SUPER STAR

Unique Identification No: SHAHLIP25036V012425

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

Section I - Definitions

STANDARD DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i) has qualified nursing staff under its employment;

ii) has qualified medical practitioner/s in charge;

iii) has fully equipped operation theatre of its own where surgical procedures are carried out;

iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

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

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

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

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 policythat 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 by the Policy Holder.

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 asunder:

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

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, daycare 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.

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

Aggregate Deductible: The aggregate of admissible hospitalisation expenses in a policy year up to which the Company is not liable.

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

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

Company / Insurer / We / Us: Company / Insurer / We / Us 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 not over 25 years.

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.

Doctor: Doctor 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.

Family: Family includes Insured Person, spouse / live in partner, dependent children between 91 days and 25 years of age not exceeding 4 in number.

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 treatment: In-patient treatment 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.

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

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

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

General Ward / Economy Ward: General Ward / Economy Ward means room with three or more patient beds in a Hospital.

Zone A: Delhi, New Delhi, Faridabad, Gurugram, Shahdara, Ahmedabad, Surat, Vadodara, Gautam Buddha Nagar, Ghaziabad, Mewat, Alwar, Baghpat, Bhiwani, Bulandshahar, Fatehabad, Hisar, jhajjar, Jind, Kaithal, Karnal, Kurukshetra, Mahendragarh, Meerut, Muzaffar nagar, Palwal, Panchsheel Nagar, Panipat, Rewari, Rohtak, Saharanpur, Sirsa, Sonipat, Mumbai (Including suburban), Rest of Gujarat, Thane, Palghar and Raigad

Zone B: Chennai, Ernakulam, Thiruvananthapuram, Bengaluru, Chengalpattu, Kanchipuram, Nashik, Pune, Tiruvallur, Hyderabad, Kollam, Wayanad, Indore, K V Ranga Reddy, Medchal Malkajgiri, Ahmed Nagar and Gwalior

Zone C: Rest of India

Section II - 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 and if such disease or injury shall require the Insured person, upon the advice of a duly qualified Medical Practitioner to incur Hospitalization expenses for Medical / Surgical treatment 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 Coverage but not exceeding the sum insured/ annual sum insured/ appropriate benefit stated in the Policy schedule.

BASIC COVER

1. **In-patient Treatment:** We will cover the following Medical Expenses incurred in respect of Hospitalization of the Insured Person during the Policy Period, up to the Sum Insured specified in the Policy Schedule against this In-Patient treatment:
   (i) Room Rent (Any Room), Boarding, Nursing Expenses as provided by the Hospital / Nursing Home
   (ii) Intensive Care Unit (ICU) Charges
   (iii) Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees
   (iv) Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses.
2. **Day Care Treatment:** We will cover the Medical Expenses incurred in respect of All Day Care Treatments of the Insured Person during the Policy Period up to the Sum Insured as specified in the Policy Schedule if such Day Care treatment requires hospitalization as an in-patient for less than 24 hours.
3. **Pre-hospitalization Expenses:** Medical expenses incurred up to 90 days immediately before the insured person is hospitalized.
4. **Post Hospitalization Expenses:** Medical expenses incurred up to 180 days immediately after the insured person is discharged from the hospital.
5. **Coverage for Modern Treatments:** The following procedures will be covered (wherever medically indicated) either as in-patient or as part of day care treatment in a hospital up to 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
6. **AYUSH Treatment:** Medical expenses for Inpatient Hospitalization incurred on treatment under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines in a AYUSH Hospital is payable up to the sum insured.
   Note: Claims under Yoga and Naturopathy system of treatment will be payable subject to prior approval from the company
7. **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.

8. **Air Ambulance:** 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 Rs.5,00,000/- in a policy year, if the said service was availed on the advice of the treating Medical Practitioner / Hospital. Expenses towards Air ambulance service is payable for only from the place of first occurrence of the illness / accident to the nearest hospital. Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s.

9. **Organ Donor Expenses:** In-patient hospitalization expenses incurred for organ transplantation (including Screening expenses) 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 for the Post Donation Complications (if any) for the complications that necessitate a Redo Surgery / ICU admission upto 180 days from the date of discharge from the hospital are also covered.
Note: The coverage limit under this benefit is upto the sum insured and over and above the sum insured.

10. **Home care Treatment:** Payable up to the sum insured 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:

    a) Fever and Infectious diseases which can be managed as In-patient
    b) Uncomplicated Urinary tract infections but needing Parenteral Antibiotics
    c) Asthma and COPD -Mild Exacerbations needing Home Nebulization
    d) Acute Gastritis / Gastroenteritis
    e) I.V. Chemotherapy [Where advised by the doctor]
    f) Palliative Cancer care requiring medical assistance
    g) Acute Vertigo
    h) Diabetic foot and Cellulitis
    i) IVDP [Cervical and Lumbar disc diseases]
    j) Major Surgeries / Arthroplasties needing IV Antibiotics Post Discharge
    k) Care for Brain and Spinal Injury Cases Post Discharge
    l) Post CVA Care at Home after Discharge

11. **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.

12. **E-Domestic Second Medical Opinion:** The Insured Person can obtain a Second Medical Opinion from a Doctor in the Company's network of Medical Practitioners practicing in India. 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 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.

13. **Premium waiver** - During the policy year, if proposer who is also an insured is diagnosed (first diagnosis) with any of the critical illness specified under Annexure - I (or) in case of Death of insured due to Accident, Premium will be waived off during renewal for the next one policy year and such premium waiver will be given up to the expiring sum insured and optional covers (if opted) once in a life time of the policy.

    Note:

    1. In case of floater policy, if the proposer who is also insured under the policy is diagnosed with the specified critical illness / in case of death of the insured due to Accident, the premium waiver will be available on the floater policy premium.
    2. In case of multi-individual policy, if the proposer who is also insured under the policy is diagnosed with the specified critical illness / in case of death of the insured due to Accident, the premium waiver will be available on the multi-individual policy premium.

14. **Cumulative Bonus:** The insured person will be eligible for cumulative bonus calculated at 50% of sum insured for each claim free year and maximum up to 100% of the sum insured.

    Special Conditions:

    a. The Cumulative bonus will be calculated on the expiring Sum Insured
    b. If the insured opts to reduce the Sum Insured at the subsequent renewal, the limit of indemnity by way of such Cumulative bonus will be considered as per the reduced sum insured
    c. Cumulative bonus will not be reduced unless the same is utilized in the event of claim
    d. During renewal, Cumulative bonus will be reduced only to the extent of utilized portion and the unutilized Cumulative bonus will be carried forward to the next policy year.
    e. This benefit is not applicable to policies with Unlimited Sum insured.

15. **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.
    - The unutilized restored sum insured cannot be carried forward to the next policy year.
    - This benefit is not applicable to policies with Unlimited Sum insured.

Unlimited Restoration – illustration

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

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

16. a) **Tele-Consultation (audio / video / text) facility:** Insured can avail tele-consultations (unlimited times) by using Star Health Mobile App with
    a. General Medical Practitioner
    b. Specialist Medical Practitioner
    c. Phycologist / Psychiatrist
    d. Dietician & Nutritionist

    b) **AI driven Face Scan:** Insured can avail, AI-driven face scan facility by using Star health mobile app to know the vital parameters such as heart rate, oxygen saturation, respiration rate up to two times per month per insured in a policy year.
    Note: The AI-driven face scan facility is a software / AI based assessment and should not be used as substitute for professional medical advice.

17. **Dental Check-up & Cleaning:** Expenses incurred towards cost of Consultation & Dental X-ray (IOPA) and scaling are payable only for one Insured Person under each policy in a policy year, available only on cashless basis.
    Note: This facility is available only in 2nd & 3rd policy year for those who purchased this policy for the first time (as a new policy) with us.

