Star Health Insurance
Personal & Caring

Star Comprehensive Insurance Policy

SHAHLIP26044V092526

Policy Wordings

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POLICY WORDINGS

STAR COMPREHENSIVE INSURANCE POLICY

Unique Identification No: SHAHLIP26044V092526

PREAMBLE

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

I - DEFINITIONS

STANDARD DEFINITIONS

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

Any one Illness: Any one Illness means continuous period of illness and it 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:

i. Central or State Government AYUSH Hospital; or

ii. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

iii. 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:

a. Having at least 5 in-patient beds;

b. Having qualified AYUSH Medical Practitioner in charge round the clock;

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

d. 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 cost 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 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.

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

ii. **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 claim 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 set up within a hospital and which has been registered with the local authorities, wherever applicable and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under :-

i. has qualified nursing staff under its employment;

ii. has qualified medical practitioner/s in charge;

iii. has a fully equipment 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 a hospitalization of more than 24 hours.

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

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

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

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

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

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

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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act Or complies with all minimum criteria as under:

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

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

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

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

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

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

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

i. 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.

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

a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

b. it needs ongoing or long-term control or relief of symptoms

c. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

d. it continues indefinitely

e. it recurs or is likely to recur

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

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

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

Maternity Expenses: Maternity expenses means

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean Sections incurred during Hospitalization).

ii. expenses towards the lawful medical termination of pregnancy during the Policy Period.

Medical Advice: Medical Advice means any consultation or advice from a Medical Practitioner including the issue 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 is 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 the scope and jurisdiction of licence.

Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication or stay in hospital or part of a stay in a 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: New Born Baby means baby born during the Policy Period and is aged up to 90 days

Non-Network Provider: Non-Network means any hospital, day care center 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 Medial 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:

i. 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

ii. 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 inpatient 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 incurred for the same condition for which the Insured Person's hospitalization was required and

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

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

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

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

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

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

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

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

SPECIFIC DEFINITIONS

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

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

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

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 or her independent source of income and not over 25 years.

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

Hazardous Sport / Hazardous Activities: Hazardous Sport / Hazardous Activities means engaging whether professionally or otherwise in any sport or activity, which is potentially dangerous to the Insured Person (whether trained, or not). Such Sport/Activity including but not limited to Winter sports, Ice hockey, Skiing, Skydiving, Parachuting, Ballooning, Scuba Diving, Bungee Jumping, Mountain Climbing, Riding or Driving in Races or Rallies, caving or pot holing, hunting or equestrian activities, diving or under-water activity, rafting or canoeing involving rapid waters, yachting or boating outside coastal waters, jockeys, horseback, Polo, Circus personnel, army/navy/air force personnel and policemen whilst on duty, persons working in underground mines, explosives, magazines, workers whilst involved in electrical installation with high-tension supply, nuclear installations, handling hazardous chemicals.

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:

i. The Medical practitioner advices the Insured person to undergo treatment at home

ii. 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

iii. 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 person/s shown in the schedule of the Policy.

Instalment: Instalment means premium amount paid through Monthly / Quarterly / Half-yearly / Yearly mode by the Policy Holder/ Insured.

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

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

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.

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

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

Zone A: Delhi, New Delhi, Faridabad, Gurugram, Shahdara, Gautam Buddha Nagar, Ghaziabad, Mewat, Alwar, Baghpat, Bharatpur, Bhiwani, Bulandshahar, Fatehabad, Hisar, Jhajjar, Jind, Kaithal, Karnal, Kurukshetra, Mahendragarh, Meerut, Muzaffar Nagar, Palwal, Panchsheel Nagar (Hapur), Panipat, Rewari, Rohtak, Saharanpur, Sirsa, Sonipat, Charkhi Dadri, Gujarat, Daman and Diu, Dadra and Nagar Haveli, Mumbai (including suburban), Thane, Palghar and Raigad

Zone B: Telangana, Ernakulam, Kollam, Wayanad, Thiruvananthapuram, Mathura, Aligarh, Pune, Nashik and Ahmed Nagar

Zone C: Chennai, Bengaluru, Chengalpattu, Kanchipuram, Tiruvallur, Indore and Gwalior

Zone D: Rest of Uttar Pradesh, Rest of Tamil Nadu, Rest of Kerala, Rest of Maharashtra, Rest of Haryana, Rest of Madhya Pradesh, Rest of Karnataka, Rest of Rajasthan, Andhra Pradesh, Punjab, Kolkata, North 24 Parganas and Paschim Bardhaman

Zone E: Rest Of India

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 for medically necessary treatment, 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.

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

   Note: Any hospitalization expenses arising under this Policy, which vary based on the room rent occupied by the Insured Person will be considered in proportion to the room rent limit / room category stated in the Policy or actuals whichever is less.

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

   iii. Anesthesia, blood, oxygen, operation theatre charges, ICU charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses. With regard to coronary stenting, medicines, Implants and such other similar items, the Company will pay cost of stent as per the Drug Price Control Order (DPCO) / National Pharmaceuticals Pricing Authority (NPPA) Capping.

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. Applicable for Sections II.3, II.4, II.9, II.14, II.15 and II.25.

