

Policy Wordings

**STAR GROUP MICRO RURAL AND FARMERS CARE
SHAHMGP21625V012021**

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

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

That if during the period stated in the Schedule the insured person shall contract any disease or suffer from any illness or sustain bodily injury through accident and if such disease or injury shall require the insured Person/s, upon the advice of a **Medical Practitioner** or of duly Qualified Surgeon to incur Hospitalization expenses for medical/surgical treatment at any **Hospital** in India as an **in-patient**, the **Company** will pay to the **Insured Person/s** the amount of such expenses as are **reasonably and necessarily** incurred up-to the limits indicated in the schedule

1. Coverage

- A) Room, boarding, nursing expenses as provided by the Hospital / Nursing Home up to 1% of Sum Insured per day.
- B) Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees.
- C) Anesthesia, blood, oxygen, operation theatre charges, ICU Chargers, surgical appliances, medicines and drugs, diagnostic materials and X-ray, diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent, similar expenses. With regard to coronary stenting, the company will pay such amount up to the extent of cost of bare metal stent/drug eluting cobalt-chromium stent/drug eluting stainless steel stent. In respect of medicines, Implants and such other similar items, the Company will pay up to the cost of alternate indigenous make.
- D) Expenses incurred on treatment of Cataract is limited to Rs.10,000/- per eye and up to Rs.15,000/- per policy period
- E) All day care procedures are covered under this policy
- F) **Coverage for Modern Treatments**

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

Sum Insured	Rs.1,00,000/-	Rs.2,00,000/-
	Sum Insured on Individual Basis: Limit per person per policy period for each treatment/procedure	
	Sum Insured on Floater Basis: Limit per policy period for each treatment/procedure (Rs.)	
Treatment / Procedure		
A.Uterine artery Embolization and HIFU	12,500/-	25,000/-
B.Balloon Sinuplasty	5,000/-	10,000/-
C.Deep Brain Stimulation	25,000/-	50,000/-
D.Oral Chemotherapy*	12,500/-	25,000/-
E.Immunotherapy-Monoclonal Antibody to be given as injection	25,000/-	50,000/-

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvarkottam High Road,
Nungambakkam, Chennai - 600 034. Phone: 044 - 2828 8800

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F.Intra Vitreal injections	5,000/-	10,000/-
G.Robotic surgeries	25,000/-	50,000/-
H.Stereotactic radio surgeries	25,000/-	50,000/-
I.Bronchical Thermoplasty	Up to Sum Insured	
J.Vaporisation of the prostate (Green laser treatment or holmium laser treatment).		
K.IONM-(Intra Operative Neuro Monitoring)		
L.Stem cell theraphy:Hematopoietic stem cells for bone marrow transplant for haematological conditions	25,000/-	50,000/-

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

Note:

1. Expenses on Hospitalization for a minimum period of 24 hours only are admissible. However this time limit will not apply for the day care treatments / procedures, where treatment is taken in Hospital/Nursing Home and the Insured is discharged on the same day.
2. **Expenses relating to the hospitalization will be considered in proportion to the room rent stated in the policy. Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category**
3. **Co-payment:** This policy is subject to co-payment of 20% of each and every admissible claim amount, for fresh as well as for the policies subsequently renewed for insured persons whose age at the time of entry in to this policy is 61 years and above. This co-payment will not apply for those insured persons who have entered the policy before attaining 61 years of age and renew the policy continuously without any break.

2. DEFINITIONS

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

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

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.

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

Company means Star Health and Allied Insurance Company Limited.

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

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

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

b) **External Congenital Anomaly:** Congenital anomaly which is in the visible and accessible parts of the body.

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

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

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

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

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

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

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

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.

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

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

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

Family means Insured Person, spouse, dependent children between 1 year and 25 years of age

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

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:

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

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

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

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.

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

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.

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 the scope and jurisdiction of licence.

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

- i. is required for the medical management of the illness or injury suffered by the insured;
- ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- iii. must have been prescribed by a *medical practitioner*;
- iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

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

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

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.

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

Sum Insured: means the Sum Insured Opted for and mentioned in the policy schedule.

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

3. Exclusions

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

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 6 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. Coverage under the policy after the expiry of 6 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 6 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- B. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- C. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- D. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- E. List of specific diseases/procedures
 1. Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye (Other than retinal detachment), Diseases of ENT, Diseases related to Thyroid, Benign diseases of the breast.
 2. Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal Tunnel Syndrome, Trigger Finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology
 3. All treatments (Conservative, Operative treatment) and all types of intervention for Diseases related to Tendon, Ligament, Fascia, Bones and Joint Including Arthroscopy and Arthroplasty / Joint Replacement [other than caused by accident].
 4. All types of treatment for Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system, Prolapse of Intervertebral Disc (other than caused by accident),
 5. All treatments (conservative, interventional, laparoscopic and open) related to Hepato-pancreato-biliary diseases including Gall bladder and Pancreatic calculi. All types of management for Kidney and Genitourinary tract calculi.
 6. All types of Hernia,
 7. Desmoid Tumor, Umbilical Granuloma, Umbilical Sinus, Umbilical Fistula,
 8. All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Cervix, Uterus, Fallopian tubes, Ovaries, Uterine Bleeding, Pelvic Inflammatory Diseases
 9. All Diseases of Prostate, Stricture Urethra, all Obstructive Uropathies,
 10. Benign Tumours of Epididymis, Spermatocele, Varicocele, Hydrocele,

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11. Fistula, Fissure in Ano, Hemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence
 12. Varicose veins and Varicose ulcers
 13. All types of transplant and related surgeries.
 14. Congenital Internal disease / defect
3. **30-day waiting period- Code- Excl 03:**
- A. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
 - B. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
 - C. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.
4. **Investigation & Evaluation- Code- Excl 04:**
- A. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
 - B. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
5. **Rest Cure, rehabilitation and respite care- Code- Excl 05:**
- A. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 1. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
 2. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
6. **Obesity/ Weight Control - Code- Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:
- A. Surgery to be conducted is upon the advice of the Doctor
 - B. The surgery/Procedure conducted should be supported by clinical protocols
 - C. The member has to be 18 years of age or older and
 - D. Body Mass Index (BMI);
 1. greater than or equal to 40 or
 2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - a. Obesity-related cardiomyopathy
 - b. Coronary heart disease
 - c. Severe Sleep Apnea
 - d. Uncontrolled Type2 Diabetes
7. **Change-of-Gender treatments- Code- Excl 07:**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
8. **Cosmetic or plastic Surgery - Code- Excl 08:**
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

9. Hazardous or Adventure sports- Code- Excl 09:

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

10. Breach of law- Code- Excl 10:

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

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

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

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

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

15. Refractive Error - Code- Excl 15: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

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

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

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

18. Maternity- Code- Excl 18:

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

19. Circumcision unless necessary for treatment of a disease not excluded under this policy or necessitated due to an accident, Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA- **Code- Excl 19**

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

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

22. Intentional self injury-Code- Excl 22

23. 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**

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

25. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other similar therapies . **-Code- Excl 26**
 26. Unconventional, Untested, Experimental therapies. **-Code- Excl 27**
 27. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy. **-Code- Excl 28**
 28. Biologicals, except when administered as an in-patient, when clinically indicated and hospitalization warranted. **-Code- Excl 29**
 29. All treatment for Priapism and erectile dysfunctions. **- Code- Excl 30**
 30. Inoculation or Vaccination (except for post-bite treatment and for medical treatment for therapeutic reasons). **- Code- Excl 31**
 31. Dental treatment or surgery unless necessitated due to accidental injuries and requiring hospitalization. (Dental implants are not payable). **- Code- Excl 32**
 32. Medical and / or surgical treatment of Sleep apnea, treatment for endocrine disorders. **- Code- Excl 33**
 33. Hospital registration charges, admission charges, record charges, telephone charges and such other charges. **- Code- Excl 34**
 34. Cochlear implants and procedure related hospitalization expenses. **- Code- Excl 35**
 35. Any hospitalizations which are not medically necessary- **Code- Excl 36**
 36. Other Excluded Expenses as detailed in the website www.starhealth.in- **Code- Excl 37**
 37. 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**
 38. Expenses incurred for treatment of diseases/illness/accidental injuries by systems of medicine other than allopathy **- Code- Excl 39**
4. **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
5. **CONDITIONS:**
1. **Claim Settlement:**
 - A. **Condition Precedent to Admission of Liability:** The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy
 - B. **Documents for Cashless Treatment:**
 - a. Call the 24 hour help-line for assistance - 1800 425 2255/1800 104 2277
 - 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

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- 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.

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

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

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

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

Sl.no.	Type of Claim	Prescribed time limit
1	Reimbursement of hospitalization and day care	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** : The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

- a. Duly completed claim form, and
- b. Pre Admission investigations and treatment papers.
- c. Discharge Summary from the hospital
- d. Cash receipts from hospital, chemists
- e. Cash receipts and reports for tests done
- f. Receipts from doctors, surgeons, anesthetist
- g. Certificate from the attending doctor regarding the diagnosis.
- h. Copy of PAN card

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.

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- 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

- 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.

- 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 as and when the same may reasonably be required on behalf of the Company at Company's cost.
6. **Addition/ Deletion:**
Addition: Enrolment of new insured persons / beneficiary will be made during the period of insurance stated in the master policy schedule. The period of insurance for such newly enrolled insured person / beneficiary will be for a period of one year as stated in the certificate of insurance issued to the insured person / beneficiary.
Deletion of insured persons / beneficiary from the Group can be made and refund will be effected on pro-rata basis from the date of request for deletion of the insured person(s) / beneficiary subject to NO claim being made in respect of that insured person(s) / beneficiary or his/her family member(s)
7. **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.
8. **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.
9. **Territorial Limit :** All treatments under this policy shall have to be taken in India.
10. **Fraud:** If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

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

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

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

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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.

11.Cancellation:

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

Cancellation table	
Period on risk	Rate of premium to be retained
Up to one mth	22.5% of the policy premium
Exceeding one mth up to 3 mths	37.5% of the policy premium
Exceeding 3 mths up to 6 mths	57.5% of the policy premium
Exceeding 6 mths up to 9 mths	80% of the policy premium
Exceeding 9 mths	Full of the policy premium

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

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

12.Automatic Expiry:

The insurance under this policy with respect to each relevant Insured Person / beneficiary / family shall expire immediately on the earlier of the following events:

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

13.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.

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

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

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

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

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

For Detailed Guidelines on migration, kindly refer the link ..

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987.

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

1. The date of expiry of certificate of insurance or
2. The date the Insured Person / beneficiary is no longer eligible to be within the classification of Insured Person(s) described in the Policy Schedule or
3. The Insured person / beneficiary ceases to be a resident of India or
4. From the date the Certificate of Insurance is cancelled either by the Company

18. Possibility of Revision of Terms of the Policy Including the Premium Rates:

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

19. 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,

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waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

20. Relief under Section 80-D: Insured Person is eligible for relief under Section 80-D of the IT Act in respect of the premium paid by any mode other than cash.

21. IMPORTANT NOTE

- a) Where the policy is issued on floater basis, the Sum Insured and sublimits 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
- c) The terms conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with and applies to each relevant insured person. Failure to comply with may result in the claim being denied.
- d) 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.

22. 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) Furnishing to the Company detailed list of Insured Person/s for preparation of Individual Certificate and ID cards
- 2) Distributing 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) Facilitating Insured Person / s in availing all insurance related services including cashless facility wherever required.
- 4) If a member leaves the group as per group rules, group administrator should facilitate to provide option to migrate to another policy at premium as applicable for such individual insurance. In such event :-
 - a. Members who have been covered continuously for a period of one year under this Star Group Micro Rural and Farmers Care with the Company, 30 days waiting period shall be waived.
 - b. Members who have been covered continuously for a period of two years under this Star Group Micro Rural and Farmers Care with the Company, 30 days waiting period and First two year exclusions / First two year waiting period shall be waived.
 - c. In respect of members who have been covered continuously for a period a four years under this Star Group Micro Rural and Farmers Care with the Company, 30 days waiting period, First two year exclusions / First two year waiting period, 6 months waiting period with reference to Pre Existing diseases shall be waived

23. 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.

24. Redressal of Grievances: In case of any grievance the insured person may contact the Company through

Website: www.starhealth.in

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Toll free: 1800 425 2255/1800 104 2277: Senior Citizens may call at 044-28243923

Contact no: 044-28319100

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

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/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://ligms.irda.gov.in/>

List of Insurance Ombudsman

Office Details	Jurisdiction of Office (Union Territory, District)
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	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
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@ecoi.co.in	Karnataka.
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	Madhya Pradesh Chattisgarh.

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Office Details	Jurisdiction of Office Union Territory, District)
Email: bimalokpal.bhopal@ecoi.co.in	
Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
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	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
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	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
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	Delhi.
Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

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Office Details	Jurisdiction of Office (Union Territory, District)
Email: bimalokpal.guwahati@ecoi.co.in	
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	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
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	Rajasthan.
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	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
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	West Bengal, Sikkim, Andaman & Nicobar Islands.
Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi,

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Office Details	Jurisdiction of Office (Union Territory, District)
<p>Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in</p>	<p>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.</p>
<p>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</p>	<p>Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.</p>
<p>Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in</p>	<p>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.</p>
<p>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</p>	<p>Bihar, Jharkhand.</p>
<p>Office of the Insurance Ombudsman,</p>	<p>Maharashtra, Area of Navi Mumbai and Thane</p>

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Office Details	Jurisdiction of Office (Union Territory, District)
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	excluding Mumbai Metropolitan Region.

	Items for which coverage is not available in the policy.
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES

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