    Incase of multi individual policy each insured can avail this benefit once in a year in 2nd & 3rd policy year.

18. **Value Added Services:** Insured can avail discounts on the services offered by our network providers on Star health mobile application
    a. Discounts on Pharmacy
    b. Discounts on Diagnostics
    c. Discounts on Consultations

19. **Freeze Your Age:** Insured age is locked at entry when they are insured for the first time under the policy and are continuously covered under subsequent renewals, till a claim is incurred under In-patient Treatment / Day care treatment / Ayush Treatment under Basic Cover or they attain the age of 56 years whichever is earlier.

    This benefit will be available only for those insured members whose age at the inception of first coverage under this policy is upto 50 years.

    This benefit shall cease once the insured member attains the age of 56 years irrespective of whether claim has been made or not. On attaining the age of 56 years the premium charged will be as per Insured's actual age on the date of renewal and thereafter the premium applicable will be as per the insured's age at each subsequent renewal.

    E.g. If an Insured is covered under the policy at age 30 years, the premium applicable at each renewal will be the same as applicable for a 30-year-old, till a claim is incurred in the policy. Post the claim is incurred, the premium charged from next renewal onwards will be as per Insured's age on the date of such renewal and we will continue to charge as per the insured's age at each subsequent renewal.

Note

1. In case of long term policies (tenure >1 year), the premium for the entire term will be charged as per the insured's entry age. No additional premium will be charged in the middle of the tenure in case of claims. However at the time of renewal (in case of a claim), the premium will be charged as per the age of the insured at such renewal date and thereafter the premium applicable will be as per the insured's age at each subsequent renewal.
2. If a floater policy, splits into multiple policies, then we will carry forward the locked age at which the floater policies were taken by individuals
3. In a multi individual policy, the age will unlock only for the individuals who claim.
4. In a floater policy, if a claim is incurred for any insured member in the policy then we will unlock the age for all the insured members covered under policy.

20. **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 during the renewal.

    This Wellness Program is enabled and administered online through Star Health Mobile Applications.
    Note: The Wellness Activities mentioned in the table below (from Serial Number 1 to 6) 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 and above	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 18 years)	1:1:0:0:0
Self, Spouse** and Dependent Children (aged above 18 years)	2:2:1:1:1
**Spouse / Live-in Partner	

Note: In case of two year, three year, four year and five year policies, total number of wellness points earned in the two year, three year, four year and five year period will be divided by two, three, four and five respectively.

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

The wellness services and activities are categorized as below:

Sr. No.	Activity	Maximum number of Wellness Points that can be earned under each activity in a policy year
1.	Sign up points for Enrolling to Wellness Program	100
2.	Manage and Track Health	
	a) Online Health Risk Assessment (HRA)	150
	b) Preventive Risk Assessment	200
3.	Affinity to Wellness	
	a) Participating in Walkathon, Marathon, Cyclothon and similar activities	200
	b) Membership in a health club	200
4.	Stay Active – If the Insured member achieves the step count target on mobile app	250
5.	Sharing 'Active Life Success Story' through adoption of Star Wellness Program	50
6.	Condition Management Program (CMP): Weight Management, Diabetes Management, Hypertension, De-Stress & Mind Body Healing Program.	150
7.	For Submission of Vaccination Certificate **Eg:** Vaccine for Covid, HPV, Pneumoccocnal, Swine Flu (H1N1), Hepatitis etc..	20
8.	For Submission of Preventive Eye Check-up report	20
9.	For Submission of Preventive Dental Check-up report	20
10.	For Submission of Mammography & PAP Test (for Women) report	20
11.	For Submission of Prostate specific antigen (PSA) test report (for Male persons aged > 50 yrs)	20
12.	Glaucoma Screening (for persons aged > 50 yrs)	20

1. **Sign up points for Enrolling to Wellness Program:** Insured person(s) can earn 100 reward points for enrolling in Star Wellness Program through Star Health Mobile application.

2. **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 150 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.

   - On submission of the test reports, Insured earns 200 reward points.

   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

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

	Initiative	Wellness Points
a.	Participating in Walkathon, Marathon, Cyclothon and similar activities - On submission of BIB Number along with the details of the entry ticket taken to participate in the event and / or - On Achieving 20,000 Step count on Star Health Mobile Application	200
b.	Membership in a health club (50 points for each quarter) - In a Gym / Yoga Centre / Zumba Classes / Aerobic Exercise / Sports Club / Pilates Classes / Swimming / Tai Chi / Martial Arts / Gymnastics / Dance Classes	200
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.		

4. **Stay Active:** Insured earns wellness reward points on achieving the step count target on 'Star Health Mobile application as mentioned below:

Criteria to get reward points
If the number of steps per day are minimum 8,000 or above for 16 days in a month, it will be considered as one active month and insured will get 20 reward points.
Note: • Incase if Insured achieves 10 active months in a policy year, he / she will get 50 additional points as bonus. • First month and last month in each policy year will not be taken into consideration for calculation of average number of steps per day under Stay Active. • The mobile app must be downloaded within 30 days of the policy risk start date to avail this benefit. • The average step count completed by an Insured member would be tracked on 'Star Mobile Application'.

5. **Condition Management Program**

(i) 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.

- 150 wellness points will be awarded in case if the results are achieved and maintained as mentioned below.

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

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

(ii) 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.

- 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, 150 wellness points will be awarded.
- These tests reports to be submitted within 1 month from the date of undergoing the Health Check-Up

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

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

- On completion of De-stress & Mind Body Healing Program 150 wellness points will be awarded.

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

6. **Reward points for Preventive Care:** Insured can earn wellness reward points for submitting the following health check-up reports once in a policy year which he / she had during the policy year.
   a. Submission of Vaccination Certificate/s: Insured can earn 20 wellness reward points by submitting the Vaccination certificate related to vaccine that he / she have had during the policy year. Eg: Vaccine for Covid, HPV, Swine Flu (H1N1), Hepatitis etc.
   b. Submission of Preventive Eye Check-up report: Insured can earn 20 wellness reward points for submitting Eye Check-up report which includes near and far vision (visual equity) and Colour vision test.
   c. Submission of Preventive Dental Check-up: Insured can earn 20 wellness reward points for submitting Dental Check-up report which includes screening of oral cavity done by a qualified Dentist.
   d. Submission of Mammography & PAP Test report: Insured can earn 20 wellness reward points for submitting x-ray Mammogramgraphy or coloured doppler mammogram for preventive breast screening and PAP smear (biopsy) report.
   e. Prostate specific antigen (PSA) test (applicable for Males aged > 50 yrs): Insured can earn 20 wellness reward points for submitting Prostate specific antigen blood report.
   f. Glaucoma Screening (for persons aged > 50 yrs): Insured can earn 20 wellness reward points by submitting reports of Glucoma screening test of both eyes including tonometery. (slit lamp test), pachymeter test, visual field test, dilated eye test and gonioscopy examination.

Terms and conditions applicable for wellness services

- 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.

A 51 year old Individual Gopal and his wife Ramya along with their two dependent children (aged below 18 yrs) buy a **Super Star** with Sum Insured 10 Lacs, let's understand how they can earn Wellness Points. Gopal has declared that he is suffering from Diabetes. Ramya has declared her BMI as 27. Gopal and Ramya enrolled under the Star wellness program and completed the following wellness activities.

