STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED
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STAR GROUP COVID INSURANCE POLICY

Unique Identification No.: SHAHLGP22147V022122

Indemnity Plan

I. PREAMBLE

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

II. DEFINITIONS

Standard Definitions

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 has been taken.

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

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:

1. Central or State Government AYUSH Hospital or
2. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine/Central Council for Homeopathy; or
3. 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.

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

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

Day Care Centre: A Day care centre means any institution established for day care treatment of illness and / or injuries or a medical set up within a hospital and which has been registered with the local authorities, wherever applicable and is under the supervision of a Registered and Qualified Medical Practitioner and must comply with all minimum criteria as under :-

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

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

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

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

Treatment normally taken on an 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 forfeited to the Company, in the event of mis-representation, mis description or non-disclosure of any material fact.

Emergency Care: Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

Grace Period: Grace period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of Pre-Existing Diseases. Coverage need not be available during the period for which no premium is received. The Grace Period for payment of the premium for all types of insurance policies shall be: fifteen Days where premium payment mode is monthly and thirty Days in all other cases.

Provided the insurers shall offer coverage during the Grace Period, if the premium is paid in instalments during the policy period.

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

- Has qualified nursing staff under its employment round the clock;
- 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;
- Has qualified medical practitioner(s) in charge round the clock.

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

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

Medical Advice: Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription.

Medical Expenses: Medical Expenses means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Medical Practitioner: Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is there by 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

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

- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a *medical practitioner*;
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India

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 provider means any hospital, day care center or other provider that is not part of the network

Notification of claim: Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

Pre-Existing Disease: Pre-existing Disease means any condition, ailment, Injury or disease:

a) That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the Insurer

or

b) For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

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

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

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:

a. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
b. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

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

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

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

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

Surgery or Surgical Procedure: Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or 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 based on established medical practice in India, is treatment experimental or unproven.

Specific Definitions

Company means Star Health and Allied Insurance Company Limited

COVID: For the purpose of this Policy, Coronavirus Disease means COVID-19 as defined by the World Health Organization (WHO) and caused by the virus SARS-CoV2.

Dependent Child means a child (natural or legally adopted) who is financially dependent and does not have his or her independent source of income and not over 25 years

Diagnosis 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.

Family means the Family that consists of the proposer and any one or more of the family members as mentioned below:

1. Legally wedded spouse.
2. Parents and Parents-in-law.
3. Dependent Children (i.e. natural or legally adopted) between the day 1 of age to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage

Group Administrator / Proposer means the person/organization who has signed in the proposal form / declaration form and named in the Policy Schedule. He may or may not be insured under the policy

Health care worker for the purpose of this policy shall mean doctors, nurses, midwives, dental practitioners and other health professionals including laboratory assistants, pharmacists, physiotherapists, technicians and people working in hospitals.

Home Care Treatment means treatment availed by the Insured Person at home for Covid on positive diagnosis of Covid in a Government authorized diagnostic Centre, which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

1. The Medical practitioner advices the Insured person to undergo treatment at home.
2. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
3. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

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.

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

Instalment: Instalment means premium amount paid through Quarterly/Half-yearly mode by the Policy holder/Insured

Policy: Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.

Policy period means period of three and half months (3 ½ months), Six and half months (6 ½), Nine and half months (9 ½) and Twelve months (12) i.e, 105 days, 195 days, 285 days and 365 days respectively as specified in the policy schedule**.**

Policy Schedule means the Policy Schedule attached to and forming part of Policy

Sub-limit: Sublimit means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit

Sum Insured: Sum Insured means wherever it appears shall mean the amount of insurance for which the premium has been paid. Where coverage is on individual basis / family floater basis the sum insured is the amount shown against each individual / family unit respectively

Waiting Period: Waiting period refers to the period during which the Company shall not be liable to make any payment for any claim which occurs or where the signs and/ or the symptoms of illness/ condition for the claim has occurred.

III. COVERAGE

In consideration of the premium paid, subject to the terms, conditions, exclusions and definitions contained herein the Company agrees as stated in the Coverage

If during the period stated in the Schedule the insured person is required to be hospitalized as an inpatient for treatment of **COVID** at a Hospital in India or given Home Care Treatment following the advice of a duly qualified**,** then the **Company** will pay to the **Insured Person/s** the amount of such Hospitalization expenses as are **reasonably and necessarily** incurred up-to the limits mentioned in the schedule but not exceeding the **sum insured** stated in the schedule hereto.

A) Room, boarding, nursing expenses as provided by the Hospital / Nursing Home

B) Medical Practitioner, Consultants, Specialist Fees. Oxygen, ICU Charges, ICCU charges, medicines and drugs, diagnostic materials and X-ray, diagnostic imaging modalities, PPE Kit, gloves, mask and such similar other expenses.

C) Emergency ambulance charges up to Rs.2000/- 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 of COVID, provided however there is an admissible claim under the policy.

D) Pre-hospitalization / home care treatment medical expenses incurred, related to an admissible hospitalization/home care treatment, for a fixed period of 15 days prior to the date of admissible hospitalization/home care treatment covered under the policy.

E) Post hospitalization / home care treatment medical expenses incurred, related to an admissible hospitalization//home care treatment, for a fixed period of 30days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

F) **Home Care Treatment Expenses** Home Care Treatment means Treatment availed by the Insured Person at home for COVID on positive diagnosis of COVID in a Government authorized diagnostic Centre,

which in normal course would require care and treatment at a hospital but is actually taken at home maximum up to 14 days per incident provided that:

1. The Medical practitioner advices the Insured person to undergo treatment at home.
2. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
3. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
4. Insured shall be permitted to avail the services as prescribed by the medical practitioner. Cashless or reimbursement facility shall be offered under homecare expenses subject to claim settlement policy disclosed in the website.
5. In case the insured intends to avail the services of non-network provider claim shall be subject to reimbursement, a prior approval from the Insurer needs to be taken before availing such services.
6. In this benefit, the following shall be covered if prescribed by the treating medical practitioner and is related to treatment of COVID,
   a. Diagnostic tests undergone at home or at diagnostics centre
   b. Medicines prescribed in writing
   c. Consultation charges of the medical practitioner
   d. Nursing charges related to medical staff
   e. Medical procedures limited to parenteral administration of medicines
   f. Cost of Pulse oximeter, Oxygen cylinder and Nebulizer

G) **AYUSH Treatment**: The Company shall indemnify medical expenses incurred for inpatient care treatment for COVID on Positive diagnosis of COVID test in a government authorized diagnostic centre including the expenses incurred on treatment of any comorbidity along with the treatment for COVID under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during the Policy Period up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

H) **Optional Cover (On payment of additional premium)**: The Company shall pay the Insured Person 0.5% of sum insured per day for each 24 hours of continuous hospitalization for which the Company has accepted a claim. The benefit shall be payable maximum up to 15 days during a policy period in respect of every insured person.

Expenses on Hospitalization are payable provided the hospitalization is for minimum period of 24 hours

Expenses relating to hospitalization will be considered in proportion to the room rent limit stated in the policy schedule or actual whichever is less.

IV. WAITING PERIOD

An initial waiting period of 15 days is applicable from the date of commencement of this Insurance.

V. EXCLUSIONS

The Company shall not be liable to make any payment under this Policy:-

Standard Exclusions

1. 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.

2. **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.
      A. 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**
      B. **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.

Specific Exclusions

3. Any claim in relation to Covid where it has been diagnosed prior to Policy Start Date.
4. Any expenses incurred on Day Care treatment and OPD treatment
5. Diagnosis /Treatment outside the geographical limits of India
6. Testing done at a Diagnostic centre which is not authorized by the Government shall not be recognized under this Policy
7. All covers under this Policy shall cease if the Insured Person travels to any country placed under travel restriction by the Government of India.
8. Other expenses as detailed in annexure 1.

VI. CONDITIONS

Standard Conditions

1. **Disclosure of information:** 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
2. **Claims Procedure**
   A. **Condition Precedent to Admission of Liability**: The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.
   B. **For Cashless Treatment**
      a. For assistance call 24 hours help-line 044-69006900 or Toll Free No. 1800 425 2255, Senior Citizens may call at 044-40020888
      b. Inform the ID number for easy reference
      c. On admission in the hospital, produce the ID Card issued by the Company at the Hospital Helpdesk
      d. Obtain the Pre-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk.
      e. The Treating Doctor will complete the hospitalisation/ treatment information and the hospital will fill up expected cost of treatment. This form is submitted to the Company
      f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.
      g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits.

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

i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.starhealth.in or contact the nearest branch or refer to the list of Networked Hospitals provided with the policy document.

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

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

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

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

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

Sl.No.	Type of Claim	Prescribed time limit
1	Reimbursement of hospitalization, day care and pre hospitalization expenses	Claim must be filed within 15 days from the date of discharge from the Hospital.
2	Reimbursement of Post hospitalization	Within fifteen days from completion of post hospitalization treatment
3	Reimbursement of Home Care expenses	Within thirty days from completion of home care treatment

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. At least 48 hrs prior to admission in Hospital in case of a planned Hospitalization

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

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

For Hospitalization Claim	1. Duly filled and signed Claim Form 2. Copy of insured Person's passport, if available (All pages) 3. Photo Identity proof of the patient (if insured person does not own a passport) 4. Original bills with itemized break-up 5. Payment receipts 6. Discharge summary including complete medical history of the patient along with other details. 7. Investigation reports including Insured Person's test reports from Authorized diagnostic centre for COVID 8. OT notes or Surgeon's certificate giving details of the operation performed, wherever applicable 9. Sticker/Invoice of the Implants, wherever applicable. 10. NEFT Details (to enable direct credit of claim amount 11. Bank account) and cancelled cheque

	12. KYC (Identity proof with Address) of the proposer, as per AML Guidelines 13. Legal heir/succession certificate, wherever applicable 14. Any other relevant document required by Company for assessment of the claim.
For Home Care Treatment	1. Duly filled and signed Claim Form 2. Copy of Insured Person's passport, if available (All pages) 3. Photo Identity proof of the patient (if insured person does not own a passport) 4. Medical practitioners prescription advising hospitalization 5. A certificate from medical practitioner advising treatment at home or consent from the insured person on availing home care benefit. 6. Discharge Certificate from medical practitioner specifying date of start and completion of home care treatment. 7. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

Note:

- NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code
- CKYC No. of the proposer
- For assistance call 24 hours help-line 044-69006900 or Toll Free No. 1800 425 2255, Senior Citizens may call at 044-40020888

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

4. **Multiple Policies**

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

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

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

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

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

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

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

   a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
   b. the active concealment of a fact by the insured person having knowledge or belief of the fact;
   c. any other act fitted to deceive; and
   d. any such act or omission as the law specially declares to be fraudulent

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

6. **Cancellation**

   i. The Policy Holder may cancel this Policy anytime during the term by giving 7 days written notice. In such an event, The Company shall

   a. refund proportionate premium for unexpired Policy period, for policy term upto one year and there is no claim (s) made during the Policy period.

   b. refund premium for the unexpired Policy period, in respect of policies with policy term more than 1 year and risk coverage for such Policy years has not commenced

   ii. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 Days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

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

7. **Renewal of Policy**: The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person;

   1. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years
   2. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period
   3. 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
   4. Coverage is not available during the grace period

8. **Premium Payment in Instalments:**If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly or Quarterly or Monthly or as mentioned in the Policy Schedule/Certificate of Insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)
   i. For monthly instalment option: Grace Period of 15 days would be given to pay the instalment premium due for the policy.
   ii. For Quarterly and Half yearly instalment option: Grace Period of 30 days would be given to pay the instalment premium due for the policy.
   iii. The insured person will get the accrued continuity benefit in respect of the (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) in the event of payment of premium within the stipulated grace Period
   iv. No interest will be charged If the instalment premium is not paid on due date.
   v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
   vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
   vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
   viii. For premium paid in instalments during the policy period, coverage is available during the grace period also

9. **Redressal of Grievances**: Incase of any grievance the insured person may contact the Company through

   Website : www.starhealth.in

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

   Ph. No. : 044-69006900 | Toll Free No. 1800 425 2255
   Senior Citizens may call at 044-69007500

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

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

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

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

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

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

10. **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

11. The premium payable under this policy shall be payable in advance. No receipt of premium shall be valid except acknowledged 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.

12. All claims under this policy shall be payable in Indian currency. All medical /surgical treatments under this policy shall have to be taken in India.

13. Any medical practitioner authorized by the company shall be allowed to examine the Insured Person/s 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 the Company's cost.

14. **Role of Group Administrator / Proposer:** The Group administrator / Proposer shall play a facilitative role between the Insurer and the Insured Person. Such role includes

1) Furnish to the Company detailed list of Insured Person/s for preparation of Individual Certificate and ID cards
2) Distribute Individual Certificate and ID cards received from the Company. (However, where the Company issues ID card / Individual Certificates in electronic form directly to the Insured Person/s this will not apply).
3) To facilitate Insured Person / s in availing all insurance related services including cashless facility wherever required.

15. **Addition Deletion of members:** Addition of members is permitted at the premium rate agreed at the inception of the policy.

16. **Automatic Termination**: The insurance under this policy with respect to each relevant insured person / family shall terminate immediately on the earlier of the following events:

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

17. **Automatic Termination of Individual Certificate of Insurance**. The Certificate of Insurance will terminate on the earliest of the following dates:

The date of expiry of certificate of insurance or

The date the Insured Person is no longer eligible within the classification of Insured Person(s) described in the Policy Schedule or

The Insured person ceases to be a resident of India or

From the date the Certificate of Insurance is cancelled either by the Company or Insured Person(s)

18. **Arbitration:** The parties to the contract may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this policy. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996."

19. **Notice and communication:** Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or email to Star Health and Allied Insurance Company Limited, No.1, New Tank Street, 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, or e-mail.

20. Important Note

a. Where the insured person has opted for floater policy, the sum insured floats amongst the insured members and all the benefits / coverage floats amongst the insured members.

b. The Policy Schedule, Certificate of Insurance and Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws. The Special Conditions if any stated in the Schedule supersede these policy wordings.

c. The terms conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with. Failure to comply may result in the claim being denied.

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

21. Customer Service If at any time the Insured Person requires any clarification or assistance, the insured may contact "Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai- 600014", during normal business hours.

22. Excluded Hospitals (providers): Insured can refer the company website using the following link to the list of excluded hospitals. https://www.starhealth.in/lookup/hospital/#excluded-hospital

List of Ombudsman

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	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	Karnataka.
BHOPAL Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202	Madhya Pradesh, Chhattisgarh.

Office Details	Jurisdiction of Office Union Territory, District)
Email: bimalokpal.bhopal@cioins.co.in	
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	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 / 24333678 Email: bimalokpal.chennai@cioins.co.in	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 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp.to Maharaja's College, M. G. Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	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,	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

Office Details	Jurisdiction of Office Union Territory, District)
Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	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 – 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	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 – 4002082/ 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe,	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).

Office Details	Jurisdiction of Office Union Territory, District)
S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022-69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).
For the details of Insurance Ombudsman please visit: https://cioins.co.in/Complaint/Online	

Items that are to be subsumed into Room Charges

Sl No	ITEM
1	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB

7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET / WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

Items that are to be subsumed into Procedure Charges

Sl No.	ITEM

1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (FOR SITE PREPARATIONS)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

Items that are to be subsumed into costs of treatment

Sl No.	ITEM
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP / CAPD EQUIPMENTS

7	INFUSION PUMP — COST
8	HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABS
16	SCRUB SOLUTION / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG