



Star Women Care Insurance Policy

UIN: SHAHLIP27051V032627

Prospectus



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P R O S P E C T U S

STAR WOMEN CARE INSURANCE POLICY

Unique Identification No: SHAHLIP27051V032627

The product is specially designed for Women and her family, it provides regular hospitalization and comprehensive maternity related benefits.

◆ Who can take this insurance?

Individual Sum Insured: Only females aged between 18 years to 75 years.

Floater Sum Insured: Adult 18 years to 75 years (at least one female (adult) should be there in the family)

Dependent Children: 91 days to 25 years. Daughter can Continue as a dependent child if Un-married and/or Un-employed beyond 25 years and max up to 30 years, and beyond 30 years she will be treated as an Adult.

Surrogate Mother: 25 years to 35 years (Proposer has to be one of the intending couple)

Oocyte Donor: 25 years to 35 years (Proposer has to be one of the intending couple)

For Females, the continuity benefits accrued under this policy before marriage will also be considered for claims under the Maternity Section.

Family means Self, Spouse and 3 dependent children (2A+ 3C).

Pregnant women can also buy this policy by submitting the scan reports taken at star health specified scan centres during their 12th and 20th Week of their pregnancy period. The cost of such scan will be borne by the insured.

In case if we accepted this proposal and issued the policy, the new born will be covered immediately after its birth till the end of the Policy Year (including for congenital defects) up to the new born sub limits mentioned in the Delivery section

After renewal new born will be covered up to the Sum Insured (including the congenital defects), if the premium is paid for the new born

Eligibility for Surrogacy Cover and / or Oocyte Donor Cover

- Intending couple/ Intending woman will be the proposer. Surrogate Mother and / or Oocyte donor will be the Insured.



- ii. The Proposal for insurance has to be made 30 days before the embryo transfer for the surrogate mother and /or 30 days before ovarian stimulation for oocyte donor.
- iii. Proposer has to be one of the intending couple.
- iv. Intending Couple can purchase separate policy for Surrogate Mother and / or Oocyte Donor
- v. **For Surrogate Mother:** After completion of 36 months period, all other coverages will continue except Surrogacy Cover
- vi. **For Oocyte Donor:** After completion of 12 months period, all other coverages will continue except Oocyte Donor Cover.

On completion of the Policy Term, the Insured can renew their Star Women Care Insurance Policy, continuity benefits will be applicable for all coverages except the respective Surrogacy cover or Oocyte donor cover or both covers.

Policy Term: One year / Two year / Three year. For policies more than one year, the Basic Sum Insured is for each year, without any carry over benefit thereof and the premium for such policies can be paid upfront as a single payment.

Note: Where the policy is issued for more than 1 year, the Sum Insured including sublimits, automatic restoration benefit (if applicable), is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year or 3rd year cannot be utilized in the 1st year itself

- i. Where the policy is issued for more than 1 year, the Sum Insured including sublimits, automatic restoration benefit (if applicable), is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year or 3rd year cannot be utilized in the 1st year itself.
- ii. If the Insured is a Surrogate Mother: The Policy Term will be given for three years only.
- iii. If the Insured is a Oocyte Donor: The Policy Term will be given for one year. They can also opt for two or three years cover. However, post 12 months, all other coverages will continue except Oocyte Donor Cover.
- iv. If the Insured is both Surrogate Mother and Oocyte Donor: The Policy Term will be given for three years. However, Oocyte Donor cover will be restricted to one year.

◆ Long Term Discount

10% discount on 2nd year premium

12.5% discount is available on 3rd year premium

Note: Long Term Discount will not be available, if premium is paid in instalment mode.

- ◆ **Type of Policy:** Individual (available only for Females) and Floater (**At-least one female (adult)** should be there in the family along with the spouse and dependent children)

- ◆ **Sum Insured Options:** Rs.5,00,000/-, Rs.10,00,000/-, Rs.15,00,000/-, Rs.20,00,000/-, Rs.25,00,000/-, Rs.50,00,000/- and Rs.1,00,00,000/-
- ◆ **Medical Underwriting / Pre-Policy Medical Check-up:** The Company may ask the members to be proposed to undergo medical underwriting either through medical tests or any other medium viz tele underwriting etc. This will vary/depend upon the Sum Insured/ Medical History/ Zone and Age. If we accept the proposal, we will reimburse at least 50% of the costs incurred by the member undertaking such Pre-Policy medical check-up.
- ◆ Pregnant women has to submit the scan reports taken at Star Health specified scan centres during their 12th and 20th week of their pregnancy period. The cost of such scan will be borne by the insured.
- ◆ **Instalment Facility available:** Premium can be paid Monthly, Quarterly, Half-yearly and Yearly. For instalment mode of payment, there will be loading as given below:
 - i. Monthly : 4%
 - ii. Quarterly : 3%
 - iii. Half Yearly : 2%
 - iv. Yearly : 0%
- ◆ **Midterm Inclusion Facility:** Is available on payment of proportionate premium for Newly Wedded spouse, New born baby and Legally adopted child.

Note:

 - i. Waiting periods as stated in the policy will be applicable from the date of inclusion of such newly wedded spouse, new born baby, legally adopted child.
 - ii. Such midterm inclusion will be subject to underwriter's approval.
- ◆ **What are the benefits available under the insurance?**
 1. **In-patient Treatment:** We will cover the following Medical Expenses incurred in respect of Hospitalization of the Insured Person during the Policy Year, up to the Sum Insured specified in the Policy Schedule against this In-Patient treatment:

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

Sum Insured (RS.)	Limit
5,00,000/-	Up to 1% of Sum Insured per day
10,00,000/-, 15,00,000/-, 20,00,000/- and 25,00,000/-	Any Room (except suite or above category)
50,00,000/- and 1,00,00,000/-	Any Room

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

- 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 Year up to the Sum Insured as specified in the Policy Schedule if such Day Care treatment requires hospitalization as an in-patient for less than 24 hours.

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

Note: Claims under Yoga and Naturopathy system of treatment will be payable subject to prior approval from the company.

- 4. Coverage for Modern Treatment:** The following expenses are payable during the Policy year for treatment/procedures (either as a day care or as an in-patient) is limited to the amount mentioned in table below

Sum Insured (Rs.)	5 lacs	10 lacs	15 lacs	20 lacs	25 lacs	50 lacs	100 lacs
	Limit per person, per Policy Year for each treatment / Procedure Rs.						
Uterine artery Embolization and HIFU	Upto 50% of Sum Insured			Up to 40% of Sum Insured			Up to 30% of Sum Insured
Balloon Sinuplasty							
Deep Brain Stimulation							
Oral Chemotherapy* (Sublimits including pre & Post Hospitalization)							
Immunotherapy- Monoclonal Antibody to be given as injection							
Intra Vitreal injections							
Robotic surgeries							
Stereotactic radio surgeries							
Bronchical Thermoplasty							
IONM-(Intra Operative Neuro Monitoring)							
Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions							

*Sublimits are all inclusive with or without hospitalization wherever hospitalization includes pre and post hospitalizations.

- 5. Pre-Hospitalization Expenses:** Medical expenses incurred up to 60 days immediately before the Insured Person is hospitalized.
- 6. Post Hospitalization Expenses:** Medical expenses incurred up to 90 days immediately after the Insured Person is discharged from the hospital.

- 7. Road Ambulance:** Subject to an admissible hospitalization claim, road ambulance expenses incurred for the following are payable :-
- for transportation of the Insured Person by private ambulance service to go to hospital when this is needed for medical reasons or
 - for transportation of the Insured Person by private ambulance service from one hospital to another hospital for better medical treatment or
 - for transportation of the Insured Person from the hospital where treatment is taken to their place of residence (if it is in same city) provided the requirement of an ambulance to the residence is certified by the medical practitioner.

- 8. Air Ambulance** charges up to 10% of the Sum Insured per year is payable, provided that
- It is for life threatening emergency health condition/s of the Insured Person which requires immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot provide.
 - Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency
 - It is prescribed by a Medical Practitioner and is Medically Necessary;
 - The Insured Person is in India and the treatment is in India only
 - Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s

Note: This benefit is available for Sum Insured options of Rs.10,00,000/- and above only.

- 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 upto the 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 Inpatient
- 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. Cumulative Bonus:** In respect of a claim free year of Insurance, the insured would be entitled to benefit of bonus of 20% of the expiring Sum Insured from the second year onwards. The maximum allowable bonus shall not exceed 100% of the Sum Insured.

Special Conditions:

- i. The Cumulative bonus will be calculated on the expiring Sum Insured.
- ii. If the insured opts to reduce the Sum Insured at the subsequent renewal, the limit of indemnity by way of such Cumulative bonus shall not exceed such reduced Sum Insured.
- iii. In the event of a claim resulting in;
 - a. Partial utilization of Sum Insured, such cumulative bonus so granted will not be reduced.



- b. Full utilization of Sum Insured and nil utilization of cumulative bonus accrued, such cumulative bonus so granted will not be reduced.
 - c. Full utilization of Sum Insured and partial utilization of Cumulative Bonus accrued, the Cumulative Bonus granted on renewal will be the balance Cumulative Bonus available and will be reduced at the same rate at which it has accrued. At any point of time, the Cumulative Bonus will not be less than "zero".
 - d. Full utilization of Sum Insured and full utilization of cumulative bonus accrued, the Cumulative Bonus on renewal will be "nil" or "zero".
- iv. If the Insured Persons in the expiring Policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated Cumulative Bonus for such Insured Person under the expiring Policy, and such expiring Policy has been Renewed on a floater Policy basis as specified in the Policy Schedule then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
- v. In case of floater policies where Insured Persons Renew their expiring Policy by splitting the Sum Insured in to two or more floater policies/ individual policies or in cases where the Policy is split due to the child attaining the maximum age of entry as applicable, the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
- 12. Automatic Restoration of Sum Insured:** There shall be automatic restoration of the Sum Insured once by 100% subject to the following :-
- i. The automatic restoration shall be immediately upon partial / full utilization of the limit of coverage.
 - ii. Such Restored Sum Insured can be utilized for all claims for subsequent hospitalisation during the Policy Year.
 - iii. The maximum liability of the Company in a Single claim under a Policy Year shall not exceed the limit of coverage.
 - iv. The unutilized restored Sum Insured cannot be carried forward.
 - v. 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".
- 13. Delivery Expenses:** Expenses for a Delivery including Delivery by Caesarean section (including pre-natal and post natal expenses) up-to the table given below is payable, subject to the following:



- i. This benefit is available only for a maximum of 2 deliveries or 2 Medically confirmed spontaneous miscarriage or 2 Medical Termination of Pregnancy (MTP) performed by a registered medical practitioner in accordance with applicable law and accepted clinical guidelines, where medically indicated in the life time under this policy.
- ii. Pre-Hospitalization and Post Hospitalization expenses are not applicable for this section.

Sum Insured (Rs.)	Limit per delivery up to (Rs.)
5,00,000/-	25,000/-
10,00,000/-, 15,00,000/-, 20,00,000/-	50,000/-
25,00,000/- and 50,00,000/-	75,000/-
1,00,00,000/-	1,00,000/-

Note:

1. Selective fetal reduction, fetal number reduction, embryo reduction, or any procedure performed solely to reduce the number of fetuses in a multiple pregnancy is not covered.
2. Coverage does not extend to pre-existing pregnancy at Policy inception unless otherwise specifically covered under the Policy.

Waiting period:

- a. Where the Sum Insured is Rs.5 Lakh and Rs.10 Lakh Sum Insured, this cover is subject to a waiting period of 24 months from the inception of this policy
- b. Where the Sum Insured is Rs.15 Lakhs and above, this cover is subject to a waiting period of 12 months from the inception of this policy

- 14. Ante-Natal Care (Pregnancy Care):** Company pays the expenses for Ante-natal care after confirmation of Pregnancy, incurred as an Out-patient up to the limits given below after the waiting period.

Sum Insured (Rs)	Limit per Policy Year
5,00,000/-, 10,00,000/-, 15,00,000/-	Rs. 2,500/-
20,00,000/-, 25,00,000/-, 50,00,000/-, 1,00,00,000/-	Rs. 5,000/-

Waiting period:

- a. Where the Sum Insured is Rs.5 Lakh and Rs.10 Lakh Sum Insured, this cover is subject to a waiting period of 24 months from the inception of this policy
- b. Where the Sum Insured is Rs.15 Lakhs and above, this cover is subject to a waiting period of 12 months from the inception of this policy

- 15. In Utero Fetal Surgery/Repair:** The Company will pay the expenses incurred for In Utero Fetal Surgeries and Procedures mentioned below after the waiting period. Payment under this benefit forms part of the Sum Insured and will impact the Bonus.

Waiting period:

- Where the Sum Insured is Rs.5 Lakh and Rs.10 Lakh, this cover is subject to a waiting period of 24 months from the inception of this policy
- Where the Sum Insured is Rs.15 Lakhs and above, this cover is subject to a waiting period of 12 months from the inception of this policy

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

Types of in utero-surgeries covered:

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

Types of in utero-surgeries/procedures covered:

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

List of procedures covered under in utero-surgeries:

- a. Amniotic band syndrome
- b. Bronchopulmonary sequestration of the lung
- c. Congenital cystic adenomatoid malformation (CCAM) of the lung
- d. Congenital diaphragmatic hernia (CDH)
- e. Congenital high airway obstruction syndrome (CHAOS)
- f. Fetal anemia
- g. Lower urinary tract obstruction (LUTO)
- h. Mediastinal teratoma
- i. Neck mass
- j. Sacrococcygeal teratoma (SCT)
- k. Spina bifida (myelomeningocele)
- l. Twin reversed arterial perfusion (TRAP) sequence
- m. Twin-twin transfusion syndrome (TTTS)

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

- i. A waiting period of 36 months from the date of first inception of this policy with the Company for the Insured Person.
- ii. Company will pay one Assisted Reproduction Treatment cycle for each Policy Year.
- iii. For the purpose of claiming under this benefit, in-patient treatment is not mandatory.

Sum Insured (Rs.)	Limit of Liability of the Company for each Policy Year (Rs.)
5,00,000/-	50,000/-
10,00,000/-	1,00,000/-
15,00,000/-	1,50,000/-
20,00,000/- and 25,00,000/-	2,00,000/-
50,00,000/-	2,50,000/-
1,00,00,000/-	3,00,000/-

a. Surrogacy Cover

The Company will indemnify the inpatient hospitalization expenses covering post-partum delivery complications for a period of 36 months incurred for the Surrogate mother up to the sub-limits specified under "Assisted Reproduction Treatment". The cover will commence from the date of initiation of treatment / procedure.



The Company will pay lump sum amount in case of "Miscarriage due to Accident" for surrogate mother as specified under Coverage 18 and waiting period mentioned under this cover is not applicable.

Important note applicable for Surrogacy Cover

- i. Coverage 14 – Ante-Natal Care and Coverage 13 – Delivery Expenses for Surrogate Mother are not payable
- ii. Intending couple, the Surrogate mother and the Surrogacy clinic has to comply with Surrogacy Act and ART Act
- iii. Surrogacy and Oocyte donation should be carried out in recognised centres registered with the National ART and Surrogacy Registry at <https://registry.artsurrogacy.gov.in/>.
- iv. Treatment under Day Care and OPD are not covered
- v. Waiting periods mentioned under Standard Exclusions (1) and (2) are not applicable under Surrogacy Cover.
- vi. For all treatments other than Surrogacy Cover, all waiting periods are applicable

b. Oocyte Donor cover

The company will indemnify the inpatient hospitalization expenses for the complications arising out of Assisted Reproductive Treatment Procedures, for the Oocyte donor up to the sub-limits specified under "Assisted Reproduction Treatment" for a period of 12 months. The cover will commence from the date of initiation of the treatment/procedure.

Important note applicable for Oocyte Cover

- i. Intending couple, the Oocyte donor and the ART Clinic have to comply with Surrogacy Act and ART Act
- ii. Surrogacy and Oocyte donation should be carried out in recognised centres registered with the National ART and Surrogacy Registry at <https://registry.artsurrogacy.gov.in/>.
- iii. Waiting periods mentioned under Standard Exclusions (1) and (2) are not applicable under Oocyte Donor Cover.
- iv. For all treatments other than Oocyte Donor Cover all waiting periods are applicable.

Conditions applicable for Surrogacy Cover and Oocyte Donor Cover:

- i. The Proposal for insurance has to be made 30 days before the embryo transfer for the surrogate mother and /or 30 days before ovarian stimulation for oocyte donor.
- ii. Proposer has to be one of the intending couple.
- iii. For Surrogate Mother: After completion of 36 months period, all other coverages will continue except Surrogacy cover

- iv. For Oocyte Donor: After completion of 12 months period, all other coverages will continue except Oocyte Donor cover

Special Exclusions applicable for Assisted Reproduction Treatment:

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:

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

- 17. Voluntary Sterilization Expenses:** The Company will pay the expenses incurred for Voluntary Sterilization (Tubectomy / Vasectomy), after a waiting period of 24 months from the date of first inception of this policy, provided if Insured is a Married Person and his/ her age is 22 years and above.

Note: Expenses incurred for Reversal of Sterilization are not payable.

- 18. Miscarriage due to Accident:** The Company will pay the lumpsum amount as per the table given below towards miscarriage arising due to accident subject to a waiting period.

Sum Insured (Rs.)	Limit of liability (Rs.)
5,00,000/- to 15,00,000/-	25,000/-
20,00,000/- and 25,00,000/-	35,000/-
50,00,000/- and 1,00,00,000/-	40,000/-



Waiting period:

- Where the Sum Insured is Rs.5 Lakh and Rs. 10 Lakh Sum Insured, this cover is subject to a waiting period of 24 months from the inception of this policy
- Where the Sum Insured is Rs.15 Lakhs and above, this cover is subject to a waiting period of 12 months from the inception of this policy
- Waiting period is not applicable for Coverage – 16(a)

Note: This benefit is available only once in lifetime

19. Hospitalization expenses for treatment of New Born Baby.

- A. Birth of New born baby during the Policy Year:** In-patient hospitalization expenses (Including Congenital Internal and External defects/anomalies) are covered from day 1 subject to a maximum of 25% of the Sum Insured (including medical and surgical treatment expenses, neonatal and Postnatal surgery/repair).

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

- B. In the subsequent year (on payment of applicable premium for New born):** In-patient hospitalization expenses (Including Congenital Internal and External defects/anomalies) are covered up to 100% of the Sum Insured.
- C. Vaccination Expenses:** Vaccination expenses for the new born baby are payable up to the 12 months from the birth of the new born. The Company's liability for vaccination is as per the limits mentioned in the table below;

Sum Insured (Rs.)	Limit (Rs.)
5,00,000/- and 10,00,000/-	2,500/-
15,00,000/- and above	3,500/-

- D. Metabolic Screening:** Test for New Born is payable once for each new born subject to a limit of Rs.3,500/-
- E. Pediatrician Consultation** up to 4 consultations per year are payable up to 12 year of age subject to policy is in force. The Company's liability for each consultation is up to Rs.500/-.