Sr. No.	Activity	Wellness Points Earned by Gopal	Wellness Points Earned by Ramya
1.	Sign up points for Enrolling to Wellness Program	100	100
2.	Manage and Track Health		
	Online Health Risk Assessment (HRA)	150	150
	Preventive Risk Assessment	200	200
3.	Affinity to Wellness		
	Participating in Walkathon, Marathon, Cyclothon and similar activities	200	0
	Membership in a health club	100	150
4.	Stay Active (Wellness points based on Step Count)	250	120
5.	For Sharing 'Active Life Success Story'	50	0
6.	Condition Management Program (CMP)	150	150
7.	Submission of Vaccination Certificate	20	20
8.	For Submission of Preventive Eye Check-up report	20	0
9.	For Submission of Preventive Dental Check-up report	0	20
10.	For Submission of Mammography & PAP Test (for Women) report	0	20
11.	For Submission of Prostate specific antigen (PSA) test report (for Male persons aged > 50 yrs)	20	0
12.	Glaucoma Screening (for persons aged > 50 yrs)	20	0
	Total Number of Wellness Points earned	1280	930
	No of wellness points based upon weightage - 1:1:0:0	640 (1280X1 / 2)	465 (930X1 / 2)

Total Number of Wellness Points earned by Gopal and Ramya = 1105 (640+465)

Based on the no of Wellness Points earned, Gopal & Ramya are eligible to get 20% discount on renewal premium

Section III - Optional Covers

The following Optional Covers are available on payment of additional premium / on reduction in premium as shown in the policy schedule.

Covers under this Section are subject to the terms, conditions, waiting periods and exclusions of this Policy.

1. **Smart Network:** If the Insured Person has opted for this Optional Cover, the Insured Person shall be entitled for a discount of 15% on premium (including the first year premium), subject to the following conditions:
   (a) The treatment as applicable under In-patient Treatment / Daycare Treatment / AYUSH Treatment is to be taken in a hospital listed under the "Smart Network" available on our website www.starhealth.in
   (b) A co-payment of 15% will be applicable (over and above other co-pay, if any) on each and every claim (except in case of accident) in case if the treatment is taken in a hospital which is outside the "Smart Network" List.

   Note
   (i) The Smart Network list is dynamic. Star Health reserves the right to change the list by adding or deleting the hospitals at its discretion. You are requested to please visit our website www.starhealth.in to find the updated list.
   (ii) This optional cover will not be available for insured persons covered under Zone-C

2. **Quick Shield** - Notwithstanding anything to the contrary in the Policy, If Insured Person has PED (Pre-Existing Disease) related to the list of Diseases / illnesses / Conditions mentioned below at the time of issuance of first Policy with the Company, then by choosing this Optional cover, the applicable PED (Pre-Existing Disease) waiting period shall be waived off and coverage will be available from from 31st day of first purchase of this policy under In-patient / Day Care Treatment.

   List of diseases / illnesses / conditions covered under this optional cover:
   (i) Diabetes - Diabetes mellitus is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages eve– organ in the body, which causes serious health consequences.

   (ii) Hypertension - Hypertension is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.

   (iii) Asthma - Asthma is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath.

   (iv) Hyperlipidemia -Hyperlipidaemia is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease.

   (v) Coronary Artery Disease with PTCA done prior to 1 year:
   a. Coronary artery disease is the build-up of lipid-rich plaque in the arteries that supply oxygen-rich blood to the heart. Plaque causes a narrowing or
   b. blockage that could result in a heart attack.
   c. PTCA (Coronary Angioplasty) is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG)
   d. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.
   e. Diagnostic angiography or investigation procedures without angioplasty / stent insertion are excluded from the scope of this definition.

   Note
   (i) Only the Initial waiting period of 30 days is applicable for this benefit.
   (ii) Premium for this optional cover will be collected for five years, If there is an admissible claim within the five years, we will deduct the balance premium from the claim amount.

3. **Coverage for Non-medical Items (Consumables):** Items as per List I will become payable If there is an admissible claim under the policy for In-patient / Day Care Treatment.
   (Exclusion No. 33 - Code Excl 37) as stated under this policy shall not apply if insured opts this coverage

4. **Future Shield:** Provides continuity benefit for all waiting periods served by the member (a) Initial waiting period, (b) Pre-Existing Disease (PED) waiting period, (c) Specific Waiting Period and (d) Maternity Waiting Period (if maternity option/s is / are opted) to the spouse added in future and this will be offered only if the proposed newly added spouse age at the time of entry is up to 35 years

   Note: Insured can only add his / her newly married spouse to the policy.
   Insured should submit marriage certificate to add the spouse. The spouse can be added anytime during the policy tenure or at Renewal.

   The newly married spouse can be added only if the marriage has happened after taking this optional cover.

   Newly Married spouse MUST be added within 120 days of the marriage to get the benefits given under Future Shield Option.

   This optional cover can be opted only by the insured covered under individual policy.

   If female individual opts this optional cover along with maternity expenses option, the claim under maternity is payable only if the spouse gets added

5. Maternity Expenses:

(Option - A) Delivery Expenses (with 24 months waiting period) and New Born Cover:

Delivery Expenses: Expenses for a Delivery including Delivery by Caesarean section (including pre-natal and postnatal expenses) up-to of the limits (including for twins/ triplets/ quadruplets) specified in the policy schedule:

Note:

i) Benefit under this section is subject to a waiting period of 24 months from the date of first commencement of Super Star Policy / from the time of opting this optional cover (whichever is later) and its continuous renewal thereof with the Company.

ii) There is no waiting period for subsequent deliveries

iii) Maximum up to 4 deliveries are payable after taking this optional cover and payable while the policy is in force

iv) Pre-hospitalization and Post Hospitalization expenses are not covered under this optional cover.

New Born Cover: Hospitalization expenses for treatment of new born is covered up to the limits (including for twins/ triplets/ quadruplets) specified below incurred in a hospital/ nursing home for Any disease, illness or accidental injuries are payable from Day 1 of its birth till the expiry date of the policy.

Sum Insured (Rs.)	Limit of liability in a policy year (Rs.)
5,00,000/- to 25,00,000/-	2,00,000/-
50,00,000/-; 1,00,00,000/-; Unlimited Sum Insured	5,00,000/-

Note:

i) 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

ii) 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.

iii) 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.

iv) 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.

v) Enhancement of sum insured is subject to underwriters' approval

vi) The above mentioned sub-limt will not apply for treatment related to congenital internal disease/ defects for the New Born.

(Option - B) Delivery Expenses (with 12 months waiting period) and New Born Cover:

Delivery Expenses: Expenses for a Delivery including Delivery by Caesarean section (including pre-natal and postnatal expenses) up-to of the limits (including for twins/ triplets/ quadruplets) specified in the policy schedule:

Note:

i) Benefit under this section is subject to a waiting period of 12 months from the date of first commencement of Super Star Policy / from the time of opting this optional cover (whichever is later) and its continuous renewal thereof with the Company.

ii) There is no waiting period for subsequent deliveries

iii) Maximum up to 4 deliveries are payable after taking this optional cover and payable while the policy is in force.

iv) Pre-hospitalization and Post Hospitalization expenses are not covered under this optional cover.

New Born Cover: Hospitalization expenses for treatment of new born is covered up to the limits (including for twins/ triplets/ quadruplets) specified below incurred in a hospital/ nursing home for Any disease, illness or accidental injuries are payable from Day 1 of its birth till the expiry date of the policy.

Sum Insured (Rs.)	Limit of liability in a policy year (Rs.)
5,00,000/- to 25,00,000/-	2,00,000/-
50,00,000/-; 1,00,00,000/-; Unlimited Sum Insured	5,00,000/-

Note:

i) 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

ii) 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.

iii) 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.

iv) 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.

v) Enhancement of sum insured is subject to underwriters' approval

vi) The above mentioned sub-limt will not apply for treatment related to congenital internal disease/defects for the New Born.

(Option - C) Assisted Reproduction Treatment: The Company will reimburse medical expenses incurred on Assisted Reproduction Treatment (ART) as per the table mentioned below, for sub-fertility subject to:

a) A waiting period of 24 months from the date of first commencement of Super Star Policy/ from the time of opting this optional cover (whichever is later) and its continuous renewal thereof with the Company.

b) This cover is available only when both self and spouse are covered under this policy for a continuous period of 24 months under Individual or floater sum insured.

