	Coverage for medical treatment (Including AYUSH) for a period exceeding three days	Coverage for medical treatment (Including AYUSH) for a period exceeding three days	Coverage for medical treatment (Including AYUSH) for a period exceeding three days	Coverage for medical treatment (Including AYUSH) for a period exceeding three days	Coverage for medical treatment (Including AYUSH) for a period exceeding three days	Coverage for medical treatment (Including AYUSH) for a period exceeding three days
8	Organ Donor Expenses	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
9	Health Checkup Assure-Individual sum Insured (up to)	1,500/-	2,000/-	4,000/-	5,000/-	5,000/-	5,000/-	8,000/-	8,000/-	8,000/-
10	Health Checkup Assure-Floater sum Insured (up to)	2,500/-	5,000/-	8,000/-	10,000/-	10,000/-	10,000/-	15,000/-	15,000/-	15,000/-
11	Home care treatment	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year
12	Delivery Charges - Normal Delivery and Caesarean Section	up-to 10% of the Sum Insured is payable	up-to 10% of the Sum Insured is payable	up-to 10% of the Sum Insured is payable	up-to 10% of the Sum Insured is payable	up-to 10% of the Sum Insured is payable	up-to 10% of the Sum Insured is payable	up-to 10% of the Sum Insured is payable	up-to 10% of the Sum Insured is payable	up-to 10% of the Sum Insured is payable
13	Waiting Period for Delivery - Normal Delivery and Caesarean Section	24 months for first delivery from first inception of the policy	24 months for first delivery from first inception of the policy	24 months for first delivery from first inception of the policy	24 months for first delivery from first inception of the policy	24 months for first delivery from first inception of the policy	24 months for first delivery from first inception of the policy	24 months for first delivery from first inception of the policy	24 months for first delivery from first inception of the policy	24 months for first delivery from first inception of the policy
14	In Utero Fetal Surgery/Intervention	24 months waiting period	24 months waiting period	24 months waiting period	24 months waiting period	24 months waiting period	24 months waiting period	24 months waiting period	24 months waiting period	24 months waiting period
15	Assisted Reproduction Treatment (per policy year)	1,00,000/-	2,00,000/-	2,00,000/-	2,00,000/-	2,00,000/-	4,00,000/-	4,00,000/-	4,00,000/-	4,00,000/-
16	Hospitalization expenses for treatment of New Born Baby (per policy period)	2,00,000/-	2,00,000/-	2,00,000/-	2,00,000/-	2,00,000/-	4,00,000/-	4,00,000/-	4,00,000/-	4,00,000/-
17	Treatment for Chronic Severe Refractory Asthma (per policy period)	Up to 10% of sum insured not exceeding Rs.5 lakhs	Up to 10% of sum insured not exceeding Rs.5 lakhs	Up to 10% of sum insured not exceeding Rs.5 lakhs	Up to 10% of sum insured not exceeding Rs.5 lakhs	Up to 10% of sum insured not exceeding Rs.5 lakhs	Up to 10% of sum insured not exceeding Rs.5 lakhs	Up to 10% of sum insured not exceeding Rs.5 lakhs	Up to 10% of sum insured not exceeding Rs.5 lakhs	Up to 10% of sum insured not exceeding Rs.5 lakhs
18	Compassionate Travel	Upto Rs.10,000/-	Upto Rs.10,000/-	Upto Rs.10,000/-	Upto Rs.10,000/-	Upto Rs.10,000/-	Upto Rs.10,000/-	Upto Rs.10,000/-	Upto Rs.10,000/-	Upto Rs.10,000/-
19	Repatriation of Mortal Remains (per policy period)	Up to Rs.15,000/-	Up to Rs.15,000/-	Up to Rs.15,000/-	Up to Rs.15,000/-	Up to Rs.15,000/-	Up to Rs.15,000/-	Up to Rs.15,000/-	Up to Rs.15,000/-	Up to Rs.15,000/-
20	Treatment in Valuable service providers network (per policy period)	1% of Sum Insured subject to a maximum of Rs.5,000/-	1% of Sum Insured subject to a maximum of Rs.5,000/-	1% of Sum Insured subject to a maximum of Rs.5,000/-	1% of Sum Insured subject to a maximum of Rs.5,000/-	1% of Sum Insured subject to a maximum of Rs.5,000/-	1% of Sum Insured subject to a maximum of Rs.5,000/-	1% of Sum Insured subject to a maximum of Rs.5,000/-	1% of Sum Insured subject to a maximum of Rs.5,000/-	1% of Sum Insured subject to a maximum of Rs.5,000/-

SCHEDULE OF BENEFITS

S.No	Sum Insured (INR)	5 lacs	10 lacs	15 lacs	20 lacs	25 lacs	50 lacs	75 lacs	1 Crore	2 Crore
21	Shared accommodation	Rs.1,000/- per day	Rs.1,000/- per day	Rs.1,000/- per day	Rs.1,000/- per day	Rs.1,000/- per day	Rs.1,000/- per day	Rs.1,000/- per day	Rs.1,000/- per day	Rs.1,000/- per day
22	AYUSH Treatment	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals
23	Second Medical Opinion	Available	Available	Available	Available	Available	Available	Available	Available	Available
24	Coverage for Modern Treatment	Upto sum insured	Upto sum insured	Upto sum insured	Upto sum insured	Upto sum insured	Upto sum insured	Upto sum insured	Upto sum insured	Upto sum insured
25	Cumulative Bonus	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured
26	Automatic Restoration of Sum Insured	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.
27	Rehabilitation and Pain Management (per policy year)	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less
28	Wellness Program	Available	Available	Available	Available	Available	Available	Available	Available	Available
29	Co-Payment (Applicable only for insured persons aged 61 years and above at the time of entry)	subject to co-payment of 10% of each and every claim amount	subject to co-payment of 10% of each and every claim amount	subject to co-payment of 10% of each and every claim amount	subject to co-payment of 10% of each and every claim amount	subject to co-payment of 10% of each and every claim amount	subject to co-payment of 10% of each and every claim amount	subject to co-payment of 10% of each and every claim amount	subject to co-payment of 10% of each and every claim amount	subject to co-payment of 10% of each and every claim amount
30	Day Care Treatments	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals

Benefit Illustration in respect of policies offered on individual and family floater basis

Age of the Members insured (in yrs)	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, (if any)	Premium After Discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount, (if any)	Premium After Discount (Rs.)	Sum Insured (Rs.)
Illustration 1										
63	31,872	10,00,000	31,872	Nil	31,872	10,00,000	57,460	6,202	51,258	10,00,000
58	25,588	10,00,000	25,588		25,588	10,00,000				
Total Premium for all members of the family is Rs.57,460/- , when each member is covered separately. Sum insured available for each individual is Rs.10,00,000/-			Total Premium for all members of the family is Rs.57,460/- , when they are covered under a single policy. Sum insured available for each family member is Rs.10,00,000/-				Total Premium when policy is opted on floater basis is Rs.51,258/- Sum insured of Rs.10,00,000/- is available for the entire family (2A)			
Illustration 2										
54	19,787	10,00,000	19,787	Nil	19,787	10,00,000	57.247	13,084	44,163	10,00,000
51	19,787	10,00,000	19,787		19,787	10,00,000				
17	5,891	10,00,000	5,891		5,891	10,00,000				
15	5,891	10,00,000	5,891		5,891	10,00,000				
13	5,891	10,00,000	5,891		5,891	10,00,000				
Total Premium for all members of the family is Rs.57.247/- , when each member is covered separately. Sum insured available for each individual is Rs.10,00,000/-			Total Premium for all members of the family is Rs.57.247/- , when they are covered under a single policy. Sum insured available for each family member is Rs.10,00,000/-				Total Premium when policy is opted on floater basis is Rs.44,163/- Sum insured of Rs.10,00,000/- is available for the entire family (2A+3C)			

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

A-Adult | C-Child