STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam,
Chennai - 600 034. ★ Phone : 044 - 28288800 ★ Email : support@starhealth.in
Website : www.starhealth.in ★ CIN : L66010TN2005PLC056649 ★ IRDAI Regn. No. : 129

Kind Attention: Policyholder

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

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

Customer Information Sheet - Star Criticare Plus Insurance Policy

Unique Identification No.: SHAHLIP21179V022021

Sl. No.	Title	Description	Refer to Policy Clause Number
	Product Name	Star Criticare Plus Insurance Policy	
1	Coverage for Section I	a. In-patient Treatment - Covers hospitalisation expenses for period more than 24 hrs	II(Section I)(A,B,C)
		b. Emergency Ambulance - up-to Rs.750/- per hospitalisation for utilizing ambulance service for transporting insured person to hospital in case of an emergency subject to maximum of Rs.1,500/- per policy period	II(Section I)(D)
		c. Pre-Hospitalisation- Medical Expenses incurred up to 30 days prior to the date of hospitalisation	II(Section I)(E)
		d. Post-Hospitalisation- Medical Expenses incurred up to 7% of hospitalization expenses subject to maximum of Rs.5,000/-	II(Section I)(F)
		e. Coverage for Modern Treatments	II(Section I)(G)
		f. Ayush Coverage: 25% of the sum insured subject to a maximum of Rs.25,000/- in the entire policy period.	II(Section I)(I)
	Coverage for Section II	A. Coverage for named critical Illness	II(Section II)
	Position after a claim under Section II	a. Policy will continue until expiry with Section I benefits and can renew under any other health policy of the company	II(Section II)
2	Major Exclusions	I. Any hospital admission primarily for investigation diagnostic purpose	III(4)
		II. Pregnancy, infertility, Congenital external disease / defects	III(17,18 & 20)
		III. Domicilary treatment, treatment outside India	IV(22)
		IV. Circumcision, sex change surgery, cosmetic surgery & plastic surgery	III(19,7,8)
		V. Refractive error correction, hearing impairment correction, corrective & cosmetic dental surgeries	III(15,8,28)
		VI. Substance abuse, Intentional self injury	III(12,22)
		VII. war, terrorism, civil war or breach of law, Hazardous sports	III(9,10,24)
		VIII.Naturopathy Treatment	III(26)
		IX. Any kind of service charge, surcharge, admission fees, registration fees levied by the hospital.	III(29)
		(Note: the above is a partial listing of the policy exclusions. Please refer to the policy clauses for the full listing)	

Sl. No.	Product Name	Description	Refer to Policy Clause Number
3	Waiting Period	Pre Existing Disease: Waiting Period of 48 months	III(1)
		Disease contracted during the first 30 days from the commencement date of the first policy (not applicable for subsequent renewals)	III(3)
		24 months of specific illness during the first 2 years from the commencement date of the first policy (not applicable for subsequent renewals)	III(2)(A)
		12 months of specific illness during the first year from the commencement date of the first policy (not applicable for subsequent renewals	
4	Payout	Cashless or Reimbursement of covered expenses up to specified limits	II(Section I)(A,B,C)
5	Loss Sharing	In case of a claim, this policy requires you to share the following costs: Expenses exceeding the followings Sublimits 1. Room/ICU charges 2. For the specified diseases 3. Deductible of Rs…… per claim / per year /both 4. % of each claim as Co-payment	II(Section I)(A) II(Section I)(G) Nil II(Section I)(H)
6	Renewal Conditions	Life long renewal	IV(10)
		Grace period of 30 days for renewing the policy is provided	
7	Cancellation	The Company may cancel this policy on grounds of misrepresentation, fraud, moral hazard, non disclosure of material fact	IV(7)
8	Claims	For Cashless Service	IV(2)(B and C)
		For Reimbursement of claim	
9	Policy servicing /Grievances /Complaints	Company Officials IRDAI/(IGMS/Call Centre) Ombudsman	IV(15) and IV(21)
10	Insured's Rights	Free Look	IV(14)
		Implied renewability	IV(10)
		Migration and Portability	IV(8) and IV(9)
		Increase in SI during policy term	Nil
		Turn Around Time (TAT) for issue of Pre-Auth	2 hrs from the time of receipt of all necessary relevant documents
11	Insured's Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.	IV(1)
		Disclosure of Material Information during the policy period such as change in occupation (Note: If applicable, please provide details of the format & to whom the form is to be sent)	Not Applicable

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

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STAR CRITICARE PLUS INSURANCE POLICY

Unique Identification No.: SHAHLIP21179V022021

PREAMBLE

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

I. DEFINITIONS

STANDARD DEFINITIONS

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

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

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

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

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

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

Cancer of Specified Severity

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
II. The following are excluded –
   i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
   ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
   iii. Malignant melanoma that has not caused invasion beyond the epidermis;
   iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
   v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
   vi. Chronic lymphocytic leukaemia less than RAI stage 3
   vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
   viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

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

Coma of Specified Severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Kidney Failure Requiring Regular Dialysis: End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

Major Organ / Bone Marrow Transplant

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

   Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

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

Myocardial Infarction (First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate bloodsupply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris
   iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

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

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

i) is required for the medical management of the illness or injury suffered by the insured;

ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii) must have been prescribed by a *medical practitioner;*

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community In India.

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

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

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

Pre-Existing Disease (Applicable for Section I): Pre-existing Disease means any condition, ailment, injury or disease:

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

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

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

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

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

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

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

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

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

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

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

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

Stroke Resulting in Permanent Symptoms

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

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

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

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

SPECIFIC DEFINITIONS

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

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

Brain Tumor: Brain Tumor means any intracranial tumour created by abnormal and uncontrolled cell division, occurring in the brain cells, lymphatic tissue, blood vessels, in the cranial nerves.

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

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

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

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

Irreversible Paraplegia: Irreversible Paraplegia means paralysis of the lower part of the body including the legs.

Irreversible Quadriplegia: Irreversible Quadriplegia means paralysis affecting all four limbs.

Major Diseases: Major Diseases means;
First Diagnosis of Cancer, Chronic Kidney Disease, Brain Tumour
Undergoing first time - Major Organ Transplant
Occurrence for the first time of the following medical events;
Cerebro-Vascular Stroke causing Hemiplegia
Acute Myocardial Infarction resulting in
Left Ventricular Ejection Fraction of < 25%
Established irreversible Coma
Established irreversible Paraplegia
Established irreversible Quadriplegia

II. COVERAGE

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

Section I

That if during the period stated in the Schedule the insured person shall contract any disease or suffer from any **illness** or sustain bodily injury through accident and if such disease or injury shall require the insured Person, upon the advice of a Physician/Medical Specialist /**Medical Practitioner** or of duly Qualified Surgeon to incur Hospitalization expenses for **medical/surgical** treatment at any Nursing Home / Hospital in India as an in-patient, the Company will pay to the Insured Person the amount of such expenses as are reasonably and necessarily incurred up-to the limits indicated but not exceeding the sum insured in aggregate in any one period stated in the schedule hereto;

A) Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home at 2% of the sum insured subject to a maximum of Rs.4,000/- per day

B) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees

C) Anaesthesia, Blood, Oxygen, Operation Theatre charges, ICU Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, cost of Pacemaker and similar expenses

D) Emergency ambulance charges up-to a sum of Rs.750/- per hospitalisation and overall limit of Rs.1,500/- per policy period for transportation of the Insured Person by private ambulance service when this is needed for medical reasons to go to hospital for treatment provided such hospitalisation claim is admissible as per the Policy

E) Relevant Pre-Hospitalization medical expenses upto 30 days prior to hospitalisation

F) Relevant Post-Hospitalisation medical expenses wherever recommended by the attending Medical practitioner up to 7% of the hospitalisation expenses incurred (excluding room and/or board charges, Hospital service charges) subject to maximum of Rs.5,000/- per occurrence

Where Package rates are charged by hospitals the Post-Hospitalisation benefit will be calculated after taking the room and boarding charges at Rs.4,000/- per day

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

Sum Insured Rs.	3,00,000/-	4,00,000/-	5,00,000/-	10,00,000/-
Treatment / Procedure	Limit per person, per policy period for each treatment / procedure Rs.			
Uterine artery Embolization and HIFU	36,000/-	50,000/-	90,000/-	1,50,000/-
Balloon Sinuplasty	14,400/-	20,000/-	36,000/-	1,00,000/-
Deep Brain Stimulation	72,000/-	1,00,000/-	1,80,000/-	3,00,000/-
Oral Chemotherapy*	36,000/-	50,000/-	90,000/-	2,00,000/-
Immunotherapy-Monoclonal Antibody to be given as injection	72,000/-	1,00,000/-	1,80,000/-	4,00,000/-
Intra Vitreal injections	14,400/-	20,000/-	36,000/-	75,000/-
Robotic surgeries	72,000/-	1,00,000/-	1,80,000/-	3,00,000/-
Stereotactic radio surgeries	60,000/-	75,000/-	1,25,000/-	2,00,000/-
Bronchical Thermoplasty	Up to sum insured			
Vaporisation of the prostate (Green laser treatment or holmium laser treatment)				
IONM-(Intra Operative Neuro Monitoring)				
Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions	72,000/-	1,00,000/-	1,80,000/-	3,00,000/-

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

Expenses on Hospitalization for minimum period of 24 hours are admissible. However this time limit will not apply for Dialysis, Chemotherapy, Radiotherapy, Cataract surgery, Dental Surgery, Lithotripsy (Kidney stone removal), Tonsillectomy, Cutting and Draining of Abscess, Liver Aspiration, Pleural Effusion Aspiration, Sclerotheraphy, taken in the Hospital / Nursing Home and the Insured is discharged on the same day

The amount payable in respect of the following treatment is up-to the limit mentioned there-against.

Cataract surgery - Rs.20,000/- in respect of one eye and Rs.30,000/- in the entire policy period

Treatment	Limit up to Rs.
Lithotripsy (Kidney stone removal)	20,000/-
Tonsillectomy	15,000/-
Cutting and draining of peripheral abcess	2,500/-
Cutting and draining of sub-cutaneous abcess	4,000/-
Liver Aspiration	2,000/-
Pleural Effusion Aspiration	2,000/-
Sclerotheraphy	5,000/-

Provided the waiver of the minimum period of 24 hours hospitalisation is limited to the above noted treatments only

In respect of persons aged above 60 years the Sum Insured shall be restricted to the amount as shown in the schedule.

H) **Co-payment:** 30% of each and every claim in respect of the insured persons whose age at the time of entry in to this policy is 61 years and above. This is also applicable for sub limits in respect of diseases/illness/injuries specified in the Schedule

I) **AYUSH coverage:** Expenses incurred for treatment of diseases/illness/accidental injuries by systems of medicines other than Allopathic shall be restricted to 25% of the sum insured subject to a maximum of Rs. 25,000/- in the entire policy period

Section II

That if during the period stated in the Schedule the insured person shall contract any Major Disease/s specified herein, the Company will pay to the Insured Person a lump-sum not exceeding the sum insured stated under Section II of the Schedule subject to the following conditions;

A. Major Disease experienced by the Insured is the first incidence of that Major Disease; and

B. The signs or symptoms of the Major Disease experienced by the Insured Person commenced after 90 days (ninety days) following the Commencement Date of the policy and

C. The Insured Person subjects himself/herself to examination by the panel doctor of the Company and the incidence of such Major Disease is confirmed by the panel doctor and

D. No claim for compensation will become payable if the insured person is suffering from any of the covered Major Disease at the time of inception of this policy

Payment of lump-sum claim under Section II is in addition to payment of hospitalisation expenses under Section I, it being however agreed that such hospitalisation expenses shall be required to be paid only until the date of diagnosis of Major Disease and on entitlement of the Insured Person for payment of lump sum. Section I benefit ceases to be paid for that Major Disease thereafter. However, Section I benefit will continue for all other diseases / illness / accident excluding the Major Diseases until the expiry of the policy and the policy shall not be renewed thereafter. The insured can choose to take a **Medi classic Insurance Policy (Individual)** or its equivalent offered by the Company with specific exclusion of the Major Disease for which the claim has been admitted and paid

Only one lump sum payment shall be provided during the Insured Person's lifetime regardless of the number of Major Diseases, incapacities or treatments suffered by the Insured Person

Note: Where the Insured Person/s is /are already insured under any other policy on lump-sum basis covering Major Diseases issued by the Company and where a claim has already been admitted the maximum amount payable under all Policies combined will not exceed the amount payable under the Policy which pays the largest benefit.

Where the claim has already been settled for such lump sum amount this policy shall be null and void

Additional provisions relating to Section II

- Each of the Disease specified in the policy must be confirmed by a registered medical practitioner appointed by the Company and must be supported by clinical, radiological, histological, pathological, histo-pathological and laboratory evidence acceptable to the Company
- Insurance under Section II of this policy shall cease upon payment of compensation on occurrence of any Major Disease and no further payment will be made for any consequent disease or dependent disease
- Waiting Period - No claim for compensation will become payable if a Major Disease specified in the policy incepts or manifests during the first 90 days of the inception of the policy. In the event of renewal with the Company this 90 days limit shall not apply
- No claim for compensation will become payable if the insured person is suffering from any of the covered Major Disease at the time of inception of this policy

III. EXCLUSIONS (Applicable for Section I only)

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

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

C. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then for the same would be reduced to the extent of prior coverage

D. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer

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

A. Expenses related to the treatment of the following listed Conditions, surgeries / treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
List of specific diseases/procedures: Expenses on treatment of Cataract, Hysterectomy for Menorrhagia or Fibromyoma, treatment for knee or joint (other than caused by an accident), Prolapse of intervertebral disc (other than caused by an accident), varicose veins and varicose ulcers, Congential Internal disease/defect.

Expenses related to the treatment of the following listed Conditions, surgeries / treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
List of specific diseases/procedures: Expenses on treatment of Benign Prostate Hypertrophy, Hernia, Hydrocele, Fistula in anus, Piles, Sinusitis and related disorders, treatment for gallstones and renal stone

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.

3. **30-day waiting period - Code Excl 03**

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

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

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

4. **Investigation & Evaluation - Code Excl 04**

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

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

5. **Rest Cure, rehabilitation and respite care - Code Excl 05:** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

1. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons
2. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

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

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

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

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

D. Body Mass Index (BMI);

1. greater than or equal to 40 or
2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   a. Obesity-related cardiomyopathy
   b. Coronary heart disease
   c. Severe Sleep Apnea
   d. Uncontrolled Type2 Diabetes

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

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

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

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

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

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

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

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

15. **Refractive Error - Code Excl 15:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

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

17. **Sterility and Infertility - Code Excl 17:** Expenses related to sterility and infertility. This includes;

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

18. **Maternity-Code Excl 18**

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

SPECIFIC EXCLUSIONS

19. Circumcision (unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident) **- Code Excl 19**

20. Any congenital disease/defect whether external **- Code Excl 20**

21. Convalescence, general debility, Run-down condition **- Code Excl 21**

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

23. Venereal disease (other than HIV) **- Code Excl 23**

24. Injury/ Disease directly or indirectly caused by or arising from or attributable to War, Invasion, act of Foreign Enemy, Warlike operations (whether war be declared or not) **- Code Excl 24**

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

26. Naturopathy **- Code Excl 40**

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

28. Dental treatment or surgery of any kind unless necessitated due to accidental injuries and requiring hospitalization **- Code Excl 32**

29. Hospital registration charges, record charges, incidental and miscellaneous expenses and telephone charges **- Code Excl 34**

30. Cost of spectacles and contact lens, hearing aids walkers, crutches wheel chairs and such other aids **- Code Excl 35**

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

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

Exclusion Code 17,18,20,21,22,23,24, 25 and 37 are applicable for both Section I and Section II.

IV. CONDITIONS

STANDARD CONDITIONS

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

2. Claim Settlement

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

B. Documents for Cashless Treatment;

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

b. Inform the ID number for easy reference

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Duly completed claim form, and

b. Pre Admission investigations and treatment papers

c. Discharge Summary from the hospital

d. Cash receipts from hospital, chemists

e. Cash receipts and reports for tests done

f. Receipts from doctors, surgeons, anesthetist

g. Certificate from the attending doctor regarding the diagnosis

h. Copy of PAN card

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

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

3. Provision for Penal Interest

i) The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document

ii) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate

iii) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document

iv) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim

v) "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

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

5. Multiple Policies (Applicable for Section 1 only)

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

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

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

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

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

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

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

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

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

c) any other act fitted to deceive; and

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

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

7. Cancellation

i. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below;

Period on risk	Rate of premium to be retained
Up to one month	⅓rd of Annual Premium
Exceeding one mth up to 3 mths	½ of Annual Premium
Exceeding 3 mths up to 6 mths	¾th of Annual Premium
Exceeding 6 mths	Full Annual Premium

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

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

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

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

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

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

10. **Renewal of policy:** The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person;
    1. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal
    2. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years
    3. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period
    4. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy
    5. Coverage is not available during the grace period
    6. No loading shall apply on renewals based on individual claims experience
    7. Where a claim has been admitted /paid under Section II of the policy the renewal shall be in accordance with the terms and conditions of the Mediclassic Insurance Policy (Individual) or its equivalent with the specific exclusion of the Major Disease for which the lump-sum has been admitted / paid

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

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

13. **Possibility of Revision of Terms of the Policy Including the Premium Rates:** The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

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

    The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

    If the insured has not made any claim during the Free Look Period, the insured shall be entitled to
    i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
    ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
    iii. where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

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

    Website : www.starhealth.in
    E-mail : gro@starhealth.in, grievances@starhealth.in
    Ph. No. : 044-69006900 | Toll Free No. 1800 425 2255
    Senior Citizens may call at 044-69007500
    Courier : 4th Floor, Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai-600014

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

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

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

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

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

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

SPECIFIC CONDITIONS

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

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

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

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

21. **Notice and communication:** Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile/email to Star Health and Allied Insurance Company Limited, No.1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai 600034. Customer Care No. 044-69006900 or Toll Free No. 1800 425 2255, e-mail: support@starhealth.in.

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

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

23. **Automatic Termination:** This policy shall terminate immediately upon the death of the Insured Person. Where a claim has been paid under Section II, the benefit under Section I will continue until expiry date of the policy.

    Where the sum insured under Section I is exhausted the benefit under Section II would continue until the expiry date of the policy or payment of benefit under Section II whichever shall first occur.

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

25. **Arbitration:** If any dispute or difference shall arise as to the quantum to be paid under this Policy(liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

    It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

    It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

    It is also further expressly agreed and declared that if the Company shall disclaim liability to the Insured for any claim hereunder and such claim shall not, within three years from the date of such disclaimer have been made the subject matter of a suit in a Court of Law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

26. **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.

27. **Important Note**
    1. **Package Charges:** The Company's liability in respect of package charges will be restricted to 80% of such amount. (Package charges refer to charges that are not advertised in the Schedule of the Hospital) will be restricted to 80% of such amount
    2. The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears. The terms, conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract and must be complied with. Failure to comply 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.

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

STAR Health Insurance
Personal & Caring
The Health Insurance Specialist

List of Insurance Ombudsman

AHMEDABAD

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

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

BENGALURU

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

JURISDICTION: Karnataka.

BHOPAL

Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.
Tel.: 0755 - 2769201 / 2769202
Fax: 0755 – 2769203
Email: bimalokpal.bhopal@cioins.co.in

JURISDICTION: Madhya Pradesh Chattisgarh.

BHUBANESHWAR

Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009.
Tel.: 0674 - 2596461 /2596455
Fax: 0674 – 2596429
Email: bimalokpal.bhubaneswar@cioins.co.in

JURISDICTION: Orissa.

CHANDIGARH

Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468
Fax: 0172 - 2708274
Email: bimalokpal.chandigarh@cioins.co.in

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

CHENNAI

Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.
Tel.: 044 - 24333668 / 24335284
Fax: 044 - 24333664
Email: bimalokpal.chennai@cioins.co.in

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

DELHI

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

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

ERNAKULAM

Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.
Tel.: 0484 - 2358759 / 2359338
Fax: 0484 - 2359336
Email: bimalokpal.ernakulam@cioins.co.in

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

GUWAHATI

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

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

HYDERABAD

Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.
Tel.: 040 – 23312122 Fax: 040 - 23376599
Email: bimalokpal.hyderabad@cioins.co.in

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

JAIPUR

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

JURISDICTION: Rajasthan.

KOLKATA

Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.
Tel.: 033 - 22124339 / 22124340
Fax : 033 – 22124341
Email: bimalokpal.kolkata@cioins.co.in

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

LUCKNOW

Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.
Tel.: 0522 - 2231330 / 2231331
Fax: 0522 - 2231310
Email: bimalokpal.lucknow@cioins.co.in

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

MUMBAI

Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.
Tel.: 022 - 26106552 / 26106960
Fax: 022 – 26106052
Email: bimalokpal.mumbai@cioins.co.in

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

PUNE

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

JURISDICTION: Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

NOIDA

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

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

PATNA

Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952
Email: bimalokpal.patna@cioins.co.in

JURISDICTION: Bihar, Jharkhand.

STAR Personal & Caring Health Insurance
The Health Insurance Specialist

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

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

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