STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

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POLICY WORDINGS

Star Health Assure Insurance Policy

Unique Identification No: SHAHLIP23131V022223

PREAMBLE

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

A. DEFINITIONS

STANDARD DEFINITIONS

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

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

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

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

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

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

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

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

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

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

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

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 incharge;

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.

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

i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

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

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

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

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

i. has qualified nursing staff under its employment round the clock;

ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii. has qualified medical practitioner(s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;

v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

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

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

a. Acute condition - Acute condition is a disease, illness or injury that is likely to

respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

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

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

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

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

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

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

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 a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

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

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

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

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

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

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

a. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer;

   or

b. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy

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

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

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

Portability: Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods 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.

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

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

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

SPECIFIC DEFINITIONS

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

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

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

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

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

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

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

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

Diseases of Spine: Diseases of Spine includes injuries to the spine and/or Infections to the spine and/or a blocked blood supply and/or

compression by a fractured bone and/or a tumour resulting in neurological sequelae.

Family: Family includes Insured Person, spouse, dependent children between 16 days and 25 years of age not exceeding 3 in number Dependent Parent and Dependent Parents in law.

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

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

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

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

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

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

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

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

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

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

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

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

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

Stroke: Any cerebrovascular incident producing permanent neurological sequelae

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

Zone:

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

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

Zone C: Rest of India

B . COVERAGE

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

If during the period stated in the Policy Schedule the **Insured Person** sustains bodily

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

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

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

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

2. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees.
3. Anesthesia, blood, oxygen, operation theatre charges, ICU charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses. With regard to coronary stenting, medicines, Implants and such other similar items the Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping.
4. All day care treatments are covered.
5. **Coverage for Non-medical Items (Consumables):** If there is an admissible claim under inpatient / day care of the policy, then Items as per List I will become payable
6. **Emergency Road ambulance:** Subject to an admissible hospitalization claim, 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 this is needed for medical reasons

      or

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

      or

   iii. for transportation of the insured person from the hospital where treatment is taken to their place of residence (if it is in same city) provided the requirement of an ambulance to the residence is certified by the medical practitioner.
7. **Air Ambulance:** Air ambulance expenses are payable subject to an admissible hospitalization claim, the Insured Person(s) is/are eligible for reimbursement of expenses incurred towards the cost of air ambulance service up to 10% of sum insured per policy year, provided that
   a. It is for emergency care of the insured person which requires immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot be provided.
   b. Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency

c. It is prescribed by a Medical Practitioner and is Medically Necessary;

d. The insured person is in India and the treatment is in India only

e. Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s.

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

9. **Post Hospitalization Expenses:** Medical expenses incurred up to 180 days immediately after the insured person is discharged from the hospital.

10. **Domiciliary Hospitalization:** Coverage for medical treatment (Including AYUSH) for a period exceeding three days, for an illness/disease/injury, which in the normal course, would require care and treatment at a Hospital but, on the advice of the attending Medical Practitioner, is taken whilst confined at home under any of the following circumstances

    1. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
    2. The patient takes treatment at home on account of non-availability of room in a hospital.

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

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

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

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

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

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

13. **Home care treatment:** Payable up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year, for treatment availed by the Insured Person at home, only for the specified conditions mentioned below, which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

a. The Medical practitioner advises the Insured person to undergo treatment at home

b. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment

c. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

d. Insured can avail "Home Care Treatment" service on cashless / reimbursement basis, if availed from the list of our Network service providers given in our website "www.starhealth.in"

List of Conditions covered under Home care treatment:

1. Fever and Infectious diseases which can be managed as Inpatient
2. Uncomplicated Urinary tract infections but needing Parenteral Antibiotics
3. Asthma and COPD -Mild Exacerbations needing Home Nebulization
4. Acute Gastritis/Gastroenteritis
5. I.V. Chemotherapy [Where advised by the doctor]
6. Palliative Cancer care requiring medical assistance
7. Acute Vertigo
8. Diabetic foot and Cellulitis
9. IVDP [Cervical and Lumbar disc diseases]
10. Major Surgeries/Arthroplasties needing IV Antibiotics Post Discharge
11. Care for Brain and Spinal Injury Cases Post Discharge
12. Post CVA Care at Home after Discharge
13. Chronic Severe Refractory Asthma (by Advanced Medicine)

14. **Delivery Expenses:** Expenses for a Delivery including Delivery by Caesarean section (including pre-natal and postnatal expenses) up-to 10% of the Sum Insured is payable, subject to the following :-

i. Benefit under this section is subject to a waiting period of 24 months from the date of first commencement of Star Health Assure Insurance policy and its continuous renewal thereof with the Company.

a. There is no waiting period for subsequent deliveries

ii. This cover is available only when

a. Both self and spouse are covered under this policy for a continuous period of 24 months under Individual or floater sum insured.

iii. Pre-hospitalisation and Post Hospitalization expenses are not applicable for this section.

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

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

Types of in utero-surgeries covered:

1. Open Fetal Surgery
2. Fetendo Fetal Surgery
3. Fetal Image-Guided Surgery (FIGS-IT)
4. EXIT procedure

Types of in utero-surgeries/procedures covered:

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

List of procedures covered under in utero-surgeries:

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

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

    a. A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person.

    b. Company will pay for one Assisted Reproduction Treatment cycle in a policy year.

    c. For the purpose of claiming under this benefit, in-patient treatment is not mandatory.

Sum Insured (Rs.)	Limit of Liability in a policy year (Rs.)
5,00,000/-	1,00,000/-
10,00,000/-, 15,00,000/-, 20,00,000/-, 25,00,000/-	2,00,000/-
50,00,000/-, 75,00,000/-, 100,00,000/-, 200,00,000/-	4,00,000/-

SPECIAL EXCLUSIONS

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

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

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

Sum Insured in Lakhs (Rs.)	Limit Per Policy Period (Rs.)
5/10/15/20/25	2,00,000/-
50/75/100/200	4,00,000/-

Special Conditions applicable for this section:

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

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

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

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

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

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

Note:

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

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

Note:

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

ii) This benefit will not be applicable where the sanction is on package rates

iii) Insured stay in Intensive Care Unit or High Dependency Units / wards will not be counted for this purpose

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

Note:

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

24. **Second Medical Opinion:** The Insured Person can obtain a Second Medical Opinion from a Doctor in the Company's network of Medical Practitioners. All the medical records provided by the Insured Person will be submitted to the Doctor chosen by him/her online and the

medical opinion will be made available directly to the Insured by the Doctor. To utilize this benefit, all medical records should be forwarded to the mail-id e_medicalopinion@starhealth.in.or through Post/Courier.

SPECIAL CONDITIONS

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

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

25. **Coverage for Modern Treatment:** The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital upto sum insured (including Pre and Post hospitalization expenses) during the policy period;
    a. Uterine artery Embolization and HIFU
    b. Balloon Sinuplasty
    c. Deep Brain Stimulation
    d. Oral Chemotherapy
    e. Immunotherapy- Monoclonal Antibody to be given as injection
    f. Intra Vitreal injections
    g. Robotic surgeries
    h. Stereotactic radio surgeries
    i. Bronchical Thermoplasty,
    j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
    k. IONM-(Intra Operative Neuro Monitoring)
    l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions

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

SPECIAL CONDITIONS

1. The Cumulative bonus will be calculated on the expiring Sum Insured
2. If the insured opts to reduce the Sum Insured at the subsequent renewal, the limit of indemnity by way of such Cumulative bonus shall not exceed such reduced sum insured
3. In the event of a claim resulting in;
    a. Partial utilization of Sum Insured, such cumulative bonus so granted will not be reduced
    b. Full utilization of Sum Insured and nil utilization of cumulative bonus accrued, such cumulative bonus so granted will not be reduced
    c. Full utilization of Sum Insured and partial utilization of cumulative bonus accrued, the cumulative bonus granted on renewal will be the balance cumulative bonus available

and will be reduced at the same rate at which it has accrued

d. Full utilization of Sum Insured and full utilization of cumulative bonus accrued, the cumulative bonus on renewal will be "nil"

27. Automatic Restoration of Sum Insured:

The policy provides automatic restoration of sum insured subject to the following condition;

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

Unlimited Restoration – illustration

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

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

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

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

1. Poly Trauma
2. Head injury
3. Diseases of the spine
4. Stroke

Pain Management treatment:

S No	Name of the covered pain management treatment	Sub-limits (Per Policy year) (Rs.)	
	Sum Insured (Rs in Lakh)	5/10/15/20	25 & above
1	Lumbar and cervical medial branch block with RF ablation for lumbar and cervical facet joint arthritis	65,000/-	75,000/-
2	Caudal epidural injection for Discogenic pain	40,000/-	50,000/-
3	Lumbar and cervical selective nerve root block for Lumbar and Cervical radicular pain	50,000/-	60,000/-
4	Caudal Neuroplasty for Failed back spine surgery	85,000/-	1,00,000/-
5	Stellate ganglion ablation for upper limb CRPS	65,000/-	75,000/-
6	Occipital nerve Pulsed RF lesioning for Migraines, Cluster headache and cervicogenic headaches	65,000/-	75,000/-
7	Lumbar sympathetic chain RF ablation for lower limb CRPS, diabetic periphery painful neuropathy and Ischaemic limb pain	65,000/-	75,000/-
8	Gasserian ganglion ablation for Trigeminal neuralgia	65,000/-	75,000/-
9	Intercostal nerve Ablation for post thoracotomy pain and Thoracic malignancy pain	65,000/-	75,000/-
10	Coeliac plexus ablation for upper gastrointestinal malignancies pain	65,000/-	75,000/-
11	Superior hypogastric plexus ablation for lower Gastro intestinal malignancies pain	65,000/-	75,000/-
12	Ganglion impar ablation for perineal cancer pain and coccydynia	65,000/-	75,000/-
13	Cooled RF ablation of genicular nerve for grade 1 and 2 osteoarthritis knee and hip	1,00,000/-	1,25,000/-
14	Suprascapular nerve RF ablation for rotator cuff partial tear and peri arthritis shoulder pain	65,000/-	75,000/-

Important Note:

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

29. Star Wellness Program: This program intends to promote, incentivize and to reward the Insured Persons' healthy life style through various wellness activities. The wellness activities as mentioned below are designed to help the Insured person to earn wellness reward points

which will be tracked and monitored by the Company. The wellness points earned by the Insured Person(s) under the wellness program, can be utilized to get discount in premium.

This Wellness Program is enabled and administered online through "Star Health" Mobile App.

Note: The Wellness Activities mentioned in the table below (from Serial Number 1 to 5) are applicable for the Insured person(s) aged 18 years and above only. The following table shows the discount on premium available under the Wellness Program;

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

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

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

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

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

The wellness services and activities are categorized as below:

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

	Additional Wellness Services	
6.	Star Tele-health services:	
7.	Medical Concierge Services	
8.	Digital Health Vault	
9.	Wellness Content	
10.	Post-Operative Care	
11.	Discounts from Network Providers	

1. **Manage and Track Health:**

a. Completion of Health Risk Assessment (HRA):

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

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

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

b) Preventive Risk Assessment:

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

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

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

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

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

List of Fitness Initiatives and Wellness points:		
	Initiative	**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) - In a Gym / Yoga Centre / Zumba Classes / Aerobic Exercise/ Sports Club/ Pilates Classes/ Swimming / Tai Chi/ Martial Arts / Gymnastics/ Dance Classes	100

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

3. **Stay Active:** Insured earns wellness points on achieving the step count target on "Star Health" Mobile App 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 "Star Health" 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 Health" Mobile App.

4. **Weight Management Program:**

a. This Program will help the Insured persons with Over Weight and Obesity to manage their Body Mass Index (BMI) through the empanelled wellness experts who will guide the Insured in losing excess weight and maintain their BMI.

- On acceptance of the Weight Management Program, Insured earns 50 wellness points.
- An additional 50 wellness points will be awarded in case if the results are achieved and maintained as mentioned below.

S. 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 theBMI between 18 and 29
2.	Overweight (If BMI is between 25 and 29)	Height & Weight (to calculate BMI)	Reducing BMI by two points and maintaining the same BMI in the policy year
– Values (for BMI) shall be submitted for every 2 months (up to 5 times in each policy year)			

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

5. **Chronic Condition Management Program:**

a. This Program will help the Insured suffering from Diabetes, Hypertension, Cardiovascular Disease or Asthma to track their health through the empanelled wellness experts who will guide the insured in maintaining/ improving the health condition.

- On acceptance of the Chronic Condition Management Program, Insured earns 100 wellness points.
- The Insured has to submit the test result values for every 3 months maximum up to 3 times in a policy year.
- If the test result values are within +/- 10% range of the values given below, for at least 2 times in a policy year, an

additional 150 wellness points will be awarded.

- These tests reports to be submitted within 1 month from the date of undergoing the Health Check-Up

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

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

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

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

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

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

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

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

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

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

Terms and conditions under wellness activity

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

ILLUSTRATION OF BENEFITS

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

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

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

S. No	Name of the wellness activity taken up during the policy year	Wellness Points Earned by Suresh	Wellness Points Earned by Lakshmi
1.	Completed Online Health Risk Assessment (HRA)	50	50
2.	Submitted Health Check-Up Report	200	200
3.	Participation in Marathon	100	0
4.	Attended to Gym	100	100
5.	Achieved 10,000 average number of steps per day during the policy year	200	200

6.	Suresh accepted the Weight management program and reached 27 BMI. Lakshmi accepted the Weight management program and reached 23 BMI	100	100
7.	Suresh Managed Diabetes & Hypertension through Chronic Condition Management Program; Lakshmi has completed De-stress & Mind Body Healing Program	250	125
	Total Number of Wellness Points earned	**1000**	**775**
	No of wellness points based upon weightage - 1:1	**500 (1000X1/2)**	**388 (775X1/2)**
Total Number of Wellness Points earned by Suresh and Lakshmi = 888 (500+388) Based on the no of Wellness Points earned, Suresh & Lakshmi are eligible to get 20% discount on renewal premium			

30. Co-payment: This policy is subject to co-payment of 10% of each and every claim amount for fresh as well as renewal policies for insured person whose age at the time of entry is 61 years and above.

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

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

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

Illustration of deductible	
If an Insured with 10 Lac Sum Insured opted for an aggregate deductible of Rs.50,000 in a year, lets understand how this deductible will be applied	
First Policy Year	
Sum Insured	Rs. 10,00,000/- (Opted Deductible is Rs. 50,000/-)
What does opting a deductible mean	Coverage will start once the Insured incurs single/ multiple claims that add up to the deductible amount in a policy year
1st Claim (Injury due to Accident)	Rs. 50,000/- (Not paid by us as it is within Deductible limit)
Balance Sum Insured	Rs. 10,00,000/-
2nd Claim (Dengue fever)	Rs. 65,000/- (Payable as the deductible limit of Rs. 50,000/- is already exhausted in the policy year)
Balance Sum Insured	Rs. 9,35,000/-
3rd Claim (bacterial gastroenteritis)	Rs. 55,000/- (Payable as the deductible limit of Rs. 50,000/- is already exhausted in the policy year)
Balance Sum Insured	Rs. 8,80,000/-

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

C.EXCLUSIONS

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

STANDARD EXCLUSIONS

1. **Pre-Existing Diseases - Code- Excl 01:**

   A. **Applicable for 3 year policy term**: Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 30

months of continuous coverage after the date of inception of the first policy with insurer.

Applicable for 1 year and 2 year policy term: Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer

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

C. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

D. **Applicable for 3 year policy term :** Coverage under the policy after the expiry of 30 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

Applicable for 1 year and 2 year policy term: Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

A. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

C. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

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

E. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

F. List of specific diseases/procedures

1. Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, Diseases related to Thyroid, Benign diseases of the breast.

2. Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal Tunnel Syndrome, Trigger Finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology

3. All treatments (Conservative, Operative treatment) and all types of intervention for Diseases related to Tendon, Ligament, Fascia, Bones and Joint Including Arthroscopy and Arthroplasty / Joint Replacement [other than caused by accident].

4. All types of treatment for Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system, Prolapse of Intervertebral Disc (other than caused by accident),

5. All treatments (conservative, interventional, laparoscopic and open) related to Hepato-pancreato-biliary diseases including Gall bladder and Pancreatic calculi. All types of management for Kidney calculi and Genitourinary tract calculi.
6. All types of Hernia,
7. Desmoid Tumor, Umbilical Granuloma, Umbilical Sinus, Umbilical Fistula,
8. All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Cervix, Uterus, Fallopian tubes, Ovaries, Uterine Bleeding, Pelvic Inflammatory Diseases
9. All Diseases of Prostate, Stricture Urethra, all Obstructive Uropathies,
10. Benign Tumours of Epididymis, Spermatocele, Varicocele, Hydrocele,
11. Fistula, Fissure in Ano, Hemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence
12. Varicose veins and Varicose ulcers
13. All types of transplant and related surgeries.
14. Congenital Internal disease / defect – {except for Unborn in Coverage (15) and New born in Coverage(17)}

Note: Waiting period for the following benefits are as follows

a. **Delivery Expenses Cover:** Benefit under this section is subject to a waiting period of 24 months from the date of first commencement of Star Health Assure Insurance policy and its continuous renewal thereof with the Company.

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

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

c. **Assisted Reproduction Treatment:** A waiting period of 24 months from the date of first inception of this policy with the Company for the insured person.

d. **New Born Baby Cover:** This cover is available only if Delivery expenses claim is paid under this policy or if Mother is covered under this policy for a continuous period of 12 months without break.

3. 30-day waiting period – Code Excl 03

A. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered

B. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months

C. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

4. Investigation & Evaluation – Code Excl 04

A. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded

B. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

5. Rest Cure, rehabilitation (except to the extent covered under Coverage 28) and respite care – Code Excl 05:

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non –skilled persons

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

6. **Obesity/ Weight Control – Code Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions;

   A. Surgery to be conducted is upon the advice of the Doctor

   B. The surgery/procedure conducted should be supported by clinical protocols

   C. The member has to be 18 years of age or older and

   D. Body Mass Index(BMI);

      1. greater than or equal to 40 or

      2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

         a. Obesity-related cardiomyopathy

         b. Coronary heart disease

         c. Severe Sleep Apnea

         d. Uncontrolled Type2 Diabetes

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

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

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

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

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

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

13. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is

arranged wholly or partly for domestic reasons **– Code Excl 13**

14. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **– Code Excl 14**
15. **Refractive Error – Code Excl 15 :** Expenses related to the treatment for correction of 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 (Except to the extent covered under Coverage 16) – Code Excl 17 :** Expenses related to sterility and infertility. This includes;
    a. Any type of contraception,sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational Surrogacy
    d. Reversal of sterilization
18. **Maternity – Code Excl 18 (Except to the extent covered under Coverage 14)**
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

SPECIFIC EXCLUSIONS

19. Circumcision (unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident), Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA **-Code-Excl 19**
20. Congenital External Condition / Defects / Anomalies (except to the extent covered under Coverage17) **- Code - Excl 20**
21. Convalescence, general debility, run-down condition, Nutritional deficiency states **- Code - Excl 21**
22. Intentional self -injury **- Code - Excl 22**
23. Injury/disease caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) **- Code - Excl 24**
24. Injury or disease caused by or contributed to by nuclear weapons/ materials **- Code - Excl 25**
25. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion **- Code - Excl 26.**
26. Unconventional, Untested, Experimental therapies **- Code - Excl 27**
27. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy **- Code - Excl 28**
28. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalization warranted.- **Code - Excl 29**

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

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

31. Any hospitalization which are not medically necessary / does not warrant hospitalization **- Code - Excl 36**

32. Existing disease/s, disclosed by the insured and mentioned in the policy schedule (under Permanent Exclusion (based on Insured's consent)**- Code - Excl 38**

D. CONDITIONS

STANDARD CONDITIONS

1. **Disclosure of Information:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the 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 helpline 044-69006900 or Toll free No. 1800425 2255.Senior Citizens may call at 044 40020888

   b. Inform the ID number for easy reference

   c. On admission in the hospital, produce the ID Card issued by the Company at the Hospital Helpdesk

   d. Obtain the Pre-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk.

   e. The Treating Doctor will complete the hospitalisation/ treatment information and the hospital will fill up expected cost of treatment. This form is submitted to the Company

   f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.

   g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits.

   h. In case of emergency hospitalization information to be given within 24 hours after hospitalization

   i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.starhealth.in or contact the nearest branch or refer to the list of Networked Hospitals provided with the policy document.

   j. KYC(Identity proof with Address) of the proposer, as per AML Guidelines

   k. NEFT documents viz; Customer name, Bank Account No., Name of the Bank, IFSC Code

   l. CKYC No. of the proposer(if available)

   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 180 days from the date of discharge from hospital

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

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

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

a. Duly completed claim form, and

b. Pre Admission investigations and treatment papers.

c. Discharge Summary from the hospital

d. Cash receipts from hospital, chemists

e. Cash receipts and reports for tests done

f. Receipts from doctors, surgeons, anesthetist

g. Certificate from the attending doctor regarding the diagnosis.

h. KYC (Identity proof with Address) of the proposer, as per AML Guidelines

Note: Call the 24 hour help-line044 6900 6900 or Toll Free No. 1800425 2255, Senior Citizens may call at 044 40020888

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

4. **Multiple Policies**

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

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

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

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

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

a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b. the active concealment of a fact by the insured person having knowledge or belief of the fact;

c. any other act fitted to deceive; and

d. any such act or omission as the law specially declares to be fraudulent

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

6. Cancellation

i. The Policyholder may cancel his policy any time during the term by giving 7 days written notice. In such an event, The Company shall

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

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

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

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

7. Migration: In case of migration of one policy to another with the same insurer, the Policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods,

waiting period for Pre-Existing Diseases, Moratorium period etc. in the previous policy to the migrated policy.

8. Portability:

A. The Insured Person has the choice to port his / her policy from one Insurer to another by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability.

B. The Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting period for Pre-Existing Disease, Moratorium period etc. from the Existing Insurer to the Acquiring Insurer in the previous policy

9. Renewal of policy:

The policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate as per the procedure stated under "withdrawal clause"

i. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days

ii. While coverage is not available during the Grace Period, if the policy is renewed during the Grace Period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting period for Pre-Existing Diseases, Moratorium period etc.) accrued under the policy shall be protected.

10. Withdrawal of policy

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.

i. A one time option to renew the existing product, if renewals within 90 days from the date of withdrawal of the product; or

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal. Insured Person can transfer the credits gained (to the extent of Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting period for Pre-Existing Diseases, Moratorium period etc.) in the previous policy to the migrated policy, provided the policy has been maintained without a break.

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

12. Premium Payment in Installments: If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly or Quarterly or Monthly or as mentioned in the Policy Schedule/ Certificate of Insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. For monthly instalment option: Grace Period of 15 days would be given to pay the instalment premium due for the policy.

ii. For Quarterly and Half yearly instalment option: Grace Period of 30 days would be given to pay the instalment premium due for the policy.

iii. The Insured Person will get the accrued continuity benefit in respect of the (Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting period for Pre-Existing Diseases, Moratorium period etc.) 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 instalments from the claim amount due under the policy.

viii. For premium paid in instalments during the Policy Period, coverage is available during the Grace Period also.

13. **Possibility of Revision of Terms of the Policy Including the Premium Rates:** The Company, may revise or modify the terms of the policy including the premium rates as per the extant Guidelines. The insured person shall be notified thirty days before the changes are effected.

14. **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 thirty days from date of receipt of the policy document whether electronically or otherwise to review the terms and conditions of the policy. If the Insured is not satisfied with any of the terms and conditions and has not made any claim, the Insured has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

The Insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any incurred by the Insurer on medical examination of the proposer and stamp duty charges

15. **Redressal of Grievance:** Incase of any grievance the insured person may contact the Company through

Website : www.starhealth.in

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

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

Senior Citizens may call at 044-69007500

Courier/ Post : Star Health and Allied Insurance Company Limited.,

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

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

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

For updated details of grievance officer, kindly refer the link

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

If Insured Person is not satisfied with the

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

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

16. **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

17. 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.

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

19. The premium under this policy shall be payable in advance. No receipt of premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance of fulfillment of the terms, provision, conditions and endorsements of this policy by the Insured Person/s, in so far as they relate to anything to be done or complied with by the Insured Person/s, shall be a condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions, and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of the Company.

20. 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.

21. **Notice and communication:** Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or email to Star Health and Allied Insurance Company Limited, Corporate Office : No. 148, Acropolis,Dr. Radha Krishnan Salai, Mylapore, Chennai - 600 004. Phone : 044 - 4788 6666,

Regd Office: No. 1, New Tank Street, Valluvar Kottam, High Road, Nungambakkam, Chennai 600034. Customer Care No. 044-69006900, or Toll Free No. 1800 425 2255, e-mail: support@starhealth.in Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery or e-mail.

22. **Territorial Limit:** All investigations/treatments under this policy shall have to be taken in India.

23. **Automatic Termination:** The insurance under this policy with respect to each relevant Insured Person policy shall expire

immediately on the earlier of the following events

- ✓ Upon the death of the Insured Person: This means that, the cover for the surviving members of the family will continue, subject to other terms of the policy.
- ✓ Upon exhaustion of the Sum Insured, Limit of Coverage, Limit of Coverage plus Restore Sum Insured.

24. **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.

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

26. **Revision of Sum Insured:** Reduction or enhancement of Sum Insured is permissible only at the time of renewal. The acceptance for enhancement and the amount of enhancement will be at the discretion of the Company and subject **to Exclusion Code Excl 01, Exclusion Code Excl 02 and Exclusion Code Excl 03.**

27. **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

28. **Important Note:**

a. Where the policy is issued for more than 1 year, the Sum Insured including sublimits, automatic restoration benefit (if applicable) is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year or 3rd year cannot be utilized in the 1st year itself. The terms conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each policy year"

b. Where the policy is issued on floater basis, The Sum Insured, cumulative bonus and other related benefits floats amongst the insured members.

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

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

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

29. **Customer Service:** If at any time the Insured Person requires any clarification or assistance, the insured may contact Star Health and Allied Insurance Company Limited, 'Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai 600014', during normal business hours.

LIST OF INSURANCE OMBUDSMAN

Office Details	Jurisdiction of Office Union Territory, District
AHMEDABAD	
Office of the Insurance Ombudsman,	
Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Gujarat Tel.: 079 - 25501201/02	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Email: oio.ahmedabad@cioins.co.in	
BENGALURU	
Office of the Insurance Ombudsman,	
Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049	Karnataka.
Email: oio.bengaluru@cioins.co.in	
BHOPAL	
Office of the Insurance Ombudsman,	
1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202/ 2769203	Madhya Pradesh, Chhattisgarh.
Email: oio.bhopal@cioins.co.in	
BHUBANESWAR	
Office of the Insurance Ombudsman,	
62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455// 2596429 / 2596003	Odisha.
Email: oio.bhubaneswar@cioins.co.in	
CHANDIGARH	
Office of the Insurance Ombudsman,	
Jeevan Deep Building, SCO 20-27, Ground Floor Sector - 17 A, Chandigarh – 160 017. Tel.: 0172 – 2706468	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
Email: oio.chandigarh@cioins.co.in	
CHENNAI	
Office of the Insurance Ombudsman,	
Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
Email: oio.chennai@cioins.co.in	
DELHI	
Office of the Insurance Ombudsman,	
2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/ 23213504/23232481	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Email: oio.delhi@cioins.co.in	
KOCHI	
Office of the Insurance Ombudsman,	
10th Floor, Jeevan Prakash, LIC Building, Opp.to Maharaja's College Ground, M. G. Road, Kochi - 682 011. Tel.: 0484 - 2358759	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
Email: oio.ernakulam@cioins.co.in	
GUWAHATI	
Office of the Insurance Ombudsman,	
Jeevan Nivesh, 5th Floor, Nr. Panbazar S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Email: oio.guwahati@cioins.co.in	
HYDERABAD	
Office of the Insurance Ombudsman,	
6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A.C. Guards, Lakdi - Ka - Pool A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
Email: oio.hyderabad@cioins.co.in	
JAIPUR	
Office of the Insurance Ombudsman,	
Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363	Rajasthan.
Email: oio.jaipur@cioins.co.in	

KOLKATA	
Office of the Insurance Ombudsman,	
Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341	West Bengal, Sikkim, Andaman & Nicobar Islands.
Email: oio.kolkata@cioins.co.in	

LUCKNOW	
Office of the Insurance Ombudsman,	
6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 – 4002082/ 3500613	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Email: oio.lucknow@cioins.co.in	

MUMBAI	
Office of the Insurance Ombudsman,	
3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022-69038800/27/29/31/32/33	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
Email: oio.mumbai@cioins.co.in	

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	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Email: oio.noida@cioins.co.in	

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

PUNE	
Office of the Insurance Ombudsman,	
Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district,Palghar District, Raigad district & Mumbai Metropolitan Region
Email: oio.pune@cioins.co.in	

THANE	
Office of the Insurance Ombudsman,	
2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.
Email: oio.thane@cioins.co.in	

Kindly refer https://cioins.co.in/Ombudsman for future updates

NON-MEDICAL ITEMS (CONSUMABLES) LIST I (68 ITEMS)

The following **List I** items are covered if the optional cover "Section III-3" is opted by the Insured

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

List II — Items that are to be subsumed into Room Charges

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

List III — Items that are to be subsumed into Procedure Charges

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

List IV — Items that are to be subsumed into costs of treatment

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

SCHEDULE OF BENEFTIS										
S.No	Sum Insured (INR)	5 lakhs	10 Lakhs	15 Lakhs	20 Lakhs	25 Lakhs	50 Lakhs	75 Lakhs	1 Crore	2 Crore
1	Room, Boarding and Nursing charges	Up to 1% of Sum Insured per day	Any Room (Except Suite or above category)				(Any room)			
2	ICU/Operation Theatre Charges	Actual								
3	Road Ambulance Charges (per policy period)	Actual								
4	Air Ambulance (per policy year)	up to 10% of sum insured								
5	Pre Hospitalisation Expenses incurred	Up to 60 days								
6	Post Hospitalisation Expenses incurred	Up to 180 days								
7	Domiciliary Hospitalization	Coverage for medical treatment (Including AYUSH) for a period exceeding three days								
8	Organ Donor Expenses	Actual								
9	Health Checkup Assure-Individual sum Insured(up to)	1500/-	2000/-	4000/-	5000/-		8000/-			
10	Health Checkup Assure-Floater sum Insured (up to)	2500/-	5000/-	8000/-	10000/-		15000/-			
11	Home care treatment	up to 10% of the sum insured subject to maximum of Rs.5 lakhs in a policy year								
12	Delivery Charges – Normal Delivery and Caesarean Section	up-to 10% of the Sum Insured is payable								
13	Waiting Period for Delivery -Normal Delivery and Caesarean Section	24 months for first delivery from first inception of the policy								
14	In Utero Fetal Surgery/Intervention	24 months waiting period								
15	Assisted Reproduction Treatment(per policy year)	1,00,000/-	2,00,000/-				4,00,000/-			
16	Hospitalization expenses for treatment of New Born Baby(per policy period)	2,00,000/-					4,00,000/-			

S.No	Sum Insured (INR)	5 Lakhs	10 Lakhs	15 Lakhs	20 Lakhs	25 Lakhs	50 Lakhs	75 Lakhs	1 Crore	2 Crore
17	Treatment for Chronic Severe Refractory Asthma(per policy period)	Up to 10% of sum insured not exceeding Rs.5 lakhs								
18	Compassionate Travel	UptoRs. 10,000/-								
19	Repatriation of Mortal Remains (per policy period)	Up to Rs.15,000/-								
20	Treatment in Valuable service providers network(per policy period)	1% of Sum Insured subject to a maximum of Rs.5,000/-								
21	Shared accommodation	Rs.1,000/- per day								
22	AYUSH Treatment	Actuals								
23	Second Medical Opinion	Available								
24	Coverage for Modern Treatment	Upto sum insured								
25	Cumulative Bonus	25% of sum insured for each claim free year subject to a maximum upto 100% of the sum insured								
26	Automatic Restoration of Sum Insured	Each time up to 100% of Sum Insured and unlimited number of times in a policy year.								
27	Rehabilitation and Pain Management(per policy year)	Up to the sub-limit (or) maximum up to 20% of the sum insured whichever is less								
28	Wellness Program	Available								
29	Co-Payment (Applicable only for insured persons aged 61 years and above at the time of entry)	subject to co-payment of 10% of each and every claim amount								
30	Day Care Treatments	Actuals								