Ref: IRDAI/E&C/ORD/MISC/153/11/2026

Order in the matter of M/s Star Health and Allied Insurance Co. Ltd arising out of Show Cause Notice ("SCN") reference No. IRDA / ENF / 2022-23 / 706 / SCN / LR / 081 dated 04th December, 2024

1. Based on the

1.1. Show Cause Notice ("SCN") reference No. IRDA / ENF / 2022-23 / 706 / SCN / LR / 081 dated 04th December, 2024 issued to Star Health and Allied Insurance Co. Ltd ("Insurer" or "Company") in connection with the inspection conducted by the Authority from 31st January to 11th February, 2022.

1.2. Submissions made by the insurer vide email dated 10 January 2025 in response to the aforesaid SCN.

1.3. Submissions made by the insurer during the personal hearing held on 18th June, 2025 at 12.00 PM, by a panel of Two Whole Time Members of the Authority - Shri Deepak Sood (Member-Non-Life) and Shri P.K. Arora (Member- Actuary).

1.4. Further submissions made by the insurer vide email dated 11th July 2025.

2. Background

2.1. The Authority had conducted a General inspection of the insurer from 31st January to 11th February 2022. The inspection report, inter alia, revealed certain violations of Regulations and Guidelines issued thereunder.

2.2. A copy of the inspection report was forwarded to the insurer on 18th April 2022 seeking their response. The insurer provided their response vide letter dated 25th May 2022.

2.3. On examining the submissions made by the insurer, Show Cause Notice (SCN) was issued on 04th December, 2024. The insurer replied to the SCN vide email dated 10th January 2025.

2.4. As requested by the insurer, personal hearing was granted to the insurer on 18th June, 2025 by the panel of Two Whole Time Members of the Authority - Shri Deepak Sood (Member-Non-Life) and Shri P.K. Arora (Member- Actuary).

2.5. On behalf of the insurer, Shri Anand Roy, MD & CEO, Shri Amitabh Jain, ED and COO, Shri K. Sanathkumar, EP, Shri Vishwajeet Mohnot, EP and Smt. Radha Vijayaraghavan, CCO and on behalf of the Authority, Shri R K Sharma (Chief General Manager), Shri Sanjay K Verma (General Manager), Shri Saket Gupta (Manager) and Shri Viswanath Valmiki (Manager) attended the hearing.

2.6. Due to the re-constitution of the panel of WTMs, the insurer was offered an opportunity of fresh hearing with the re-constituted panel of Member (Non-Life) and Member (F&I) vide email dated 10th March, 2026 to which the insurer responded that all relevant facts and justifications were comprehensively presented during personal hearing held on 18th June 2025 and chose not to avail the personal hearing.

2.7. The submissions made by the insurer vide its letter dated 25th May 2022, submission made after SCN vide email dated 10th January 2025 and submission made during the personal hearing on 18th June 2025 and those made vide email dated 11th July 2025 have been carefully considered by the Authority and are summarized below:

3. Charge 1 (Observation No. - 23)

3.1. Violation of Regulation 13(iii) of IRDAI (Health Insurance) Regulations, 2016.

3.2. Inspection Observation

While examining the details of Advance Premium and the relevant documents, it was noticed that the insurer has been collecting advance

premium for renewal of some policies more than 90 days in advance which is a violation of proviso to Regulation 13(iii) of the IRDAI (Health Insurance) Regulations, 2016.

3.3. Summary of Insurer's Submissions

3.3.1. The insurer, in its response, accepted that the lapse has occurred due to a technical issue and the system has since been modified to ensure that such lapse does not occur in the future.

3.3.2. It has been submitted that the earlier validation system in the insurer's system was applied at the policy conversion stage wherein the validation was for the date of approval of policy rather than the date of collection of premium. This gap has now been rectified.

3.3.3. Insurer further submitted that IRDAI Master circular on Protection of Policyholders Interest, 2024 has done away with the requirement of 90 days' limit on advance premium for renewal of health policy.

3.3.4. During the personal hearing, the insurer submitted that, in February 2023, two steps validation mechanism was introduced to avoid collection of premium beyond 90 days in advance.

3.3.5. The Panel, during the Personal Hearing, instructed the insurer to submit an undertaking covering the cases (along with the amount of premium) where was received more than 90 days in advance before the repeal of this requirement. The insurer has submitted the undertaking, as required.

3.4. Issues and Concerns on Charge 1

3.4.1. The Insurer has accepted that lapses did occur, as observed by the Inspection team, which led to the violation of Proviso to Regulation 13(iii) of the IRDAI (Health Insurance) Regulations, 2016.

3.4.2. The Insurer has further submitted during the personal hearing that the required modifications were brought in to ensure compliance to the stated regulation.

3.5. Decision on Charge 1

Given that the additional validation and required modification were brought to ensure compliance with the regulations, the insurer is hereby cautioned for the lapse and advised to ensure compliance with extant regulations and circulars as applicable.

4. Charge 3 (Observation No.- 18)

4.1. Violation of Regulation 27(v) of the IRDAI (Health Insurance) Regulations, 2016.

4.2. Inspection Observation

4.2.1. The Insurer was asked to furnish select documents/records with regard to the repudiation of cases selected on sample basis. Upon perusal of the documents provided, it was observed that the insured persons had undergone treatment in hospitals as per the advice of the medical experts and the treating doctors. However, the Insurer has repudiated the claims on the ground that the condition of the patient did not require hospitalization and that he/she should have been treated at home.

4.2.2. The Insurer, in its communication to the Insured, quoted guidelines from All India Institute of medical Sciences, New Delhi and Ministry of Health and Family Welfare, Government of India regarding the treatment of Covid 19 patients and stated that the patient required only self-isolation by home quarantine.

4.3. Summary of Insurer's submissions

4.3.1. The Insurer drew attention to the fact that the Covid 19 pandemic was an unprecedented situation for the healthcare industry which led

to reliance on guidance and protocols issued by the Institutions like WHO, ICMR, AIIMS etc.

4.3.2. The guidelines and protocols issued by the State Health Department during the Covid 19 pandemic were framed under the Disaster Management Act and the Clinical Establishment Act and were legally binding on the healthcare sector.

4.3.3. The Insurer also emphasized that many hospitals took advantage of the prevailing situation and overcharged under various heads.

4.3.4. Further, the Insurer has also referred in its email to the authority dated 24 July 2021 where it informed that all the Covid Claims are being repudiated after review by its In-house Claims Appellate Committee.

4.4. Concerns with respect to Charge 3

4.4.1. The Insurer has invoked quoted guidelines from All India Institute of medical Sciences, New Delhi and Ministry of Health and Family Welfare, Government of India to deny claims.

4.4.2. The Insurer, in its response, submitted the policy document of its flagship product, Family Health Optima Policy to the Authority. The policy document clearly mentions that “In cases where the insured contract any disease or suffer from any illness and if such disease or injury shall require the insured, upon the advice of a duly Qualified Physician / Medical Specialist / Medical Practitioner or of duly Qualified Surgeon to incur Hospitalization expenses during the period stated in the schedule for medical/surgical treatment at any Nursing Home / Hospital in India as an in-patient, it will indemnify the Insured the amount of such expenses.

4.4.3. The coverage provided under the policy stipulates that the expenses must be incurred upon advice of a Qualified Physician / Medical Specialist / Medical Practitioner or of duly Qualified Surgeon.

4.4.4. While hospitals are expected to follow treatment guidelines and protocols issued by various bodies, Covid 19 was an exceptional period and ailment. Despite various protocols issued, medical professionals may have preferred to take precautions and act with extra caution in many cases. In marginal cases, medical professionals, in the interest of taking a prudent approach would have suggested hospitalization. Being a pandemic, such hospitalization may also have been preferred for isolating the patient to safe guard family members and others. The insurer ought to have considered this in evaluating the hospitalization.

4.4.5. Therefore, the claims processed by the Insurer are, in a manner, inconsistent with its own policy terms and conditions and therefore it is a violation of IRDAI Circulars on Covid Claim settlements and Regulation 27 (v) of IRDAI (Health Insurance) Regulations, 2016 which states “Every Insurance Claim shall be disposed of in accordance to the Terms and Conditions of the policy contract”.