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

d) 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/-; 7,50,000/-	1,00,000/-
10,00,000/-; 15,00,000/-; 20,00,000/-; 25,00,000/-	2,00,000/-
50,00,000/-; 1,00,00,000/-; Unlimited Sum Insured	4,00,000/-

The Company shall not be liable to make any payments under this policy in respect of any expenses 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

6. **Women Care:** Pregnant women can buy this policy by submitting 12 and 20 week scan reports of their pregnancy period, in case if we accept such proposal and issued the policy, the New Born will be covered immediately after its birth covered till end of the policy year (for congenital defects up to the sum insured) up to the following limits:

Sum Insured (Rs.)	Limit of liability in a policy year (Rs.)
5,00,000/- to 25,00,000/-	2,00,000/-
50,00,000/-; 1,00,00,000/-; Unlimited Sum Insured	5,00,000/-

7. **High-end Diagnostics:** The following diagnostics tests are payable on OPD basis if required as a part of a treatment up to Rs.25,000 in a policy year
   - Brain Perfusion Imaging
   - CT guided biopsy
   - CT urography
   - Digital Subtraction Angiography(DSA)
   - Liver Biopsy
   - Magnetic Resonance Cholangiography Scan
   - PET CT
   - PET MRI
   - Renogram

   Note: Only the Initial waiting period of 30 days is applicable for this benefit.

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

   Option A - Accidental Death of Insured Person: If following an Accident that causes death of the Insured Person within 12 Calendar months from the date of Accident, then the Company will pay an amount as compensation the Sum Insured mentioned in the Schedule

   Option B - Accidental Death and Permanent Disablement of the Insured Person: If following an Accident which caused permanent impairment of the Insured's mental or physical capabilities, then the Company will pay the benefits as provided in the "Table of Benefits – B1", depending upon the degree of disablement provided that;

   a) The disablement occurs within 12 Calendar months from the date of the Accident

   b) The disablement is confirmed and claimed for, prior to the expiry of a period of 60 days since occurrence of the disablement

   Conditions applicable for Personal Accident Cover:

   1. If the Accident affects any physical function, which was already impaired prior to the accident, a deduction as per "Table – B2" will be made in respect of this prior disablement
   2. In the event of Permanent Disablement, the Insured Person will be under obligation:
      a) To have himself / herself examined by doctors appointed by the Company and the Company will pay the costs involved thereof.
      b) To authorize doctors providing treatments or giving expert opinion and any other authority to supply the Company any information that may be required. If the obligations are not met with due to whatsoever reason, the Company may be relieved of its liability to pay.
   3. This optional cover is applicable for the person specifically mentioned in the Schedule
   4. Where a claim has been paid during the policy period the cover under this optional cover ceases until the expiry of the policy for the insure who made a claim under this optional cover. However even if the sum insured under this section is exhausted by way of claim, the coverage under health section will continue until expiry of the policy period
   5. Any claim under health portion will not affect the Sum Insured under this optional cover

6. Where there is an admissible claim for Accidental Death during the policy period, the health cover will continue for the remaining insured persons

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

Table of Benefits - B1	
Benefits	**Percentage of the Basic Sum Insured**
1. Death	100%
2. Permanent Total Disablement	100%
Total and irrevocable loss* of	
(i) Sight of both eyes	100%
(ii) Physical separation of two entire hands	100%
(iii) Physical separation of two entire foot	100%
(iv) One entire hand and one entire foot	100%
(v) Sight of one eye and loss of one hand	100%
(vi) Sight of one eye and loss of one entire foot	100%
(vii) Use of two hands	100%
(viii) Use of two foot	100%
(ix) Use of one hand and one foot	100%
(x) Sight of one eye and use of one hand	100%
(xi) Sight of one eye and use of one foot	100%

Table - B2			
Physical function already impaired prior to accident			**Percentage of Sum Insured Deducted**
1	Loss of toes all	All	20
	Loss of Great toe	both phalanges	5
	Loss of Great toe	one phalanx	2
	Other than Great, if more than		
	One toe lost, for each toe	For each toe	1
2	Loss of hearing both ears	Both ears	75
	Loss of hearing one ear	One ear	30
3	Loss of four fingers and thumbs of One hand		40
4	Loss of four fingers		35
	Loss of thumb both phalanges	Both phalanges	25
		One phalanx	10
5	Loss of index finger three phalanges	Three phalanges	10
	Two phalanges	Two phalanges	8
	One phalanx	One phalanx	4
6	Loss of middle finger	Three phalanges	6
		Two phalanges	4
		One phalanx	2
7	Loss of ring finger	Three phalanges	5
		Two phalanges	4
		One phalanx	2
8	Loss of little finger	Three phalanges	4
		Two phalanges	3
		One phalanx	2
9	Loss of metacarpals	First or second	3
		Additional (third fourth or fifth)	2
10	Any other Permanent partial disablement		Percentage as assessed by the Medical Board or by the government doctor

Geographical Scope: The cover under this section applies World Wide

9. **Annual Health Check-up:** Available up to 1% of Sum Insured subject to maximum of Rs.25,000/- in a policy year, available from Day 1 of the policy. The tests MUST be booked through digital assets (e.g. Mobile App). This benefit is available only on cashless basis.

Note:

This annual health check-up limit can also be utilized for vaccination expenses

In case of floater policy the limits are applicable per policy, in case of Individual / multi-individual policy this limit is applicable per each insured person.

10. **Voluntary Co-payment:** In case Voluntary Co-payment is opted as mentioned in the Policy Schedule, the Insured Person will be liable to bear the specified Co-payment percentage (over and above other co-pay, if any) of admissible claim amount of each and every claim amount.
    i. Voluntary Co-payment once chosen cannot be modified mid-term.
    ii. Voluntary Co-payment if chosen by the Insured Person(s) shall be applicable on Section II (1 to 11)
    iii. Voluntary co-payment will not be available in case voluntary deductible has been opted
    iv. Once opted, the insured can not reduce the co-payment percentage (or) opt out of this optional cover.
11. **Voluntary Deductible:** In case Voluntary Deductible is opted as mentioned in the Policy Schedule, the Insured Person will be liable to bear the specified Deductible amount.
    i. Voluntary Deductible will apply on aggregate basis for all hospitalisation expenses during the policy year which fall under basic cover.
    ii. The deductible will apply on individual basis in case of individual policy and on floater basis in case of floater policy.
    iii. Voluntary Deductible if chosen by the Insured Person(s) shall be applicable on Section II (1 to 11)
    iv. Voluntary deductible will not be available in case voluntary co-payment has been opted
    v. Once opted, the insured can not reduce the voluntary deductible amount (or) opt out of this optional cover.
12. **Room Rent Modification:** If the Insured person has opted for this optional cover as mentioned in the policy schedule, the Insured shall have an option to modify the room rent eligibility to Single Private AC Room / Shared Room / General Ward.
    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
13. **E- International Second Opinion:** In case E-International Second Option is opted as mentioned in the policy schedule, Insured can obtain a Second Medical Opinion from our panel of internationally available medical practitioners, The Insured Person may choose one of the Medical Practitioners out of the 3 choices given by Us / Our Empanelled Service Provider. 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.

    Note: -
    - Incase of individual policy the insured can utilize this facility once in a policy year.
    - Incase of floater / multi individual policy each insured can utilize this facility once in a policy year.
    - 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.
14. **Durable Medical Equipment Cover:** Incase Durable Medical Equipment cover is opted as shown in the Schedule, the expenses incurred by Insured towards renting or purchase of any of the listed durable medical equipment up to a limit of Rs. 5 Lakhs will be payable once during the life time of the policy, if the same has been prescribed by the treating Medical Practitioner Post Hospitalization for the same condition for which the Hospitalization claim was admissible

    List of Durable Medical Equipment Covered under this optional Cover:
    1. CPAP Machine
    2. Ventilator
    3. Wheelchair
    4. Prosthetic device
    5. Suction Machine
    6. Commode Chairs
    7. Infusion pump
    8. Continuous Passive motion devices in case of Knee Replacement
    9. Oxygen concentrator

    Note: Once this limit is exhausted, the cover will cease to exist and cannot be opted again upon subsequent renewals.
15. **Compassionate Visit:** Incase Compassionate Visit is opted as shown in the Schedule, If Insured is admitted for life-threatening emergency away from his / her usual place of residence recorded in the policy we will pay up to Rs.10,000/- per occurrence for an immediate family member (other than travel companion) for travel towards the place where the hospital is located provided if the hospitalization claim is admissible under the policy.

16. **Hospital Cash Benefit:** Incase Hospital Cash benefit is opted as shown in the Schedule, the Company will pay to the Insured Person, Hospital Cash (lump-sum) amount as specified in the Policy Schedule for every completed 24 hours of hospitalization up to the number of days as specified in the Policy Schedule, provided the claim is admissible under In-patient treatment or Ayush treatment.

17. **Reduction of Specified disease / procedure Waiting Period:** The Insured Person can reduce the Specified disease / procedure waiting period from 24 months to 12 months. This option is available only for the first purchase of this policy and also only upto Sum Insured chosen at that time. This option is not available for renewal / ported / migrated policies. Offering reduction of Specified disease / procedure waiting period is subject to Underwriter's approval.

18. **Reduction of Pre-Existing Diseases Waiting Period (Other than those listed under Quick Shield-if Opted):** The Insured Person can reduce the Pre-Existing Disease/s waiting period from 36 months to 24 months / 12 months. This option is available only for the first purchase of this policy and also only upto Sum Insured chosen at that time. This option is not available for renewal / ported / migrated policies. Offering reduction of Pre-Existing Diseases waiting period is subject to Underwriter's approval.
Note: If the Pre-Existing Disease/s falls under the list of specific disease waiting period (Exclusion No. 2 - Code Excl 02), the longer among the Pre-Existing Disease and specific disease waiting period shall apply.

19. **Limitless Care:** Will cover the Medical Expenses incurred in respect of Hospitalization of the Insured Person under In-Patient / Day Care Treatment of the Insured Person for any one claim during the lifetime of the Policy without any limits on the Sum Insured subject to the following conditions:
    (a) Once opted, the optional cover has to be opted continuously by the Insured Person until any one claim is made under this cover.
    (b) Once a claim has been made under this Optional Cover, the cover will cease to exist and cannot be opted again upon subsequent renewals.
    (c) Optional Cover 10. Voluntary Co-payment or Optional Cover 11. Voluntary Deductible if opted by the Insured Person shall be applicable under this Optional Cover.
    (d) Following the payment of claim under Limitless Care, the Total Sum Insured shall be reduced to zero for that Policy Year
    (e) This optional cover shall not be available to policies with Unlimited Sum insured

20. **Super Star Bonus (Guaranteed Bonus):** If the Insured Person has opted for this optional cover, Insured will get an additional Cumulative Bonus of 100% of expiring or renewed Annual Sum Insured (whichever is lower) at the end of each Policy Year irrespective of a claim in the Policy Year, provided that the Policy has been continuously renewed with the Company subject to the conditions mentioned below:
    i. The Super Star Bonus can be accumulated up to an Unlimited Sum Insured.
    ii. This cover shall not be available to policies with Unlimited Sum Insured.
    iii. In case, the Insured Person opts out of this cover at the time of renewal, all the bonus accumulated under this will be reduced to zero

21. **NRI Advantage:** If a Non Resident Indian (NRI) / Overseas Citizen has opted this optional cover under this policy, we will provide a 10% discount on the applicable premium provided that the Insured Person(s) -
    i. Provides declaration upon Policy Issuance and subsequent renewals that they are based abroad in entirety for the Policy Year
    ii. Provides proof of overseas residence for the upcoming year upon each renewal to continue availing the discount
    iii. Possesses and provides other relevant identity proof documents as mandated for Citizenship of India
    iv. Has an Indian bank account for premium / claims payment.
    v. If the Insured person ceases to reside outside India, then no further discount shall be applicable upon renewal.
    vi. This discount can be availed only for a maximum period of five continuous Policy Years and the same will be applicable on a Policy level. All waiting periods as per the policy terms and conditions will be applicable for the Insured Persons.
    vii. The coverage is available only for treatments taken in India

Note (applicable to Section-III Optional Covers): In case if Insured opted optional cover/s which has a waiting period, the waiting period will be calculated from the date of first commencement of Super Star Policy (or) from the time of opting/re-opting this optional cover (whichever is later) and its continuous renewal thereof with the Company.

List of Benefits which are in addition to the Sum Insured
Basic Cover
Organ Donor Expenses
Cumulative Bonus
Automatic Restoration of Sum Insured
Optional Cover
Personal Accident Cover
Annual Health Check-up
Compassionate Visit
Hospital Cash Benefit
Limitless care
Super Star Bonus (Guaranteed Bonus)
Maternity Expenses
High-end Diagnostics
Durable Medical Equipment Cover

IV. EXCLUSIONS

STANDARD EXCLUSIONS

1. **Pre-Existing Diseases - Code Excl 01**
   - A. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer
   - B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   - C. If the Insured Person is continuously covered without any break as defined under the portability norms of the extent IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
   - D. Coverage under the policy after the expiry of 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
     - i. 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.
     - ii. Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal Tunnel Syndrome, Trigger Finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology
     - iii. 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].
     - iv. 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)
     - v. 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.
     - vi. All types of Hernia
     - vii. Desmoid Tumor, Umbilical Granuloma, Umbilical Sinus, Umbilical Fistula
     - viii. All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Cervix, Uterus, Fallopian tubes, Ovaries, Uterine Bleeding, Pelvic Inflammatory Diseases
     - ix. All Diseases of Prostate, Stricture Urethra, all Obstructive Uropathies
     - x. Benign Tumours of Epididymis, Spermatocele, Varicocele, Hydrocele
     - xi. Fistula, Fissure in Ano, Hemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence
     - xii. Varicose veins and Varicose ulcers
     - xiii. All types of transplant and related surgeries.
     - xiv. Congenital Internal disease / defect (except for New Born Cover - Section (III) (5) (Option A and Option B)
3. **30-day waiting period – Code Excl 03 (Not Applicable for Accidents)**
   - A. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered
   - B. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months
   - C. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently
4. **Investigation & Evaluation – Code Excl 04**
   - A. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
   - B. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

5. **Rest Cure, rehabilitation and respite care – Code Excl 05:** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or nonskilled 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 weightloss:
         a. Obesity-related cardiomyopathy
         b. Coronary heart disease
         c. Severe Sleep Apnea
         d. Uncontrolled Type2Diabetes
7. **Change-of-Gender treatments – Code Excl 07:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
8. **Cosmetic or plastic Surgery – Code Excl 08:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
9. **Hazardous or Adventure sports – Code Excl 09:** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
10. **Breach of law – Code Excl 10:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
11. **Excluded Providers – Code Excl 11:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
12. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof **– Code Excl 12**
13. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons **– Code Excl 13**
14. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **– Code Excl 14**
15. **Refractive Error – Code Excl 15:** Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.
16. **Unproven Treatments – Code Excl 16:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
17. **Sterility and Infertility – Code Excl 17 (Except to the extent covered under Section III (5) Option C):** 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 Section III (5) Option – A & B):**
    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 **- Code Excl 20** (Except to the extent covered under Section III (5) (Option – A & B) and (6))

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

31. 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**

32. Any hospitalizations which are not Medically Necessary / does not warrant hospitalization **– Code Excl 36**

33. Other excluded expenses as detailed in the website www.starhealth.in **– Code Excl 37**

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

V. CONDITIONS

STANDARD CONDITIONS

1. Disclosure of Information: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of 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 help-line 044-69006900 or Toll Free No.1800 425 2255, Senior Citizens may call at 044 40020888

b. Inform the ID number for easy reference

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

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

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

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

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

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

i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the Insured may visit www.starhealth.in or contact the nearest branch

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

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

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

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

C. **For Reimbursement claims:** Time limit for submission of

Sl.No.	Type of Claim	Prescribed time limit
1	Reimbursement of hospitalization, day care and pre hospitalization expenses	Claim must be filed within 15 days from the date of discharge from the Hospital.
2	Reimbursement of Post hospitalization	within 15 days after completion of 180 days from the date of discharge from hospital

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

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

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

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

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

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

4. **Multiple Policies**

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

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

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

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

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

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

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

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

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

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

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

6. **Cancellation**
   i. The Policyholder may cancel his policy anytime during the term by giving 7 days written notice. In such an event, The Company shall
      a. refund proportionate premium for unexpired policy period, for policy term upto one year and there is no claim (s) made during the policy period.
      b. refund premium for the unexpired policy period, in respect of policies with policy term more than 1 year and risk coverage for such policy years has not commenced
   ii. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud

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

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

   For Detailed Guidelines on migration, kindly refer the link
   https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

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

   For Detailed Guidelines on portability, kindly refer the link
   https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

9. **Renewal of policy:** The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.
   i) Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
   ii) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
   iii) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
   iv) Coverage is not available during the grace period.
   v) No loading shall apply on renewals based on individual claims experience

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

11. **Moratorium Period:** After completion of sixty continuous months of coverage (including portability and migration) under the health insurance policy no look back to be applied. This period of sixty months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of sixty continuous months would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud non-disclosure, misrepresentation and exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

12. **Premium Payment in Instalments:** 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 "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the installment premium is not paid on due date.

v. In case of installment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

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, and to return the same if not acceptable.

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

    i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

    ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

    iii. where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

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
    Senior Citizens may call at 044-69007500

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

    Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at 044-43664600.

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

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

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

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. **Midterm Inclusion** of Newly Married Spouse, Legally adopted child and New Born baby is Permissible on payment of proportionate premium subject to the following:
    (i) The cover for new born commences from 91st day of its birth
    (ii) Waiting periods as stated in the policy will be applicable from the date of inclusion of such newly married spouse, new born baby, legally adopted child
    (iii) Such midterm inclusion will be subject to underwriter's approval

22. **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, No 1 New Tank Street, Vallurvar Kottam High Road Nungambakkam Chennai - 600034, Toll Free Fax No. 1800 425 5522, 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.

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

24. **Automatic Expiry:** 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.

25. **Policy disputes:** Any dispute concerning the interpretation of the terms, conditions, limitations and / or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

26. **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

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

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

29. **Important Note**
    a) Where the policy is issued for more than 1 year, the Basic Sum Insured including sublimits, cumulative bonus (if applicable), automatic restoration benefit (if applicable) is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd or 3rd or 4th or 5th year cannot be utilized in the 1st year itself. The terms, conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each policy year
    b) Where the policy is issued on floater basis, the basic sum insured cumulative bonus and other related benefits floats amongst the insured persons
    c) The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws
    d) The terms, conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each relevant Insured Person. Failure to comply with may result in the claim being denied
    e) The attention of the policy holder is drawn to our website www.starhealth.in for anti fraud policy of the company for necessary compliance by all stake holders

30. **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, No.1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai 600034, 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. Tel.: 079 - 25501201/02/05/06	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Email: bimalokpal.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: bimalokpal.bengaluru@cioins.co.in	
BHOPAL	
Office of the Insurance Ombudsman,	
1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202	Madhya Pradesh, Chhattisgarh.
Email: bimalokpal.bhopal@cioins.co.in	
BHUBANESWAR	
Office of the Insurance Ombudsman,	
62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455	Odisha.
Email: bimalokpal.bhubaneswar@cioins.co.in	
CHANDIGARH	
Office of the Insurance Ombudsman,	
S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
Email: bimalokpal.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: bimalokpal.chennai@cioins.co.in	
DELHI	
Office of the Insurance Ombudsman,	
2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Email: bimalokpal.delhi@cioins.co.in	
KOCHI	
Office of the Insurance Ombudsman,	
10th Floor, Jeevan Prakash, LIC Building, Opp.to Maharaja's College, M. G. Road, Kochi - 682 011. Tel.: 0484 - 2358759	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
Email: bimalokpal.ernakulam@cioins.co.in	
GUWAHATI	
Office of the Insurance Ombudsman,	
Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Email: bimalokpal.guwahati@cioins.co.in	
HYDERABAD	
Office of the Insurance Ombudsman,	
6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
Email: bimalokpal.hyderabad@cioins.co.in	
JAIPUR	
Office of the Insurance Ombudsman,	
Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363/2740798	Rajasthan.
Email: bimalokpal.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: bimalokpal.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 Email: bimalokpal. lucknow@cioins.co.in	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: bimalokpal.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	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
Email: bimalokpal.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: bimalokpal.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: bimalokpal.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	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).
Email: bimalokpal.pune@cioins.co.in	

For the details of Insurance Ombudsman please visit: https://cioins.co.in/Complaint/Online

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

54 CRITICAL ILLNESSES LIST

S.No.	Annexure - I
1	Cancer of Specified Severity
2	Myocardial Infarction
3	Kidney Failure Requiring Regular Dialysis
4	Open Chest CABG
5	Permanent Paralysis of Limbs
6	Stroke Resulting in Permanent Symptoms
7	Surgery for Major Organ / Bone Marrow Transplant
8	Benign Brain Tumour
9	Blindness
10	Deafness
11	HIV Due to Blood Transfusion and Occupationally Acquired HIV
12	End Stage Lung Failure
13	End Stage Liver Failure
14	Major Third degree Burns
15	Coma of Specified Severity
16	Repair / Replacement of Heart Valves
17	Motor Neuron Disease with Permanent Symptoms
18	Multiple Sclerosis with Persisting Symptoms
19	Aorta Graft Surgery
20	Severe Rheumatoid Arthritis
21	Alzheimer's Disease
22	Primary (Idiopathic) Pulmonary Hypertension
23	Loss of Limbs
24	Terminal illness
25	Tuberculosis Meningitis
26	Apallic Syndrome

27	Brain Surgery
28	Major Head Trauma
29	Crohn's Disease
30	Infective Endocarditis
31	Creutzfeldt-Jacob Disease (CJD)
32	Medullary Cystic Disease
33	Loss of Speech
34	Encephalitis
35	Fulminant Hepatitis
36	Muscular Dystrophy
37	Systemic Lupus Erythematosus with Lupus Nephritis
38	Dissecting Aortic Aneurysm
39	Severe Ulcerative Colitis
40	Amputation of Feet due to Complications from Diabetes
41	Aplastic Anemia
42	Bacterial Meningitis
43	Chronic Adrenal Insufficiency (Addison's Disease)
44	Chronic Relapsing Pancreatitis
45	Eisenmenger's Syndrome
46	Hemiplegia
47	Loss of Independent Existence
48	Loss of One Limb and One Eye
49	Myelofibrosis
50	Other Serious Coronary Artery Disease
51	Pheochromocytoma
52	Poliomyelitis
53	Progressive Scleroderma
54	Progressive Supranuclear Palsy

CRITICAL ILLNESS MEANS

STANDARD DEFINITIONS

1. **CANCER OF SPECIFIED SEVERITY:** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

   The following are excluded –

   i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

   ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

   iii. Malignant melanoma that has not caused invasion beyond the epidermis;

   iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

   v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

   vi. Chronic lymphocytic leukaemia less than RAI stage 3

   vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

   viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5 / 50 HPFs;

2. **MYOCARDIAL INFARCTION:** The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

   ii. New characteristic electrocardiogram changes

   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

   The following are excluded:

   A. Other acute Coronary Syndromes

   B. Any type of angina pectoris

   C. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. **OPEN CHEST CABG-:** The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

   The following are excluded
   Angioplasty and / or any other intra-arterial procedures are excluded.

4. **REPAIR / REPLACEMENT OF HEART VALVES:** The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves or Trans catheter aortic valve implantation (TAVI) under anesthesia, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve. The diagnosis of the valve abnormality must be supported by an echocardiography / a cardiac catheterization and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques apart from TAVI (Trans catheter aortic valve implantation), including but not limited to, balloon valvotomy / valvuloplasty are excluded. "

5. **COMA OF SPECIFIED SEVERITY:** A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

   The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. **KIDNEY FAILURE REQUIRING REGULAR DIALYSIS:** End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. **STROKE RESULTING IN PERMANENT SYMPTOMS:** Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

   The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. **SURGERY FOR MAJOR ORGAN / BONE MARROW TRANSPLANT:** The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

   The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

9. **PERMANENT PARALYSIS OF LIMBS:** Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. **MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS:** Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. **MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS**
    I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
       i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
       ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
    II. Neurological damage due to SLE is excluded

12. **BENIGN BRAIN TUMOR:** Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

    This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
    i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord are excluded

13. **BLINDNESS:** Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:

i. corrected visual acuity being 3 / 60 or less in both eyes or ;

ii. the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

14. **DEAFNESS:** Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

15. **END STAGE LUNG FAILURE:** End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and

iv. Dyspnea at rest.

16. **END STAGE LIVER FAILURE:** Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy

iv. Liver failure secondary to drug or alcohol abuse is excluded.

17. **LOSS OF SPEECH:** Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

18. **LOSS OF LIMBS:** The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

19. **MAJOR HEAD TRAUMA:** Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

i. **Washing:** the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. **Dressing:** the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. **Transferring:** the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. **Mobility:** the ability to move indoors from room to room on level surfaces;

v. **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. **Feeding:** the ability to feed oneself once food has been prepared and made available. Spinal cord injury are excluded:

20. **PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION:** An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. **MAJOR THIRD DEGREE BURNS:** There must be third-degree burns with scarring that cover at least 40% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 40% of the body surface area.

SPECIFIC DEFINITIONS

1. **ALZHEIMER'S DISEASE** Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner.

   The following conditions are however not covered:
   a. non-organic diseases such as neurosis and psychiatric Illnesses;
   b. alcohol related brain damage; and
   c. any other type of irreversible organic disorder / dementia.

2. **CREUTZFELDT-JACOB DISEASE (CJD)** Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A Registered Doctor who is a neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.

3. **ENCEPHALITIS** Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Doctor who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks.

   Encephalitis caused by HIV infection is excluded.

4. **FULMINANT HEPATITIS** A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:
   a. Rapid decreasing of liver size;
   b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
   c. Rapid deterioration of liver function tests;
   d. Deepening jaundice; and
   e. Hepatic encephalopathy.

   Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

5. **MUSCULAR DYSTROPHY** A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a Registered Doctor who is a consultant neurologist. The condition must result in the inability of the Life Insured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" for a continuous period of at least 6 months.

   Activities of daily living:
   i. **Washing:** the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
   ii. **Dressing:** the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii. **Transferring:** The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
   iv. **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   v. **Feeding:** the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
   vi. **Mobility:** The ability to move indoors from room to room on level surfaces at the normal place of residence

6. **AORTA GRAFT SURGERY** The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

   The following are exclude from this definition
   a. Surgery performed using only minimally invasive or intra-arterial techniques.
   b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

7. **SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS** A multi-system autoimmune disorder characterised by the development of autoantibodies directed against various self-antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a Registered Doctor specialising in Rheumatology and Immunology.

   The WHO Classification of Lupus Nephritis:
   Class I Minimal Change Lupus Glomerulonephritis

   Class II Messangial Lupus Glomerulonephritis

   Class III Focal Segmental Proliferative Lupus Glomerulonephritis

   Class IV Diffuse Proliferative Lupus Glomerulonephritis

   Class V Membranous Lupus Glomerulonephritis

8. **DISSECTING AORTIC ANEURYSM** A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a Registered Doctor who is a specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.

9. **INFECTIVE ENDOCARDITIS** Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:
   I. Positive result of the blood culture proving presence of the infectious organism(s);
   II. Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and
   III. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a Registered Doctor who is a cardiologist.

10. **SEVERE ULCERATIVE COLITIS** Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.

    All of the following criteria must be met:
    - the entire colon is affected, with severe bloody diarrhoea; and
    - the necessary treatment is total colectomy and ileostomy; and
    - the diagnosis must be based on histopathological features and confirmed by a Registered Doctor who is a specialist in gastroenterology.

11. **AMPUTATION OF FEET DUE TO COMPLICATIONS FROM DIABETES** Diabetic neuropathy and vasculitis resulting in the amputation of both feet at or above ankle as advised by a Registered Doctor who is a specialist as the only means to maintain life. Amputation of toe or toes, or any other causes for amputation shall not be covered.

12. **APALLIC SYNDROME** Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.

13. **APLASTIC ANEMIA** Chronic persistent bone marrow failure which results in anemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:
    - Blood product transfusion;
    - Marrow stimulating agents;
    - Immunosuppressive agents; or
    - Bone marrow transplantation.

    The diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:
    a. Absolute neutrophil count of less than 500/mm³ or less
    b. Platelets count less than 20,000/mm³ or less
    c. Reticulocyte count of less than 20,000/mm³ or less

    Temporary or reversible Aplastic Anemia is excluded.

14. **BACTERIAL MENINGITIS:** Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:
    a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
    b. A consultant neurologist.

    Bacterial Meningitis in the presence of HIV infection is excluded.

15. **BRAIN SURGERY** The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are all excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Registered Doctor who is a qualified specialist.

16. **CHRONIC ADRENAL INSUFFICIENCY (ADDISON'S DISEASE)** An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a Registered Doctor who is a specialist in endocrinology through one of the following:
    - ACTH simulation tests;
    - insulin-induced hypoglycemia test;
    - plasma ACTH level measurement;
    - Plasma Renin Activity (PRA) level measurement.

    Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.

17. **CHRONIC RELAPSING PANCREATITIS** An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Registered Doctor who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterised by irreversible morphological change and typically causing pain and / or permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence.

    Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

18. **CROHN'S DISEASE** Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:
    I. Stricture formation causing intestinal obstruction requiring admission to hospital, and
    II. Fistula formation between loops of bowel, and
    III. At least one bowel segment resection.

    The diagnosis must be made by a Registered Doctor who is a specialist Gastroenterologist and be proven histologically on a pathology report and / or the results of sigmoidoscopy or colonoscopy.

19. **EISENMENGER'S SYNDROME** Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a Registered Doctor who is a specialist with echocardiography and cardiac catheterisation and supported by the following criteria:
    I. Mean pulmonary artery pressure > 40 mm Hg;
    II. Pulmonary vascular resistance > 3mm / L / min (Wood units); and
    III. Normal pulmonary wedge pressure < 15 mm Hg.

20. **HEMIPLEGIA** The total and permanent loss of the use of one side of the body through paralysis caused by illness or injury, except when such injury is self-inflicted.

21. **HIV DUE TO BLOOD TRANSFUSION AND OCCUPATIONALLY ACQUIRED** HIV Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:
    I. The blood transfusion was medically necessary or given as part of a medical treatment;
    II. The blood transfusion was received in India after the Policy Date, Date of endorsement or Date of reinstatement, whichever is the later;
    III. The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and
    IV. The Life Insured does not suffer from Thalassaemia Major or Haemophilia.

    Infection with the Human Immunodeficiency Virus (HIV) which resulted from an Accident occurring after the Policy Date, date of endorsement or date of reinstatement, whichever is the later whilst the Life Insured was carrying out the normal professional duties of his or her occupation in India, provided that all of the following are proven to the Company's satisfaction:
    I. Proof that the Accident involved a definite source of the HIV infected fluids;
    II. Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented Accident. This proof must include a negative HIV antibody test conducted within 5 days of the Accident; and
    III. HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

    This benefit is only payable when the occupation of the Life Insured is a Registered Doctor, housemen, medical student, registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in India. This benefit will not apply where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.

22. **LOSS OF INDEPENDENT EXISTENCE** Inability to perform at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months and leading to a permanent inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor.

    All psychiatric related causes are excluded.

    Activities of daily living:
    i. **Washing:** the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
    ii. **Dressing:** the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. **Transferring:** The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;

iv. **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

v. **Feeding:** the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.

vi. **Mobility:** The ability to move indoors from room to room on level surfaces at the normal place of residence

23. **LOSS OF ONE LIMB AND ONE EYE** Total, permanent and irrecoverable loss of sight of one eye and loss by severance of one limb at or above the elbow or knee.

    The loss of sight of one eye must be clinically confirmed by a Registered Doctor who is an eye specialist, and must not be correctable by aides or surgical procedures.

24. **MEDULLARY CYSTIC DISEASE** Medullary Cystic Disease where the following criteria are met:
    - the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
    - clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
    - the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

    Isolated or benign kidney cysts are specifically excluded from this benefit.

25. **MYELOFIBROSIS** A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Life Insured requires a blood transfusion at least monthly. The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a Registered Doctor who is a specialist.

26. **OTHER SERIOUS CORONARY ARTERY DISEASE** Severe coronary artery disease in which at least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only (non-invasive diagnostic procedures excluded).

    For purposes of this definition, "major coronary artery" refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).

27. **PHEOCHROMOCYTOMA** Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.

    The Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.

28. **POLIOMYELITIS** The occurrence of Poliomyelitis where the following conditions are met:
    1. Poliovirus is identified as the cause,
    2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

29. **PROGRESSIVE SCLERODERMA** A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

    The following are excluded:
    - Localised scleroderma (linear scleroderma or morphea);
    - Eosinophilic fasciitis; and CREST syndrome.

30. **PROGRESSIVE SUPRANUCLEAR PALSY** Confirmed by a Registered Doctor who is a specialist in neurology of a definite diagnosis of progressive supranuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability.

31. **SEVERE RHEUMATOID ARTHRITIS** Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:
    - Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
    - Permanent inability to perform at least two (2) "Activities of Daily Living";
    - Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and
    - The foregoing conditions have been present for at least six (6) months.

32. **TERMINAL ILLNESS** The conclusive diagnosis of an illness, which in the opinion of a Registered Doctor who is an attending Consultant and agreed by our appointed Registered Doctor, life expectancy is no greater than twelve (12) months from the date of notification of claim, regardless of any treatment that might be undertaken.

33. **TUBERCULOSIS MENINGITIS** Meningitis caused by tubercle bacilli, resulting in permanent neurological deficit. Such a diagnosis must be confirmed by a Registered Doctor who is a specialist in neurology.

SL	Name of the Optional cover			When this optional can be opted -At First purchase/ At Renewal/ Both	Once Opted Can Insured Opt out during renewal	Premium to be Paid	Once Opted out whether insured can opt in again?	Is Medical Underwriting Mandatory
1	**Smart Network**			Both	Yes	Not Applicable	No	No
2	**Quick shield**			At first purchase	Not Applicable	Up to 5 policy years, (If there is an admissible claim within the five years, we will deduct the balance premium from the claim amount)	Not Applicable	Yes
3	**Coverage for Non-Medical Items (Consumables cover Table I (68 items))**			Within the first three policy years	Yes	Every Year	No	No
4	**Future Shield**			At first purchase	Yes (But to get the benefits Insured should continue till he/ she adds the newly wedded spouse)	Payable till the newly wedded spouse added in the policy	No	(Required during addition of spouse)
5	**Maternity Expenses**	**Delivery Expenses (with 24 months waiting period) and New Born Cover**	**Delivery Expenses Limit per delivery Option 1 – Rs.50,000/- Option 2 – Rs.1,00,000/-**	Both	Yes	Every year (Coverage for maternity expenses will be available till this optional cover is renewed)	Yes (Waiting period will apply afresh)	No
		Delivery Expenses (with 12 months waiting period) and New Born Cover	**Delivery Expenses Covered up to Rs.30,000/- per delivery**					
		Assisted Reproduction Treatment						
6	**Women Care**			At first purchase	Not Applicable	Only Once	Not Applicable	Yes
7	**High-end Diagnostics**			Within the first three policy years	Yes	Every year	No	Yes (Medical underwriting is required where PED is declared)
8	**Personal Accident Cover For earning member – Sum Insured limit is up to Two times of basic indemnity sum insured subject to maximum of Rs. 2 Crore. For dependent spouse - Up to 50% of earning spouse SI (or) Max Up to Rs.15 Lakh; Entry Age - From 18 years to 65 years and renewal is available up to 75 years.**		**Option A - Accidental Death Cover**	Both	Yes	Every year	Yes	Yes (Medical underwriting is required where PED is declared and Financial Underwriting is required if Sum Insured opted is more than Rs.25 Lakh)
			Option B - Accidental Death and Permanent Total Disablement Cover					

SL	Name of the Optional cover		When this optional can be opted -At First purchase/ At Renewal/ Both	Once Opted Can Insured Opt out during renewal	Premium to be Paid	Once Opted out whether insured can opt in again?	Is Medical Underwriting Mandatory
9	Annual Health Check-up		Within the first three policy years	No	Every year	Not Applicable	No
10	Voluntary Co-payment	10% /20% /30% /40% /50%	Both	No	Not Applicable	Not Applicable	No
11	Voluntary Deductible	10k / 25k / 50k / 1L / 2L / 3L / 4L / 5L	Both	No	Not Applicable	Not Applicable	No
12	Room Rent Modification	Single Private AC Room Shared Room General Ward	Both	Available (only during 1st renewal)	Not Applicable	No	No
13	E- International Second Opinion		Both	Yes	Every year	Yes	No
14	Durable Medical Equipment Cover (Lifetime limit of Rs 5Lakh)		Within the first three policy years	Yes	Every year till limit is exhausted	No	No
15	Compassionate Visit		Both	Yes	Every year	Yes	No
16	Hospital Cash	Limits Per day - Rs. 1,000 / 2,000 / 3,000 / 4,000 / 5,000 No. of hospital cash days in a policy year - 30 days / 60 days / 90 days / 180 days	Both	Yes	Every year	No	No
17	Reduction of Specified Disease / Procedure Waiting Period	24 months to 12 months	At first purchase	Not Applicable	Two years	Not Applicable	Yes
18	Reduction of Pre-Existing Diseases Waiting Period (Other than those listed under Quick shield if opted)	36 months to 24 months 36 months to 12 months	At first purchase	Not Applicable	Three years Two years	Not Applicable	Yes
19	Limitless Care		Within the first three policy years	Yes	Payable till a claim is paid under this optional cover	No	Yes (Medical underwriting is required where PED is declared)
20	Super Star Bonus (Guaranteed Bonus)		Both	Yes	Every year	No	Yes (Medical underwriting is required where PED is declared)
21	NRI Advantage		Both	Yes	Not Applicable	Yes	No