3. **AYUSH Treatment:** Medical expenses for Inpatient Hospitalization incurred on treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha 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

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

Sum Insured (Rs.)	Uterine artery Embolization and HIFU	Balloon Sinuplasty	Deep Brain Stimulation	Oral Chemotherapy* (Sublimits including Pre and Post Hospitalization)	Immunotheraphy-Monoclonal Antibody to be given as injection	Intra Vitreal injections
	Sum Insured on Individual Basis: Limit per person, per Policy Period for each treatment / procedure Sum Insured on Floater Basis: Limit per Policy Period for each treatment / procedure Rs.					
5,00,000/-	1,25,000/-	50,000/-	2,50,000/-	1,25,000/-	2,50,000/-	50,000/-
7,50,000/-	1,25,000/-	50,000/-	2,50,000/-	1,25,000/-	2,75,000/-	60,000/-
10,00,000/-	1,50,000/-	1,00,000/-	3,00,000/-	2,00,000/-	4,00,000/-	75,000/-
15,00,000/-	1,75,000/-	1,25,000/-	4,00,000/-	2,50,000/-	5,00,000/-	1,00,000/-
20,00,000/-	2,00,000/-	1,50,000/-	4,50,000/-	2,75,000/-	5,50,000/-	1,25,000/-
25,00,000/-	2,00,000/-	1,50,000/-	5,00,000/-	3,00,000/-	6,00,000/-	1,50,000/-
50,00,000/-	2,25,000/-	1,75,000/-	6,00,000/-	4,00,000/-	7,50,000/-	1,75,000/-
75,00,000/-	2,50,000/-	2,00,000/-	7,00,000/-	5,00,000/-	9,00,000/-	2,00,000/-
1,00,00,000/-	3,00,000/-	2,00,000/-	7,50,000/-	6,00,000/-	10,00,000/-	2,00,000/-
*Sublimits are all inclusive with or without hospitalization wherever hospitalization includes pre and post hospitalization.						

<table>
<tr><th>Sum Insured (Rs.)</th><th>Robotic surgeries</th><th>Stereotactic radio surgeries</th><th>Bronchial Thermoplasty</th><th>Vaporisation of the prostate (Green laser treatment or holmium laser treatment)</th><th>IONM-(Intra Operative Neuro Monitoring)</th><th>Stem cell theraphy: Hematopoietic stem cells for bone marrow transplant for haematological condition</th></tr>
<tr><td></td><td colspan="6">Sum Insured on Individual Basis: Limit per person, per Policy Period for each treatment / procedure
Sum Insured on Floater Basis: Limit per Policy Period for each treatment / procedure Rs.</td></tr>
<tr><td>5,00,000/-</td><td>2,50,000/-</td><td>2,00,000/-</td><td colspan="3" rowspan="9">Up to Sum Insured</td><td>2,50,000/-</td></tr>
<tr><td>7,50,000/-</td><td>2,75,000/-</td><td>2,25,000/-</td><td>2,75,000/-</td></tr>
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5. **Pre-Hospitalization Expenses:** Medical expenses incurred for a period not exceeding 60 days prior to the date of hospitalization are payable subject to an admissible hospitalization claim.

6. **Post-Hospitalization Expenses:** Medical expenses incurred for a period up to 90 days from the date of discharge from the hospital wherever recommended by the Medical Practitioner / Hospital, where the treatment was taken are payable, provided

   i. such expenses so incurred are following an admissible claim for hospitalization

   and

   ii. such expenses so incurred are in respect of ailment for which the Insured Person was hospitalized.

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.2,50,000/- per hospitalization not exceeding Rs.5,00,000/- per Policy Period, 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 from the Donor to the Recipient Insured Person are payable provided the claim for transplantation is payable. In addition, the expenses incurred by the Donor (if any) for the complications that necessitate a Redo Surgery / ICU admission will be covered.

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

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

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

ii. 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

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

iv. Insured can avail "Home Care Treatment" service on cashless basis from the list of our Network service providers given in our website "www.starhealth.in"

v. Claim under this benefit forms part of Sum Insured

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.

    The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

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

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

12. **Cumulative Bonus:** Where the Sum Insured under the policy is Rs.5,00,000/-, the Insured Person would be entitled to the benefit of Cumulative Bonus calculated at 50% of the Basic Sum Insured under this policy following after every claim free year up to a maximum of 100%.

Where the Sum Insured under the policy is Rs.7,50,000/-or above, the Insured Person would be entitled to the benefit of Cumulative Bonus calculated at 100% of the Basic Sum Insured under this policy following a claim free year. The maximum benefit of cumulative bonus is 100% of the Basic Sum Insured.

Claims under Sections II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, II.10, II.11, II.14, II.15 and II.25 will impact the eligibility and accumulation of Cumulative Bonus.

Special Conditions for Cumulative Bonus

i. The Cumulative Bonus will be calculated on the expiring Basic Sum Insured.

ii. If the insured opts to reduce the Basic Sum Insured at the subsequent renewal, the limit of indemnity by way of such Cumulative Bonus shall not exceed such reduced Basic Sum Insured.

iii. In the event of a claim resulting in

   a. Partial utilization of Basic Sum Insured, such cumulative bonus so granted will be reduced at the same rate at which it has accrued

   b. Full utilization of Basic Sum Insured and nil utilization of cumulative bonus accrued, such cumulative bonus so granted will be reduced at the same rate at which it has accrued

   c. Full utilization of Basic Sum Insured and partial utilization of cumulative bonus accrued, the cumulative bonus granted on renewal will be the balance cumulative bonus available and after the reduction at the same rate at which it has accrued. At any point of time, the cumulative bonus will not be less than "zero"

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

13. Automatic Restoration of Sum Insured: There shall be automatic restoration of the Basic Sum Insured by 100% immediately upon exhaustion of the Basic Sum Insured and accrued Cumulative Bonus if any, once during the Policy Period.

It is made clear that such restored Sum Insured can be utilized for the subsequent hospitalization even for the illness /disease for which claim/s was / were already made.

Such restoration will be available for Sections II.1, II.3, II.5, II.6, II.7, II.8 and II.11

Hospitalization due to continuous period of illness including its relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken will be considered as same hospitalization as per "Any one Illness" definition. Any claim payable under this benefit shall be subject to the definition as provided under "Any one Illness".

14. Delivery and New Born

A. Expenses for a Delivery including Delivery by Caesarean Section (including pre-natal and post-natal expenses) up to the limits mentioned in the table below per Delivery, subject to a maximum of 2 deliveries in the entire life time of the Insured Person are payable while the policy is in force.

B. Expenses up to the limits mentioned in the table below, incurred in a hospital/

nursing home on treatment of the New-born for any disease, illness (including any congenital disorders) or accidental injuries are payable provided there is an admissible claim under Section II.14.A above and while the policy is in force. In case of Policy Term is more than one year, such expenses are payable only till the expiry of the policy or policy anniversary whichever is earlier.

Delivery and New Born			
Sum Insured Rs.	Limit for Delivery		Limit of Company's liability for New Born Cover Rs.
	Normal Delivery Rs.	Delivery by Ceasarean Section Rs.	
5,00,000/-	15,000/-	20,000/-	1,00,000/-
7,50,000/-	25,000/-	40,000/-	1,00,000/-
10,00,000/- to 25,00,000/-	30,000/-	50,000/-	1,00,000/-
50,00,000/- to 1,00,00,000/-	50,000/-	1,00,000/-	2,00,000/-

C. Vaccination expenses for the new born baby are payable up to the limits mentioned in the table below, until the new born baby completes one year of age and is added in the policy on renewal. Claim under this is admissible only if claim under Section II.14.A above has been admitted and while the policy is in force.

Limits for Vaccination	
Sum Insured Rs.	Limit per Policy Period (Rs.)
5,00,000/- to 25,00,000/-	5,000/-
Above 25,00,000/-	10,000/-

Special Conditions applicable for this Section

i. Benefit under this Section is subject to a waiting period of 24 months from the date of first commencement of Star Comprehensive Insurance Policy and its continuous renewal thereof with the Company. A waiting period of 24 months will apply afresh following a claim under Section II.14.A above.

ii. Pre-hospitalization and Post Hospitalization expenses and Hospital Cash Benefit are not applicable for this Section.

iii. This cover is available only when;

   a. both Self and Spouse are covered under this policy either on floater basis or on individual basis and both Self and Spouse should have been covered for a continuous period of 24 months under Star Comprehensive Insurance Policy,

   b. the policy covering the self and spouse are in force when the benefit under this Section becomes payable.

iv. Claims under this Section

   a. will not reduce the Sum Insured;

   b. will affect Cumulative Bonus.

15. Bariatric Surgery: Expenses incurred on hospitalization for bariatric surgical procedure and its complications thereof are payable subject to limits mentioned in the table given below, during the Policy Period. This maximum limit of Rs.2,50,000/- and Rs.5,00,000/- are inclusive of pre-hospitalization and post-hospitalization expenses.

Sum Insured (Rs.)	Limit per Policy Period (Rs.)
5,00,000/- to 15,00,000/-	2,50,000/-
Above 15,00,000/-	5,00,000/-

Special conditions:

i. This benefit is subject to a waiting period of 36 months from the date of first commencement of this policy and continuous renewal thereof with the Company.

ii. The minimum age of the insured at the time of surgery should be above 18 years.

iii. This benefit shall not apply where the surgery is performed for

a. Reversible endocrine or other disorders that can cause obesity

b. Current drug or alcohol abuse

c. Uncontrolled, severe psychiatric illness

d. Lack of comprehension of risks, benefits, expected outcome, alternatives and lifestyle changes required with bariatric surgery

e. Bariatric surgery performed for Cosmetic reasons

iv. The indication for the procedure should be found appropriate by two qualified surgeons and the Insured Person shall obtain prior approval for cashless treatment from the Company.

v. To make a claim, the Insured Person should satisfy the following criteria as devised by NIH (National Institute of Health)

a. The BMI should be greater than 40 or greater than 35 with co-morbidities (like Diabetes, High Blood Pressure etc.)

b. The Insured Person is unable to lose weight through traditional methods like diet and exercise.

Note: Claims under this Section shall be processed only on cashless basis. The limit of cover provided under this Section forms part of the Sum Insured and will impact cumulative bonus.

16. Expenses of **Medical Consultations as an Out Patient** incurred in a Networked Facility for other than Dental and Ophthalmic treatments, up to the limits mentioned in the table below are payable. Payment under this benefit does not form part of Sum Insured, and is payable while the policy is in force.

Out-Patient Consultation	
Sum Insured Rs.	Limit for Out Patient consultation per policy period for other than Dental and Ophthalmic Treatments (up to Rs.)
5,00,000/-	1,200/-
7,50,000/-	1,500/-
10,00,000/-	2,100/-
15,00,000/-	2,400/-
20,00,000/-	3,000/-
25,00,000/-	3,300/-
50,00,000/-, 75,00,000/- and 1,00,00,000/-	5,000/-
Limit of per consultation is Rs. 300/-	

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

17. **Out-patient Dental and Ophthalmic Treatment:** Expenses incurred on acute treatment to a natural tooth or teeth or the services and supplies provided by a licensed dentist, up to limits mentioned in the table below are payable.

    Expenses incurred for the treatment of the eye or the services or supplies provided by a licensed ophthalmologist, hospital or other provider that are medically necessary to treat eye problem including cost of spectacles / contact lenses, not exceeding the limit mentioned in the table below are payable.

    The Insured Persons become eligible for this benefit after continuous coverage under Star Comprehensive Insurance Policy with the Company, after every block of 3 years and payable while the policy is in force.

Note:

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

ii. Claims under this Section will not reduce the Sum Insured.

Out-patient Dental and Ophthalmic Treatment	
Sum Insured (Rs.)	Limit for Out Patient Dental and Ophthalmic Treatments for each block of 3 continuous years (up to Rs.)
5,00,000/- and 7,50,000/-	5,000/-
10,00,000/- to 25,00,000/-	10,000/-
Above 25,00,000/-	15,000/-

18. **Preventive Health Check-up:** We will arrange for a Preventive Health Check-up at Our Network Providers for the applicable package as specified below as per opted Sum Insured and subject to the conditions specified below:

Sum Insured (Rs.)	Package applicable
5,00,000/- to 10,00,000/-	Package A
Above 10,00,000/-	Package B

i. An initial waiting period of 30 days shall apply from the first inception of Policy. This waiting period shall not be applicable during subsequent renewals.

ii. Health Check-up can be availed once per Policy Year per Insured Person who is covered as Adult in the Policy and all the tests must have been done on the same date.

iii. For the updated and applicable list of tests available under such package, Insured Persons are required to check our website www.starhealth.in.

iv. The pre-defined health check-up packages may be modified from time to time without prior notice.

v. This cover can be availed through Star health mobile application, other digital platforms, or by calling at our Toll free number: 1800 425 2255.

vi. The Network Provider/Health Service Provider shall be assigned by Us upon receiving the Insured Person's request to avail a Health Check-up under this cover.

vii. Utilization of this Health Check-up shall not impact the Sum Insured.

viii. In case of long term policies, Insured Person(s) are eligible for a Health Check-up once every Policy Year.

19. 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. The Insured Person can obtain an E-Domestic Second Medical Opinion via Star Health Mobile App, by booking an appointment with a Doctor.

Special Conditions

i. This should be specifically requested by the Insured Person

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

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

iv. 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

v. Utilizing this facility alone will not amount to making a claim

20. Unlimited Tele-Consultation: We will arrange Tele Consultations with qualified Medical Practitioner or Healthcare professional through various modes of communication like audio, video, online portal, chat through Star Health mobile application or digital platforms.

The services provided under this cover will be made available subject to following conditions:

i. The Medical Practitioner may recommend over-the-counter medications based on the information provided.

ii. Tele Consultations should not substitute in-person consultation with independent Medical Practitioner/ Healthcare professional.

iii. The proposer should seek assistance from a health care professional when interpreting and applying them to the Insured Person's individual circumstances. If the Insured Person has any concerns about His/ her health, He/ She may consult His/ her general practitioner. We shall not hold any responsibility towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner/ Health care professional.

iv. There shall be no maximum limit on the count of Tele-Consultations that can be availed in a Policy Year by each Insured Person.

v. We/Medical Practitioner/Health care professional may refer the Insured Person to another specialist or a general physician (outside of our empaneled network) if required, and the charges for such specialist or a general physician will have to be borne by the Insured Person.

vi. We shall not be liable for any discrepancy in the information provided under this cover.

vii. Availing services is at the sole discretion and risk of the Insured Person.

21. **AI driven Face Scan:** The Insured Person 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 Person 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.

22. **Hospital Cash Benefit:** Subject to an admissible Hospitalization claim, Cash Benefit up to the limits mentioned in the table below for each completed day of Hospitalization for a maximum of 7 days per occurrence is payable.

This Benefit is available for a maximum of 120 days during the entire Policy Period.

This benefit is subject to an excess of first 24 hours of Hospitalization for each and every claim. Claims under this Section will not reduce the Sum Insured.

Hospital Cash	
Sum Insured (Rs.)	**Hospital Cash Benefit - Limit of Company's liability per day (Rs.)**
5,00,000/-	500/-
7,50,000/- and 10,00,000/-	750/-
15,00,000/- and 20,00,000/-	1,000/-
25,00,000/-	1,500/-
50,00,000/-, 75,00,000/- and 1,00,00,000/-	2,500/-

23. **Accidental Death and Permanent Total Disablement:** 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:

i. **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.

ii. **Permanent Total 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.

Special Conditions

i. 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.

ii. In the event of Permanent Total 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.

iii. This Section is applicable for the person specifically mentioned in the Schedule.

iv. The Sum Insured for this Section is equal to the Sum Insured opted for Health Section.

v. Where a claim has been paid during the Policy Period the cover under this Section ceases until the expiry of the policy. Upon renewal the cover applies to the person specifically chosen again. 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.

vi. At any point of time, only one person will be eligible to be covered under this Section. Dependent Children and persons above 70 years can be covered under this Section up to the Sum Insured of Rs.10,00,000/-.

vii. Any claim under health portion will not affect the Sum Insured under this Section.

viii. Where there is an admissible claim for Accidental Death during the Policy Period, the health cover will continue for the remaining Insured Persons.

ix. 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.

x. Where there is an admissible claim under this Section, during the Policy Period, the personal accident cover will be applicable for another person chosen at the time of renewal.

xi. Geographical Scope: The cover under this Section applies World Wide.

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

Table - B2			
Physical function already impaired prior to accident			Percentage of Sum Insured Deducted
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

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

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

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

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

Wellness Points Earned	Discount in Premium
200 to 350	2%
351 to 600	5%
601 to 750	7%
751 to 1000	10%

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

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

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

Each Insured Person will be given an Individual login facility, which will be linked to his/ her policy.

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

The wellness services and activities are categorized as below:

Sl. No	Activity	Maximum number of Wellness Points that can be earned under each policy in a policy year
	Manage and Track Health	
1	a. Online Health Risk Assessment (HRA)	50
	b. Preventive Risk Assessment	200
2.	Affinity to Wellness	
	a. Participating in Walkathon, Marathon, Cyclothon and similar activities	100
	b. Membership in a health club (for 1 year or more)	100
3.	Stay Active – If the Insured member achieves the step count target on "Star Health" Mobile App	200
4.	a. Weight Management Program (for the Insured who is Overweight / Obese)	100
	b. Sharing Insured Fitness Success Story through adoption of Star Wellness Program (for the Insured who is not Overweight / Obese)	50
5.	a. Chronic Condition Management Program (for the Insured who is suffering from Chronic Condition/s - Diabetes, Hypertension, Cardiovascular Disease or Asthma)	250
	b. On Completion of De-Stress & Mind Body Healing Program (for the Insured who is not suffering from Chronic Condition/s - Diabetes, Hypertension, Cardiovascular Disease or Asthma)	125
Additional Wellness Services		
6.	Online Chat with Doctor	
7.	Medical Concierge Services	
8.	Period & Fertility Tracker	
9.	Digital Health Vault	
10.	Wellness Content	
11.	Health Quiz & Gamification	
12.	Post-Operative Care	
13.	Discounts from Network Providers	

1. **Manage and Track Health**

   a. **Completion of Health Risk Assessment (HRA):**

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

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

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

   b. **Preventive Risk Assessment:**

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

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

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

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

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

	Initiative	Wellness Points
a.	Participating in Walkathon, Marathon, Cyclothon and similar activities On submission of BIB Number along with the details of the entry ticket taken to participate in the event.	100
b.	Membership in a health club (for 1 year or more) - In a Gym / Yoga Centre / Zumba Classes / Aerobic Exercise/ Sports Club/ Pilates Classes/ Swimming / Tai Chi/ Martial Arts / Gymnastics/ Dance Classes	100
Note: In case if Insured is not a member of any health club, he/she should join into club within 3 months from the date of the policy risk commencement date. Insured person should submit the health club membership.		

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

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

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

4. **Weight Management Program:**

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

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

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

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

5. **Chronic Condition Management Program:**

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

   - On acceptance of the Chronic Condition Management Program, Insured earns 100 wellness points.
   - The Insured has to submit the test result values for every 3 months maximum up to 3 times in a Policy Year.

- If the test result values are within +/- 10% range of the values given below, for at least 2 times in a Policy Year, an additional 150 wellness points will be awarded.
- These tests reports to be submitted within 1 month from the date of undergoing the Health Check-Up

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

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

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

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

6. **Online Chat with Doctor:** Insured can consult qualified healthcare professionals at their convenience. The Doctor Chat feature allows Insured to "Chat" with qualified Doctors, available from Monday to Friday between 9.00 AM and 6.00 PM to help Insured with advice and quick consultations including on Diet & Nutrition and Second Medical Opinion. They do not prescribe any medications or diagnose any health issues.

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

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

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

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

11. **Health Quiz & Gamification:**

    - The wellness portal provides a host of Health & Wellness Quizzes. The wellness quizzes are geared towards helping the Insured to be more aware of various health choices.

    - Gamification helps in creating fun and engaging health & wellness experiences. It helps to create a sense of achievement in users and increases motivation levels.

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

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

Terms and conditions under wellness activity;

i. Any information provided by the Insured in this regard shall be kept confidential.

ii. There will not be any cash redemption against the wellness reward points.

iii. Insured should notify and submit relevant documents, reports, receipts etc. for various wellness activities within 1 month of undertaking such activity/test.

iv. No activity, report, document, receipt can be submitted in the last month of each Policy Year.

v. 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.

vi. 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.

vii. We reserve the right to remove the wellness reward points if found to be achieved in unfair manner.

viii. Star Health, its group entities, or affiliates, their respective directors, officers, employees, agents, vendors, are not responsible or liable for, anyactions, claims, demands, losses, damages, costs, charges and expenses which a Member claims to have suffered, sustained or incurred, by way ofand / or on account of the Wellness Program.

ix. Services offered are subject to guidelines issued by IRDAI from time to time.

ILLUSTRATION OF BENEFITS

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

Scenario – 1

A 40 year old Individual Ramesh buys Star Comprehensive Insurance Policy (Individual Sum Insured) with Sum Insured 25 Lacs, let's understand how he can earn Wellness Points by doing different wellness activities. Ramesh has declared that his Body Mass Index (BMI) as 24 and he is a Diabetic. Ramesh enrolled under the Star Wellness Program and completed the following wellness activities

Sl. No.	Name of the wellness activity taken up during the policy year	Wellness Points Earned
1.	Completed Online Health Risk Assessment (HRA)	50
2.	Submitted Health Check-Up Report (two test results are not within normal values)	100
3.	Participated in Walkathon	100
4.	Attended to Gym	100
5.	Achieved 10,000 average number of steps per day during the policy year	200
6.	Shared his fitness success story	50
7.	Managed Diabetes through Chronic Condition Management Program	250
	Total Number of Wellness Points earned	**850**

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

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

Scenario – 2

A 42 year old Individual Suresh and his wife Lakshmi along with their two dependent children (aged below 18 yrs) buy a Star Comprehensive Insurance Policy (Floater Sum Insured) with Sum Insured 25 Lacs, let's understand how they can earn Wellness Points under the Floater Policy. Suresh has declared that he is suffering from Diabetes & Hypertension. Suresh has declared his Body Mass Index (BMI) as 30 & Lakshmi has declared her BMI as 25

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

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

Total Number of Wellness Points earned by Suresh and Lakshmi = 888 (500+388)

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

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

Scenario – 3

A 27 year old Individual Umesh buys Star Comprehensive Insurance Policy (Individual Sum Insured) for two year period, with Sum Insured 25 Lacs, let's understand how he can earn Wellness Points by doing different wellness activities. Umesh has declared that his Body Mass Index (BMI) is 24 and he is not suffering with any Chronic Condition. Umesh enrolled under the Star Wellness Program and completed the following wellness activities.

Sl. No	Name of the wellness activity taken up during the Policy Year	Wellness Points Earned in the First Year	Wellness Points Earned in the Second Year
1.	Completed Online Health Risk Assessment (HRA)	50	50
2.	Submitted Health Check-Up Report	200	200
3.	Participated in Walkathon	100	100
4.	Attended to Yoga Classes	100	100
5.	Achieved 10,000 average number of steps per day during the Policy Year	200	200
6.	Submitted his fitness success story	50	50
7.	Completed De-stress & Mind Body Healing Program	125	125
	Total Number of Wellness Points earned	825	825

Total Number of Wellness Points earned by Umesh = 1650 (825+825)

Calculation of Wellness Points as per two year policy condition = 825 (1650/2)

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

25. Optional Cover (Buy Back of Pre-Existing Disease Waiting Period): On payment of additional premium the Insured Person has the option to opt for reduction of waiting period in respect of Pre-Existing Diseases from 36 months to 12 months. This option is available only for the first purchase of this Star Comprehensive Insurance Policy and only upto Sum Insured chosen at that time. This option is not available for renewal or policies ported from other Insurance Companies. The Insured Person has to undergo pre-acceptance medical screening at Company's nominated center. If we accept the proposal, we will reimburse at least 50% of the costs incurred by the member undertaking such pre-acceptance medical screening.

Where the Insured Person has opted for this benefit the exclusions shall read as follows;

1. Pre-Existing Diseases : Code Excl 01

A. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with insurer

B. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase

C. Coverage under the policy after the expiry of 12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer

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

A. Expenses related to the treatment of the following listed Conditions, surgeries/ treatments shall be excluded until the expiry of 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. 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 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 to the extent provided under Section II.14 for New Born)

III - EXCLUSIONS

STANDARD EXCLUSIONS

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

1. Pre-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 applicable norms on portability stipulated by IRDAI, 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 to the extent provided under Section II.14 for New Born)

3. 30-day waiting period – Code Excl 03

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

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

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

4. **Investigation & Evaluation – Code Excl 04**
   A. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
   B. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded
5. **Rest Cure, rehabilitation and respite care – Code Excl 05:** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   1. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or nonskilled persons
   2. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs
6. **Obesity/ Weight Control – Code Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions;
   A. Surgery to be conducted is upon the advice of the Doctor
   B. The surgery/Procedure conducted should be supported by clinical protocols
   C. The member has to be 18 years of age or older and
   D. Body Mass Index (BMI);
      1. greater than or equal to 40 or
      2. than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         a. Obesity-related cardiomyopathy
         b. Coronary heart disease
         c. Severe Sleep Apnea
         d. Uncontrolled Type2 Diabetes
7. **Change-of-Gender treatments – Code Excl 07:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
8. **Cosmetic or plastic Surgery – Code Excl 08:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
9. **Hazardous or Adventure sports – Code Excl 09:** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, parajumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
10. **Breach of law – Code Excl 10:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

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

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

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

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

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

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

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

18. **Maternity – Code Excl 18**
    a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean Sections incurred during hospitalization) except ectopic pregnancy and to the extent covered under Section II.14
    b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Period

SPECIFIC EXCLUSIONS

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

20. Congenital External Condition / Defects / Anomalies (except to the extent provided under Section II.14 for New Born) - **Code Excl 20**

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

22. Intentional self injury - **Code Excl 22**

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

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

25. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy - **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. Dental treatment or surgery unless necessitated due to accidental injuries and requiring hospitalization (Dental implants are not payable) (except to the extent covered under Section II.17) **- Code Excl 32**

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

32. Cochlear implants and procedure related hospitalization expenses. Cost of spectacles and contact lens (in excess of what is specifically provided), hearing aids, walkers and crutches, wheel chairs, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis, infusion pump and such other similar aids - **Code Excl 35**

33. Any hospitalizations which are not Medically Necessary / does not warrant Hospitalization - **Code Excl 36**

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

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

B. Applicable for Section II.23

1. Any claim relating to events occurring before the commencement of the cover or otherwise outside the Period of Insurance - **Code Sec10 Excl 01**

2. Any injuries/conditions which are Pre-existing conditions - **Code Sec10 Excl 02**

3. Any claim arising out of Accidents that the Insured Person has caused - **Code Sec10 Excl 03**

    i. intentionally or

    ii. by committing a crime / involved in it or

    iii. as a result of / in a state of drunkenness or addiction (drugs, alcohol).

4. Insured Person engaging in Air Travel unless he/she flies as a fare-paying passenger on an aircraft properly licensed to carry passengers. For the purpose of this exclusion Air Travel means being in or on or boarding an aircraft for the purpose of flying therein or alighting there from - **Code Sec10 Excl 04**

5. Accidents that are results of war and warlike occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, seizure capture arrest restraints detainments of all kings princes and people of whatever nation, condition or quality whatsoever - **Code Sec10 Excl 05**

6. Participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority - **Code Sec10 Excl 06**

7. Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from - **Code Sec10 Excl 07**
   i. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.
   ii. Nuclear weapons material
   iii. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
   iv. Nuclear, chemical and biological terrorism

8. Any claim arising out of sporting activities in so far as they involve the training or participation in competitions of professional or semi-professional sports persons - **Code Sec10 Excl 08**

9. Participation in Hazardous Sport / Hazardous Activities - **Code Sec10 Excl 09**

10. Persons who are physically challenged, unless specifically agreed and endorsed in the policy - **Code Sec10 Excl 10**

11. Any loss arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law - **Code Sec10 Excl 11**

12. Any payment in case of more than one claim under the policy during the period of insurance by which the maximum liability of the Company in that period would exceed the amount specified in the Schedule - **Code Sec10 Excl 12**

13. Any other claim after a claim has been admitted by the Company and becomes payable for Death or Permanent Total Disablement, as mentioned in Table - **Code Sec10 Excl 13**

14. Any claim arising out of an accident related to pregnancy or childbirth, infirmity, whether directly or indirectly - **Code Sec10 Excl 14**

15. Any claim for Death or Permanent Total Disablement of the Insured Person from self-endangerment unless in self-defense or to save human life - **Code Sec10 Excl 15**

IV - CONDITIONS

STANDARD CONDITIONS

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

2. **Claim Settlement**

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

B. **Documents for Cashless Treatment:**

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

b. Inform the ID number for easy reference

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

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

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

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

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

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

i. Cashless facility can be availed only in 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 AML Guidelines

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

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

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

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

Sl.No.	Type of Claim	Prescribed time limit
1	Reimbursement of hospitalization, day care and pre hospitalization expenses	Claim must be filed within 15 days from the date of discharge from the Hospital
2	Reimbursement of Post hospitalization	Within 15 days after completion of 90 days from the date of discharge from hospital

D. **Notification of Claim:** Upon the happening of any event giving rise or likely to give rise to a claim under the Policy, a Notification of Claim with full particulars shall be sent to the Company within stipulated time limit as described below:

Emergency Hospitalization (Cashless / Reimbursement): Within 24 hours of date and time of Hospitalization if the Insured Person has been hospitalized in an Emergency.

Planned Hospitalization (Cashless / Reimbursement): At least 48 hours prior to the proposed treatment or date and time of Hospitalization.

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 claims:

a. Duly completed claim form, and

b. Pre Admission investigations and treatment papers in original.

c. Discharge Summary in original from the hospital

d. Cash receipts in original from hospital, chemists

e. Cash receipts and reports for tests done in original

f. Receipts from doctors, surgeons, anesthetist in original

g. Certificate from the attending doctor regarding the diagnosis.

h. Copy of PAN card

i. Copy of Aadhaar Card

j. Any other document specific to the treatment / illness

k. Prescriptions and receipt for Pre and Post-Hospitalization expenses

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

m. NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code

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

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

For the comprehensive list of documents to be submitted while filing a reimbursement claim, please refer our website under the link https://www.starhealth.in/claims/#claim-process

F. Claims of Out Patient Consultations / treatments will be settled on cashless basis.

G. For Accidental Death Claims: Claim Form

a. Death Certificate

b. Post-mortem Certificate, if conducted

c. FIR (wherever required)

d. Police Investigation report (wherever required)

e. Viscera Sample Report (wherever required)

f. Forensic Science Laboratory report (wherever required)

g. Legal Heir Certificate

h. Succession Certificate (wherever required)

For Permanent Total Disablement Claims:

Certificate from Government doctor confirming the disability and its percentage.

Note:

i. The Company authorized doctor may examine the insured if required

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

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

H. Following an admissible claim under Section II.23, the coverage under Personal Accident insurance upon renewal will be applicable for the person to be chosen by the Proposer at the time of renewal, subject to other terms, conditions contained herein.

I. **Co-payment:** This policy is subject to co-payment of 10% of each and every claim amount for fresh as well as renewal policies for Insured Persons whose age at the time of entry is 61 years and above. This co-payment will not apply for those insured persons who have entered the policy before attaining 61 years of age and renew the policy continuously without any break. This co-payment is applicable for Sections II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, II.10, II.11, II.15 and II.25.

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**

Not Applicable for Sections II.19, II.22, II.23 and II.24

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

Applicable for Sections II.22 and II.23

In case of multiple policies which provide fixed benefits, on the occurrence of the insured event, each insurer shall make the claim payments independent of payments received under other similar polices in accordance with the terms and conditions of the policies.

Note:

The Policyholder is expected to disclose all the health insurance policies under which the lives proposed for insurance are covered.

The company reserves the right to cancel any / all of the policies (except the 1st issued Policy) opted by the Policyholder ab-initio, in case of any non-disclosure of previous policies and / or having multiple policies that exceeds the maximum Sum Insured filed as per the Product.

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:

i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

iii. any other act fitted to deceive; and

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

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

6. Cancellation

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

   a. refund proportionate premium for unexpired Policy Period, if Policy Term 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:** In case of migration of one policy to another with the same insurer, the Policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No

Claim Bonus, Specific Waiting Periods, Waiting period for Pre-Existing Diseases, Moratorium period etc. in the previous policy to the migrated policy.

8. **Portability:**

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

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

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

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

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

10. **Withdrawal of policy:**

    In the likelihood of this product being withdrawn in future, the Company will intimate the Policyholder about the same 90 days prior to expiry of the policy.

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

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

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

12. **Premium Payment in Instalments:** If the Policyholder has opted for Payment of Premium on an instalment basis i.e. Yearly or Half Yearly or Quarterly or Monthly, 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, Half yearly and Yearly instalment option: Grace Period of 30 days would be given to pay the instalment premium due for the policy.

    iii. The Policyholder will get the accrued continuity benefit in respect of the (Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting period for Pre-Existing Diseases, Moratorium period etc.) in the event of payment of premium within the stipulated Grace Period.

    iv. No interest will be charged if the instalment premium is not paid on due date.

    v. In case of instalment premium due not received within the Grace Period, the policy will get cancelled.

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

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

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

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

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

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

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

15. **Redressal of Grievance:** Incase of any grievance the Insured Person may contact the Company through

    Website : www.starhealth.in

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

    Ph. No. : 044- 69006900

    Toll Free No : 1800 425 2255

    Senior Citizens may call at 044-69007500

Courier/ Post: Star Health and Allied Insurance Company Limited.,4th Floor, Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai- 600014.

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

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

For updated details of grievance officer, kindly refer the link

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

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

Grievance may also be lodged at IRDAI Integrated Grievance Management System

– https://bimabharosa.irdai.gov.in/

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

SPECIFIC CONDITIONS

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

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

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

20. Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged injury or diseases requiring Hospitalization when and as often as the same may reasonably be required on behalf of the Company at Company's cost.

21. **Notice and Communication:**

   i. Any 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, Registered Office: No. 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034/Corporate Office: No. 148, Acropolis, Dr. Radha Krishnan Salai, Mylapore, Chennai - 600 004.

   Customer Care No. 044-69006900 or Toll-Free No. 1800 425 2255 e-mail: support@starhealth.in

   ii. Any legal notice under this policy shall be in writing and delivered by hand, post, or email to Claims Department, 4th Floor, Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai- 600014;

      a. e-mail for Consumer Matter: claims.legal@starhealth.in

      b. e-mail for Ombudsman: claims.ombudsman@starhealth.in

   Notices and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery or e-mail.

   If notices or communications are not sent to the addresses or email IDs mentioned above, the Company will not be able to respond promptly.

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

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

   i. Upon the death of the Insured Person. This also means that in case of family floater policy, cover for the other surviving members of the family will continue, subject to other terms of the policy

   ii. Upon exhaustion of the Limit of Coverage

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

25. **Excluded Hospitals (providers):** Insured can refer the company website using the following link to get the list of excluded hospitals.

   https://www.starhealth.in/lookup/hospital/#excluded-hospital

26. **Revision of Sum Insured:** Reduction or enhancement of Basic Sum Insured is permissible only at the time of renewal.

   The acceptance for enhancement and the amount of enhancement will be at the discretion of the Company. Where the Basic Sum Insured is enhanced, the amount of such additional Basic Sum Insured including the respective sublimits shall be subject to the following terms. Exclusion as under shall apply afresh from the date of such enhancement for the increase in the Basic Sum Insured, that is, the difference between the expiring policy Basic Sum Insured and the increased current Basic Sum Insured.

   i. First 30 days as per exclusion - Code Excl 03

   ii. 24 months with continuous coverage without break (with grace period) in respect of diseases / treatments as per exclusion - Code Excl 02

   iii. 36 months of continuous coverage without break (with grace period) in respect of Pre-Existing diseases as per exclusion - Code Excl 01

iv. 36 months of continuous coverage without break (with grace period) for diseases / conditions diagnosed / treated irrespective of whether any claim is made or not in the immediately preceding three Policy Periods

v. The above applies to each relevant Insured Person

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

28. Important Note

i. 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 year or 3rd year cannot be utilized in the 1st year itself. The terms conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each Policy Year.

ii. Where the policy is issued on floater basis, the Basic Sum Insured, cumulative bonus and other related benefits floats amongst the Insured Persons.

iii. 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.

iv. 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.

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

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

31. Third-Party Claims: Only the authorized Third-Party Administrator (TPA), legal heirs, Proposer, or approved Insurance Intermediaries have the right to make or follow up on reimbursement claims under this policy. The claims will be settled directly to the Proposer's account. In case of the Proposer's death, the settlement will be made to the nominee's account as the case may be.

Claims by unauthorized third party will not be entertained, and the Company reserves the right to reject such claims. This rejection does not breach the terms of the policy.

32. Professional Conduct: The Company shall ensure that its staff and representatives shall conduct themselves in courteous and professional manner in all their interactions with the insured/proposer, whether in person, through email, telephone or any other online or offline platforms. The insured/proposer hereby irrevocably agrees to conduct themselves in courteous and professional manner in all interactions with the Company. Any unprofessional or inappropriate behaviour by the insured/proposer may result in strict action by the Company, including without limitation, legal action under the Bharatiya Nyaya Sanhita, Act 2023, as amended from time to time.

LIST OF INSURANCE OMBUDSMAN

Office Details	Jurisdiction of Office Union Territory, District
AHMEDABAD	
Office of the Insurance Ombudsman,	
Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Gujarat Tel.: 079 - 25501201/02	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Email: oio.ahmedabad@cioins.co.in	
BENGALURU	
Office of the Insurance Ombudsman,	
Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049	Karnataka.
Email: oio.bengaluru@cioins.co.in	
BHOPAL	
Office of the Insurance Ombudsman,	
1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202/ 2769203	Madhya Pradesh, Chhattisgarh.
Email: oio.bhopal@cioins.co.in	
BHUBANESWAR	
Office of the Insurance Ombudsman,	
62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455// 2596429 / 2596003	Odisha.
Email: oio.bhubaneswar@cioins.co.in	
CHANDIGARH	
Office of the Insurance Ombudsman,	
Jeevan Deep Building, SCO 20-27, Ground Floor Sector - 17 A, Chandigarh – 160 017. Tel.: 0172 – 2706468	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
Email: oio.chandigarh@cioins.co.in	

CHENNAI	
Office of the Insurance Ombudsman,	
Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
Email: oio.chennai@cioins.co.in	
DELHI	
Office of the Insurance Ombudsman,	
2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/ 23213504/23232481	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Email: oio.delhi@cioins.co.in	
KOCHI	
Office of the Insurance Ombudsman,	
10th Floor, Jeevan Prakash, LIC Building, Opp.to Maharaja's College Ground, M. G. Road, Kochi - 682 011. Tel.: 0484 - 2358759	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
Email: oio.ernakulam@cioins.co.in	
GUWAHATI	
Office of the Insurance Ombudsman,	
Jeevan Nivesh, 5th Floor, Nr. Panbazar S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Email: oio.guwahati@cioins.co.in	
HYDERABAD	
Office of the Insurance Ombudsman,	
6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A.C. Guards, Lakdi - Ka - Pool A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
Email: oio.hyderabad@cioins.co.in	

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

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

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

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

NOIDA	
Office of the Insurance Ombudsman,	
Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Email: oio.noida@cioins.co.in	

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

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

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

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

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

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

Items that are to be subsumed into costs of treatment

Sl No.	Item
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALIZATION 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