4.4.6. Moreover, the panel, in the personal hearing, enquired whether the insurer has communicated to the policyholder in each sample case why hospitalization is not required. The insurer was also instructed to give details of the actions initiated against the hospitals involved in the malpractice of overcharging. While the Insurer has submitted documents related to actions taken against the hospitals on sample basis, it has failed to provide documents proving that the communication was sent to the policyholder leading to the conclusion that no such communication was sent to the policyholder. The insurer is unable to justify its decision of stating “hospitalization not required”.

4.4.7. The subjective nature of what constitutes "necessary" hospitalization is further exaggerated by the insurer in a unique situation like the Covid pandemic. In cases where this provision is invoked there must be more than due justification which cannot be easily established in a situation like Covid pandemic.

4.5. Decision on Charge 3

4.5.1. In view of the above, in exercise of the powers vested under Section 102 of the Insurance Act, 1938, the Authority hereby imposes a penalty of Rs. One Crore for the violation of Regulation 27(v) of the IRDAI (Health Insurance) Regulations, 2016.

4.5.2. The Insurer is further advised to ensure that the all the policies are serviced according to the terms and conditions of the policy documents and no arbitrary deductions/denial are made to the claim without proper justification.

5. Charge 2 (Observation No.- 17) & Charge 4&5 (Observation No. - 19 and 20)

5.1. Violation of-

a) Regulation 27(v) of the IRDAI (Health Insurance) Regulations, 2016;

b) Regulation 33 (d) (ii) and (iv) of IRDA (Health Insurance) Regulations, 2016;

c) Regulation 21 (3) (c) (i) (c) of IRDAI (TPA – Health Services) Regulation, 2016;

d) Clause 6 of Guidelines of Corporate Governance Dated 18.05.16 issued vide Circular IRDA / F&A / GDL / CG / 100 / 05 / 2016.

5.2. Inspection Observation (No. 17)

5.2.1. Insurer is making deductions from the claims of the policyholders, which are out of purview of the terms & conditions of the policies issued. In the document inspected namely “Bill Assessment Sheet” the reason for deductions was mentioned as “Member Payment vis a vis terms & conditions of the policy issued”.

5.2.2. The Insurer was advised to furnish select documents/records with regard to settlement of cases selected on sample basis by the Inspection team. The Insurer, in its response, furnished “Bill

Assessment Sheet – Member payment" which furnished details of items which were partially or completely disallowed at the time of claim settlement.

5.2.3. Upon perusal of the submitted document, it was found that none of the terms and conditions of the policy issued empowered the insurer to make deductions on these grounds.

5.2.4. The insurer was also advised to furnish explanation / clarification on the disallowance of items of expenses by giving reference to the particular terms & conditions of the policy issued, in terms of which the said deductions were made. However, the insurer did not furnish any such information.

5.3. Inspection Observation (No. 19 and 20)

5.3.1. The Inspection team requested the Insurer to furnish the copy of communication, if any sent to the claimant, among the sample cases, giving details of the item wise deductions made from the claim filed and also the detailed reasons for the said deductions according to the terms and conditions of the policy issued.

5.3.2. The Insurer submitted a document namely "Bill Assessment Sheet – Member Payment and communication" informing the claimant about the amount for which the claim has been finally settled. However, the Insurer could not demonstrate that the communication part of the document was actually sent from its system to the claimants.

5.3.3. It was noted on the perusal of copy of communications furnished by the Insurer that it has not informed the policyholder of the particular terms and conditions of the policy under which the claim has been repudiated.

5.4. Summary of Insurer's Submissions

5.4.1. The insurer submitted that as there was no uniformity in the charges levied by the hospitals for treatment of patients with Covid-19, some

of the hospitals resorted to unreasonable billing exploiting the situation.

5.4.2. While settling claims, the insurer applied "reasonable and customary charges" wherever hospitals had resorted to excessive billing. In determining reasonable and customary charges for Covid 19 treatment, they were guided by the rates prescribed by various Governments and other bodies.

5.4.3. All the deductions were made in accordance with the "reasonable and customary" and "medical necessary" definitions which were the basic coverage definition under the policy terms duly approved by the Authority.

5.4.4. In the personal hearing, the insurer was advised to submit the percentage of reasonable and customary deduction made to the total claim amount for the last five year ending with FY 2024-25.

5.4.5. Insurer submitted that in the 15 cases under consideration, no complaints have been filed by the customers before the Ombudsman or any redressal forum. This would imply that these customers were not aggrieved and were satisfied with the insurer's settlement.

5.4.6. The Panel, in the personal hearing, advised the insurer to submit the following details duly certified by CCO and CEO:

5.4.6.1. Data showing the total deductions made from the claim paid and the amount of deduction made on account of "Reasonable and Customary" charges for last five years ending with FY 2024-25;

5.4.6.2. Provide percentage of reasonable and customary deduction made to the total claim amount for last five years ending with FY 2024-25.

5.4.7. The data, as advised in the personal hearing, was submitted by the Insurer.

5.4.8. The Insurer, in its response, stated that in respect of payment of reimbursement claims, the communication to the claimant is automatically sent consisting of a Covering Letter, Discharge Voucher and the Bill Assessment Sheet showing the details of the settlement.

5.4.9. The insurer has accepted that during the stated period, due to technical error, the covering letter was not sent which contains the details of Grievance Redressal Mechanism and Details of the Ombudsman of the competent jurisdiction.

5.4.10. The insurer, in its reply to SCN dated 10 Jan 2022, accepted the observations made by the Authority regarding policy conditions not indicated in rejection letters and state to having taken the corrective action.

5.5. Concerns with respect to Charge 2, 4 and 5

5.5.1. The insurer, resorted to arbitrary deductions as seen in the cases sampled in the inspection report. The reasons for many of these deductions, as submitted by the Insurer, were mentioned as “Claims Processed as per GIC Rates”.

5.5.2. Using, GI Council rates to deny or reduce COVID claims without tagging the repudiation to applicable policy clauses is detrimental to the interests of the policyholders and therefore is a violation of IRDAI’s Covid Claim Circulars as well as regulation 27 (v) of the IRDAI (Health Insurance) Regulations 2016 which states that every Insurance Claim shall be disposed of in accordance with the Terms & Conditions of the policy contract and the extant Regulations governing the settlement of claims.

5.5.3. In addition, Authority issued a circular vide Reference No.: IRDAI / HLT / REG / CIR / 054 / 03 / 2020 dated 04th March, 2020 where it instructed the Insurers that “The costs of admissible medical expenses during the course of treatment including the treatment during quarantine period shall be settled in accordance with the

applicable terms and conditions of policy contract and the extant regulatory framework".

5.5.4. The Insurer, in its response, to the SCN vide email dated 10th January, 2025 submitted reasons for the deductions made in the cases sampled by the Inspection team. In many cases, the amount settled was reconsidered by the Insurer for the sample cases highlighted by the inspection team and an additional claim amount was paid. This shows that the deduction/denial in the first instance was not as per the terms and conditions of the policy contracts and the Insurer only reconsidered them when the cases were highlighted by the Authority, as an afterthought.

5.5.5. From the data submitted by the insurer post-personal hearing, it has been noted that both percentage of Reasonable and Customary Charges to total deduction and Percentage of Reasonable and Customary Charges to Total Allowances were highest in FY 2021-22. The increase in such deductions strongly indicate that the clause was being invoked not in isolated circumstances, but as a matter of practice to reduce payment of claim amount to the policyholders. The insurer has claimed that the hospitals resorted to excessive billing given the vulnerability induced by COVID 19 but failed to substantiate the same for the cases cited by tagging the deductions to respective clauses or item-wise overbilling.

5.5.6. The Insurer, in its response after the personal hearing, has furnished some sample cases where policyholders were provided detailed breakdown of claim amounts, along the specific terms and conditions under which repudiations or deductions were made. However, it is observed that the insurer has submitted sample cases which differ materially from the cases identified during the inspection. This discrepancy raises concerns regarding the accuracy, completeness and reliability of the information furnished by the insurer.

5.5.7. The insurer has indicated that they have improved their processes by including a formal covering letter in all their claims communication along with the Bill assessment sheet in order to provide more clarity and transparency to their customers. The response of the insurer is silent on informing the policyholder of the particular terms and conditions of the policy contract under which the deduction or repudiation of the claim has been done.

5.5.8. Regulation 33(d)(iv) of IRDAI (Health Insurance) Regulations, 2016 mandates that where a claim is denied or repudiated, the communication about the denial or the repudiation shall be made only by the Insurer, specifically stating the reasons for the denial or repudiation, while necessarily referring to the corresponding policy conditions. The insurer shall also furnish the grievance redressal procedures available with the Insurance Company and with the Insurance Ombudsman along with the detailed addresses of the respective offices. The practice of not communicating decisions regarding claim settlements along with detailed reasons corresponding to the policy terms deprives the claimants of making an informed decision to challenge the decision of the Insurer and significantly harms policyholders by creating confusion- and, increasing financial stress. Insurers are, at all-times, expected to be transparent in their communication and keep policyholders informed and engaged throughout the claims process.

5.5.9. By not communicating the decision to repudiate the claims to the policyholders and by not mentioning the specific terms and conditions under which repudiations were made, the Insurer has violated Regulation 33(d)(iv) and 33(d)(ii) of IRDAI (Health Insurance) Regulations, 2016 (where there is no TPA, Regulation 21(3) to be followed) Regulation 21(3) (c) (i) (c) of IRDAI (TPA – Health Services) Regulation, 2016.

5.6. Decision on Charge 2, 4 and 5 -

In view of the above, in exercise of the powers vested under Section 102 of the Insurance Act, 1938, the Authority hereby imposes a penalty of Rs. One Crore for the violation of Regulation 27(v) and 33(d)(ii) and (iv) of IRDA (Health Insurance) Regulations, 2016; Regulation 21(3)(c)(i)(c) of IRDAI (TPA – Health Services) Regulation, 2016.

6. Charge 6 (Observation No. - 21)

6.1. Violation of Regulation 20 (9) of IRDAI (TPA – Health Services) Regulation, 2016.

6.2. Inspection Observation

6.2.1. Upon examination of copies of bills, invoices, discharge summaries and documents titled "Bill Assessment Sheet – Hospital Payment", furnished by the Insurer and setting out the details of deductions made from the claims submitted, it was observed, in respect of sample cases examined, that the Insurer had made deductions towards discounts purportedly agreed to be offered by the Network Service Providers, without verifying whether such discounts had actually been granted by the respective Network Service Providers by way of upfront deductions in the bills raised by them on the claimants.

6.2.2. The insurer was informed that since the discount, although stated to be agreed between the insurer and the respective network service provider, is not reflecting in the bills itself, it implies that the benefit of discount did not pass to the respective policyholder under the policy.

6.3. Summary of Insurer's submissions

6.3.1. The Insurer submitted that the hospital submits the final bill, prior to the discharge of the patient, requesting for final authorization. If the

charges are found to be excessive, the Insurer's medical team negotiates with the hospital for reduction. Based on these negotiations, hospital submits the final bill wherein the negotiated reduction is shown as "Discounts". The final authorization given by the Insurer takes into account such reductions agreed by the hospital, a copy of which is communicated to the customer.

6.3.2. The full benefit of such reductions have been passed on the policyholders' since without the negotiated reductions, the insured would have suffered additional loss of sum insured and higher proportion of non-payables. In all cases, the insured had borne only the non-payables as per policy.

6.3.3. The Insurer in its response to the SCN vide email dated 10 January 2025 stated that

6.3.3.1. Tariff discounts are deducted while making payments to the Hospitals and the Sum Insured is protected.

6.3.3.2. In terms of Regulation 20 (9) of IRDAI (Third Party Administrators - Health Services) Regulations, 2016, the "benefit is passed on to the insured". It does not specifically state that methodology of passing the benefit and can be in cash as discount line item or reduction in the claim amount thereby protecting the sum insured of the customer in the policy.

6.4. Concerns on Charge 6

6.4.1. The Insurer needs to ensure that the discounts, if any stated to be agreed between the Network Service Providers and / or TPA and / or Insurers, are mentioned in the bills raised upon the policyholders upfront.

6.4.2. Where such discounts are not reflected in the bills raised by the hospitals but are instead adjusted by the insurer through deductions from the hospital bills, the insurer is required to have an effective

mechanism to ensure that such discounts are not subsequently recovered by the hospital from the policyholder(s) as under the pretext of "disallowed items". The matter assumes greater seriousness where the insurer has also failed to communicate to the policyholder the specific reasons for the deductions made while settling the claim, thereby compromising transparency and the policyholder's ability to understand and verify the deductions.

6.4.3. Regulation 20(9) requires insurers and TPAs to ensure that discounts agreed with hospitals are passed on to the policyholder or claimant. Sub-regulation (c) prescribes how this is to be done as under:

i. hospitals must be mandated to show the agreed discount in the final bill, so the claimant can see the actual bill raised;

ii. where the admissible claim exceeds the sum insured, the discount is applied to the gross bill before the claimant bears the excess;

iii. co-payment or deductible is applied only after netting off the discount.

6.4.4. Regulation 20(9) prescribes specific procedures, namely disclosure in the bill and netting for co-payment, deductible and excess. The Insurer has failed to demonstrate compliance with these procedures despite being advised to do so at the hearing.

6.5. Decision on Charge 6

6.5.1. In view of the above, the insurer is warned for not establishing effective procedures to ensure that hospital discounts are reflected on the invoice itself and the policyholder is made aware of the same.

6.5.2. The insurer is further directed to put in place the required systems to ensure the final settlement letter issued from the insurer to the policyholder narrates each allowed, disallowed, non-payable and discount items clearly. The final settlement

letter should also provide details of the Sum Insured reduced from the policy limit, following settlement of the claim

7. Charge 7 (Observation No. - 22)

7.1. Violation of Proviso 5(ii) of Annexure I read with Regulation 17(2) of IRDAI (Protection of Policyholders Interests) Regulations, 2017.

7.2. Inspection Observation

Upon a perusal of copy of communications sent by the insurer to the complainants offering resolution of grievances lodged by them; it was observed that the insurer is not mentioning the details of Insurance Ombudsmen, where the Policyholder can approach in case of their being not satisfied with the resolution offered.

7.3. Summary of Insurer's submission

7.3.1. The insurer submitted the sample letters issued to the policyholders with details of the Ombudsmen mentioned therein. The insurer submitted that there might have been errors earlier in some cases but now the system has been rectified.

7.3.2. The Insurer, has highlighted actions taken related to information on Grievance Redress procedure and Ombudsman available on its website, and communication sent to zonal officer regarding display of related information.

7.4. Concerns on Charge 7

The Insurer did not provide the complainant with the name and address of the Insurance Ombudsman having jurisdiction, thereby depriving the aggrieved Policyholder of his/her opportunity to approach the Insurance Ombudsman for redressal of the grievance. Accordingly, the Insurer has violated Proviso 5(ii) of Annexure I read with Regulation 17(2) of the IRDAI (Protection of Policyholders' Interests) Regulations, 2017. Post the

inspection, the insurer has taken corrective steps as mentioned in para 8.3.2 which is taken on record.

7.5. Decision on Charge 7

In view of the above, the insurer is cautioned for the lapse and warned to ensure that Grievance redressal mechanisms and name and address of the Insurance Ombudsman is sent to the policyholder in the communication as required under the regulations.

8. Charge 8 (Observation No. - 29)

8.1. Violation of Clause 6 of the Guidelines No. IRDA / F&A / GDL / CG / 100 / 05 / 2016 Dt.18th May, 2016.

8.2. Inspection Observation

While comparing the details of Schedule V i.e. Return on payment of commission, remuneration and reward to agents/intermediaries for the years 2020-21 and 2019-20 as per the IRDAI (Payment of Commission or Remuneration or Reward to Insurance Agents and Intermediaries) Regulations, 2016 with the details provided by insurer in inspection formats NL_INT-1, NL_INT-2 i.e. details containing agent wise/broker wise/corporate agent wise/etc., it was noticed that there were differences in the amounts reported in the returns.

FY 2020-21 (Rupees. in crore*)*

Details	**As per Return**	**As per Agent / CA / Broker wise breakup provided in INT1-INT2**	**Difference**
Commission and Remuneration	1153.54 (1044.19 + 79.73 + 29.82)	1120.28 (1056.44 + 31.27 + 32.57)	33.26
Rewards	156.99	154.65	2.34

FY 2019-20 (Rupees. In crore)

Details	As per Return	As per Agent / CA / Broker wise breakup provided in INT1-INT2	Difference
Commission and Remuneration	816.37 (744.27 + 54.36 + 17.74)	799.18 (755.90+ 24.07 + 19.21)	17.19
Rewards	100.88	100.75 (94.25+6.5)	0.13

8.2.1. Further the insurer reported rewards paid to Agents as Rs.146.63 crore in Schedule V return for FY 2020-21, however as per Trial Balance as on 31st March,2021 (refer Schedule 3) the Rewards to Agents were Rs.148.60 crore and there were expenses in the name of "agent club expenses" which were Rs.8.39 crore. If agent club expenses are added to the rewards, the total rewards come to Rs.156.99 crore. Thus in the Schedule V, rewards paid to agents were under reported by the insurer.

8.2.2. Similarly, the insurer reported rewards paid to Agents as Rs.90.99 crore in Schedule V return for FY 2019-20, however as per Trial Balance as on 31st March,2020(refer Schedule 3) the Rewards to Agents were Rs.91.74 crore and there were agent club expenses which were Rs.9.13 crore, if added to the rewards, the total rewards comes to Rs.100.88 crore. Thus in the Schedule V rewards paid to agents were under reported.

8.2.3. Insurer lacks proper internal controls with respect to the amounts reported in Return filed under Schedule V.

8.3. Summary of Insurer's submissions

8.3.1. The Insurer submitted that the differences were due to accounting adjustment entries and submitted reconciliation for the observed

differences. The insurer submitted that they had submitted the data as per the formats submitted by the inspection team which did not have the provision for other intermediaries such as IMFs and Web Aggregators. Once all are taken into account, there was no discrepancy between Schedule V and NLINT submitted by the insurer.

8.3.2. The Insurer, during the personal hearing, reaffirmed that they submitted data as per formats submitted by Inspection team which did not have provision for other Intermediaries such as IMFs and Web Aggregators. Once all are taken into account, there was no discrepancy between Schedule V and NLINT submitted by the Insurer.

8.4. Decision on Charge 8

The submissions of the insurer are taken on record and the charge is not pressed further.

9. Summary of Decisions:

Charge no.	Violation of Provisions	Decision
1	Regulation 13(iii) of IRDAI (Health Insurance) Regulations,2016	Caution and Advisory
3	Regulation 27(v) of the IRDAI (Health Insurance) Regulations, 2016	Penalty of Rs. One Crore and Advisory
2, 4 &5	i. Regulation 27(v) of the IRDAI (Health Insurance) Regulations, 2016; ii. Regulation 33 (d) (ii) and (iv) of IRDA (Health Insurance) Regulations, 2016;	Penalty of Rs. One Crore

Charge no.	Violation of Provisions	Decision
	iii. Regulation 21(3) (c) (i) (c) of IRDAI (Third Party Administrators - Health Services) Regulations, 2016.	
6	Violation of Regulation 20(9) of IRDAI (Third Party Administrators - Health Services) Regulations, 2016	Warning and Direction
7	Proviso 5(ii) of Annexure I read with Regulation 17(2) of IRDAI (Protection of Policyholders Interests) Regulations, 2017	Warning and Caution
8	Clause 6 of the Guidelines No. IRDA / F&A/GDL /CG /100 /05 / 2016 Dt.18th May, 2016	Charge Not pressed

10. The penalty amount of Rs. 2 Crore (Two Crore) shall be remitted by the Insurer by debiting from the Shareholders' Account within a period of forty-five days from the date of receipt of this order through NEFT / RTGS (details for which will be communicated separately). An intimation of remittance may be sent to Shri Sanjay Kumar Verma, General Manager (Enforcement & Compliance) at the Insurance Regulatory and Development Authority of India, Survey No. 115/1, Financial District, Nanakramguda, Hyderabad 500032, email id enforcement@irdai.gov.in with a copy to Accounts Department at accounts@irdai.gov.in.

11. Further,

a) The Order shall be placed before the Board of the Insurer in the upcoming Board Meeting and the Insurer shall provide a copy of the minutes of the deliberations.

b) The Insurer shall submit an Action Taken Report to the Authority on direction given within 90 days from the date of this Order.

12. If the Insurer feels aggrieved by this Order, an appeal may be preferred to the Securities Appellate Tribunal as per the provisions of Section-110 of the Insurance Act, 1938.

Sd/-	Sd/-
Deepak Sood	Rajay Kumar Sinha
Member (Non-Life)	Member (F&I)

Place: Hyderabad

Date: 20th November, 2026