STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

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PROSPECTUS - SUPER SURPLUS INSURANCE POLICY

Unique Identification No.: SHAHLIP21212V042021

Super Surplus Insurance Policy is a top-up plan with sum insured on individual. There are two plans viz. Gold Plan and Silver Plan available under this policy

❖ **Eligibility**

- Any person aged between 18 years and 65 years can take this insurance. Beyond 65 years, only renewals are allowed. Economically dependent children aged from 91 days to 25 years can be covered with parents
- Family means self, spouse and economically dependent children not over 25 years of age
- In case of economically dependent children, when they complete 25 yrs of age, a separate policy has to be taken. In such an event, continuity of benefits in terms of waiting period will be provided

❖ **Pre-acceptance medical screening:** No pre-acceptance medical screening. However the proposer has to submit all the past medical records of the person proposed for insurance.

❖ **What is the policy term?:** The policy is available for one year which can be renewed.

❖ **How many plans available?**
There are two plans available; Gold Plan and Silver Plan.

GOLD PLAN

❖ **What are the sum insured and the respective defined limits available?**

Sum Insured Rs.	Defined Limit Rs.
5,00,000/-, 7,00,000/-, 10,00,000/-, 15,00,00/-20,00,000/- and 25,00,000/-	3,00,000/-
5,00,000/-; 10,00,000/- 15,00,000/-, 20,00,000/- and 25,00,000/-	5,00,000/-
5,00,000/-; 10,00,000/-; 15,00,000/-; 20,00,000/- and 25,00,000/-	10,00,000/-
Note: Defined Limit once opted cannot be changed either during the currency of the policy or at the time of renewal	

❖ **What are the benefits available under Gold Plan?**

A) Room Rent (single standard AC room), Boarding, nursing expenses as provided by the Hospital / Nursing Home.

B) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees, Anaesthesia, Blood, Oxygen, ICU charges, Operation Theatre charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-ray, cost of Pacemaker and similar expenses. With regard to coronary stenting, the company will pay such amount up to the extent of cost of bare metal stent/drug eluting cobalt-chromium stent/drug eluting stainless steel stent. In respect of medicines, Implants and such other similar items, the Company will pay up to the cost of alternate indigenous make.

C) Emergency ambulance charges up-to a sum of Rs.3000/- per hospitalization 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 hospitalization claim is admissible as per the Policy.
Subject to the above terms the insured person is eligible for reimbursement, expenses incurred towards cost of air ambulance up-to 10% of the sum insured, provided the same is availed on the advices of the treating medical practitioner / Hospital. Air ambulance is payable for only from the place of first occurrence of illness / accident to the nearest appropriate hospital. Such air ambulance should have been duly licensed to operate as such by competent authorities of the Government/s. This is applicable for sum insured option of Rs.7 lakh and above.

D) The Insured Person is given the facility of obtaining a Medical Second Opinion from a Doctor in the Company's network of Medical Practitioners. All the medical records provided by the Insured Person will be submitted to the Doctor either online: e_medicalopinion@starhealth.in or through post/courier Subject to the following conditions;

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

E) **Pre-Hospitalization** medical expenses incurred for a period not exceeding 60 days immediately prior to the date of Hospitalization, for the disease/illness, injury sustained following an admissible claim under the policy.

F) **Post-Hospitalization** medical expenses incurred under the policy towards Consultant fees, Diagnostic charges, Medicines and Drugs wherever recommended by the Hospital / Medical Practitioner, where the treatment was taken, for a period not exceeding 90 days after discharge from the Hospital following an admissible claim under the policy, provided such expenses so incurred are in respect of ailment for which the insured person was hospitalized.

G) **Delivery Expenses:** Expenses for a Delivery including Delivery by Caesarean section (including pre-natal, post-natal expenses and lawful medical termination of pregnancy) up-to Rs.50,000/- per policy period, subject to a maximum of 2 deliveries in the entire life time of the insured person are payable *while the policy is in force.*

Special Conditions

1. This Benefit is subject to a waiting period of 12 months from the date of commencement of first Super Surplus Insurance Policy and continuous renewal thereof with the company
2. Pre-hospitalization and Post Hospitalization expenses are not applicable for this benefit
3. This cover is available only when both Self and Spouse are Covered under this policy until the period when the benefit becomes payable. Claims under this section will not reduce the Sum Insured

H) **Organ Donor Expenses** for organ transplantation where the insured person is the recipient are payable provided the claim for transplantation is payable and subject to the availability of the sum insured. Donor screening expenses and post-donation complications of the donor are not payable.

I) **Recharge Benefit:** If the **sum insured** under the policy is exhausted/ exceeded during the policy period, additional indemnity up to the limits stated in the table given below would be provided once for the remaining policy period. Such additional indemnity can be utilized even for the same hospitalization or for the treatment of diseases / illness / injury / for which claim was paid / payable under the policy. The unutilized Recharge amount cannot be carried forward.

Defined Limit Rs.	Recharge Limit Rs.
3,00,000/-	50,000/-
5,00,000/-	75,000/-
10,00,000/-	1,00,000/-

J) **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.	5,00,000	7,00,000	10,00,000	15,00,000	20,00,000	25,00,000
Treatment / Procedure	Limit per person per policy period for each treatment / procedure Rs.					
Uterine artery Embolization and HIFU	1,25,000	1,25,000	1,50,000	1,75,000	2,00,000	2,00,000
Balloon Sinuplasty	50,000	50,000	1,00,000	1,25,000	1,50,000	1,50,000
Deep Brain Stimulation,	2,50,000	2,50,000	3,00,000	4,00,000	4,50,000	5,00,000
Oral Chemotheraphy*	1,25,000	1,25,000	2,00,000	2,50,000	2,75,000	3,00,000
Immunotherapy-Monoclonal Antibody to be given as injection	2,50,000	2,75,000	4,00,000	5,00,000	5,50,000	6,00,000
Intra Vitreal injections	50,000	60,000	75,000	1,00,000	1,25,000	1,50,000
Robotic surgeries	2,50,000	2,75,000	3,00,000	4,00,000	4,50,000	5,00,000
Stereotactic radio surgeries	2,00,000	2,75,000	2,25,000	2,50,000	2,75,000	3,00,000
Bronchical Thermoplasty	Upto Sum Insured					
Vaporisation of the prostate (Green laser treatment or holmium laser treatment)						
IONM-(Intra Operative Neuro Monitoring)						
Stemcell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological	2,50,000	2,75,000	3,00,000	4,00,000	4,50,000	5,00,000

*Sublimit all inclusive with or without hospitalization wherever hospitalization includes pre and post hospitalization.

K) All expenses arising out of treatment for HIV / AIDS are covered, provided at the time of first commencement of insurance under this policy, their CD4 count is not less than 350.

Note (Applicable for Benefits A to H and J)

1. Expenses on Hospitalization for minimum period of 24 hours only are admissible. However this time limit will not apply for the day care treatments / procedures, where treatment is taken in the Hospital / Nursing Home and the Insured is discharged on the same day
2. **The Company's liability will begin only when the aggregate of the hospitalization expenses admissible under this policy during this policy period exceed the Defined limit.** The amount payable shall be the amount in excess of the **defined limit**, however not exceeding the Sum Insured for the policy period
3. **Expenses relating to the hospitalization will be considered in proportion to the room rent stated in the policy**
4. For the purpose of calculating the Defined limit the pre-hospitalization and post-hospitalization expenses will not be taken into account
5. **Co-payment:** This policy is subject to co-payment of 10% of each and every claim amount, for fresh as well as renewal policies for insured persons whose age at the time of entry into this policy is 61 years and above. This co-payment will not apply for those insured persons who have entered the policy before attaining 61 years of age and renew the policy continuously without any break

❖ **What is the special feature of this Gold plan?**

The Company's liability under the policy will begin when the aggregate of the admissible hospitalization expenses during the policy period exceed the Defined limit. The amount payable shall be the amount in excess of the Defined limit**,** however not exceeding the Sum Insured for the policy period.

The Proposer can opt at the beginning of 6th year before renewal of this policy or later during any successive renewal , for an Indemnity Health Insurance policy without defined limit offered by the Company with continuity of benefits for the average sum insured of immediately preceding 5 years period subject to the following;

a) All Insured Persons are insured with the Company under this policy before the age of 50 years and have been continuously renewed without any break

b) No claim has been made during the immediately preceding 5 years

c) This policy shall not be further renewed if the option is exercised

❖ **What is defined limit and how does it work when there is a claim during the policy period?**

Defined Limit means the limit of admissible claim amount as per the terms of the policy, opted for and mentioned in the Schedule of the policy, up to which the Company will not be liable during the policy period.

Illustration

Scenario	Claim No.	Sum Insured under the policy (Rs.)	Defined Limit under the policy (Rs.)	Hospitalization Amount (Rs.)	Defined Limit applied for claim (Rs.)	Claim Payable (Rs.)	Balance Sum Insured available for next claim (Rs.)
1	1	10,00,000	3,00,000	3,00,000	3,00,000	0	10,00,000
	2			6,00,000	0	6,00,000	4,00,000
	3			6,00,000	0	4,00,000	0
2	1	10,00,000	3,00,000	6,00,000	3,00,000	3,00,000	7,00,000
	2			5,00,000	0	5,00,000	2,00,000
	3			3,00,000	0	2,00,000	0

❖ **Exclusions (Applicable for Both Silver and Gold Plan):** The Company shall not be liable to make any payments under this policy in respect of any expenses what so ever incurred by the insured person in connection with or in respect of;

1. Pre-Existing Diseases - Code Excl 01

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

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

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

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

D. **Applicable for Silver Plan:** Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

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

A. **Applicable for Silver Plan:** 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

Applicable for Gold Plan: 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

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 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

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 heath 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:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres **- Code Excl 15**
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: (Except to the extent of coverage (G))**
    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
19. Circumcision(unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident), Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA **- Code Excl 19**
20. Congenital External Condition / Defects / Anomalies **- Code Excl 20**
21. Convalescence, general debility, run-down condition, Nutritional deficiency states - **Code Excl 21**
22. Intentional self injury **- Code Excl 22**
23. Venereal Disease and Sexually Transmitted Diseases (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. 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 similar therapies **- Code Excl 26**
27. Unconventional, Untested, Experimental therapies **- Code Excl 27**
28. Autologous derived Stromal vascular Fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy **- Code Excl 28**
29. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalization warranted **- Code Excl 29**
30. All treatment for Priapism and erectile dysfunctions **- Code Excl 30**
31. Inoculation or Vaccination (except for post–bite treatment and for medical treatment for therapeutic reasons) **- Code Excl 31**
32. Dental treatment or surgery unless necessitated due to accidental injuries and requiring hospitalization. (Dental implants are not payable) **- Code Excl 32**
33. Medical and / or surgical treatment of Sleep apnea, treatment for endocrine disorders **- Code Excl 33**
34. Hospital registration charges, admission charges, record charges, telephone charges and such other charges **- Code Excl 34**
35. Cochlear implants and procedure related hospitalization expenses **- Code Excl 35**
36. Expenses incurred for treatment of diseases/illness/accidental injuries which does not warrant hospitalization **- Code Excl 36**
37. Other Excluded Expenses as detailed in our website www.starhealth.in **- Code Excl.37**
38. 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**
39. Expenses incurred for treatment of disease/illness/accidental injuries by systems of medicine other than allopathy **- Code Excl 39**
40. Any medical expenses incurred towards treatment of New Born Baby **- Code Excl 44**

SILVER PLAN

❖ **What are the sum insured and the respective deductibles?**

Sum Insured Rs.	Deductible Rs.
7,00,000/-	3,00,000/-
10,00,000/-	3,00,000/-
Note: Deductible opted cannot be changed at the time of renewal	

❖ **What are the benefits available under Silver Plan?**

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

B) Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees.

C) Anesthesia, Blood, Oxygen, ICU charges, Operation Theatre charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-ray, cost of Pacemaker and similar expenses. With regard to coronary stenting, the company will pay such amount up to the extent of cost of bare metal stent/drug eluting cobalt-chromium stent/drug eluting stainless steel stent. In respect of medicines, Implants and such other similar items, the Company will pay up to the cost of alternate indigenous make.

D) Pre-Hospitalization medical expenses incurred for a period not exceeding 30 days immediately prior to the date of Hospitalization, for the disease/illness, injury sustained following an admissible claim under the policy.

E) Post-Hospitalization medical expenses incurred under the policy towards Consultant fees, Diagnostic charges, Medicines and Drugs wherever recommended by the Hospital / Medical Practitioner, where the treatment was taken, for a period not exceeding 60 days after discharge from the Hospital following an admissible claim under the policy, provided however such expenses so incurred are in respect of ailment for which the insured person was hospitalized.

F) **Coverage for Modern Treatments:** The expenses payable during the entire policy period for the following Treatment / Procedures (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 in Rs.	Uterine artery Embolization and HIFU,	Balloon Sinuplasty,	Deep Brain Stimulation	Oral Chemotherapy* (Sublimits including Pre and Post Hospitalisation)	Immunotherapy-Monoclonal Antibody to be given as injection	Intra Vitreal injections
	Limit per person per policy period for each treatment / procedure Rs.					
7,00,000/-	1,25,000/-	50,000/-	2,50,000/-	1,25,000/-	2,75,000/-	60,000/-
10,00,000/-	1,50,000/-	1,00,000/-	3,00,000/-	2,00,000/-	4,00,000/-	75,000/-

Sum Insured in Rs.	Robotic surgeries	Stereotactic radio surgeries	Bronchical Thermoplasty	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
	Limit per person per policy period for each treatment / procedure Rs.					
7,00,000/-	2,75,000/-	2,75,000/-	Up to Sum Insured			2,75,000/-
10,00,000/-	3,00,000/-	2,25,000/-				3,00,000/-

*Sublimits all inclusive with or without hospitalisation where ever hospitalisation includes pre and post hospitalisation.

G) All expenses arising out of treatment for HIV / AIDS are covered, provided at the time of first commencement of insurance under this policy, their CD4 count is not less than 350.

Note

1. **Expenses relating to the hospitalization will be considered in proportion to the room rent stated in the policy**
2. For the purpose of calculating the Deductible per hospitalization, pre hospitalization expenses and post hospitalization expenses will not be taken into account
3. Expenses on Hospitalization for minimum period of 24 hours only are admissible. However this time limit will not apply for the day care treatments / procedures, where treatment is taken in the Hospital / Nursing Home and the Insured is discharged on the same day

❖ **What is the special feature of this Silver plan?**

Under this plan, the policy comes into operation when the per hospitalization expenses exceeds deductible opted.

Illustration

Scenario	Claim No.	Sum Insured under the policy (Rs.)	Deductible Limit under the policy (Rs.)	Hospitalization Amount (Rs.)	Deductible Limit applied for claim (Rs.)	Claim Payable (Rs.)	Balance Sum Insured available for next claim (Rs.)
1	1	10,00,000	3,00,000	3,00,000	3,00,000	0	10,00,000
	2			6,00,000	3,00,000	3,00,000	7,00,000
	3			9,00,000	3,00,000	6,00,000	1,00,000

❖ **Moratorium Period (Applicable for both Silver and Gold Plan):** 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.

❖ **What is a claim procedure? (Applicable for both Silver and Gold Plan)**

1. 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. Call the 24 hour help-line for assistance - 1800 425 2255/1800 102 4477
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-authorization Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk
e. The Treating Doctor will complete the hospitalization/ treatment information and the hospital will fill up expected cost of treatment. This form is submitted to the Company
f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate
g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits
h. In case of emergency hospitalization information to be given within 24 hours after hospitalization
i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.starhealth.in or contact the nearest branch

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	**Siler Plan:** within 15 days after completion of 60 days from the date of discharge from hospital **Gold Plan:** within 15 days after completion of 90 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. **For Reimbursement claims**

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, anaesthetist
g. Certificate from the attending doctor regarding the diagnosis.
h. Copy of PAN card

F. For Obtaining Medical opinion Second Opinion **(Applicable for Gold Plan)**

a. Send mail to e_medicalopinion@starhealth.in attaching scanned copies of medical reports about which the insured seeks the second opinion.
b. The response will be communicated by email.

G. **Applicable for Gold Plan:** Intimation of all hospitalizations during the policy period irrespective of whether a claim is made or not must be given to the Company within 15 days of its occurrence.

For both Reimbursement and Cashless claims: certified true copies of the bills, receipts, discharge summary and other medical documents will be accepted, provided

- such hospitalization is claimed from any other source, up to the 'defined limits' opted for and
- such documents are certified as true copies by the company / body, if any, from which claim was made up to the 'defined limits'.

H. **Provision of Penal Interest**

a) 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.
b) 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.
c) 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.
d) 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.
e) "Bank rate" shall mean the rate fixed by the Reserve Bank of India.

❖ **What is renewal procedure?(Applicable for Both Silver and Gold Plan)**

Renewal: 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.

Note:

1. Defined Limit / Deductible once opted cannot be changed either during the currency of the policy or at the time of renewal.

❖ **Can the sum insured under the policy be reduced or enhanced?**

Reduction or enhancement of sum insured is permissible only at the time of renewal.

Enhancement of sum insured is subject to no claim being lodged or paid under this policy, Both the acceptance for enhancement and the amount of enhancement will be at the discretion of the Company. Where the sum insured is enhanced, the amount of additional sum insured by way of such enhancement shall be subject to the following terms.

1. **Exclusion - Code Excl 01, Exclusion - Code Excl 02 and Exclusion - Code Excl 03** that is, the difference between the expiring policy sum insured and the increased current sum insured.
2. Exclusions as under shall apply afresh from the date of such enhancement for the additional sum insured in respect of diseases / conditions diagnosed / treated irrespective of whether any claim is made or not in the immediately preceding three policy periods;
   - **i) For Silver Plan** : 36 months of continuous coverage without break
   - **ii) For Gold Plan**: 12 months of continuous coverage without break The above applies to each relevant insured person

❖ **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

❖ **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 details contact "portability@starhealth.in" or call Telephone No +91-044-28288869.

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

❖ **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.

❖ **Withdrawal of the 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.

❖ **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

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

❖ **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	25% of the annual premium
Exceeding one month up to 3 months	40% of the annual premium
Exceeding 3 months up to 6 months	60% of the annual premium
Exceeding 6 months up to 9 months	80% of the annual premium
Exceeding 9 months	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.

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

✓ Upon the death of the Insured Person

✓ Upon exhaustion of the sum insured under the policy

❖ **How much does it cost to take this insurance?**
The premium sheet is attached.

❖ **Is there any Income Tax Benefit?**
Insured Person is eligible for relief under Section 80-D of the Income Tax Act in respect of the amount paid by any mode other than cash.

❖ **What are the discounts available in the premium?**
A discount of 5% is allowable for On-line purchase.

❖ **How to buy this insurance?**
All that needs to be done is to call the nearest office

❖ **Important**

IRDAI clarifies to Public that

- IRDAI or its officials do not involve in activities like sale of any kind of insurance or financial products nor invest premiums.
- IRDAI does not announce any bonus.
- Public receiving such phone calls are requested to lodge a police complaint along with details of phone call, number.

❖ **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.

PREMIUM CHART (Excluding Tax)

SILVER PLAN

Deductible Rs.3,00,000/-

Age in Yrs	Sum Insured (Rs.)	
	7,00,000	10,00,000
91days-35	1,165	1,460
36-45	1,460	1,820
46-50	1,820	2,275
51-55	2,025	2,530
56-60	2,130	2,660
61-65	2,240	2,800
66-70	2,580	3,220
71-75	2,965	3,705
76-80	3,410	4,260
Above 80	3,920	4,900

GOLD PLAN

Defined Limit Rs.3,00,000/-

Age in Yrs	Sum Insured (Rs.)					
	5,00,000	7,00,000	10,00,000	15,00,000	20,00,000	25,00,000
91days-35	1,530	1,835	2,140	2,675	3,210	3,690
36-45	1,960	2,350	2,745	3,430	4,115	4,730
46-50	2,545	3,055	3,565	4,455	5,345	6,150
51-55	3,055	3,665	4,280	5,345	6,415	7,375
56-60	3,515	4,215	4,920	6,150	7,375	8,485
61-65	4,215	5,060	5,900	7,375	8,850	10,180
66-70	4,850	5,820	6,785	8,485	10,180	11,705
71-75	5,575	6,690	7,805	9,755	11,705	13,460
76-80	6,410	7,695	8,975	11,220	13,460	15,480
Above 80	7,375	8,845	10,320	12,900	15,480	17,800

Defined Limit Rs.5,00,000/-

Age in Yrs	Sum Insured (Rs.)				
	5,00,000	10,00,000	15,00,000	20,00,000	25,00,000
91days-35	1,225	1,715	2,140	2,570	2,950
36-45	1,570	2,195	2,745	3,290	3,785
46-50	2,040	2,855	3,565	4,280	4,920
51-55	2,445	3,425	4,280	5,135	5,900
56-60	2,810	3,935	4,920	5,900	6,785
61-65	3,375	4,720	5,900	7,080	8,145
66-70	3,880	5,430	6,785	8,145	9,365
71-75	4,460	6,245	7,805	9,365	10,770
76-80	5,130	7,180	8,975	10,770	12,385
Above 80	5,900	8,255	10,320	12,385	14,240

Defined Limit Rs.10,00,000/-

Age in Yrs	Sum Insured (Rs.)				
	5,00,000	10,00,000	15,00,000	20,00,000	25,00,000
91days-35	920	1,285	1,605	1,925	2,215
36-45	1,175	1,645	2,060	2,470	2,840
46-50	1,530	2,140	2,675	3,210	3,690
51-55	1,835	2,570	3,210	3,850	4,425
56-60	2,110	2,950	3,690	4,425	5,090
61-65	2,530	3,540	4,425	5,,310	6,110
66-70	2,910	4,075	5,090	6,110	7,025
71-75	3,345	4,685	5,855	7,025	8,080
76-80	3,850	5,385	6,730	8,080	9,290
Above 80	4,425	6,195	7,740	9,290	10,680