STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED
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Website : www.starhealth.in ★ CIN : U66010TN2005PLC056649 ★ IRDAI Regn. No. : 129

STAR NET PLUS

Unique Identification No.: SHAHLGP21267V022021

The Proposal, Declaration and other documents if any given by the proposer forms the basis of this policy of insurance

In consideration of the premium paid in full and subject to the terms and conditions as set out in the Schedule with all its Parts, the Company by this Policy agrees as under :-

1. Section I – HIV Cover Section

The insured person shall contract the covered disease / illness/ accidental injuries as defined herein, the Company will pay to the Insured the limit mentioned in the Schedule as a lump sum.

In the event of any claim becoming admissible under this insurance, the Company will pay to the Insured as follows:-

The lump-sum amount as specified in the Policy Schedule for the covered disease / illness / accidental injuries, subject to terms, conditions, limitations and exclusions mentioned therein, if the Insured Person is declared as having reached the stage of AIDS (if the cd4 count falls below 150) as defined herein and the same is diagnosed and certified by a team of doctors appointed / nominated by the Company after conducting appropriate test(s) and during the Period of Insurance and if all of the following conditions are satisfied.

The stage of AIDS experienced by the Insured Person is the first incidence; and

The signs or symptoms experienced by the Insured Person commenced more than 90 days (ninety days) following the Commencement Date of the policy.

The Insured Person subjects himself/herself to examination by the panel doctor of the Company and AIDS is confirmed by the panel doctor.

Only one lump sum payment shall be provided during the Insured Person's lifetime regardless of the number of treatments undergone by the Insured Person. The cover for the respective individual will be automatically terminated after the lump sum payment is made as above and the cover for the respective person shall not be renewed.

2. Section II – Medical Section

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

A. In the event of any claims becoming admissible under this Scheme, the Company will pay to the Insured Person or the estate of the Insured Person.

B. The amount of such expenses as would fall under different heads up to the limits mentioned, and as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person, but not exceeding the Sum insured in aggregate mentioned in the schedule hereto.

1. Room, Boarding Expenses as provided by the Hospital / Nursing Home at 2% of the sum insured.
2. Nursing expenses.
3. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees.
4. Anaesthesia, Blood, Oxygen, Operation Theatre charges, ICU charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, cost of Pacemaker and similar expenses.
5. Emergency ambulance charges up-to a sum of Rs. 750/- per hospitalisation and overall limit of Rs. 1,500/- per policy period for transportation of the insured person by private ambulance service when this is needed for medical reasons to go to hospital for treatment provided such hospitalisation claim is admissible as per the Policy.
6. Relevant **Pre-Hospitalization** medical expenses incurred for a period not exceeding 30 days prior to the date of Hospitalisation, on the disease/illness, injury sustained following an admissible claim under the policy
7. A Sum equivalent to 7% of the hospitalisation expenses incurred comprising of Nursing charges, Surgeon/consultant fees, Diagnostic charges, Medicines and Drugs only subject to a maximum of Rs. 5,000/- per occurrence towards **Post Hospitalisation** Medical expenses wherever recommended by the attending Medical Practitioner.
8. Coverage for Modern Treatment: The expenses payable during the entire policy period for in respect of the following treatment / procedures conditions (either as a day care or as in-patient exceeding 24hrs of admission in the hospital) are covered up to sum insured
   a) Uterine artery Embolization and HIFU
   b) Balloon Sinuplasty
   c) Deep Brain Stimulation
   d) Oral Chemotherapy (including pre &Post Hospitalization)
   e) Immunotherapy-Monoclonal Antibody to be given as injection
   f) Intra Vitreal injections
   g) Robotic surgeries
   h) Stereotactic radio surgeries
   i) Bronchical Thermoplasty
   j) Vaporization of the prostate (Green laser treatment or holmium laser treatment)
   k) IONM-(Intra Operative Neuro Monitoring)
   l) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
9. AYUSH : In patient Hospitalizations Expenses incurred for treatment of diseases / illness / accidental injuries by system of medicines other than allopathic is payable up to 25% of sum insured.
   Where package rates are charged by the hospitals the Post-Hospitalisation benefit will be calculated after taking the room and boarding charges at 2% of the Sum Insured per day.

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

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

Cataract surgery- Rs.20000/- in respect of one eye and Rs.30000/- in the entire policy period

Lithotripsy (Kidney stone removal)	-	Rs.20000/-
Tonsillectomy	-	Rs.7500/-
Cutting and Draining of Abscess	-	Rs.1500/-
Liver Aspiration	-	Rs.2000/-
Pleural Effusion Aspiration	-	Rs.2000/-
Sclerotheraphy	–	Rs.5000/-

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

Note: Company's liability in respect of all claims admitted during the period of insurance shall not exceed the Sum insured per person mentioned (under Section II – Medical Section) in the Schedule.

3. Definitions

AIDS means Acquired Immuno Deficiency Syndrome where the CD4 count of the HIV infected person goes below 150 and this (AIDS) has to be confirmed in conjunction with other relevant tests and parameters.

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

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

AYUSH 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;
   a) Having at least 5 in-patient beds
   b) Having qualified AYUSH Medical Practitioner in charge round the clock
   c) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
   d) Maintaining daily records of the patients and making them accessible to the insurance Company's authorized representative

AYUSH 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 inpatient services and must comply with all the following criterion;

1. 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
2. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

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

Claims ratio means the ratio of amounts paid (or outstanding) including claims cost, if any, to the premium paid

Company means Star Health and Allied Insurance Company Limited

Co-payment is a cost-sharing requirement under a health insurance policy that provides that the insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

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

HIV means Human Immuno Virus.

Hospital / Nursing Home 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;

a. Has qualified nursing staff under its employment round the clock
b. 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
c. Has qualified medical practitioner(s) in charge round the clock
d. Has a fully equipped operation theatre of its own where surgical procedures are carried out e. Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

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 means Government or Non Governmental Organization or Agencies active in the field of serving the cause of people with HIV / AIDS which has proposed this policy and who remits the premium with service tax, as applicable, to the Company under this policy.

Insured Person means the name/s of persons shown in the schedule of the Policy who are covered under this policy, for whom the insurance is proposed, appropriate premium is paid.

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

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

Network Hospital means hospitals or health care providers enlisted by an insurer, TPAor jointly by an insurer and TPAto provide medical services to an insured by a cashless facility.

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

Pre-Insurance medical test means the clinical and laboratorial tests including CD4 test and/or HIV Viral Load Test or any other test as may be required, conducted on the Insured persons, to establish HIV infection and also to rule out the stage of AIDS.

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

i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement

Pre-hospitalization Medical Expenses 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 inpatient hospitalization claim for such hospitalization is admissible by the insurance company

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 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

Portability (Applicable for Section II) means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre existing condition and time bound exclusions, from one insurer to another insurer

Qualified Nurse is 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 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.

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

4. Special Conditions: Under Section 1

The eligibility of a claim under the policy must be confirmed by a registered medical practitioner as defined herein and must be supported by clinical and laboratory evidence acceptable to the Company.

Insurance under this policy shall cease upon payment of the compensation as provided herein and no further payment will be made for any consequent disease or dependent disease.

Payment of claims will be made to the **Insured** whose discharge shall be final and binding. It is for the **Insured** to decide to pass on the benefit of a claim to the claimant either by way of treatment or cash in lieu thereof.

Waiting Period- No claim for compensation will become payable if illness/disease/condition specified in the policy incepts or manifests during the first 90 days of the inception of the policy. In the event of renewal with the Company this 90 days limit shall not apply.

5. Exclusions under Section I

a) The Company shall not be liable to make any payments under this Policy in respect of any expenses what so ever incurred by any Insured person in connection with or in respect of expenses towards the treatment of HIV.

b) All medical conditions which are **Pre Existing** when the cover incepts for the first time including the stage of AIDS except HIV which is specifically covered.

c) AIDS confirmed during the first 90 days from the commencement date of the policy.

6. Exclusions (Applicable for Section II)

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

1. Pre-Existing Diseases - Code Excl 01

A. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
C. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
D. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

A. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

The expenses on treatment of Cataract, Hysterectomy for Menorrhagia or Fibromyom, Knee replacement Surgery (other than caused by an accident), Joint Replacement Surgery(other than caused by an accident), Prolapse of intervertibral disc(other than caused by accident), Varicose veins and Varicose ulcers.

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.

The expenses on treatment of diseases such as Benign Prostate Hypertrophy, Hernia, Hydrocele, Congenital Internal disease/defect, Fistula in anus, Piles, Sinusitis and related disorders, Gallstones and renal stones removal are not payable.

B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
C. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
D. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
E. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

3. **30-day waiting period - Code Excl 03**
   A. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   B. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
   C. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

4. **Investigation & Evaluation - Code Excl 04**
   A. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   B. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. **Rest Cure, rehabilitation and respite care - Code Excl 05:** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   1. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   2. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

6. **Obesity / Weight Control - Code Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:
   A. Surgery to be conducted is upon the advice of the Doctor
   B. The surgery/Procedure conducted should be supported by clinical protocols
   C. The member has to be 18 years of age or older and
   D. Body Mass Index (BMI);
      1. greater than or equal to 40 or
      2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         a. Obesity-related cardiomyopathy
         b. Coronary heart disease
         c. Severe Sleep Apnea
         d. Uncontrolled Type2 Diabetes

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

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

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

10. 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**

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

12. **Maternity - Code Excl 18:**
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
   b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

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

14. Congenital External Condition / Defects / Anomalies **- Code Excl 20**

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

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

17. 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**

18. Injury or disease directly or indirectly caused by or contributed to by nuclear weapons/material **- Code Excl 25**

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

20. Dental treatment or surgery unless necessitated due to accidental injuries and requiring hospitalization. (Dental implants are not payable) **- Code Excl 32**

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

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

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

24. 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**

25. Naturopathy - **Code Excl 40**

26. Exclusion of medical expenses incurred for treatment of Tuberculosis and Gastro-Enteritis **- Code Excl 44**

7. Moratorium Period

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

8. Conditions

Conditions Applicable for Section I

1. This policy is available for all persons irrespective of age. However, the Company can decline cover to any persons subsequent to pre-insurance medical tests.
2. The renewals shall be automatic provided the renewal premium is paid before expiry of the current policy. The yearly renewal premiums may vary over the period as and when this policy product is reviewed and amended with the clearance of the Statutory Authorities.
3. Pre-insurance medical tests are a pre-condition for all persons also who are included for the first time under this insurance, at the time of renewal of the policy. Insurer can decline cover for any person or persons based on the outcome of such tests.
4. The Insured shall obtain and furnish the Company with all documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim.
5. The findings of such medical team shall be final and binding in deciding the admissibility of a claim.
6. **Automatic Termination:** This policy shall terminate in respect of the relevant Insured person immediately on the earlier of the following events:
   a) Upon the death of the relevant Insured person
   b) Upon payment of benefit under the policy in respect of the relevant Insured person.
7. **Limitation:** It is also further expressly agreed and declared that if the Company shall disclaim liability to the Insured for any claim hereunder and such claim shall not, within three years from the date of such disclaimer have been made the subject matter of a suit in a Court of Law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.
8. **Payment of Claim:** All claims under this policy shall be payable in Indian currency.
9. **Conditions applicable for Section I and II**
   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:**
      i. Call the 24 hour help-line for assistance - 1800 425 2255/1800 102 4477
      ii. Inform the ID number for easy reference
      iii. On admission in the hospital, produce the ID Card issued by the Company at the Hospital Helpdesk
      iv. Obtain the Pre-authorization Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk.
      v. The Treating Doctor will complete the hospitalization / treatment information and the hospital will fill up expected cost of treatment.
      vi. This form is submitted to the Company
      vii. The Company will process the request and call for additional documents/ clarifications if the information furnished is inadequate.
      viii. 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.
      ix. In case of emergency hospitalization information to be given within 24 hours after hospitalization
      x. Cashless facility can be availed only in networked Hospitals

      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 permissible reimbursement.

In non-network hospitals payment must be made up-front by Insured /Insured Person and then reimbursement will be effected on submission of documents upon its admissibility.

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.

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

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

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

a. Duly completed claim form, and
b. Pre Admission investigations and treatment papers.
c. Discharge Summary from the hospital in original
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. **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.

G. **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.

H. **Multiple Policies**

1. 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.
2. 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.
3. 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.
4. 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.

I. **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.

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

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

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

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

6. 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

7. Notice and communication : Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile/email to Star Health and Allied Insurance Company Limited, No 1 New Tank Street, Vallurvar Kottam High Road Nungambakkam Chennai 600034 Fax 04428319100 Toll Free Fax No. 1800 425 5522 E-Mail support@starhealth.in

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

8. Territorial Limit : All treatments under this policy shall have to be taken In India.

9. 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 foundfraudulent 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 followingacts 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 theground of Fraud, if the insured person / beneficiary can prove that the misstatementwas 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.

10. Cancellation

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

PERIOD ON RISK	RATE OF PREMIUM TO BE RETAINED
Up to one month	⅓rd of the annual premium
Up to three months	½nd of the annual premium
Up to six months	¾th of the annual premium
Exceeding six 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.

b) 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.

11. Automatic Termination: The insurance under this policy shall terminate immediately on the earlier of the following events:

✓ Upon the death of the Insured Person
✓ Upon exhaustion of the Sum Insured in respect of such person

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

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

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

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

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

14. **Migration(Applicable for Section II only):** 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

15. **Portability(Applicablefor Section II only):** 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

16. **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

17. **Package Charges:** The Company's liability in respect of package charges will be restricted to 80% of such amount. (Package charges refer to charges that are not advertised in the Schedule of the Hospital) Where Package rates are charged the Post-Hospitalisation benefit will be calculated after taking the room and boarding charges at 2% of the sum insured per day

18. **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.

19. **Important Note**
    a) The Policy Schedule and any Endorsement are to be read together and any word or such meaning wherever it appears.
    b) The terms conditions, waiting periods and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each relevant insured person. Failure to comply may result in the claim being denied.
    c) The attention of the policy holder is drawn to our website www.starhealth.in for anti fraud policy of the company for necessary compliance by all stake holders.

20. **Customer Service** If at any time the Insured Person requires any clarification or assistance, the insured may contact the offices of the Company at the address specified, during normal business hours.

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

    Website : www.starhealth.in
    Toll free : 1800 425 2255/1800 104 2277
    Senior Citizens may call at 044-28243923
    E-mail : grievances@starhealth.in
    Fax : 04428319100
    Courier : No 1 New Tank Street, Vallurvar Kottam High Road Nungambakkam Chennai 600034

    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 044-28243921

    For updated details of grievance officer, kindly refer the link
    https://www.starhealth.in/grievanec-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:/ligms.irda.gov.in/

STAR Personal & Caring | Health Insurance

The Health Insurance Specialist

List of Insurance Ombudsman

AHMEDABAD

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

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

BENGALURU

Office of the Insurance Ombudsman,
Jeevan Soudha Building,PID No. 57-27-N-19
Ground Floor, 19/19, 24th Main Road,
JP Nagar, 1st Phase,
Bengaluru – 560 078.
Tel.: 080 - 26652048 / 26652049
Email: bimalokpal.bengaluru@ecoi.co.in

JURISDICTION: Karnataka.

BHOPAL

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

JURISDICTION: Madhya Pradesh Chattisgarh.

BHUBANESHWAR

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

JURISDICTION: Orissa.

CHANDIGARH

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

JURISDICTION: Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.

CHENNAI

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

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

DELHI

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

JURISDICTION: Delhi

ERNAKULAM

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

JURISDICTION: Kerala, Lakshadweep, Mahe-a part of Pondicherry

GUWAHATI

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

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

HYDERABAD

Office of the Insurance Ombudsman,
6-2-46, 1st floor, "Moin Court",
Lane Opp. Saleem Function Palace,
A. C. Guards, Lakdi-Ka-Pool,
Hyderabad - 500 004.
Tel.: 040 - 67504123 / 23312122
Fax: 040 - 23376599
Email: bimalokpal.hyderabad@ecoi.co.in

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

JAIPUR

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

JURISDICTION: Rajasthan.

KOLKATA

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

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

LUCKNOW

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

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

MUMBAI

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

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

PUNE

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

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

NOIDA

Office of the Insurance Ombudsman,
Bhagwan Sahai Palace
4th Floor, Main Road,
Naya Bans, Sector 15,
Distt: Gautam Buddh Nagar,
U.P - 201301.
Tel.: 0120-2514250 / 2514252 / 2514253
Email: bimalokpal.noida@ecoi.co.in

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

PATNA

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

JURISDICTION: Bihar and Jharkhand.

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