Note 1: Expenses for treatment of new born baby is covered subject to

- Admissible delivery claim or
- At the time of inception of the policy, if the mother has submitted the Scan reports taken during 12th and 20th week of her pregnancy and the same has been accepted by the Company for issuance of the policy. In such case, the new born baby will be covered (Including Congenital Internal and External defects/anomalies) without any waiting period.

20. Star Mother Cover:

- i. Where the Insured Person is a child age less than 12 years, the Company will provide for expenses up to **Single Private A/c room** for stay of the mother in the hospital provided,
 - a. Insured child is under treatment in ICU
 - b. There is an admissible claim for hospitalization
- ii. This benefit is available only for the period the Insured Person was under treatment in ICU.
- iii. If the room is not available in the same hospital, the Company will reimburse Rs.2,500/- per day subject to maximum of 7 days per hospitalization towards stay of the mother in the Hotel room if the hotel room is within 2 kms from the hospital.

- 21. 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 Year. 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 Year (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 24 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 benefit shall be processed only on cashless basis.

22. Expenses of Medical Consultations as an Outpatient up to the limits mentioned in the table below are payable.

Sum Insured (Rs.)	Limit per Policy Year up to (Rs.)
5,00,000/- to 15,00,000/-	2,500/-
20,00,000/- & 25,00,000/-	3,500/-
50,00,000/- and 1,00,00,000/-	5,000/-

Note:

1. This benefit is available only for female Insured Person
2. Unlimited Gynecologist Consultation through Star tele health app is available

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

23. Shared Accommodation: If the Insured Person occupies, a shared accommodation during in-patient hospitalization, then sum of Rs.2,000/- per day subject to a maximum of 7 days (per hospitalization) will be payable for each continuous and completed period of 24 hours of stay in such shared accommodation.

Note:

- i. This benefit is payable only if there is an admissible claim for hospitalization under the policy
- ii. This benefit will not be applicable where the sanction is on package rates
- iii. Insured stay in Intensive Care Unit or High Dependency Units / wards will not be counted for this purpose

24. Preventive Health Check Up: Expenses incurred towards cost of preventive health check-up for the tests mentioned in the table up to the limits for each Policy Year is payable.

Gender	Benefit Description	Limit per Policy Year up to (Rs.)	Tests
Female	Adolescent (Puberty Age) : 13 to 19 yrs	1,000/-	USG Abdomen
Female	Adult (Reproductive Age) 20-39 yrs	3,000/-	Thyroid profile, PAP, Vitamin D, USG Abdomen
Female	Middle Aged (Menopausal age) :40 yrs – 59 yrs	5,000/-	Dexa Scan, Sonomamogram, PAP, USG Abdomen
Female	Sr Citizens Age 60 yrs and above	4,000/-	Dexa Scan, PAP, USG Abdomen
Male	Any age	1,000/-	Any tests

The above limit is inclusive of cost of Vaccination.

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

25. 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:

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

26. 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.

27. Rehabilitation and Pain Management: The Company will pay the medical expenses for Rehabilitation and Pain Management up to the sub-limit (or) maximum up to 10% of the Sum Insured whichever is less, per Policy Year.

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

- i. Poly Trauma
- ii. Head injury
- iii. Diseases of the spine
- iv. Stroke

Pain Management treatment:

The Company will pay the expenses for the following, if availed at authorized centres as an In-patient/ Day Care treatment

	Subject - Pain Management Cover	Sub-limits (Per Policy Year) (RS.)		
		Rs.5 Lakhs SI	Rs. 10/15/20 lakhs SI	Rs. 25 Lakhs and above SI
1	Lumbar and cervical medial branch block with RF ablation for lumbar and cervical facet joint arthritis	50,000/-	65,000/-	75,000/-
2	Caudal epidural injection for Discogenic pain	30,000/-	40,000/-	50,000/-
3	Lumbar and cervical selective nerve root block for Lumbar and Cervical radicular pain	40,000/-	50,000/-	60,000/-
4	Caudal Neuroplasty for Failed back spine surgery	50,000/-	85,000/-	1,00,000/-
5	Stellate ganglion ablation for upper limb CRPS	50,000/-	65,000/-	75,000/-
6	Occipital nerve Pulsed RF lesioning for Migraines, Cluster headache and cervicogenic headaches	50,000/-	65,000/-	75,000/-
7	Lumbar sympathetic chain RF ablation for lower limb CRPS, diabetic periphery painful neuropathy and Ischaemic limb pain	50,000/-	65,000/-	75,000/-
8	Gasserian ganglion ablation for Trigeminal neuralgia	50,000/-	65,000/-	75,000/-
9	Intercostal nerve Ablation for post thoracotomy pain and Thoracic malignancy pain	40,000/-	65,000/-	75,000/-
10	Coeliac plexus ablation for upper gastrointestinal malignancies pain	40,000/-	65,000/-	75,000/-
11	Superior hypogastric plexus ablation for lower Gastro intestinal malignancies pain	40,000/-	65,000/-	75,000/-
12	Ganglion impar ablation for perineal cancer pain and coccydynia	50,000/-	65,000/-	75,000/-
13	Cooled RF ablation of genicular nerve for grade 1 and 2 osteoarthritis knee and hip	50,000/-	1,00,000/-	1,25,000/-
14	Suprascapular nerve RF ablation for rotator cuff partial tear and peri arthritis shoulder pain	40,000/-	65,000/-	75,000/-

Important. Note:

- Rehabilitation and/or Pain management treatment can be taken only at the Authorized centres mentioned in the website – www.starhealth.in
- Payment under this benefit forms part of the Sum Insured and will impact the Bonus.



28. Coverage for Non-medical Items: If there is an admissible claim under the policy, then reasonable and customary charges for the Items as per List I will become payable.

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

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

Note: The Wellness Activities mentioned in the table below 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%

* the weightage is given as per the following table:

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

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

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

The wellness services and activities are categorized as below:

Sr. No.	Activity	Maximum number of Wellness Points that can be earned under each activity in a Policy Year
1.	Manage and Track Health	
	a. Online Health Risk Assessment (HRA)	50
	b. Preventive Risk Assessment	200
2.	Affinity to Wellness	
	a. Participating in Walkathon, Marathon, Cyclothon and similar activities	100
	b. Membership in a health club (for 1 year or more)	100
3.	Stay Active – If the Insured member achieves the step count target on “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.	Medical Concierge Services	
7.	Digital Health Vault	
8.	Wellness Content	
9.	Post-Operative Care	
10.	Discounts from Network Providers	

1. Manage and Track Health:

a. Completion of Health Risk Assessment (HRA):

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

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

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

b. Preventive Risk Assessment:

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

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

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

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

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

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

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

3. **Stay Active:** Insured earns wellness points on achieving the step count target on “Star 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.

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

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

5. Chronic Condition Management Program:

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

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

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

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

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

6. **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.
7. **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.
8. **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.
9. **Post Operative Care:** It is done through follow up phone calls (primarily for surgical cases) for resolving their medical queries.
10. **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. 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.
- v. 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.
- vi. We reserve the right to remove the wellness reward points if found to be achieved in unfair manner.



- vii. Star Health, its group entities, or affiliates, their respective directors, officers, employees, agents, vendors, are not responsible or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which a Member claims to have suffered, sustained or incurred, by way of and / or on account of the Wellness Program.
- viii. Services offered are subject to guidelines issued by IRDA 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 42 year old Individual Suresh and his wife Lakshmi along with their two dependent children (aged below 18 yrs) buy a **Star Women Care 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.

Sr. No	Name of the wellness activity taken up during the Policy Year	Wellness Points Earned by Suresh	Wellness Points Earned by Lakshmi
1.	Completed Online Health Risk Assessment (HRA)	50	50
2.	Submitted Health Check-Up Report	200	200
3.	Participation in Marathon	100	0
4.	Attended to Gym	100	100
5.	Achieved 10,000 average number of steps per day during the Policy Year	200	200
6.	Suresh accepted the Weight management program and reached 27 BMI Lakshmi accepted the Weight management program and reached 23 BMI	100	100
7.	Suresh Managed Diabetes & Hypertension through Chronic Condition Management Program; Lakshmi has completed De-stress & Mind Body Healing Program	250	125
	Total Number of Wellness Points earned	1000	775
	No of wellness points based upon weightage - 1:1	500 (1000x1/2)	388 (775x1/2)

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

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

29. Optional Cover (Lump sum on diagnosis of Cancer): (Available on payment of additional premium and shown in the policy schedule)

If the Insured Person shall contract Cancer as a first incidence, then Company will pay the Sum Insured stated in the Schedule as lump-sum.

Note:

- This benefit is available only for the Insured Persons named in the schedule.
- The available Sum Insured options under this benefit cover are 5/10/15/20 and 25 lacs only
- This benefit is available on individual Sum Insured basis only.
- Available only once in lifetime.
- Once a claim has been paid under this optional cover, the optional cover cannot be renewed further.
- On payment of claim under the optional cover, the optional cover will cease and the policy will continue for the balance period without this optional cover. Subsequently on renewal, the policy will be renewed without the optional cover
- This cover should be opted only at the time of first inception of this policy and cannot be opted at the time of renewal.
- This optional cover is available only for female Insured Persons who is aged between 91 days to 65 years.
- Enhancement of Sum Insured under this benefit is subject to underwriting

Waiting Period: An initial waiting period of 180 days is applicable from the date of commencement of this policy. In case of enhancement of Sum Insured this waiting period shall apply afresh to the extent of Sum Insured increase.

Applicable for all covers / benefits under this policy			
SI No	Description Cover	Forming Part of Sum Insured / Not Forming Part of Sum Insured	Claim under this benefit will
1	Room, Boarding, Nursing Expenses, Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees, Anesthesia, Blood, Oxygen, Operation theatre charges, ICU charges, Surgical appliances, Medicines and Drugs, Diagnostic materials and X-ray, Diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses. 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.	Forming Part of Sum Insured	Impact Cumulative Bonus

S No	Description Cover	Forming Part of Sum Insured / Not Forming Part of Sum Insured	Claim under this benefit will
2	Day Care Treatment	Forming Part of Sum Insured	Impact Cumulative Bonus
3	AYUSH Treatment	Forming Part of Sum Insured	Impact Cumulative Bonus
4	Coverage for Modern Treatment	Forming Part of Sum Insured	Impact Cumulative Bonus
5	Pre-Hospitalization Expenses	Forming Part of Sum Insured	Impact Cumulative Bonus
6	Post Hospitalization Expenses	Forming Part of Sum Insured	Impact Cumulative Bonus
7	Road Ambulance	Forming Part of Sum Insured	Impact Cumulative Bonus
8	Air Ambulance	Forming Part of Sum Insured	Impact Cumulative Bonus
9	Organ Donor Expenses	Forming Part of Sum Insured	Impact Cumulative Bonus
9a	Complications necessitating Redo surgery or ICU admission for the Organ donor	Not Forming Part of Sum Insured	Impact Cumulative Bonus
10	Home Care Treatment	Forming Part of Sum Insured	Impact Cumulative Bonus
11	Automatic Restoration of Sum Insured	Not Forming Part of Sum Insured	not impact Cumulative Bonus
12	Delivery Expenses	Not Forming Part of Sum Insured	Impact Cumulative Bonus
13	Ante-Natal Care (Pregnancy Care)	Not Forming Part of Sum Insured	not impact Cumulative Bonus
14	In Utero Fetal Surgery/Repair	Forming Part of Sum Insured	Impact Cumulative Bonus
15	Assisted Reproduction Treatment	Forming Part of Sum Insured	Impact Cumulative Bonus
16	Voluntary Sterilization Expenses	Forming Part of Sum Insured	Impact Cumulative Bonus
17	Miscarriage due to Accident	Forming Part of Sum Insured	Impact Cumulative Bonus

Hospitalization expenses for treatment of New Born Baby			
18	A. Birth of New born baby during the Policy Year	Forming Part of Sum Insured	Impact Cumulative Bonus
	B. In the subsequent year (on payment of applicable premium for New born)	Forming Part of Sum Insured	Impact Cumulative Bonus
	C. Vaccination Expenses	Forming Part of Sum Insured	not impact Cumulative Bonus
	D. Metabolic Screening	Forming Part of Sum Insured	not impact Cumulative Bonus
	E. Pediatrician Consultation	Forming Part of Sum Insured	not impact Cumulative Bonus
19	Star Mother Cover	Forming Part of Sum Insured	Impact Cumulative Bonus
20	Bariatric Surgery	Forming Part of Sum Insured	Impact Cumulative Bonus
21	Medical Consultations as an Outpatient	Not Forming Part of Sum Insured	not impact Cumulative Bonus
22	Shared accommodation	Forming Part of Sum Insured	Impact Cumulative Bonus
23	Preventive Health Check Up	Not Forming Part of Sum Insured	not impact Cumulative Bonus
24	Unlimited Tele Consultation	Not Forming Part of Sum Insured	not impact Cumulative Bonus
25	AI driven Face Scan	Not Forming Part of Sum Insured	not impact Cumulative Bonus
26	Rehabilitation and Pain Management	Forming Part of Sum Insured	Impact Cumulative Bonus
27	Coverage for Non-medical Items:	Forming Part of Sum Insured	Impact Cumulative Bonus
28	Star Wellness Program	Not Forming Part of Sum Insured	not impact Cumulative Bonus
29	Optional Cover (Lump sum on diagnosis of Cancer)	Not Forming Part of Sum Insured	Impact Cumulative Bonus

- ◆ Add-on cover: Star Flexi | UIN: SHAHLIA27050V022627 and its subsequent revisions.

