STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New York Street, Nelavar Kottam High Road, Nungambakkam, Chennai - 600 034. ★ Phone : 044 - [illegible] ★ Email : [illegible]
Website : www.starhealth.in ★ CIN : U66010TN2005PLC056649 ★ IRDAI Regn. No. : 129

Kind Attention: Policyholder

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

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

Customer Information Sheet - Young Star Insurance Policy

Unique Identification No.: [illegible]

Sl. No.	Title:	Description	Refer to Policy Clause Number
	Product Name:	Young Star Insurance Policy	
1	What am I covered for:	Coverage Applicable for both Silver and Gold Plan	
		a. In-patient Treatment: Expenses for hospitalization expenses for period more than 24 hrs	5(A)(i)(C)
		b. Emergency Road Ambulance: Expenses incurred for transportation of the insured person by private ambulance service to get to the hospital and in any condition from one hospital to another hospital	4(C)
		c. Pre-Hospitalization: Medical Expenses incurred up to 30 days prior to the date of hospitalization	5(D)
		d. Post-Hospitalization: Medical Expenses incurred up to 180 days from the date of discharge from the hospital	5(E)
		e. All Day care procedures are covered	5(G)
		f. In Medical Opinion: The Insured Person is given the facility of obtaining a "2nd Medical Opinion" from the Company's empanelled	4(H)
		g. Health check Up: Expenses incurred towards cost of health check up up to the limits mentioned	4(I)
		h. Automatic Restoration: Automatic restoration of the Basic Sum Insured by 100% once during the policy period, immediately upon payment/full utilization of the limit of coverage	6(J)
		i. Cumulative Bonus: The insured person will be eligible for Cumulative bonus calculated at 20% of basic sum insured for each claim free year subject to a maximum of 100% of the basic sum insured	6(K)
		j. Additional Basic Sum Insured for Road Traffic Accident (RTA): If the insured person meets with a Road Traffic Accident resulting in in-patient hospitalization, then the Basic Sum Insured shall be increased by 25% subject to a maximum of Rs. 10 lakhs	6(L)
		k. Star Wellness Program: Financial discount for healthy life style	5(M)
		l. Coverage for Modern treatment	4(N)
		Coverage Applicable only for Gold Plan	
		a. Delivery Expenses: Expenses for a Delivery including Delivery by Caesarean section (including pre-natal and post natal expenses) upto Rs.30,000/- per delivery is payable	5(K)
		b. Hospital Cash Benefit: The Company will pay a Cash Benefit of Rs.1,000/- for each completed day of hospitalization subject to a maximum of 7 days per hospitalization and 14 days per policy period	4(R)
2	What are the Major Exclusions in the policy	i. Any hospital admission primarily for investigation/diagnostic purpose	5(H)
		ii. Pregnancy, infertility	5(I)(7) and 5(I)(8)
		iii. Domiciliary treatment, treatment outside India	5(D)(6)
		iv. Circumcision, sex change surgery, cosmetic surgery & plastic surgery	5(I)(5), 5(I)(7), 5(I)(9)
		v. Refractive error correction, hearing impairment correction, correction & cosmetic dental surgeries	5(I)(10), 5(C)(2)
		vi. Substance abuse, self inflicted injuries	5(I)(12), 5(I)(2)
		vii. Hazardous sports, war, invasion, civil war or breach of law	5(I)(3), 5(I)(13), 5(I)(4)
		viii. Any kind of service charges, surcharge, admission fees, registration fees levied by the hospital	5(D)(4)
		(Note: the above is a partial listing of the policy exclusions. Please refer to the policy clauses for the full listing)	
3	Waiting Periods	Initial Waiting Period: 30 days	5(D)
		Specific waiting period: 12 months	5(D)
		Pre existing diseases: 12 months	5(D)
4	Payment basis	Reimbursement of covered expenses up to specified limits	5(A)(i)(C)
		Fixed amount on the occurrence of a covered event	5(B)

Sl. No.	Title	Description	Refer to Policy Clause Number
5	Loss Sharing	In case of a claim, this policy requires you to share the following costs Expenses exceeding the following: Sublimits 1. Room/ICU charges 2. For the following specified diseases 3. Deductible of one day 4. % of each claim as Co-payment	II(i) II(ii) Note under III(I)(1) Nil
6	Renewal Conditions	Lifelong Renewal Grace period of 30 days for renewing the policy is provided	V(13)
7	Renewal Benefits	Health Checkup: Expenses incurred for health check-up up to the limits mentioned in the table Cumulative Bonus: Cumulative bonus calculated at 20% of basic sum insured for each claim free year subject to a maximum of 100% of the basic sum insured	II(i) and II(ii)
8	Cancellation	The Company may cancel this policy on grounds of misrepresentation, fraud, moral hazard, non disclosure of material fact	V(7)
9	Claims	For Cashless Service For Reimbursement of claim	V(2)(i) & V(2)(ii)
10	Policy servicing /Grievances /Complaints	Company Officials BO/RO/CMO/Call Centre) Ombudsman [Note: Please provide the contact details, toll free numbers email]	V(16) and V(22)
11	Insured's Rights	Free Look	V(17)
		Implied renewability	V(13)
		Migration and Portability	V(8) and V(9)
		Increase in SI during policy term	Nil
		Turn Around Time (TAT) for issue of Pre-Auth	2 hrs from the time of receipt of all necessary relevant documents
12	Instalment Option	Instalment option is available	V(11)
13	Insured's Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.	V(1)
		Disclosure of Material Information during the policy period such as change in occupation (Note: If applicable, please provide details of the format & to whom the same is to be sent)	Not Applicable

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

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 - For Silver Plan										
54	15,515	5,00,000	15,515	Nil	15,515	5,00,000	27,945	3,210	24,735	5,00,000
58	12,430	5,00,000	12,430		12,430	5,00,000				
	Total Premium for all members of the family is Rs.27,945/-, when each member is covered separately. Sum Insured available for each individual is Rs. 5,00,000/-		Total Premium for all members of the family is Rs.27,945/-, when they are covered under a single policy. Sum Insured available for each family member is Rs.5,00,000/-				Total Premium when policy is opted on floater basis is Rs.24,735/- Sum Insured of Rs.5,00,000/- is available for the entire family (2A)			
Illustration 2 - For Silver Plan										
47	8,345	5,00,000	8,345	Nil	8,345	5,00,000	19,295	[illegible]	[illegible]	5,00,000
44	6,395	5,00,000	6,395		6,395	5,00,000				
19	4,555	5,00,000	4,555		4,555	5,00,000				
	Total Premium for all members of the family is Rs.19,295/-, when each member is covered separately. Sum Insured available for each individual is Rs. 5,00,000/-		Total Premium for all members of the family is Rs.19,295/-, when they are covered under a single policy. Sum Insured available for each family member is Rs.5,00,000/-				Total Premium when policy is opted on floater basis is Rs.[illegible]/- Sum Insured of Rs.5,00,000/- is available for the entire family (2A+1C)			

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

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YOUNG STAR INSURANCE POLICY

Unique Identification No.: SHAHLIP22039V042122

PREAMBLE

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

I. DEFINITIONS

STANDARD DEFINITIONS

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

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

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

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

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

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

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

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 –

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

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

i. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours.

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

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.

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

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

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

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

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

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

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

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

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

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

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

Maternity expenses: Maternity expenses means;

a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
b) expenses towards lawful medical termination of pregnancy during the policy period.

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

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

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

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

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

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

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

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.

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

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement

or

b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

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

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

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

i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

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

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

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

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

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

Basic Sum Insured: Basic Sum Insured means the sum insured opted for and for which the premium is paid.

Company: Company means Star Health and Allied Insurance Company Limited.

Dependent Child: Dependent Child means a child (natural or legally adopted) who is financially dependent and does not have his or her independent source of income and not over 25 years.

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

DPCO/NPPA: Drug Price Control Order / National Pharmaceuticals Pricing Authority.

Family: Family means Insured Person, spouse, dependent children, (between 91 days to 25 years of age).

Insured Person: Insured Person means the name(s) of person(s) shown in the schedule of the Policy.

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

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

Limit of Coverage: Limit of Coverage means Basic Sum Insured plus the Cumulative Bonus earned, wherever applicable.

Policy Term: Policy Term means the period between the Commencement Date and Expiry Date specified in the Schedule.

Policy Year/ Policy Period: Policy Year/ Policy Period means a year following the Commencement Date and its subsequent annual anniversary.

Single Private A/c Room: Single Private A/c Room means a single occupancy air-conditioned room with attached wash room and a couch for the attendant. The room may have a television and / or a telephone. Such room must be the most economical of all accommodations available in that hospital as single occupancy. This does not include Deluxe room or a suite.

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

6. COVERAGE - (Applicable for both Silver and Gold Plan)

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 Schedule, the insured person shall contract any disease or suffer from any illness or sustain bodily injury through an accident and if such disease or injury shall require the insured Person, upon the advice of a **Medical Practitioner** to incur Hospitalisation expenses for medical/surgical treatment at any Hospital in India as an In-patient, the Company will pay to the Insured Person/s the amount of such expenses as are reasonably and necessarily incurred up to the **Limit of Coverage** mentioned in the Schedule.

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

Note: Hospitalisation expenses which vary based on the room rent occupied by the insured person will be considered in proportion to the maximum rent limit / room category stated in the policy or actuals whichever is less.

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

C. Anesthesia, Blood, Oxygen, Operation Theatre charges, ICU charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-ray, diagnostic imaging modalities, Dialysis, Chemotherapy, Radiotherapy, cost of Pacemaker, stent and such other similar expenses. With regard to coronary stenting, the Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping.

D. **Emergency Road Ambulance:** Subject to an admissible hospitalisation claim, Emergency Road Ambulance expenses incurred for the following are payable:

i. for transportation of the insured person by private ambulance service to go to hospital when there is a need for hospitalisation

or

ii. for transportation of the insured person by private ambulance service from one hospital to another hospital for better medical treatment.

E. **Pre-hospitalization Expenses:** Medical expenses incurred up to 60 days immediately before the insured person is hospitalized.

F. **Post Hospitalization Expenses:** Medical expenses incurred up to 90 days immediately after the insured person is discharged from the hospital.

G. All Day care procedures are covered.

H. **E-Medical Opinion:** The Insured Person is given the facility of obtaining "E-Medical Opinion" from the Company's expert panel.

Subject to the following conditions:

i. This should be specifically requested for by the Insured Person.

ii. This opinion is given without examining the patient, based only on the medical records submitted.

iii. The opinion should be only for medical reasons and not for medico-legal purposes.

iv. Any liability due to any errors or omissions or consequences of any action taken in reliance of the opinion provided by the Medical Practitioner is outside the scope of this policy.

v. Utilising the facility alone will not amount to making a claim.

I. **Cost of Health Check up:** Expenses incurred towards Cost of Health check up up to the limits mentioned in the table below on completion of each policy year (irrespective of claim), provided health check up is done at a Network facility:

Sum Insured / Policy Type (Rs.)	Rs.3,00,000	Rs.5,00,000	Rs.10,00,000	Rs.15,00,000 and above
Individual (Rs.)	1,500	2,000	3,000	3,500
Floater (Rs.)	NA	3,000	4,000	5,000

Note:

1. This benefit is payable on renewal and when the renewed policy is in force.
2. The maximum limit for this benefit shall not exceed the limit applicable for the renewed sum insured.
3. Payment under this benefit does not form part of the Basic Sum Insured.

4. Payment of expenses towards cost of health checkup will not prejudice the Company's right to deal with the claim in case of non-disclosure of material fact and for pre-existing diseases in terms of the policy.
5. The condition mentioned under the benefit cannot be carried forward.

J. **Automatic Restoration of Basic Sum Insured:** There shall be automatic restoration of the Basic Sum Insured once by 100% subject to the following:

1. The automatic restoration shall be immediately upon partial/full utilization of the limit of coverage.
2. Such Restored basic sum insured can be utilized for all claims during the policy period.
3. The maximum liability of the Company in a Single claim under a policy year shall not exceed the limit of coverage.
4. The unutilized restored sum insured cannot be carried forward.
5. This benefit is not available for Modern Treatment.

K. **Cumulative Bonus:** The insured person will be eligible for Cumulative bonus calculated at 20% of basic sum insured for each claim free year subject to a maximum of 100% of the basic sum insured.

Special Conditions:

1. The Cumulative bonus will be calculated on the ongoing Basic Sum Insured.
2. If the insured opts to restore the Basic Sum Insured at the subsequent renewal, the limit of indemnity by way of such Cumulative bonus shall not exceed such enhanced basic sum insured.
3. In the event of a claim resulting in:
   a. Partial utilization of Basic Sum Insured, such cumulative bonus so granted will be reduced at the same rate at which it has accrued.
   b. Full utilization of Basic Sum Insured and all utilization of cumulative bonus accrued, such cumulative bonus so granted will be reduced at the same rate at which it has accrued.
   c. Full utilization of Basic 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.
   d. Full utilization of Basic Sum Insured and full utilization of cumulative bonus accrued, the cumulative bonus so granted will be 'nil'.

L. **Additional Basic Sum Insured for Road Traffic Accident (RTA):** If the insured person meets with a Road Traffic Accident resulting in in-patient hospitalization, then the Basic Sum Insured shall be increased by 25% subject to a maximum of Rs.10,00,000/- and subject to the following:

1. It is evidenced that the insured person was wearing helmet and was either sitting at travelling as pillion rider in a two wheeler at the time of accident as evidenced by Police record and Hospital record.
2. The additional Basic Sum Insured shall be available only once during the policy period.
3. The additional Basic Sum Insured shall be available after exhaustion of the limit of coverage.
4. The additional Basic Sum Insured can be utilized only for that particular hospitalization following the Road Traffic Accident.
5. Automatic Restoration of Basic Sum Insured shall not apply for this benefit.
6. This benefit shall not be applicable for any Care Sum Insured.
7. The unutilized additional sum insured cannot be carried forward for the corresponding policy year(s) of any renewal.
8. Claim under this benefit will impact the Cumulative bonus.

M. **Star Wellness Program:** The program intends to promote, incentivize and empower 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 to premium. This Wellness Program is available and administered online through Star Wellness Platform (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 renewal premium available under the Wellness Program:

Wellness Points Earned	Discount (%)
250 to 350	2%
351 to 500	5%
501 to 750	7%
751 to 1000	10%

In case of floater policy the weightage is given as per the following table & earned points:

Insured Person	Weightage
Self, Spouse	1:1
Self, Spouse and Dependent Children (age up to 18 years)	1:1:0.5
Self, Spouse and Dependent Children (age above 18 years)	2:2:1:1

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

Insured will be granting infinity which will be treated as best policy.

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

The wellness activities and activities are categorized as follows:

Sr.No.	Activity	Maximum Earning 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.	**Activity 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
4(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 Conditions - Diabetes, Hypertension, Cardiovascular Disease or Asthma)	200
5(b).	On Completion of De-Stress & Mind Body Healing Program (for the insured who is not suffering from Chronic Conditions - Diabetes, Hypertension, Cardiovascular Disease or Asthma)	125
	Additional Wellness Benefits	
6.	Virtual Consultation Benefit	
7.	Medical Concierge Services	
8.	Period & Fertility Tracker	
9.	Digital Health Vault	
10.	Wellness Content	
11.	Health Quiz & Contribution	
12.	Post Operative Care	
13.	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 understand 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 of insured's own convenience.

   - 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.

Mandatory Tests for Preventive Risk Assessment
1. Complete Hemogram Test
2. Blood Sugar [Fasting/Post Sugar (PP)] + Postprandial (PP) [or] HbA1c
3. Lipid profile (Total cholesterol, HDL, LDL, Triglycerides, Total Cholesterol / HDL Cholesterol Ratio)
4. Serum Creatinine

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

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

	Activities	Wellness Points
a.	Participating in Walkathon, Marathon, Cyclothon and similar activities. On submission of BIB Number along with the details of the entry ticket taken to participate in the event.	100
b.	Membership in a health club (for 1 year or more) - 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 steps 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(a) **Weight Management Program:** 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:

Sl. 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)

4(b) In case if the Insured is not Overweight / Obese, the Insured can submit his/her **Fitness Success Story with us, on how the Insured Started / Improved Maintaining his/her "Active/Healthy Life Style" through adoption of Star Wellness Activities.**

On submission of the Fitness Success Story through adoption of Star Wellness Activities, Insured earns 50 wellness points.

5(a) **Chronic Condition Management Program:** 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.

Sl. 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 & Postprandial test value	HbA1c	< 6.5
		Fasting Blood Sugar (FBS) Range & 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 & 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

5(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. **Virtual Consultation Service:** '**Medical Consultation**' is available through our in-house Medical Practitioners/Empanelled Service providers round the clock to the Insured through an online portal, mobile application as a chat service, voice call or a callback service. Consultations including on '**Diet & Nutrition**' and '**Second Medical Opinion**' is available.

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. **Period & Fertility Tracker:** The online easy tracking program helps every woman with their period health and fertility care. The program gives access to trackers for period and ovulation which maps out cycles for months. This helps in planning for conception/ prevention and tracks goals/ outcomes if planning pregnancy.

9. **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 and family members.

10. **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.

11. **Health Quiz & Gamification:**
    - The wellness portal provides a host of Health & Wellness Quizzes. The wellness quizzes are geared towards helping the Insured to be more aware of various health choices.
    - Gamification helps in creating fun and engaging health & wellness experiences. It helps to create a sense of achievement in users and increases motivation levels.

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

13. **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.
- No activity, report, document, receipt can be submitted in the last month of each policy year.
- For services that are provided through empanelled service provider, Star Health is only acting as a facilitator; hence would not be liable for any incidental 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 advice/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 – 1

A 24 year old individual Ramesh buys Young Star Insurance Policy on 10th July 2019 with Sum Insured of 25 Lacs, let's understand how he can earn Wellness Points by doing different wellness activities. Ramesh has declared that his Body Mass Index (BMI) as 25. Ramesh enrolled under the Star Wellness Program and completed the following wellness activities.

Sl. No.	Name of the wellness activity taken up during the policy year	Wellness Points Earned
1.	Completed Online Health Risk Assessment (HRA)	50
2.	Submitted Health Check Up Report (one test result is not within normal range)	150
3.	Participated in Walkathon	100
4.	Attended to Yoga Classes	100
5.	Achieved 10,000 average number of steps per day during the policy year	200
6.	Ramesh accepted the Weight management program and reached 23 BMI	100
7.	Ramesh has completed De-stress & Mind Body Healing Program	125
	Total Number of Wellness Points earned	825

Based on the number of Wellness Points earned Ramesh is eligible to get 10% discount on renewal premium.

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

Scenario – 2

A 30 year old individual Suresh and his wife Lakshmi aged 25 years buy Young Star Insurance Policy (Floater Sum Insured) on 10th July 2019 with sum insured of 50 Lacs, let's understand how they can earn Wellness Points under the Health Policy. Suresh has declared his Body Mass Index (BMI) as 26 & Lakshmi has declared her BMI as 25. Suresh and Lakshmi enrolled under the Star wellness program and completed the following wellness activities.

Sl. 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	100
4.	Attended to Aerobic Lessons	100	100
5.	On achieving the step count target	200	150
6.	Suresh accepted the Weight management program and reached 24 BMI Lakshmi accepted the Weight management program and reached 23 BMI	100	100
7.	Suresh & Lakshmi has completed De-stress & Mind Body Healing Program	125	125
	Total Number of Wellness Points earned	875	825
	No of wellness points based upon weightage - 1:1	437 (875X1/2)	412 (825X1/2)

Total Number of Wellness Points earned by Suresh and Lakshmi = 849 (437+412)

Based on the no of Wellness Points earned, Suresh & Lakshmi are eligible to get 10% discount on renewal premium

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

Scenario – 3

A 35 year old individual Umesh buys Young Star Insurance Policy for two year period with Sum Insured of 1Crore, let's understand how he can earn Wellness Points by doing different wellness activities. He is suffering from Hypertension. Umesh enrolled under the Star Wellness Program and completed the following wellness activities.

Sl. No.	Name of the wellness activity taken up during the policy year	Wellness Points Earned in the First Year	Wellness Points Earned in the Second Year
1.	Completed Online Health Risk Assessment (HRA)	50	50
2.	Submitted Health Check Up Report	200	200
3.	Participated in Walkathon	100	100
4.	Attended to Tai Chi Classes	100	-
5.	Achieved 10,000 average number of steps per day during the policy year	200	150
6.	Submitted his fitness success story	100	100
7.	Managed Hypertension through Chronic management program	250	250
	Total Number of Wellness Points earned	1000	850

Total Number of Wellness Points earned by Umesh = 1850 (1000+850)
Calculation of Wellness Points as per two year policy condition = 925 (1850/2)

Based on the number of Wellness Points earned, Umesh is eligible to get 10% discount on renewal premium

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

Sum Insured in Rs.	Uterine artery Embolization and HIFU	Balloon Sinuplasty	Deep Brain Stimulation	Oral Chemotherapy (limited to pre and post hospitalization)	Immunotherapy-Monoclonal Antibody to be given as injection	Intra Vitreal Injections
	Sum Insured on Individual Basis: Limit per person, per policy period for each treatment / procedure. Sum Insured on Floater Basis: Limit per policy period for each treatment / procedure Rs.					
3,00,000/-	37,500/	15,000/	75,000/	37,500/	75,000/	15,000/
5,00,000/-	1,25,000/	50,000/	2,00,000/	1,25,000/	2,50,000/	50,000/
10,00,000/-	1,50,000/	1,00,000/	3,00,000/	2,00,000/	4,00,000/	75,000/
15,00,000/-	1,75,000/	1,25,000/	4,00,000/	2,50,000/	5,00,000/	1,00,000/
20,00,000/-	2,00,000/	1,30,000/	4,30,000/	2,75,000/	5,50,000/	1,25,000/
25,00,000/-	2,00,000/	1,50,000/	5,00,000/	3,00,000/	6,00,000/	1,50,000/
50,00,000/-	2,25,000/	1,75,000/	6,00,000/	4,00,000/	7,00,000/	1,75,000/
75,00,000/-	2,50,000/	2,00,000/	7,00,000/	5,00,000/	9,00,000/	2,00,000/
1,00,00,000/-	3,00,000/	2,50,000/	7,50,000/	6,00,000/	10,00,000/	2,50,000/

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

Sum Insured in Rs.	Robotic surgeries	Stereotactic radio surgeries	Bronchical Thermoplasty	Vaporisation of the prostrate (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
	Sum Insured on Individual Basis: Limit per person, per policy period for each treatment / procedure. Sum Insured on Floater Basis: Limit per policy period for each treatment / procedure Rs.					
3,00,000/-	75,000	75,000	Up to Sum Insured			75,000
5,00,000/-	2,00,000	2,00,000				2,00,000
10,00,000/-	3,00,000	2,25,000				4,00,000
15,00,000/-	4,00,000	2,50,000				5,00,000
20,00,000/-	4,00,000	2,75,000				5,50,000
25,00,000/-	5,00,000	3,00,000				6,00,000
50,00,000/-	6,00,000	3,50,000				7,50,000
75,00,000/-	7,00,000	3,75,000				9,00,000
1,00,00,000/-	7,00,000	4,00,000				10,00,000

III. COVERAGE AVAILABLE ONLY UNDER GOLD PLAN

A. **Delivery Expenses:** Expenses for a Delivery including Delivery by Caesarean section (including pre-natal and post natal expenses) up to Rs. 30,000/- per delivery is payable, subject to the following:

1. This benefit is available only for a maximum of 2 deliveries in the life time cover of the policy
2. This Benefit is subject to a waiting period of 36 months from the date of first commencement of Young Star Insurance Policy and its continuous renewal thereof with the Company
3. A waiting period of 24 months will apply afresh following a claim under this benefit
4. Pre hospitalization and Post Hospitalization expenses and Hospital Cash Benefit are not applicable for this section
5. This cover is available only when
   i. both Self and Spouse are covered under this policy either on floater basis or on individual basis and both Self and Spouse have been covered for a continuous period of 36 months under Young Star Insurance Policy
   ii. the policy covering the self and spouse are in force when this benefit becomes payable
6. Claims under this section will not reduce the Sum Insured
7. Claim under this section will impact the Cumulative bonus

B. **Hospital Cash Benefit:** The Company will pay a Cash Benefit of Rs. 1000 for each completed day of hospitalization subject to a maximum of 7 days per hospitalization and 14 days per policy period, provided, there is a valid claim for hospitalization under this policy.

Note

1. This benefit is subject to 1 day Deductible
2. Payment under this benefit does not form part of the Basic sum insured
3. Claim under this section will impact the Cumulative bonus

IV. 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. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with insurer
   B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase
   C. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage
   D. Coverage under the policy after the expiry of 12 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 following listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident
   B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase
   C. 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:
      i. Diseases of ENT and Thyroid
      ii. All types of Hydrocele, Hernia, Varicocele, Piles, Fistula and Fissure in Ano
      iii. Diseases of Female Reproductive system
      iv. Calculus diseases of the Gall Bladder, Kidney and Urinary Tract

3. **30-day waiting period - Code Excl 03**
   A. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered
   B. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
   C. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

4. **Investigation & Evaluation - Code Excl 04**
   A. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
   B. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

5. **Rest Cure, rehabilitation and respite care - Code Excl 05:** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   1. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons
   2. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

6. **Obesity / Weight Control - Code Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   A. Surgery to be conducted is upon the advice of the Doctor
   B. The surgery/Procedure conducted should be supported by clinical protocols
   C. The member has to be 18 years of age or older and
   D. Body Mass Index (BMI);
      1. greater than or equal to 40 or
      2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         a. Obesity-related cardiomyopathy
         b. Coronary heart disease
         c. Severe Sleep Apnea
         d. Uncontrolled Type2 Diabetes

7. **Change-of-Gender treatments - Code Excl 07:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

8. **Cosmetic or plastic Surgery - Code Excl 08:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

9. **Hazardous or Adventure sports - Code Excl 09:** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

10. **Breach of law - Code Excl 10:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

11. **Excluded Providers - Code Excl 11:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

12. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof - Code Excl 12

13. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons - Code Excl 13

14. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure - Code Excl 14

15. **Refractive Error - Code Excl 15:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

16. **Unproven Treatments - Code Excl 16:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. **Sterility and Infertility - Code Excl 17:** Expenses related to sterility and infertility. This includes:
    a. Any type of contraception, sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational Surrogacy
    d. Reversal of sterilization

18. **Maternity - Code Excl 18 (Except to the extent covered under Delivery Section - Gold plan)**
    a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy
    b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

SPECIFIC EXCLUSIONS

19. Circumcision unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident, Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA - Code Excl 19

20. Congenital External Disease / Defects / Anomalies - Code Excl 20

21. Convalescence, general debility, run-down condition, Nutritional deficiency states - Code Excl 21

22. Intentional self injury - Code Excl 22

23. Venereal Disease and Sexually Transmitted Diseases (other than HIV) - Code Excl 23

24. Injury/disease directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) - Code Excl 24

25. Injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials - Code Excl 25

26. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies - Code Excl 26

27. Unconventional, Untested, Experimental therapies - Code Excl 27

28. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy and other such similar therapies - Code Excl 28

29. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalization warranted - Code Excl 29

30. All treatment for Priapism and erectile dysfunctions - Code Excl 30

31. Inoculation or Vaccination (except for post-bite treatment and for medical treatment for therapeutic reasons) - Code Excl 31

32. Dental treatment or surgery unless necessitated due to accidental injuries and requiring hospitalization. (Dental implants are not payable) - Code Excl 32

33. Medical and / or surgical treatment of [illegible] disorders - Code Excl 33

34. Hospital registration charges, admission charges, record charges, telephone charges and such other charges - Code Excl 34

35. Cost of spectacles and contact lens, hearing aids, Cochlear implants and procedure related hospitalisation expenses, walkers and crutches, wheel chairs, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis, infusion pump and such other similar aids - Code Excl 35

36. Any hospitalization which are not Medically Necessary / Non-[illegible] Hospitalization - Code Excl 36

37. Other Excluded Expenses as detailed in the website www.starhealth.in - Code Excl 37

38. Existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), for specified ICD codes - Code Excl 38

V. 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 mis-representation, mis-description or non-disclosure of any material fact by the policy holder.

2. **Claim Settlement**

   A. **Condition Precedent to Admission of Liability:** The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

   B. **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 customer ID Card issued by the Company at the Hospital Helpdesk
      d. Obtain the Pre-authorization Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk
      e. The Treating Doctor will complete the hospitalization/treatment information and the hospital will fill up expected cost of treatment. 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 Network Hospitals. For details of Network Hospitals, the insured may visit www.starhealth.in or contact the nearest branch
      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

S.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 90 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. Copy of PAN card
      i. 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 Instalment option

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

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

Period on risk	Rate of premium to be retained
Up to one month	45% of the total premium received
Exceeding one month up to 4 months	87.5% of the total premium received
Exceeding 4 months up to 6 months	100% of the total premium received
Exceeding 6 months up to 7 months	60% of the total premium received
Exceeding 7 months up to 10 months	80% of the total premium received
Exceeding 10 months	100% of the total premium received

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

Period on risk	Rate of premium to be retained
Up to one month	87.5% of the total premium received
Exceeding one month up to 3 months	100% of the total premium received
Exceeding 3 months up to 4 months	87.5% of the total premium received
Exceeding 4 months up to 6 months	100% of the total premium received
Exceeding 6 months up to 7 months	85% of the total premium received
Exceeding 7 months up to 9 months	100% of the total premium received
Exceeding 9 months up to 10 months	80% of the total premium received
Exceeding 10 months	100% of the total premium received

Cancellation table applicable for Policy Term 2 Years without Instalment option

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

Cancellation table applicable for Policy Term 2 Years with Instalment option of Half-yearly premium payment frequency

Period on risk	Rate of premium to be retained
Up to one month	45% of the total premium received
Exceeding one month up to 4 months	87.5% of the total premium received
Exceeding 4 months up to 6 months	100% of the total premium received
Exceeding 6 months up to 7 months	50% of the total premium received
Exceeding 7 months up to 10 months	85% of the total premium received
Exceeding 10 months up to 12 months	100% of the total premium received
Exceeding 12 months up to 15 months	80% of the total premium received
Exceeding 15 months up to 18 months	100% of the total premium received
Exceeding 18 months up to 21 months	90% of the total premium received
Exceeding 21 months	100% of the total premium received

Cancellation table applicable for Policy Term 2 Years with Instalment option of Quarterly premium payment frequency

Period on risk	Rate of premium to be retained
Up to one month	87.5% of the total premium received
Exceeding one month up to 3 months	100% of the total premium received
Exceeding 3 months up to 4 months	87.5% of the total premium received
Exceeding 4 months up to 6 months	100% of the total premium received
Exceeding 6 months up to 7 months	85% of the total premium received
Exceeding 7 months up to 9 months	100% of the total premium received
Exceeding 9 months up to 10 months	80% of the total premium received
Exceeding 10 months up to 12 months	100% of the total premium received
Exceeding 12 months up to 13 months	87.5% of the total premium received
Exceeding 13 months up to 15 months	100% of the total premium received
Exceeding 15 months up to 16 months	85% of the total premium received
Exceeding 16 months up to 18 months	100% of the total premium received
Exceeding 18 months up to 19 months	80% of the total premium received
Exceeding 19 months up to 21 months	100% of the total premium received
Exceeding 21 months up to 22 months	92.5% of the total premium received
Exceeding 22 months	100% of the total premium received

Cancellation table applicable for Policy Term 3 Years without Instalment option	
Period on risk	**Rate of premium % to be retained**
Up to one month	17.5% of the policy premium
Exceeding one month up to 3 months	22.5% of the policy premium
Exceeding 3 months up to 6 months	30% of the policy premium
Exceeding 6 months up to 9 months	37.5% of the policy premium
Exceeding 9 months up to 12 months	42.5% of the policy premium
Exceeding 12 months up to 15 months	50% of the policy premium
Exceeding 15 months up to 18 months	57.5% of the policy premium
Exceeding 18 months up to 21 months	65% of the policy premium
Exceeding 21 months up to 24 months	72.5% of the policy premium
Exceeding 24 months up to 27 months	80% of the policy premium
Exceeding 27 months up to 30 months	85% of the policy premium
Exceeding 30 months up to 33 months	92.5% of the policy premium
Exceeding 33 months	Full of the policy premium

Cancellation table applicable for Policy Term 3 Years with Instalment option of Half-yearly premium payment frequency	
Period on risk	**Rate of premium % to be retained**
Up to one month	40% of the total premium received
Exceeding one month up to 4 months	87.5% of the total premium received
Exceeding 4 months up to 6 months	100% of the total premium received
Exceeding 6 months up to 7 months	40% of the total premium received
Exceeding 7 months up to 10 months	80% of the total premium received
Exceeding 10 months up to 12 months	100% of the total premium received
Exceeding 12 months up to 15 months	40% of the total premium received
Exceeding 15 months up to 18 months	100% of the total premium received
Exceeding 18 months up to 21 months	40% of the total premium received
Exceeding 21 months up to 24 months	100% of the total premium received
Exceeding 24 months up to 27 months	35% of the total premium received
Exceeding 27 months up to 30 months	100% of the total premium received
Exceeding 30 months up to 33 months	92.5% of the total premium received
Exceeding 33 months	100% of the total premium received

Cancellation table applicable for Policy Term 3 Years with Instalment option of Quarterly premium payment frequency	
Period on risk	**Rate of premium % to be retained**
Up to one month	87.5% of the total premium received
Exceeding one month up to 3 months	100% of the total premium received
Exceeding 3 months up to 4 months	87.5% of the total premium received
Exceeding 4 months up to 6 months	100% of the total premium received
Exceeding 6 months up to 7 months	90% of the total premium received
Exceeding 7 months up to 9 months	100% of the total premium received
Exceeding 9 months up to 10 months	90% of the total premium received
Exceeding 10 months up to 12 months	100% of the total premium received
Exceeding 12 months up to 13 months	87.5% of the total premium received
Exceeding 13 months up to 15 months	100% of the total premium received
Exceeding 15 months up to 16 months	95% of the total premium received
Exceeding 16 months up to 18 months	100% of the total premium received
Exceeding 18 months up to 19 months	95% of the total premium received
Exceeding 19 months up to 21 months	100% of the total premium received
Exceeding 21 months up to 22 months	92.5% of the total premium received
Exceeding 22 months up to 24 months	100% of the total premium received
Exceeding 24 months up to 25 months	97.5% of the total premium received
Exceeding 25 months up to 27 months	100% of the total premium received
Exceeding 27 months up to 28 months	97.5% of the total premium received
Exceeding 28 months up to 30 months	100% of the total premium received
Exceeding 30 months up to 31 months	95% of the total premium received
Exceeding 31 months up to 33 months	100% of the total premium received
Exceeding 33 months up to 34 months	95% of the total premium received
Exceeding 34 months	100% of the total premium received

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

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

8. **Migration:** 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.
    1. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
    2. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
    3. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
    4. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
    5. Coverage is not available during the grace period.
    6. No loading shall apply on renewals based on individual claims experience.

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

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

13. **Premium Payment in Instalments:** If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly 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-XXXXXXXX
Senior Citizens may call at 044-XXXXXXXX

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-XXXXXXXX.

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

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

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

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

SPECIFIC CONDITIONS

18. The Insured Person/s shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim.

19. All claims under this policy shall be payable in Indian currency.

20. The premium payable under this policy shall be payable in advance. No receipt of premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance 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. **Special Conditions**

A. If the insured person avails this policy before the age of 36 years and has continuously renewed without any break, then, on completion of 40 years of age the insured person will be offered a discount of 10% on the premium applicable at renewal at the age of 40 years for the sum insured opted at the inception of this policy. This discount is available for all the subsequent renewals. This discount is not cumulative. This discount will not be given if the insured person migrates to any other policy offered by the Company.

If an individual policy is converted into family floater policy at the time of renewal, then the discount is available on the family floater policy only if the age of the insured person, acted under the family floater policy, is less than the age of 36 years.

Note: If individual members are covered for different sum insureds, then the discount is available on the premium paid for the lowest of all the sum insureds at the time of inception of the policy.

B. **Midterm Inclusion:** Permissible on payment of proportionate premium subject to the following:

a. Newly Married / Wedded spouse, and/or legally adopted child. Intimation about the marriage/adoption should be given within 45 days from the date of marriage or date of adoption

b. New born baby: Intimation about the new born baby should be given within 90 days from the date of birth. The cover for new born commences from 91st day of its birth

Special conditions:

a. Waiting periods as stated in the policy will be applicable from the date of inclusion of such newly married/wedded spouse, new born baby, legally adopted child

b. Such midterm inclusion will be subject to underwriter's approval

23. **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-XXXXXXXX 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.

24. **Territorial Limit:** All claims/treatments under the policy shall have to be taken in India.

25. **Automatic Expiry:** The insurance under this policy with respect to each relevant Insured Person shall expire immediately on the earlier of the following events;

- ✓ Upon the death of the Insured Person. This also means that in case of family floater policy, cover for the other surviving members of the family will continue, subject to other terms of the policy
- ✓ Upon exhaustion of the Limit of Coverage Plus Restored Basic Sum Insured under the policy

26. **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.

27. **Arbitration:** If any dispute or difference shall arise as to the quantum to be paid under the 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.

28. **Revision of Basic Sum Insured** is permissible only at the time of renewal, subject to underwriter's approval. If the policy is renewed for enhanced sum insured, then **Exclusion Code- Excl 01, Exclusion Code- Excl 02 and Exclusion Code- Excl 03** will apply afresh to the enhanced sum insured (that is for the difference between the expiring basic sum insured and renewed basic sum insured) from the effective date of such enhancement.

29. **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.

30. **Important Note**

a) Where the policy is issued for more than 1 year, the Basic Sum Insured including sublimits, cumulative bonus (if applicable), automatic restoration benefit (if applicable) is for each of the year without any carry over benefit thereof. The said benefits if any, 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 basic sum insured, cumulative bonus and other related benefits floats amongst the insured persons.

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.

31. **Customer Service:** If at any time the Insured Person requires any clarification or assistance, the Insured may contact No.1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai 600034, during normal business hours.

List of Insurance Ombudsmen

AHMEDABAD

Office of the Insurance Ombudsman,
Jeevan Prakash Building, 6th floor,
Tilak Marg, Relief Road,
Ahmedabad - 380 001.
Tel.: 079 - 25501201/02/05/06
Email: bimalokpal.ahmedabad@cioins.co.in

JURISDICTION: Gujarat, Dadra & Nagar Haveli, Daman and Diu.

BENGALURU

Office of the Insurance Ombudsman,
Jeevan Soudha Building,
PID No. 57-27-N-19 Ground Floor, 19/19,
24th Main Road, JP Nagar, III Phase,
Bengaluru - 560 078.
Tel.: 080 - 26652048 / 26652049
Email: bimalokpal.bengaluru@cioins.co.in

JURISDICTION: Karnataka.

BHOPAL

Office of the Insurance Ombudsman,
1st floor, "Jeevan Sadan",
60-B, Hoshangabad Road,
Opp. Gayatri Mandir, Bhopal - 462 011.
Tel.: [illegible] / 2760201 / 2760202
Email: bimalokpal.bhopal@cioins.co.in

JURISDICTION: Madhya Pradesh (Jhabua).

BHUBANESWAR

Office of the Insurance Ombudsman,
62, Forest park, Bhubaneswar - 751 009.
Tel.: 0674 - 2596461/2596455
Email: bimalokpal.bhubaneswar@cioins.co.in

JURISDICTION: Odisha.

CHANDIGARH

Office of the Insurance Ombudsman,
S.C.O. No. 101, 102 & 103, 2nd Floor,
Batra Building, Sector 17 - D,
Chandigarh - 160 017.
Tel.: 0172 - 2706196 / 2706468
Email: bimalokpal.chandigarh@cioins.co.in

JURISDICTION: Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.

CHENNAI

Office of the Insurance Ombudsman,
Fatima Akhtar Court, 4th Floor, 453,
Anna Salai, Teynampet,
Chennai - 600 018.
Tel.: 044 - 24333668 / 24335284
Email: bimalokpal.chennai@cioins.co.in

JURISDICTION: Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).

DELHI

Office of the Insurance Ombudsman,
2/2 A, Universal Insurance Building,
Asaf Ali Road,
New Delhi - 110 002.
Tel.: 011 - 23232481/23213504
Email: bimalokpal.delhi@cioins.co.in

JURISDICTION: Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

ERNAKULAM

Office of the Insurance Ombudsman,
2nd Floor, Pulinat Bldg.,
Opp. Cochin Shipyard, M. G. Road,
Ernakulam - 682 015.
Tel.: 0484 - 2358759 / 2359338
Email: bimalokpal.ernakulam@cioins.co.in

JURISDICTION: Kerala, Lakshadweep, Mahe a part of Union Territory of Puducherry.

GUWAHATI

Office of the Insurance Ombudsman,
Jeevan Nivesh, 5th Floor,
Nr. Panbazar over bridge, S.S. Road,
Guwahati - 781001(ASSAM).
Tel.: 0361 - 2632204 / 2602205
Email: bimalokpal.guwahati@cioins.co.in

JURISDICTION: Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

HYDERABAD

Office of the Insurance Ombudsman,
6-2-46, 1st floor, "Moin Court",
Lane Opp. Saleem Function Palace,
A. C. Guards, Lakdi-Ka-Pool,
Hyderabad - 500 004.
Tel.: 040 - 23312122
Email: bimalokpal.hyderabad@cioins.co.in

JURISDICTION: Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.

JAIPUR

Office of the Insurance Ombudsman,
Jeevan Nidhi - II Bldg., Gr. Floor,
Bhawani Singh Marg,
Jaipur - 302 005.
Tel.: 0141 - 2740363
Email: bimalokpal.jaipur@cioins.co.in

JURISDICTION: Rajasthan.

KOLKATA

Office of the Insurance Ombudsman,
Hindustan Bldg. Annexe, 7th Floor,
4, C. R. Avenue, Kolkata - 700 072.
Tel.: 033 - 22124339 / 22124340
Email: bimalokpal.kolkata@cioins.co.in

JURISDICTION: West Bengal, Sikkim, Andaman & Nicobar Islands.

LUCKNOW

Office of the Insurance Ombudsman,
4th Floor, Jeevan Bhawan, Phase-II,
Nawal Kishore Road, Hazratganj,
Lucknow - 226 001.
Tel.: 0522 - 2231330 / 2231331
Email: bimalokpal.lucknow@cioins.co.in

JURISDICTION: Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharthnagar.

MUMBAI

Office of the Insurance Ombudsman,
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.
Tel.: 69038821/23/24/25/26/27/28/29/30/31
Email: bimalokpal.mumbai@cioins.co.in

JURISDICTION: Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).

NOIDA

Office of the Insurance Ombudsman,
Bhagwan Sahai Palace
4th Floor, Main Road, Naya Bans, Sector 15,
Distt: Gautam Buddh Nagar, U.P.-201301.
Tel.: 0120-2514252 / 2514253
Email: bimalokpal.noida@cioins.co.in

JURISDICTION: State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

PATNA

Office of the Insurance Ombudsman,
2nd Floor, Lalit Bhawan,
Bailey Road, Patna 800 001.
Tel.: 0612 2547068
Email: bimalokpal.patna@cioins.co.in

JURISDICTION: Bihar, Jharkhand.

PUNE

Office of the Insurance Ombudsman,
Jeevan Darshan Bldg., 3rd Floor,
C.T.S. No.s. 195 to 198, N.C. Kelkar Road,
Narayan Peth, Pune - 411 030.
Tel.: 020-41312555
Email: bimalokpal.pune@cioins.co.in

JURISDICTION: Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Kindly refer our website, for future updates in Ombudsmen address.

ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES

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

ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES

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

ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT

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