This Add on cover can be availed along with this Product. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All terms and conditions of the Add-on cover will apply.



EXCLUSIONS

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

STANDARD EXCLUSIONS

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

- A. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 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 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

- A. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- B. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- C. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- D. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- E. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures

1. Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, Diseases related to Thyroid, Benign diseases of the breast.
2. Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal Tunnel Syndrome, Trigger Finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology
3. All treatments (Conservative, Operative treatment) and all types of intervention for Diseases related to Tendon, Ligament, Fascia, Bones and Joint Including Arthroscopy and Arthroplasty / Joint Replacement [other than caused by accident].
4. All types of treatment for Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system, Prolapse of Intervertebral Disc (other than caused by accident),
5. All treatments (conservative, interventional, laparoscopic and open) related to Hepato-pancreato-biliary diseases including Gall bladder and Pancreatic calculi. All types of management for Kidney calculi and Genitourinary tract calculi.
6. All types of Hernia,
7. Desmoid Tumor, Umbilical Granuloma, Umbilical Sinus, Umbilical Fistula,
8. All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Cervix, Uterus, Fallopian tubes, Ovaries, Uterine Bleeding, Pelvic Inflammatory Diseases
9. All Diseases of Prostate, Stricture Urethra, all Obstructive Uropathies,
10. Benign Tumours of Epididymis, Spermatocele, Varicocele, Hydrocele,
11. Fistula, Fissure in Ano, Hemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence
12. Varicose veins and Varicose ulcers
13. All types of transplant and related surgeries.
14. Congenital Internal disease / defect [except for Unborn in Coverage (15) and New Born in Coverage (19)]

Note: Waiting period for the following benefits are as follows:

- a. **Bariatric Surgery:** A waiting period of 24 months from the date of first commencement of this policy and continuous renewal thereof.
- b. **Assisted Reproduction Treatment:** A waiting period of 36 months from the date of first inception of this policy with the Company
- c. **Voluntary Sterilization Expenses:** A waiting period of 24 months from the date of first inception of this policy



- d. **Ante-Natal Care (Pregnancy Care):** For Sum Insured option of Rs.5 lakhs and Rs.10 lakhs – A waiting period of 24 months from the date of first inception of this policy. For Sum Insured option of Rs.15 lakhs and above – A waiting period of 12 months from the date of first inception of this policy.
- e. **In Utero Fetal Surgery / Repair:** For sum insured option of 5 lakhs and 10 lakhs – A waiting period of 24 months from the date of first inception of this policy. For sum insured option of 15 lakhs and above – A waiting period of 12 months from the date of first inception of this policy

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

- f. **Delivery Expenses:** For Sum Insured option of Rs.5 lakhs and Rs.10 lakhs – A waiting period of 24 months from the date of first inception of this policy. For Sum Insured option of Rs.15 lakhs and above – A waiting period of 12 months from the date of first inception of this policy.
- g. **Miscarriage due to Accident:** For Sum Insured option of Rs.5 lakhs and Rs.10 lakhs – A waiting period of 24 months from the date of first inception of this policy. For Sum Insured option of Rs.15 lakhs and above – A waiting period of 12 months from the date of first inception of this policy.

3. 30-day waiting period-Code-Excl 03 (Not Applicable for Accidents)

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

4. Investigation & Evaluation-Code-Excl 04

- A. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- B. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. Rest Cure, rehabilitation (except to the extent covered under Coverage-27) and respite care – Code Excl 05: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

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



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

6. Obesity / Weight Control - Code Excl 06 (except to the extent covered under Coverage-21): Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions;

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
 - a. greater than or equal to 40 or
 - b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

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

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

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

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



11. **Excluded Providers: Code-Excl 11** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code-Excl 12**
13. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code-Excl 13**
14. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code-Excl 14**
15. **Refractive Error: Code-Excl 15** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
16. **Unproven Treatments: Code-Excl 16** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
17. **Sterility and Infertility-Code-Excl 17 (Except to the extent covered under Coverage -16 and 17):** Expenses related to sterility and infertility. This includes:
 - i. Any type of contraception, sterilization
 - ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - iii. Gestational Surrogacy
 - iv. Reversal of sterilization
18. **Maternity-Code-Excl 18** (except to the extent covered under Coverage-13)
 - i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Period.

SPECIFIC EXCLUSIONS

19. Circumcision (unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident), Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA - **Code-Excl 19**
20. Congenital External Condition / Defects / Anomalies (except to the extent covered under Coverage -19) - **Code-Excl 20**
21. Convalescence, general debility, run-down condition, Nutritional deficiency states - **Code-Excl 21**
22. Intentional self - injury - **Code-Excl 22**
23. Injury/disease caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) - **Code-Excl 24**
24. Injury or disease caused by or contributed to by nuclear weapons/ materials - **Code-Excl 25**
25. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion - **Code-Excl 26.**
26. Unconventional, Untested, Experimental therapies - **Code-Excl 27**
27. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy - **Code-Excl 28**
28. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalization warranted. - **Code-Excl 29**
29. Inoculation or Vaccination (except to the extent covered under Coverage II-27C and 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) - **Code-Excl 32**
31. Hospital registration charges, admission charges, record charges, telephone charges and such other charges - **Code-Excl 34**
32. Cost of spectacles and contact lens, hearing aids, Cochlear implants and procedures, walkers and crutches, wheel chairs, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis, infusion pump and such other similar aids. - **Code-Excl 35**
33. Any hospitalization which are not medically necessary / does not warrant hospitalization - **Code-Excl 36**
34. Existing disease/s, disclosed by the insured and mentioned in the policy schedule under Permanent Exclusion (based on Insured's consent) - **Code-Excl 38**



◆ 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.

◆ 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. 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 must 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 whichever is earlier.

For the Notification of claim purpose,

Emergency Hospitalization shall mean a serious medical condition or symptom resulting from Injury or Illness which arises suddenly and unexpectedly, and requires immediate Emergency care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.

Planned Hospitalization shall refer to the hospitalization that is medically necessary and advised by a registered Medical Practitioner in advance, where the admission to the Hospital is scheduled at a later date rather than being required immediately on an Emergency basis.

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

C. Process for Cashless Treatment:

- a. Intimate us as specified in section B above.
- 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. 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.
 - i. For assistance call 24 hours help-line 044-69006900 or Toll Free No. 1800 425 2255, Senior Citizens may call at 044-40020888.
 - j. Submit 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.

D. Time limits and Documents for Reimbursement claims:

- a. Intimate us as specified in section B above.
- b. Submit the documents for the reimbursement claims within the time limits as prescribed below:

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 maximum number of Post hospitalization number of days applicable under the product.

- c. Documents to be submitted for Reimbursement claims:
 - i. Duly completed claim form, and
 - ii. Pre Admission investigations and treatment papers in original
 - iii. Discharge Summary in original from the hospital
 - iv. Cash receipts in original from hospital, chemists
 - v. Cash receipts and reports for tests done in original



- vi. Receipts from doctors, surgeons, anesthetist in original
- vii. Certificate from the attending doctor regarding the diagnosis.
- viii. Copy of PAN card
- ix. Copy of Aadhaar Card
- x. Any other document specific to the treatment / illness
- xi. Prescriptions and receipt for Pre and Post-Hospitalization expenses
- xii. KYC (Identity proof with Address) of the proposer, as per AML Guidelines
- xiii. NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code
- xiv. CKYC No. of the proposer (if available)
- xv. 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>.

- E. **Note:** The Company reserves the right to call for additional information / 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.

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

- ◆ **Cancellation**

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

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

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

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

- ◆ **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.

- ◆ **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.

- ◆ **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.

For Surrogate Mother: After completion of 36 months period, all other coverages will continue except Surrogacy Cover.

For Oocyte Donor: After completion of 12 months period, all other coverages will continue except Oocyte Donor Cover.



- ◆ **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.
- ◆ **Premium Payment in Instalments:** If the Policyholder has opted for Payment of Premium on an instalment basis i.e. Yearly, 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
- ◆ **Medical Underwriting Loading:** Company may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance).
 - i. The maximum risk loading applicable for an individual shall not exceed above 125% per diagnosis / medical condition and an overall risk loading up to 200% per Insured Person.
 - ii. This loading is applied from the Commencement Date of the Policy including subsequent renewal(s) with the Company.
 - iii. Company will inform about the applicable risk loading or exclusion or both as the case may be through a counter offer.



- iv. The Company will issue Policy only after getting the Proposer's consent and additional premium (if any).

◆ **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.

- ◆ **Redressal of Grievance:** In case of any grievance the Insured Person may contact the Company through

Website : www.starhealth.in

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

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

Senior Citizens may call at 044-69007500

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

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

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

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

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

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



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

- ◆ **Withdrawal of the 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.

- 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
- 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.

- ◆ **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.

- ◆ **IMPORTANT NOTE**

- Where the policy is issued for more than 1 year, the Sum Insured including sublimits, automatic restoration benefit (if applicable), is for each of the year, without any carry over benefit thereof. The said benefits / covers available for the 2nd year or 3 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.
- Where the policy is issued on floater basis, the Sum Insured floats amongst the insured members.
- 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
- 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.
- 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.

- ◆ **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>
- ◆ **Buy this insurance:** Please contact our nearest Branch Office /our Agent or visit our website www.starhealth.in for online purchase. 5% discount for first purchased online and its renewals (If the policy is first purchased online and the same is renewed online, then 5% discount will be given for such renewals too).
- ◆ **Important:** "IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint".
- ◆ **Prohibition of Rebates:** Section 41 of Insurance Act 1938 (Prohibition of rebates): No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer: Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakhs rupees.
- ◆ **Other Terms And Clauses:**

Medical protocols and Position statements:

We will periodically publish and refresh medical protocols and position statements on Our website <https://www.starhealth.in>. These protocols and position statements will be generally based on Textbooks and reputed Medical Journals, AIIMS (All India Institute of Medical Sciences), ICMR (Indian Council of Medical Research), Clinical Establishment Act, Department of health research under Ministry of Health, General Insurance Council (GI Council), reputed International institutions and similar other organizations. These protocols and position statements will provide:

- Indication for hospitalization: The criteria for hospitalization including various category of rooms (ICU, Normal room or any other room)
- What is the right treatment (medicine, procedure) for the condition & severity, implants and medical devices
- Clarification about our position on coverage of various treatments.



Any treatment, medicine not approved by CDSCO (Central Drugs Standard Control Organization), FDA (Food and Drug Administration) and other appropriate authorities in India will not be covered. We will also use instructions on the drug, procedure published by manufacturers, approver of the drug, and procedure in different countries, especially the country of discovery or invention on indications, contraindications and usage. Extra / Off label usage (using a drug or procedure for conditions other than it was explicitly approved for) will not be covered under the Policy.

We may fully pay, part pay, suggest alternatives, investigate, or may even deny certain medicines, procedures, investigations, therapies, prolong hospitalization stay. If any treatment based on the scientific evaluation is not payable fully or partially payable, we may at least pay up to the cost of currently prevailing most common alternative treatments for the condition and not less.

Talk to Star & Home Health Care

You can reach the "Talk to Star" hospitalization guidance service by calling on below no's to get instant help with hospital networks, cashless processes, inclusion and exclusions along with next steps & hospitalization assistance, all in one place.

We seek your intimation to us and availing 'Home Health Care' facility before planning for admission to any Network or Non-Network Hospital, in case of below conditions/symptoms:

Fever, Infectious diseases, Respiratory infections, Urinary Tract Infections, Gastritis etc.

Talk to Star on: 7200 222 333 or 7676 905 905

UTILIZATION OF Sum Insured

The sequence of utilization of the Sum Insured in this Policy will be as follows

- Basic Sum Insured
- Cumulative Bonus (if applicable)
- Automatic Restoration of Sum Insured triggers on utilization of the Limit of Coverage in whole or in part.

Illustration for Utilization of Sum Insured

Illustration 1 An Insured Person with Star Women Care Insurance Policy, Tenure 1 year, Third year in progress, Basic Sum Insured Rs.5,00,000/-

Number of Claims	Claim amount (Rs.)	Available Benefit Limit			Admissible claim amount (Rs.)	Utilization of Sum Insured
		Basic Sum Insured (Rs.)	Bonus (Rs.)	Automatic Restoration of Sum Insured (Rs.)		
1 st Claim	5,00,000	5,00,000	2,00,000	-	5,00,000	Basic SI (Full)
2 nd Claim	7,00,000	-	2,00,000	5,00,000	7,00,000	Bonus (full) + Automatic Restore (Full)

Illustration 2 An Insured Person with Star Women Care Insurance Policy, Tenure 1 year, Second year in progress, Basic Sum Insured Rs.5,00,000/-

Number of Claims	Claim amount (Rs.)	Available Benefit Limit			Admissible claim amount (Rs.)	Utilization of Sum Insured
		Basic Sum Insured (Rs.)	Bonus (Rs.)	Automatic Restoration of Sum Insured (Rs.)		
1 st Claim	3,00,000	5,00,000	1,00,000	-	3,00,000	Basic SI (partial)
2 nd Claim	6,00,000	2,00,000	1,00,000	3,00,000	6,00,000	Basic (balance) + Bonus (full) + Automatic Restoration (partial)
3 rd Claim	2,00,000	-	-	2,00,000	2,00,000	Automatic Restoration (Balance)

1 Year - Premium Chart (Excluding GST)

A-Adult | C-Child

Premium in (Rs.) for 1A – Female only							
Age-band (in years) / SI	5,00,000	10,00,000	15,00,000	20,00,000	25,00,000	50,00,000	1,00,00,000
18-25	7,965	10,300	12,740	13,955	15,970	18,645	22,680
26-35	8,363	10,300	15,288	16,048	18,366	21,442	26,082
36-40	9,618	11,860	17,436	18,354	20,901	24,616	29,889
41-45	11,400	14,720	18,690	20,580	23,273	27,662	33,485
46-50	13,466	16,540	20,365	22,654	25,195	30,839	37,343
51-55	14,889	18,330	22,045	24,754	27,174	34,136	41,402
56-59	19,058	23,490	28,277	31,731	34,850	43,727	52,915
60	19,965	25,839	29,623	33,242	36,509	45,810	55,435
61-65	25,553	33,127	38,016	42,658	46,871	58,784	71,022
66-70	32,929	42,719	49,044	55,011	60,456	75,768	91,405
71-75	42,521	55,187	63,382	71,066	78,122	97,851	1,17,898
Above 75	54,984	71,390	82,022	91,944	1,01,085	1,26,555	1,52,345
Premium in (Rs.) for 2A – Female & Male							
Age-band (in years) / SI	5,00,000	10,00,000	15,00,000	20,00,000	25,00,000	50,00,000	1,00,00,000
18-25	11,735	15,265	18,460	20,400	23,070	27,660	33,855
26-35	12,322	15,265	22,152	23,460	26,531	31,809	38,933
36-40	14,716	18,230	26,244	27,853	31,366	37,852	46,184
41-45	18,135	23,535	29,342	32,555	36,461	44,294	53,813
46-50	23,436	28,905	35,285	39,391	43,607	53,960	65,441
51-55	27,762	34,285	41,302	46,347	50,925	63,935	77,511
56-59	35,695	44,115	53,167	59,635	65,541	82,205	99,435
60	37,395	48,527	55,699	62,475	68,662	86,119	1,04,170
61-65	48,114	62,486	71,770	80,487	88,484	1,10,919	1,33,947
66-70	62,167	80,751	92,774	1,04,011	1,14,362	1,43,270	1,72,766
71-75	80,438	1,04,500	1,20,087	1,34,602	1,48,011	1,85,323	2,23,234
Above 75	1,04,181	1,35,372	1,55,590	1,74,361	1,91,747	2,39,998	2,88,844
Premium in (Rs.) for Child							
Age up to 25 years*/SI	5,00,000	10,00,000	15,00,000	20,00,000	25,00,000	50,00,000	1,00,00,000
1st Child	3,859	3,943	4,019	4,284	4,509	5,180	5,981
2nd Child	3,428	3,487	3,548	3,780	3,977	4,563	5,263
3rd Child	3,049	3,087	3,132	3,336	3,511	4,021	4,633
*Female child can continue maximum up to 30 yrs if unmarried and unemployed							
Premium Chart in (Rs.) for Optional Cover – Cancer							
Age - band (in years) / SI	5,00,000	10,00,000	15,00,000	20,00,000	25,00,000		
91days-35yrs	895	1,795	2,690	3,590	4,485		
36-45	4,110	8,220	12,325	16,435	20,545		
46-55	9,810	19,620	29,430	39,240	49,050		
56-65	14,305	28,615	42,920	57,225	71,535		
Above 65	21,105	42,205	63,310	84,415	1,05,515		

Benefit Illustration

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

Age of the Members insured (in years)	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)	Premium or consolidated premium for all members of family(Rs.)	Floater discount,if any	Premium after discount (Rs.)	Sum insured (Rs.)
Illustration 1										
45	11,400	5,00,000	11,400	Nil	11,400	5,00,000	19,365	4,106	15,259	5,00,000
20	7,965	5,00,000	7,965		7,965	5,00,000				
Total Premium for all members of the family is Rs.19,365/- , when each member is covered separately. Sum insured available for each individual is Rs.5,00,000/-			Total Premium for all members of the family is Rs.19,365/- , when they are covered under a single policy. Sum insured available for each family member is Rs.5,00,000/-				Total Premium when policy is opted on floater basis is Rs.15,259/- . Sum insured of Rs.5,00,000/- . Is available for the entire family (1A+1C)			
Illustration 2										
56	23,490	10,00,000	23,490	Nil	23,490	10,00,000	54,390	20,383	34,007	10,00,000
25	10,300	10,00,000	10,300		10,300	10,00,000				
23	10,300	10,00,000	10,300		10,300	10,00,000				
18	10,300	10,00,000	10,300		10,300	10,00,000				
Total Premium for all members of the family is Rs.54,390/- , when each member is covered separately. Sum insured available for each individual is Rs.10,00,000/-			Total Premium for all members of the family is Rs.54,390/- , when they are covered under a single policy. Sum insured available for each family member is Rs.10,00,000/-				Total Premium when policy is opted on floater basis is Rs.34,007/- . Sum insured of Rs.10,00,000/- . Is available for the entire family (1A+3C)			
Note: 1. Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable. 2. Floater discount shown here is difference between Premium applicable for Individual Sum Insured and Floater Sum Insured.										
A-Adult, C-Child										

LIST I – Items for which coverage is available in the policy

SI No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)

SI No	Item
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG / SHORT / HINGED)
46	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY