Policy Wordings

Tata AIG Health Supercharge Policy Wordings

Tata AIG General Insurance Company Limited (**We**, **Our** or **Us**) will provide the insurance, described in this **Policy** and any endorsements thereto, for the **Policy Period**, as defined in the **Policy** to the **Insured Person**(s) named in the **Policy Schedule** based on the Disclosure to Information Norm, including in reliance upon the statements contained in the Proposal Form or any other mode of communication which shall be the basis of this **Policy** and are deemed to be incorporated herein in return for the receipt of the required premium in full and compliance with all the applicable terms, conditions and exclusions of this **Policy** and opted Plan. The insurance provided under this **Policy** is only in force for the **Insured Person** with respect to such and so many of the benefits as indicated by the **Sum Insured** set opposite such benefit in the **Policy Schedule**.

Section 1 – Definitions

The terms defined below and at other junctures in the **Policy** Wording have the meanings ascribed to them wherever they appear in this **Policy** and where appropriate, references to the singular include references to the plural; references to the male includes other genders and references to any statutory enactment includes subsequent changes to the same.

I. Standard Definitions

1. Accident

An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. 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.

3. AYUSH Day Care Centre

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

4. AYUSH Hospital

An AYUSH **Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH **Medical Practitioner**(s) comprising of any of the following:

a. Central or State Government AYUSH **Hospital** or
b. Teaching **Hospital** attached to AYUSH college recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy, or
c. AYUSH **Hospital**, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH **Medical Practitioner** and must comply with all the following criterion:
   i. Having atleast 5 in-patient beds;
   ii. Having qualified AYUSH **Medical Practitioner** in charge round the clock;
   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where **Surgical Procedure**s are to be carried out;
   iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

5. AYUSH Treatment

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

6. Break in policy

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

7. 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.

8. Condition Precedent

Condition Precedent means a **Policy** terms or condition upon which the **Insurer**'s liability under the **Policy** is conditional upon.

9. 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.

10. Co-Payment

Co-payment means a cost sharing requirement under a health insurance **Policy** that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the **Sum Insured**.

11. Day Care Centre

A day care centre means any institution established for **Day Care Treatment** of **Illness** and/or injuries or a medical setup 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 fully equipped operation theatre of its own where **Surgical Procedure**s are carried out;
iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

12. 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.

13. Dental Treatment

Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and **Surgery**.

14. Domiciliary hospitalization

Domiciliary hospitalization means medical treatment for an **Illness**/disease/**Injury** which in the normal course would require care and treatment at a ***Hospital*** but is actually taken while confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a **Hospital**, or
ii. the patient takes treatment at home on account of non-availability of room in a **Hospital**.

15. Grace Period

"Grace period" means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. For single premium payment policies, coverage is not available during the period for which no premium is received. However, If the premium is paid in instalments during the policy period, coverage will be available during the grace period , within the policy period. The grace period for payment of the

premium shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

16. Hospital

A **Hospital** means any institution established for **Inpatient Care** and **Day Care Treatment** of **Illness** and/or injuries and which has been registered as a **Hospital** with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under 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 Procedure**s are carried out;
v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

17. Hospitalization

Hospitalization means admission in a **Hospital** for a minimum period of 24 consecutive '**Inpatient Care**' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

18. 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:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

19. 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**.

20. Inpatient Care

Inpatient care means treatment for which the **Insured Person** has to stay in a **Hospital** for more than 24 hours for a covered event.

21. 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.

22. 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.

23. Medical Advice

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

24. 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 **Hospital**s or doctors in the same locality would have charged for the same medical treatment.

25. 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 thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

26. 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.

27. Migration

"Migration" means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

28. Network Provider

Network Provider means **Hospital**s 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**.

The updated list of Network Provider is available on **Our** website (www.tataaig.com).

29. Non-Network Provider

Non-Network means any **Hospital**, **Day Care Centre** or other provider that is not part of the network.

30. 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.

31. OPD treatment

OPD treatment means the one in which the Insured visits a clinic / **Hospital** or associated facility like a consultation room for diagnosis and treatment based on the advice of a **Medical Practitioner**. The Insured is not admitted as a day care or in-patient.

32. Pre-Existing Disease

"Pre-existing disease (PED)" means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

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

33. Pre-hospitalization Medical Expenses

Pre-hospitalization **Medical Expenses** means **Medical Expenses** incurred during predefined number of days preceding the **Hospitalization** of the **Insured Person**, provided that:

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

34. Portability

"Portability" means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

35. Post-hospitalization Medical Expenses

Post-hospitalization Medical Expenses means **Medical Expenses** incurred during predefined number of days immediately after the **Insured Person** is discharged from the **Hospital** provided that:

i. Such **Medical Expenses** are for the same condition for which the **Insured Person**'s **Hospitalization** was required, and
ii. The inpatient **Hospitalization** claim for such **Hospitalization** is admissible by the insurance company.

36. 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.

37. 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.

38. 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.

39. Room Rent

Room Rent means the amount charged by a **Hospital** towards Room and Boarding expenses and shall include the associated **Medical Expenses**.

40. 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**.

41. 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.

II. Specific Definitions (Definitions other than as mentioned under Section 1 (i) above)

1. Age

Means the completed Age of the **Insured Person** on his / her last birthday as on date of commencement of the **Policy** and as per the English calendar.

2. Aggregate Deductible

Aggregate Deductible is an irrevocable cost sharing requirement under this **Policy** which provides that **We** will not be liable for a specified amount in aggregate for all claims during the **Policy Year**.

3. Bonus

Bonus means an increase or addition in the **Sum Insured** granted by the **Insurer** up to the specified percentage of **Sum Insured**, without an associated increase in premium.

4. Policy

Policy means the contract of insurance including but not limited to **Policy Schedule**, Endorsements, Policy Wordings (inbuilt covers & optional covers, if opted), Riders, etc., as applicable.

5. Policy Period

Policy Period means the time during which this Policy is in effect. Such period commences from Commencement Date and ends on the Expiry Date and specifically appears in the **Policy Schedule**.

6. Policy Schedule

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

7. Policy Year

Policy Year means a period of twelve consecutive months beginning from the date of commencement of the **Policy Period** and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, or the **Policy** Expiry date whichever is earlier.

8. Shared Accommodation

Shared Accommodation means a **Hospital** room with two or more in-patient beds. This definition does not apply to ICU or ICCU.

9. Single Private Room

Single Private Room means an air-conditioned room in a **Hospital** where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a single occupancy room in that **Hospital**. This does not include a deluxe room or a suite or a VIP room.

10. Sub-Limit

Sub-limit means a cost sharing requirement under a health insurance **Policy** in which **We** would not be liable to pay any amount in excess of the pre-defined limit. The Sublimit as applicable under the **Policy** is specified in the **Policy Schedule** / **Policy** wordings, against the relevant Cover in force under the **Policy**.

11. Sum Insured

"Sum Insured" refers to the amount specified in the **Policy Schedule** at the inception of a **Policy Year**, excluding any **Bonus**. Sum Insured represents **Our** maximum, total and cumulative liability under the **Policy**, for all the **Insured Person**(s) covered in aggregate, for the respective **Policy Year**.

- Upon the successful admission of a claim, the Sum Insured for the remaining **Policy Year** shall be accordingly reduced by the amount of the claim settled (inclusive of 'taxes') or admitted.
- In cases where the **Policy Period** is 2/3 years, the specified Sum Insured in the **Policy Schedule** signifies the limit for the initial **Policy Year**. This limit shall expire at the conclusion of the first year, and fresh limit up to the opted Sum Insured will become available for the subsequent second/third year.

12. We, Us, Our, Insurer

means The TATA AIG General Insurance Company Limited that has provided Insurance Cover under this **Policy**.

13. You, Your, Insured Person

means the person whose name specifically appears in the **Policy Schedule** as an Insured Person/ Policyholder.

14. Valued Provider – Pan India

'Valued Provider - Pan India' is a specific network of **Hospitals**, designated as such and mentioned in the **Policy Schedule**. It consists of a defined list of **Hospitals** or health care providers enlisted by **Us**, and/or TPA to provide medical services to an **Insured Person** by a **Cashless Facility**. Where the Policyholder has selected Value Plan, You shall be eligible only for 'Valued Provider -Pan India' and reference made to '**Network Provider**' in the **Policy** wordings shall be substituted with 'Valued Provider - Pan India', except for Section 4 Sub-section (ii)21 **Zone** & Applicability of Plan under 'Value Plan'. The updated list of Valued Provider – Pan India is available on **Our** website (www.tataaig.com).

15. Zone(s)

For the purposes of application of **Higher Zone Co-Payment** and Premium calculation and payment, India has been categorized in 3 different zones:

- Zone A: Mumbai (including Mumbai Metropolitan Region), Delhi (including National Capital Region, Faridabad, Ghaziabad), Ahmedabad, Surat & Baroda
- Zone B: Hyderabad (including Secunderabad), Bengaluru, Kolkata, Indore, Chennai, Chandigarh (including, Mohali, Punchkula, Zirakpur), Pune (including Pimpri Chinchwad) and Rajkot
- Zone C: Rest of India

It is hereby clarified that wherever the term 'Pan India' is mentioned, it includes all the three zones i.e. Zone A, Zone B & Zone C.

Please note that the above-mentioned categorization of zones is subject to change at **Our** sole discretion. Any such change made which shall impact an existing policyholder, shall be intimated under 3 months' notice and shall be applicable from the immediate next **Renewal**.

Section 2 – Benefits

If during the **Policy Period** one or more **Insured Person**(s) is required to be hospitalized for treatment of an **Illness** or **Injury** at a **Hospital** / **Day Care Centre**, following **Medical Advice** of a duly qualified **Medical Practitioner**, the Company shall indemnify Medically Necessary expenses towards the Coverage mentioned in the **Policy Schedule** for the amount of such **Reasonable and Customary Charges** or compensate to the extent agreed, upto the limits mentioned, subject to terms and conditions of the **Policy** . Provided further that, any amount payable under the **Policy** shall be subject to the terms of coverage (including any **Co-Payment**, sub limits, **Aggregate Deductible**), exclusions, conditions and definition contained herein. Maximum liability of the Company under all such Claims during each **Policy Year** shall be the Floater **Sum Insured** opted and 5X Supercharge **Bonus** (if accrued) specified in the **Policy Schedule**. The coverages available to a specific **Insured Person**/ **Policy** shall be as per the Plan mentioned in the **Policy Schedule**.

In case of family floater **Policy**, the **Sum Insured** & **Aggregate Deductible**, if applicable, shall be for all **Insured Persons** on an aggregate basis, on a per **Policy Year** basis.

Our maximum liability under the **Policy** for payment of all claims arising out of **Any One Illness** in aggregate under B1, B2, B3, B4, B5, B6, B7, B8, B9, C1 (if opted) and C3 (if opted) shall not exceed the opted **Sum Insured** and accrued **Bonus** under 5X Supercharge Bonus, subject to the balance **Sum Insured**/ sub limits (as applicable).

B1. In-Patient Treatment

We will cover **Medical Expenses** for **Medically Necessary Treatment** in a **Hospital**, due to disease/**Illness**/**Injury**, that requires an **Insured Person**'s admission in a **Hospital** for an **Inpatient Care**, during the **Policy Period**.

The Company shall indemnify **Medical Expenses** as listed below:

i. **Room Rent**, Boarding, Nursing Expenses as provided by the **Hospital** / Nursing Home upto the limit per day/room category as specified in the **Policy Schedule**
ii. **Intensive Care Unit** (ICU) / Intensive Cardiac Care Unit (ICCU) expenses
iii. Surgeon, Anesthetist, **Medical Practitioner**, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the **Hospital**
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

If the **Insured Person** is admitted in a room whose category/**Room Rent** is higher than the one that is specified in the **Policy Schedule**, then the **Insured Person** shall bear a rate able proportion of the **Room Rent** and the total **Associated Medical Expenses**, including surcharge or taxes thereon in the proportion of the 'difference between the **Room Rent** actually incurred & the **Room Rent** of the entitled room category/**Room Rent** limit' to 'the **Room Rent** actually incurred'.

- For the purpose of this Benefit "**Associated Medical Expenses**" shall include the applicable nursing charges, operation theatre charges, fees of **Medical Practitioner** including surgeon/ anesthetist/ specialist within the same **Hospital** where the **Insured Person** has been admitted. "**Associated Medical Expenses**" does not include cost of pharmacy & consumables, cost of implants & medical devices and cost of diagnostics.
- Proportionate deductions are not applicable for **ICU Charges**.
- Such proportionate deductions, if any, will not be applied in respect of the **Hospitals** which do not follow differential billing or for those **Associated Medical Expenses** in respect of which differential billing is not adopted based on the room category

B2. Pre-Hospitalization expenses

We will cover for expenses for Pre-Hospitalization consultations, investigations and medicines incurred upto 90 days prior to the date of admission to the **Hospital**. Any pre-hospitalization expenses incurred prior to **Policy Period** shall not be covered.

The benefit is payable if **We** have admitted a claim under B1, B4 or B5.

B3. Post-Hospitalization expenses

We will cover for expenses for Post-Hospitalization consultations, investigations and medicines incurred upto 90 days after discharge from the **Hospital**.

The benefit is payable if **We** have admitted a claim under B1, B4 or B5.

B4. Day Care Treatment

We will cover expenses for **Day Care Treatment**, due to disease/**Illness**/**Injury**, taken in a **Hospital** or a **Day Care Centre**, during the **Policy Period**.

B5. Domiciliary Treatment

We will cover for expenses related to **Domiciliary Hospitalization** of the **Insured Person** if the treatment exceeds beyond three consecutive days and is availed during the **Policy Period**. The treatment must be for management of an **Illness** and not for enteral feedings or end of life care.

At the time of claiming under this benefit, **We** shall require certification from the treating doctor fulfilling the conditions as mentioned under the general definitions (Section 1) of this **Policy**.

B6. Organ Donor

We shall cover the Medical Expenses, up to the limits as specified in the **Policy Schedule**, incurred by or in respect of the organ donor, for an organ transplant **Surgery**, solely towards the harvesting of the organ donated subject to the following conditions:

Conditions

i. The organ donation conforms to the Transplantation of Human Organs (Amendment) Bill, 2011 and the organ is for the use of the **Insured Person**;
ii. The **Insured Person** is the recipient of the organ so donated by the organ donor and the claim of such **Surgery** is accepted by **Us** under B1 of this **Policy**;
iii. The organ transplant is medically necessary for the **Insured Person** as certified by a **Medical Practitioner**
iv. Claim under this section shall be assessed as per the claim of the recipient **Insured Person**

What is not covered

i. **Pre-Hospitalization Medical Expenses** or **Post Hospitalization Medical Expenses** of the organ donor
ii. Screening Expenses of the organ donor
iii. Any other medical expense as a result of harvesting from the organ donor
iv. Costs directly or indirectly associated with the acquisition of the donor's organ
v. Transplant of any organ/tissue where the transplant is experimental or investigational
vi. Expenses related to organ transportation or preservation
vii. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

B7. AYUSH Benefit

We will cover for **Medical Expenses** incurred for treatment as in-patient or Day Care Treatment in an **AYUSH Hospital/ AYUSH day care centre**, for a room category/ **Room Rent** limit, as specified in the **Policy Schedule** and applicability of **Associated Medical Expenses**.

This benefit shall also cover Pre-Hospitalization medical expenses for a period of upto 90 days before the date of admission to the AYUSH hospital/ AYUSH day care centre and Post-Hospitalization Medical Expenses for a period upto 90 days, subject to AYUSH In-Patient hospitalization or AYUSH day care treatment claim being admissible under this benefit.

Claims under this section shall be assessed as per the applicable insurance guidelines related to AYUSH and benchmark rates as available on Ministry of AYUSH website (https://ayushnext.ayush.gov.in/site/insurance-guidelines-related-to-ayush). For your reference, the document has been uploaded on Our website under "Annexure B for AYUSH Benefit" (www.tataaig.com).

B8. Road Ambulance Cover

We will cover for expenses incurred on transportation of **Insured Person** in a registered ambulance to a **Hospital** for admission in case of an Emergency or from one **Hospital** to another **Hospital** for better medical facilities and treatment, subject to a maximum limit as specified in the **Policy Schedule** per **Hospitalization**.

For this claim to be paid, the claim must be admissible under B1 or B4 of this **Policy**.

B9. Restore benefit

We will automatically reinstate 100% of the **Sum Insured**, if the balance **Sum Insured** and accrued 5X Supercharge Bonus is insufficient to pay an admissible claim under B1 to B6. The restore benefit will be available once during the **Policy Year** but shall not be available for the first admissible **Hospitalization**/ **Domiciliary Hospitalization** claim in each **Policy Year**.
Notwithstanding the above, **Our** maximum liability in aggregate for all claims during a **Policy Year** under B9 'Restore benefit' shall not exceed the **Sum Insured**

Restore benefit will be available once during the **Policy Year** subject to the following conditions:

a. The reinstated **Sum Insured** can be used by the **Insured Person**(s) for any claim (related or unrelated **Illness**/ **Injury**) under B1 to B6 of the **Policy**.
b. However, in case of **Any One Illness**, this benefit for related **Illness**/ **Injury** would be available to the **Insured Person**(s), who have claimed earlier, only for **Hospitalization**/

Domiciliary Hospitalization where date of admission is beyond 45 days from the date of discharge of the immediately preceding **Hospitalization**/ date of end of **Domiciliary Hospitalization**, for which claim has been paid.

c. In this **Policy**, the reinstated **Sum Insured** will be available for all **Insured Persons** on floater basis.
d. The unutilized restored **Sum Insured** cannot be carried forward to the next **Policy Year**.
e. This benefit shall also be applicable annually for policies with tenure of more than 1 year
f. Restore will not trigger or be available for utilization for the first claim under each **Policy Year**.
g. Accrued 5X Supercharge Bonus, if any, will not be reinstated.

B10. Compassionate Travel

In the event the **Insured Person** is Hospitalized in India for more than Five consecutive days in a place where no adult member of his immediate family is present, **We** will cover expenses related to a round trip economy class domestic air ticket, or first class railway ticket, to allow the Immediate Family Member be at his bedside for the duration of his stay in the **Hospital**, subject to a maximum limit as specified in the **Policy Schedule** during a **Policy Year**.

This benefit shall be payable if **We** have accepted an inpatient **Hospitalization** claim for the **Insured Person**(s) under In Patient Treatment (B1).

This benefit has a separate limit (over and above base **Sum Insured**).

We shall require additional documents as proof of travel for supporting the claim under this benefit.

B11. Prolonged Hospitalization Benefit

We will pay a fixed amount as specified in the **Policy Schedule** per **Policy Year** in the event of **Hospitalization** of the **Insured Person** for an **Illness**/disease/**Injury** for a continuous period exceeding 10 days, subject to **Hospitalization** at **Our Network Provider**.

This benefit is over and above of the base **Sum Insured** and can be availed only once per **Policy Year** at **Policy** level, provided that the In-patient Treatment claim is admissible under B1 of this **Policy**.

B12. Medical Devices Cover

We will cover expenses incurred by the **Insured Person** towards renting or purchase of below mentioned medical devices during the **Policy Year** only if the same is prescribed by the treating **Medical Practitioner** post **Hospitalization** for the same condition for which the **Hospitalization**

claim was admissible. This benefit will be triggered only if the In-patient Treatment claim is admissible under B1 of this **Policy**.

List of medical devices:

i. Crutches
ii. Wheel chair
iii. Walker
iv. Walking stick
v. Lumbo-sacral belt

The benefit is payable subject to a maximum limit as specified in the **Policy Schedule** per **Policy Year** and this benefit has a separate limit (over and above base **Sum Insured**), notwithstanding the exclusion mentioned under Section 3(ii) sub-section 2(xii).

B13. Vaccination cover

We will cover the cost of the following vaccines if the **Insured Person**(s)is vaccinated during the **Policy Year**:

- Anti-rabies vaccine following an animal bite

- Typhoid vaccine

The benefit is payable (notwithstanding the exclusion mentioned under Section 3.ii.sub-section 1.viii), subject to a maximum limit as specified in the **Policy Schedule** per **Policy Year** and this benefit has a separate limit (over and above the base **Sum Insured**). Expenses related to the doctor, nurse or any incidental expenses are not payable.

B14. Second Opinion

At **Your** request, **We** will provide the **Insured Person** second medical opinion from **Our** empanelled service provider in India, if an **Insured Person** is diagnosed with the below mentioned **Illness**es during the **Policy Period**. The expert opinion would be directly sent to the **Insured Person**.

i. Cancer

ii. Kidney Failure

iii. Myocardial Infarction

iv. Angina

v. Coronary bypass **Surgery**

vi. Stroke/Cerebral hemorrhage

vii. Organ failure requiring transplant

viii. Heart Valve replacement

ix. Brain tumors

Second Opinion will be based only on the information and documentation provided to **Us** which will be shared with **Our** empanelled service provider. Conditions as mentioned under 'Disclaimer Clause (applicable to B14, B15 & B16)' in the **Policy** shall apply.

B15. Wellness Services

We / **Our** Empanelled Service Provider will provide below mentioned wellness services designed to assist **Insured Persons** in maintaining and improving good health and fitness. These Wellness Services will be available for the **Insured Person** during the **Policy Period** and as specified in the **Policy Schedule**.

i. Teleconsultation - General

We /**Our** empanelled Service Provider will arrange for teleconsultations upon **Insured Person**'s request through telecommunications and digital communication technologies for **Insured Person**'s health related complaints or preventive health care by a qualified **Medical Practitioner/ Health Care Professional**, as per the limit specified in **Your Policy Schedule**.

This service can only be availed subject to condition below:

- Consultation will be provided through various specified modes of communication like audio, video, online portal, chat, digital customer application or any other digital mode.

ii. Teleconsultation - Speciality

We /**Our** empanelled Service Provider will arrange for teleconsultations upon **Insured Person**'s request through telecommunications and digital communication technologies for **Insured Person**'s health related complaints or preventive health care by a qualified & specialist **Medical Practitioner/ Health Care Professional**, as per the limit/speciality specified in **Your Policy Schedule**.

This service can only be availed subject to conditions below:

- Consultation will be provided through various specified modes of communication like audio, video, online portal, chat, digital customer application or any other digital mode.

iii. Ambulance Booking facility

We / **Our** empanelled Service Provider will provide a facility to book a road ambulance in India, for transportation of an **Insured Person** to a **Hospital** for admission or from one **Hospital** to another **Hospital** for better medical facilities and treatment.

This booking service can be availed at **Our** Network subject to the transportation of the **Insured Person** will be offered to the nearest **Hospital**.

Important: This service shall be subject to availability of a competent service provider in **Your** area.

iv. Emergency - Help me feature

In case of an emergency, **Insured Person** will have an option to share his/her location with the '**designated caregiver**' through **Our** customer application provided the **Insured Person** has registered on **Our** App.
The app will trigger a message and/ or call to the designated caregiver informing about the emergency and sharing the location of the **Insured Person**.

For the purpose of this benefit, 'designated caregiver' shall mean that individual who has been specified as a caregiver at the time of registration in the customer App.

Please note

- This service will be available subject to suitable infrastructure, connectivity, device restrictions and device functionality.

v. Redeemable voucher/Discount on services

We / **Our** empanelled service provider will provide redeemable vouchers/ discount (as approved by the regulator from time to time) on certain specified products/ services to promote wellness and fitness of the **Insured Person**.

vi. Health Condition Management

We / **Our** empanelled service provider will provide consultative services related to health conditions/ **Illness**es with the objective of maintaining good health and improving it through various health condition management programmes including but not limited to nutrition management, weight management, chronic condition management, stress management, health coach (as approved by the regulator from time to time) and offered by **Us**.
Consultative services will be provided through various specified modes of communication like audio, video, online portal, chat, digital customer application or any other digital mode.

Definition:
For the purpose of B15 of this **Policy**, a Health Care Professional is a person who holds a valid qualification from regulatory body as set up by the Government of India or a State Government or any other relevant authority and is engaged in actions with an objective of maintaining and improving individual's good health.

B16. Wellness Program

We / **Our** empanelled service provider will provide a wellness program designed to promote wellness and fitness amongst the **Insured Persons**. This wellness program is structured to reward the **Insured Person** in the form of measurable wellness score for the prescribed physical efforts/fitness activity undertaken by such **Insured Person** during the **Policy Period**. This is a voluntary program available for **Insured Person** with **Age** above 18 years, at the start of the **Policy Year**. It is advisable to the **Insured Person** to consult his/her physician before starting any physical exercise/ activity.

It is a pre-condition for enrolment under this wellness programme, that the **Insured Person** should have undergone the health risk assessment as specified below and depending on the outcome from health risk assessment, the wellness reward and its scoring should be administered. The earnings under the wellness program is linked to **Your** wellness category and shall be valid for one year from the date of credit of daily score in **Insured Person**'s wellness account, provided the **Policy** is renewed within the **Grace Period**. Daily score will be credited after the completion of a healthy day.

For the purpose of understanding if the daily score is credited on 1st Jan 2023 it will be valid up to 31st Dec 2023.

i) Health risk assessment

We / **Our** empanelled service provider will provide a health risk assessment (HRA) questionnaire, which is an online tool for evaluation of status of health and quality of the **Insured Person**'s life. This tool helps **Insured Person**s to review their lifestyle practises which may impact their health status.

To undertake the health risk assessment, **You** can log into **Your** account on **Our** customer application. This can be undertaken once a **Policy Year**.

On completion of the health risk assessment and based on the **Insured Person**'s assessment results, **We** / **Our** empanelled service provider will identify the wellness category in which the **Insured Person** falls in.

Wellness categories for this purpose are defined as below:

- Green – low risk for developing lifestyle disease as compared to peers in the same **Age** and gender group.
- Yellow – moderate risk for developing lifestyle disease as compared to peers in the same **Age** and gender group.
- Red – higher risk for developing lifestyle disease as compared to peers in the same **Age** and gender group.

The overall wellness category is valid till the expiry of the **Policy Year** in which the **Insured Person** undergoes the assessment and will be updated based on HRA results of subsequent assessment undergone by the **Insured Person** in each consecutive **Policy Year**, subject to **Renewal** of the **Policy** within the **Grace Period**. In the event of a long-term **Policy** (greater than 1 year) the **Insured Person** has to undergo HRA in each **Policy Year** to be eligible for wellness rewards. If the **Insured Person** does not undergo assessment in the consecutive **Policy Year**, henceforth no rewards will be earned for any physical activity undertaken. However, earned rewards will be carried forward till its validity and will be available for utilization.

ii) Wellness Rewards

Mechanism to earn Wellness Reward:

We will encourage physical exercise and fitness and recognise the effort by rewarding the **Insured Person** on daily basis for each healthy day.

A healthy day can be earned by undertaking below activity on a calendar day:

1. Recording 10, 000 steps / day# in the activity tracking apps or fitness tracker devices as prescribed by the company or **Our** empanelled service provider: or
2. Burning 500 calories or more in a day through activity as measured by fitness tracker devices.

The company may at its discretion change the above criteria and the same would be mentioned in the **Policy Schedule**/ customer application.

Wellness reward will be earned depending on the wellness category of the **Insured Person** and as per the grid below:

	Wellness category		
	Green	**Yellow**	**Red**
Rewards per Healthy Day	10	7	5

Note:

- HRA registration will be allowed anytime during the **Policy Year** and healthy activities will be tracked throughout the **Policy Year**, however, for each **Policy Year** , activities completed in first 300 days of the **Policy Year** will be considered for reward in the same year, activities completed on or after 301st day of the **Policy Year** will be carried forward to the next **Policy Year** and will be available for utilization in the next year provided the **Policy** has been inforce or renewed with **Us** without any break within the **Grace Period**.
- In case of individual **Policy**, each **Insured Person** would be tracked separately and shall earn wellness reward based on one's own individual performance/physical activity as per the grid above
- In case of family floater **Policy**, each **Insured Person**, with **Age** above 18 years, at the start of the **Policy Year**, would be tracked separately and shall earn wellness reward based on one's own individual performance/physical activity as per the grid above. In order to compute the wellness reward for such policies, average of individual performance rewards would be considered for computation of wellness reward.
- # The company may also use alternative measurement criteria in lieu of steps and calories burnt and the same shall be mentioned on the **Policy Schedule**
- Data entered manually in the fitness tracking apps or devices will not be considered for tracking healthy day
- Calories burnt during basic metabolism shall not be considered for tracking healthy day (here basic metabolism refers to activities done while at rest to maintain vital functions such as breathing and keeping warm etc.)

Mechanism to Utilise Wellness Reward:

Wellness Reward accumulated through fitness activities can be converted into monetary value as per method defined below and can be utilized towards the payment of services/items under below categories, available through **Our** Network/ empanelled service provider:

- **OPD consultation/ treatment**
- Pharmaceuticals
- Health-check-ups/ diagnostics
- Health Supplements
- Coverage of cost of treatment of any admissible claim in respect of non-payable items that are specified under the terms and conditions of the base **Policy**
- Or any other items as prescribed by the company or **Our** empanelled service provider as approved by the Regulator as a redeemable item from time to time.

Note:

- Wellness Reward can be converted into a monetary value after every Healthy Day, during the Cover Period
- Monetary value of the Wellness score earned is equivalent to the:
  Wellness score earned X (Per year **Policy** Premium without Taxes/ 10,000).
  - In case of **Policy** with tenure more than one year, 'per year **Policy** Premium without Taxes' = (Total **Policy** premium without tax, for the tenure/ **Policy** tenure).
  - In case of family floater **Policy**, reward will be calculated on average premium per person which is equivalent to the Total **Policy** premium without tax/ number of **Insured Person**(s) covered in the **Policy** on floater basis

Illustration

Zone	Zone C
Plan Name	Geo Plan
Age of the Insured Person 1 (Years)	39
Age of the Insured Person 2 (Years)	36
Age of the Insured Person 3 (Years)	7
Sum Insured opted under the Policy (Rs.)	5 Lacs
Plan Type	Family Floater
Policy Tenure (years)	1
Total number of Insured Persons covered under the Policy	3
Net Premium paid (without Tax) - For all insured persons	12182

Wellness Category (post Health Risk Assessment) for adult Insured 1	Green
Wellness Category (post Health Risk Assessment) for adult Insured 2	Green

For adult Insured 1

Healthy Day	Wellness Reward earned (per day by Insured 1)	Wellness Reward converted to Monetary Value (per day)	Wellness Reward credited after Healthy Day	Wellness Reward valid up to 365 days (provided the **Policy** is active and **Insured Person** is covered)
1 to 300 day	10	4.06	Date of credit of Wellness score	365 days from the Date of credit of Wellness score
301 day onwards	10	4.06	Date of **Policy** Anniversary - in case of Multi year **Policy** Date of **Renewal** - in case of 1 yr **Policy**	365 days from: - Date of **Policy** Anniversary - in case of Multi year **Policy** - Date of **Renewal** - in case of 1 yr **Policy**, as applicable
Maximum Total in a **Policy Year**		1482.14		

For adult Insured 2

Healthy Day	Wellness Reward earned (per day by Insured 1)	Wellness Reward converted to Monetary Value (per day)	Wellness Reward credited after Healthy Day	Wellness Reward valid up to 365 days (provided the **Policy** is active and **Insured Person** is covered)

1 to 300 day	10	4.06	Date of credit of Wellness score	365 days from the Date of credit of Wellness score
301 day onwards	10	4.06	Date of **Policy** Anniversary - in case of Multi year **Policy** Date of **Renewal** - in case of 1 yr **Policy**	365 days from: - Date of **Policy** Anniversary - in case of Multi year **Policy** - Date of **Renewal** - in case of 1 yr **Policy**, as applicable
Maximum Total in a **Policy Year**		1482.14		

Steps to register for Wellness Program and earn & spend Wellness Rewards

Step 1. Register yourself on customer application

- The **Insured Person** will download Tata AIG customer application on **Your** device and complete registration process by providing **Policy** and **Insured Person**'s details.

Step 2. Complete health risk assessment

- Submit response to the online health questionnaire on **Your** device.
- On completion of the health risk assessment, a Wellness category will be assigned to the **Insured Person** for the **Policy Year** and will be updated based on the latest health risk assessment in next **Policy Year**.

Step 3. Comply with mechanism to earn Wellness Rewards

- **We** will track the physical exercise and fitness activities completed by the **Insured Person**, through the customer app.
- Activities completed on a calendar day will be considered as a Healthy Day and reward will be credited to **Insured Person**'s wellness account.

Step 4. Convert Healthy Day into monetary value and spend

- **Insured Person** will have an option to convert the accumulated rewards into the monetary value and spend it on items/ services offered under the **Policy**
- The unutilized rewards will be carried forward to next **Policy Year** till this **Policy** is renewed with **Us** within **Grace Period** and is inforce subject to validity period of the reward point)

Disclaimer Clause (applicable to B14, B15 & B16)

1. Availing the services under this benefit is purely upon the **Insured Person**'s sole discretion and risk.
2. For services that are provided through empanelled service providers, **We** are acting as a facilitator; hence would not be liable for any incremental costs or the services. Any additional services availed, or expenses incurred on such services or benefits which are other than

those covered under this **Policy** and explicitly excluded by this **Policy**, shall not be covered under this **Policy** and all expenses incurred shall be borne by the **Insured Person**.

3. **We** shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which **Insured Person** claims to have suffered, sustained or incurred, by way of and / or on account of the benefit. **We** shall not be liable for any deficiency or discrepancy in the services provided by empanelled service provider under this **Policy**.
4. **Insured Person** may consult any medical professional at any empanelled service provider at its sole discretion. The cost of service arising out of **Insured Person** choice of medical professional at any empanelled service provider shall be completely borne by the **Insured Person** unless covered otherwise. However, the services under this **Policy** should not be construed to constitute **Medical Advice** and/or substitute the **Insured Person**'s visit/ consultation to an independent **Medical Practitioner**/healthcare professional.
5. The **Medical Practitioner** may suggest/recommend/prescribe over the counter medications based on the information provided, if required on a case-to-case basis. Provided that any recommendation under this **Policy** shall not be valid for any medico legal purposes.
6. The **Insured Person** is free to choose whether or not to act on the recommendation after seeking consultation.
7. Any advice, recommendations or suggestions made by any medical professional shall be solely based on the information and documentation provided by the **Insured Person** to such medical professional. **We** shall not be liable towards any loss or damage (immediate or consequential) arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the medical professional from whom **We** have availed services or taken benefit or for any consequence of any act or omission in reliance thereon.
8. **We** at **Our** discretion may provide discounts on any of the above services which may vary from time to time subject to IRDAI regulations
9. Any discount offered under redeemable voucher/discount on services by **Our** empanelled service providers are subject to modification or withdrawal. **We** do not assume any liability towards the quantum of discount, quality of product/services and timeline within which the product/service is rendered.
10. For Ambulance Booking facility–
    a. These services are provided through **Our** empanelled service provider in select cities. Please contact **Us** / refer to **Our** digital customer application for more details on this service.
    b. **We** do not assume any liability towards quality and turnaround times of service rendered, any loss or damage arising out of or in relation to these services rendered by the empanelled service provider.
    c. This facility may be availed through **Our** digital customer application or through calling **Our** call centre on the tollfree number specified in the **Policy Schedule**.
11. Above mentioned services are non-portable, annual contracts, independent of **Policy** contract and not lifelong renewable. The Services provided may be added / deleted / modified at **Our** discretion and the same shall be notified to the policyholders in advance prior to change effective date.
12. Provision of these services is subject to availability as per the duration specified by **Us**/the empanelled service provider. Details are available on **Our** website (www.tataaig.com)
13. Any service availed by the **Insured Person** under this Benefit will not impact **Bonus** if applicable.
14. **We** reserve the right to change any service provider during the currency of the **Policy** or at **Renewal**. The same shall be intimated to the **Insured Person** atleast 15 days prior to the effective date of change. During such change, all the credits earned by the **Insured Person** shall be transferred to the new service provider.
15. In case **We** or the assistance service provider fails to provide any of the services as mentioned in this **Policy** or is unable to implement, in whole or in part due to force majeure,

non-availability of services, change in law, rule or regulations which affects the services, or if any regulatory or governmental agency having jurisdiction over a party takes a position which affects the services , then the assistance services' suspended, curtailed or limited performance shall not constitute breach of contract and the company or the assistance service provider shall have no liability whatsoever including but not limited to any loss or damage resulting therefrom.

16. **We** shall not accept any liability towards quality of the services made available by service provider. The service provider is responsible for providing the availed services and **We** are not liable for any defects or deficiencies on the part of the service provider.

B17. 5X Supercharge Bonus

i. **We** will provide 5X Supercharge Bonus in the form of 50% of the base **Sum Insured** of the expiring **Policy**, on each **Renewal** of the **Policy**, irrespective of claims in preceding **Policy Year**s, provided that the **Policy** is renewed with **Us** without a break. The total accrued 5X Supercharge Bonus shall not exceed 500% of the base **Sum Insured** in any **Policy Year**.

ii. In policies with a tenure of more than one year, Bonus shall accrue post completion of each **Policy Year**.

iii. The 5X Supercharge Bonus so accrued will be available only in respect of those **Insured Person**(s) who were **Insured Person**(s) in the previous **Policy Year** and continue to be **Insured Person**(s) in the subsequent **Policy Year**.

iv. For the purpose of computation of 5X Supercharge Bonus, the percentage (%) of Bonus will be applied on the **Sum Insured** of the expiring **Policy** only. The Restore Benefit amount or the Restore Infinity amount (if opted) will not be taken into consideration for such computation.

v. Any accrued 5X Supercharge Bonus can only be utilized for an admissible claim under benefit B1 to B8 and Optional Cover C3 if opted.

vi. In case the **Sum Insured** under the **Policy** is reduced at the time of **Renewal** then the accrued 5X Supercharge Bonus under this benefit shall be reduced in proportion to the reduced **Sum Insured**.

vii. 5X Supercharge Bonus will lapse if the **Policy** is not renewed before **Policy** expiry (including the **Grace Period**).

Optional Covers

The Optional Cover(s) can only be opted along with the base covers under the **Policy** and cannot be opted in isolation or as a separate product. The Optional cover(s) are provided as per the table given below on payment of additional premium or discounts and subject to the terms and conditions and exclusions as stated in the **Policy** Terms and Conditions and Exclusions. These Optional Cover(s), if selected, should be opted for all Insured Persons to be covered under the **Policy** unless stated otherwise and shall be available only if the same are specifically mentioned in the **Policy Schedule.**

The insurance provided under these Optional cover(s) are only with respect to such and so many of the coverages as are indicated in the **Policy Schedule.**

The availability of optional cover(s) shall be as per the grid below and once opted they will have to be mandatorily covered at each **Renewal**.

S.No.	Benefits	Can be availed by the policyholder/Insured Person
C1	Restore Infinity	Only at Inception of first **Policy** /coverage
C2	Emergency Air Ambulance Cover	At Inception of first **Policy** /coverage OR **Renewal**
C3	Consumables benefit	Only at Inception of first **Policy** /coverage
C4	Preventive Annual Health Check-Up	Only at Inception of first **Policy** /coverage
C5	Advanced Cover	Only at Inception of first **Policy** /coverage
C6	Accidental Death Benefit	At Inception of first **Policy** /coverage OR **Renewal**

C1. Restore Infinity

We will provide reinstatement of **Sum Insured** unlimited number of times during a **Policy Year** post exhaustion of the Restore Benefit, as mentioned under B9 of this **Policy** to pay an admissible **Hospitalization** claim, subject to below conditions:

a. **Our** maximum liability in aggregate for all claims arising out of a single **Hospitalization** shall not exceed the **Sum Insured**.
b. Claims falling under B1 to B4 shall be only admissible under this optional cover.
c. All other provisions and conditions mentioned under B9 of this **Policy** shall be applicable.
d. This optional cover will not be available for claims arising out of any type of Cancer Treatment &/or Dialysis.

C2. Emergency Air Ambulance Cover

We will reimburse cost of air ambulance for transportation of the **Insured Person** in an airplane or helicopter subject to maximum of limit as specified in the **Policy Schedule** per **Policy Year** for **Emergency Care** of life-threatening health conditions which require immediate and rapid ambulance transportation to a **Hospital** for further medical management.

The medical evacuation should be prescribed by a **Medical Practitioner** and should be Medically Necessary.

This benefit shall only be payable if **We** have accepted an inpatient **Hospitalization** claim for the **Insured Person** under B1 of this **Policy** and the transportation is carried out within India.

This benefit has a separate limit (over and above base **Sum Insured**).

The **Sum Insured** as mentioned shall be on a floater basis for all **Insured Person**s on a per **Policy Year** basis.

For the purpose of this Optional Cover Emergency Care means management for an **Illness** or **Injury** which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a **Medical Practitioner** to prevent death or serious long term impairment of the **Insured Person**'s health.

C3. Consumables Benefit

Notwithstanding the exclusion mentioned under Section 3.ii (Specific Exclusions).1.(xi), if this specific optional cover has been opted, then **We** will pay for expenses incurred, for specified consumables, subject to balance **Sum Insured**, which are mentioned in Annexure I – List I of Optional Items (Consumables Benefit) available on **Our** website (www.tataaig.com) which are consumed during the period of **Hospitalization** directly related to the **Insured Person**'s medical or surgical treatment of **Illness**/disease/**Injury**.

However, any item which is i) neither a medical consumable; ii) nor medically necessary; iii) nor prescribed by the treating **Medical Practitioner** shall be excluded.

For this benefit to be payable, there must be an admissible claim under B1 or B4 of this **Policy**. The assessment of payout under this Optional Cover shall follow the assessment of claim done under B1 and B4 except for application of **Associated Medical Expenses**.

C4. Preventive Annual Health Check-Up

Notwithstanding the exclusion mentioned under Section 3.ii (Specific Exclusions).1.(viii), At the request of the **Insured Person**, **We**/ **Our** empanelled service provider will arrange for below listed medical tests every **Policy Year** provided the **Policy** is in force with **Us**. The health check-ups shall be arranged by **Us** only on cashless basis either at **Our** empanelled service providers or at **Insured Person**'s residence, as per availability.

Health Check Up will be available for all **Insured Person**s covered under the **Policy** irrespective of claim. Check-ups under this benefit can be availed once in a **Policy Year**.

List of tests:

a. Complete Blood Count with Erythrocyte Sedimentation Rate (CBC with ESR) test
b. Fasting Blood Sugar Test
c. Hemoglobin A1C Test (Hba1c)
d. Lipid Profile Test
e. Liver Function Test
f. Electrocardiogram (ECG) Test
g. Urine Routine Analysis

For the purpose of this benefit, Preventive Health Check-up means the above medical test(s) undertaken for general assessment of health status and does not include any diagnostic or investigative medical tests for evaluation of **Illness** or a disease.

C5. Advanced Cover

In lieu of the policyholder opting for this Advanced Cover and paying additional premium for the specific **Insured Person**(s), the word "36 months" should be read as "30 days" under Section3 (i) subsection 1(i) only for the following named **Pre-Existing Diseases**:

a) Diabetes Mellitus (Type 2),
b) Hypertension,
c) Hyperlipidemia &
d) Asthma

The above substitution shall only be applicable for such specified **Insured Person**(s) for whom 'Advanced Cover' has been opted and additional premium paid, which shall be specified in the **Policy Schedule**.
The above would be applicable if the above-named **Pre-Existing Diseases** have been declared by **You** for the specific **Insured Person** for whom this coverage has been opted and the same has been accepted by **Us** at the time of first coverage under this **Policy**.

The additional premium charged under this optional cover shall be a rate applied on the applicable base premium for that individual at the **Policy** inception or on the **Policy Renewal** date.

In case of **Portability**, the "30 days" as mentioned above should be read as "0 Days" and waiver of waiting period for the above named four **Illnesse**s shall be restricted to the lower of the expiring **Sum Insured** or opted **Sum Insured** under this **Policy**, provided the above named **Pre-Existing Diseases** had been declared by **You** at the time of applying for the first **Policy** and mentioned as accepted under the expiring ported/**Our Policy** .

If this optional cover is availed under the **Policy** then it has to be mandatorily opted for all **Insured Persons** who have any of the above mentioned pre-existing disease.

C6. Accidental Death Benefit

In case an **Insured Person** suffers an **Accident** during the **Policy Period** and this is the sole and direct cause of his death within 365 days from the date of **Accident**, then **We** will pay the **Sum Insured** as mentioned against the respective **Insured Person** in the **Policy Schedule**. This benefit is not applicable for insured children or **Insured Person** less than 18 years of **Age** as on **Policy** commencement date.

This benefit has a separate limit (over and above base **Sum Insured**).

Section 3 – Exclusions

We will neither be liable nor make any payment for any claim in respect of any **Insured Person** which is caused by, arising from or in any way attributable to any of the following exclusions.

i. Standard Exclusions

1. Exclusions with waiting periods

i. ***Pre-Existing Diseases*** *Waiting Period (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 36 months of continuous coverage after the date of inception of the first **Policy** with **Us**.
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 36 months for any Pre-Existing Disease is subject to the same being declared at the time of application and accepted by **Us**.

ii. *Specified Disease/Procedure Waiting Period (Code- Excl 02):*

a. Expenses related to the treatment of the 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**.

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.

List of Specific disease/conditions/treatments:

I. Tumors, Cysts, polyps including breast lumps (benign)
II. Polycystic ovarian disease, Fibromyoma, Adenomyosis, Endometriosis
III. Prolapsed Uterus
IV. Rheumatism
V. Ligament, Tendon or Meniscal tear
VI. Prolapsed Inter-Vertebral Disc
VII. Cholelithiasis
VIII. Pancreatitis
IX. Fissure/fistula in anus, haemorrhoids, pilonidal sinus
X. Ulcer & erosion of stomach & duodenum
XI. Gastro Esophageal Reflux Disorder (GERD)
XII. Liver Cirrhosis
XIII. Perineal Abscesses
XIV. Perianal / Anal Abscesses
XV. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.
XVI. Benign Hyperplasia of prostate
XVII. Varicocele
XVIII. Cataract, Retinal detachment, Glaucoma
XIX. Congenital Internal Diseases

List of procedure/surgeries/treatments:

XX. Adenoidectomy
XXI. Mastoidectomy
XXII. Tonsillectomy
XXIII. Tympanoplasty
XXIV. **Surgery** for nasal septum deviation
XXV. Nasal concha resection
XXVI. **Surgery** for Turbinate hypertrophy
XXVII. Hysterectomy
XXVIII. Osteoarthritis, joint replacement, osteoporosis,

XXIX. Systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid, Gout
XXX. Cholecystectomy
XXXI. Hernioplasty or Herniorraphy
XXXII. **Surgery**/procedure for Benign prostate enlargement
XXXIII. **Surgery** for Hydrocele/ Rectocele/Spermatocele
XXXIV. **Surgery** of varicose veins and varicose ulcers

iii. 30 Days 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.

2. Medical Exclusions

i. Investigation and 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.

ii. 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:
   i. 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.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. Obesity/ Weight Control (Code- Excl 06):

Expenses related to surgical treatment of obesity that does not fulfil 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);
   i. greater than or equal to 40 or

ii. 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:
   1. Obesity-related cardiomyopathy
   2. Coronary heart disease
   3. Severe Sleep Apnea
   4. Uncontrolled Type2 Diabetes

iv. Change-of-Gender treatments: Code- Excl07:

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

v. 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 Person**. For this to be considered a medical necessity, it must be certified by the attending **Medical Practitioner**.

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

vii. 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- Excl13)*

viii. 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-Excl14)*

ix. Refractive error (Code- Excl 15): Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

x. 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.

xi. Sterility and Infertility (Code- Excl 17):

Expenses related to Sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy

iv. Reversal of sterilization

xii. Maternity (Code - Excl 18):

1. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during **Hospitalization**) except ectopic pregnancy;
2. Expenses towards miscarriage (unless due to an **Accident**) and lawful medical termination of pregnancy during the **Policy Period**.

3. Non-Medical Exclusions

i. 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.

ii. 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.

iii. 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.

ii. Specific Exclusions (Exclusions other than as those mentioned under Section 3 (i) subsection 1, 2 &3 above)

We will neither be liable nor make any payment for any claim in respect of any **Insured Person** which is caused by, arising from or in any way attributable to any of the following exclusions.

1. Medical Exclusions

i. Alcoholic pancreatitis or Alcoholic liver disease;
ii. Congenital External Diseases, defects or anomalies;
iii. Stem cell therapy; however, hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under this **Policy**, subject to applicable **Sub-Limit**s;
iv. Growth Hormone Therapy;
v. Sleep-apnoea and Sleeping disorder;
vi. Admission primarily for administration (via any form or mode) of immunoglobulin infusion or supplementary medications like Zolendronic Acid, etc;
vii. Venereal disease, sexually transmitted disease or **Illness**;

viii. All preventive care including Health Check-ups, vaccination including inoculation and immunisations;

ix. Cost of dentures, dental implants and braces; **Dental Treatment** or Dental **Surgery** of any kind unless incidental to an admissible **Hospitalization** claim where the cause of admission is **Accident**;

x. Any existing disease specifically mentioned as Permanent exclusion in the **Policy Schedule**.

xi. Non payable items as mentioned in Annexure I – List I of optional items available on **Our** website (www.tataaig.com)

2. Non-Medical Exclusions

i. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not) or caused during service in the armed forces of any country, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.

ii. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

- Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any **Illness**, incapacitating disablement or death

- Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any **Illness**, incapacitating disablement or death.

- Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any **Illness**, incapacitating disablement or death.

iii. Any **Insured Person**'s participation or involvement in naval, military or air force operation.

iv. Intentional self-Injury or attempted suicide while sane or insane.

v. Items of personal comfort and convenience like television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service.

vi. Treatment rendered by a **Medical Practitioner** which is outside his discipline.

vii. Doctor's fees charged by the **Medical Practitioner** sharing the same residence as an **Insured Person** or who is an immediate relative of an **Insured Person**'s family.

viii. Hearing aids, spectacles or contact lenses, etc. including optometric therapy.

ix. Any treatment and associated expenses for alopecia, baldness, wigs or toupees, medical supplies including elastic stockings, diabetic test strips and similar products.

x. Any treatment or part of a treatment that does not form part of '**Reasonable and Customary Charges**', nor is medically necessary;

xi. Expenses which are either not supported by a prescription of a **Medical Practitioner** or are not related to **Illness** or disease for which claim is admissible under the **Policy**.

xii. Any external appliance and/or device used for diagnosis or treatment except when used intra-operatively.

xiii. Any **Illness** diagnosed or **Injury** sustained or where there is change in health status of the member after date of proposal and before commencement of **Policy** and the same is not communicated and accepted by **Us**.

Section 4 – General Terms and Clauses

i. Standard General Terms & Clauses

1. Disclosure of Information

The **Policy** shall be void and all premium paid thereon shall be forfeited to the Company in the event of established fraud, misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this **Policy** shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. **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**.

3. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.

ii. 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.

iii. 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.

iv. 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.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).

4. 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.

5. 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 and we will assist the insured person in facilitating the same.

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**.

6. 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.

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**.

7. Cancellation

I. The policyholder may cancel this **Policy** by giving 7 days written notice and in such an event, the Company shall refund proportionate premium for unexpired policy period. No refunds of premium shall be made in respect of Cancellation where any claim has been admitted or has been lodged or any benefit under this **Policy** has been availed by the **Insured Person**.

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

8. 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** at least 30 days before the **Policy Renewal** date as per IRDAI guidelines. 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 to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy, as applicable.

For Detailed Guidelines on **Migration**, kindly refer

Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and subsequent amendments thereof.

9. Portability

The **Insured Person** will have the option to port the **Policy** to other insurers by applying to such **Insurer** to port the entire **Policy** along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the **Policy Renewal** date as per IRDAI guidelines. 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 to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy, as applicable.

For Detailed Guidelines on **Portability**, kindly refer

Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and their subsequent amendments thereof.

10. Renewal of Policy

The **Policy** shall ordinarily be renewable except on grounds of established fraud, non-disclosure or misrepresentation by the **Insured Person**.

i. **Renewal** shall not be denied on the ground that the **Insured Person** had made a claim or claims in the preceding **Policy Year**s.

ii. Request for **Renewal** along with requisite premium shall be received by the Company before the end of the **Policy Period**.

iii. Single premium payment mode Policy can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period after the end of the policy period. If not renewed under the Grace Period, the Policy shall terminate at the end of the Grace period.

iv. The grace period for payment of the premium during the Policy Period, for instalment premium shall be fifteen days where premium payment mode is monthly and thirty days in all other cases (Annually/Half-Yearly/Quarterly/Limited Premium Paying Term).

v. Coverage during such grace period (in case of instalment premium):

   a. Within the policy period - coverage will be available from the due date of instalment premium till the date of receipt of premium by Company within the grace period.

   b. 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. Coverage is not available during the grace period after the end of the policy period.

vi. The insured person will get the accrued continuity benefit to the extent of Sum Insured, No Claim Bonus, Specified Waiting Periods, waiting periods for pre-existing diseases, Moratorium period, as applicable, in the event of payment of premium within the stipulated grace Period.

vii. No loading shall apply on **Renewal**s based on individual claims experience.

11. Withdrawal of **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 5X Supercharge **Bonus**, waiver of waiting period as per IRDAI guidelines, provided the **Policy** has been maintained without a break.

12. Moratorium Period

After completion of five continuous years of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This continuous period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of five continuous years would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, **Co-Payment**s, **Aggregate Deductible**s as per the **Policy** contract.

13. Possibility of Revision of Terms of the **Policy** Including the Premium Rates

The Company 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.

14. Free look period

The insured person shall be provided a free look period of thirty days beginning from the date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy, and to return the same if not acceptable. If the **Insured Person** has not made any claim during the Free Look Period, the **Insured Person** shall be entitled toa refund of the premium paid subject to deduction of proportionate risk premium for the period of cover and the expenses, if any, incurred by Us on medical examination of the proposer and stamp duty charges.

15. Redressal of Grievance

At TATA AIG, we strive to provide the best service to our customers. If you're not satisfied and wish to lodge a complaint, please call our 24/7 toll-free number 1800-266-7780/1800 22 9966 (For Senior Citizens) or 022-66939500 (toll charges apply), or email us at customersupport@tataaig.com. We will investigate and respond within the regulatory turnaround time (TAT).

Escalation Level 1

If you do not receive a response or are not satisfied with the resolution, please contact us at manager.customersupport@tataaig.com.

Escalation Level 2

If you still need assistance, reach out to the Head of Customer Services at head.customerservices@tataaig.com. We will provide our final response within the regulatory TAT.

If you're still not satisfied after this process, you may approach the Insurance Ombudsman of concerned jurisdiction.

You can also lodge a grievance on the Bima Bharosa Grievance Redressal Portal: https://bimabharosa.irdai.gov.in

The name and address of the Insurance Ombudsman of competent jurisdiction is provided under Annexure A of this Policy.

16. 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**/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**.

i. Specific terms and clauses (terms and clauses other than those mentioned under Section 4 (i) above)

17. Insured Person

i. Only those persons named as an **Insured Person** in the Schedule shall be covered under this **Policy**.

ii. Any eligible person may be added during the **Policy Period** after his proposal has been accepted by **Us**, additional premium has been paid and **We** have issued an endorsement confirming the addition of such person as an **Insured Person**.

18. Risk Loadings

i. **We** may apply a risk loading on the premium payable (based upon the declarations made in the proposal and the health status of the persons proposed for insurance).
ii. The loading shall be applied basis outcome of **Our** underwriting.
iii. These loadings are applied from Commencement Date of the **Policy** including subsequent **Renewal**(s) with **Us** or on the receipt of the request of increase in **Sum Insured** (for the increased **Sum Insured**).
    a. **We** will inform **You** about the applicable risk loading through a counter offer letter.
    b. **You** need to revert to **Us** with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter.
    c. In case, **You** neither accept the counter offer nor revert to **Us** within 15 days, **We** shall cancel **Your** application and refund the premium paid within next 10 days subject to deduction of the Pre-**Policy** Check up charges, as applicable.
iv. Please note that **We** will issue **Policy** only after getting **Your** consent.

19. Entire Contract

i. This **Policy**, its Schedule, endorsement(s), proposal constitutes the entire contract of insurance. No change in this **Policy** shall be valid unless approved by **Us** and such approval be endorsed hereon.

ii. This **Policy** and the Schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this **Policy** or of the Schedule shall bear such meaning wherever it may appear.

20. Notices

i. Any notice, direction or instruction under this **Policy** shall be in writing and if it is to:

a. Any **Insured Person**, then it shall be sent to **You** at **Your** address specified in the Schedule to this **Policy** and **You** shall act for all **Insured Person**s for these purposes.

b. **Us**, it shall be delivered to **Our** address specified in the Schedule to this **Policy**. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on **Our** behalf unless **We** have expressly stated to the contrary in writing.

21. Zone & Applicability of Plan

Premium payable under the 'Geo Plan' will be computed based on the residential location/address as provided by the proposer/**Insured Person** in the proposal form.
Premium to be received by Company before **Policy** Commencement date.
The payment of premium and applicability of Plan shall be as per the grid given below:

Plan Selected	**Available for insured person(s) residing in***	**Premium Applicable as per:**	**Network Applicable**	**Specific Co-Payment applicable#**
Value Plan	Anywhere within India	Premium as per Value Plan	**Valued Provider – Pan India^**	30% **Co-Payment** if **Hospitalization** happens outside **Our** network of **Valued Provider – Pan India.**
Geo Plan	Zone B or Zone C	Premium as per Geo Plan for Zone B or Zone C	**Network Provider**	20% **Co-Payment** if **Hospitalization** happens in Zone A. This **Co-Payment** shall be applied on both, cashless as well as reimbursement claims.

*Premium payable under the **Policy** will be computed based on the residential location/address as provided by the proposer/**Insured Person** in the proposal form and the plan opted.

This is over and above any other **Co-Payment** applicable under the **Policy**.

Change from Value Plan to Geo Plan shall not be permitted. Any change from Geo Plan to Value Plan shall only be allowed at the time of **Renewal** and shall be subject to underwriting.

^For clarity: The "**Valued Provider – Pan India**" network list is different from **Our** standard list of "**Network Provider**". The standard list of **Network Provider** shall not be applicable to the **Insured Person**, if covered under Value Plan. List of **Valued Provider – Pan India** will be updated from time to time and will be available on **Our** website www.tataaig.com

22. Premium Refund in case of demise of the Insured Person

The coverage for the **Insured Person**(s) shall automatically terminate in case of his/ her (**Insured Person**) demise. However, the cover shall continue for the remaining **Insured Persons** till the end of **Policy Period**.
Provided no claim has been made and deletion from **Policy** takes place on account of death of the **Insured Person** during the **Policy Period**, pro-rata refund of premium of the deceased **Insured Person** for the balance period of the **Policy** will be made. Refund will be made to the **Policy** holder or the nominee as the case may be in case of demise of the **Policy** holder. **We** would require death certificate of the Deceased **Insured Person** for processing of the refund amount.

The other **Insured Persons** may also apply to renew the **Policy**. In the event of change of Proposer, all relevant particulars in respect of such person (including his/her relationship with the **Insured Person**) must be submitted to the company along with the application.

Section 5 – Claims Procedure and Claims Payment

This section explains about the procedure involved to file a valid claim by the **Insured Person** and processes related to assessment, cost sharing and management of the claim. All the procedures and processes such as **Notification of Claim**, availing cashless service, supporting claim documents and related claim terms of payment are explained in this section.

1. Notification of Claim

Every claim needs to be notified to **Us** either in writing or email or through a call to **Our** tollfree number, as mentioned in the **Policy Schedule**, within the stipulated timelines as mentioned below.

	Event	**We or Our TPA* must be informed:**

1	If any treatment for which a claim may be made and that treatment requires planned **Hospitalization**/ **Day Care Treatment**/ AYUSH/ Domiciliary Treatment:	At least 48 hours prior to the **Insured Person**'s admission/ start of treatment.
2	If any treatment for which a claim may be made and that treatment requires emergency **Hospitalization**/ **Day Care Treatment**	Within 24 hours of the **Insured Person**'s admission to **Hospital** or at the time of discharge, whichever is earlier.

TPA as mentioned in the **Policy Schedule, if applicable.*

Timely intimation of claim in **Our** prescribed format is a pre-condition for admission of liability.

We may waive off this condition in extreme cases of hardship where it is proved to **Our** satisfaction that under the circumstances in which **You** were placed, it was not possible for **You** or any other person to give notice or file claim within the prescribed time limit.

2. Cashless Service

Treatment, Consultation or Procedure:	**Taken at:**	**Cashless Service is Available:**	**We must be given notice that the Insured Person wishes to avail cashless service accompanied by full particulars:**
If any planned treatment, consultation or procedure for which a claim may be made:	**Network Provider**	**We** will provide cashless service by making payment to the extent of **Our** liability directly to the Network **Hospital**.	At least 48 hours before the planned **Hospitalization**
If any treatment, consultation or procedure for which a claim may be	**Network Provider**	**We** will provide cashless service by making payment to the	Within 24 hours of the **Hospitalization** and prior to discharge

made, requiring emergency **Hospitalization**		extent of **Our** liability directly to the Network **Hospital**.	

3. Procedure for Cashless Service

i. Cashless Service is only available at **Our Network Provider/ Valued Provider – Pan India**, as applicable.

ii. In order to avail cashless treatment, the following procedure must be followed by **You**:

a. Prior to taking treatment and/or incurring **Medical Expenses** at a Network **Hospital**, **You** must notify **Our** designated TPA/**Us** and request pre-authorization.

b. **Our** designated TPA/**We** will check **Your** coverage as per the eligibility and send an authorization letter to the provider. **You** have to provide the ID card issued to **You** along with any other information or documentation that is requested by the TPA/**Us** to the Network **Hospital**.

c. In case of deficiency in the documents sent to TPA/**Us** for cashless authorization or the ailment /treatment is not covered under the policy, the same shall be communicated to the **Hospital/You** by TPA/**Us.**

d. **We/TPA will respond** within TAT as prescribed by the Regulator under the Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 and its subsequent amendments thereof

e. Rejection of cashless in no way indicates rejection of the claim. **You** are required to submit the claim along with required documents for **Us** to decide on the admissibility of the claim.

f. If the cashless is approved, the original bills and evidence of treatment in respect of the same shall be left with the Network **Hospital**.

g. Pre-authorization does not guarantee that all costs and expenses will be covered. **We** reserve the right to review each claim for **Medical Expenses** and accordingly coverage will be determined according to the terms and conditions of this **Policy**.

4. Supporting Documentation & Examination

i. **We** or **Our** TPA may **require** documentation, medical records and information to establish the circumstances of the claim, its quantum or **Our** liability for the claim within 15 days or earlier of **Our** request or the **Insured Person**'s discharge from **Hospitalization** or completion of treatment.

ii. In case the delay is at Your end, failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if **You** can satisfy **Us** that it was not reasonably possible for **You** to give proof within such time.

iii. **We** may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the **Insured Person**.

iv. Such documentation will include the following:

a. **Our** claim form, duly completed and signed for on behalf of the **Insured Person**. **We**, upon receipt of a notice of claim, will furnish **Your** representative with such forms as **We**

may require for filing proofs of loss or **You** may download the claim form from **Our** Web site.

b. Original Bills (pharmacy purchase bill, consultation bill, diagnostic bill, medical devices) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become **Our** property.
c. All medical reports, case histories, investigation reports, indoor case papers/ treatment papers (in reimbursement cases, if available), discharge summaries.
d. A precise diagnosis of the treatment for which a claim is made.
e. A detailed list of the individual medical services and treatments provided and a unit price for each in case not available in the submitted **Hospital** bill.
f. Prescriptions that name the **Insured Person** and in the case of drugs: the drugs prescribed, their price and a receipt for payment. In case of pre/post **Hospitalization** claim Prescriptions must be submitted with the corresponding Doctor/**Hospital** invoice.
g. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made, if and where applicable.
h. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of **Injury** and Alcohol or drug influence at the time of **Accident**, if available.
i. Copy of settlement letter from other insurance company or TPA.
j. Stickers and invoice of implants used during **Surgery**.
k. Copy of MLC (Medico legal case) records, if carried out and FIR (First information report), if registered, in case of claims arising out of an **Accident** and available with the claimant.
l. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements.
m. Legal heir/succession certificate, if required
n. PM report (wherever applicable)
o. The Company reserves the right to call for additional documents wherever required.

v. Note: In case **You** are claiming for the same event under an indemnity-based **Policy** with Us and with another **Insurer** and are required to submit the original documents related to **Your** treatment with that particular **Insurer**, then We will require the attested copies of such documents along with a declaration from the particular **Insurer** specifying the availability of the original copies of the specified treatment documents with it.

vi. **We** at **Our** own expense, shall have the right and opportunity to examine **Insured Persons** through **Our** Authorised **Medical Practitioner** whose details will be notified to **Insured Person** when and as often as **We** may reasonably require during the pendency of a claim hereunder.

5. Claims Assessment and Payment

i. General

a. **We** shall be under no obligation to make any payment under this **Policy** unless:
   - **We** have received all premium payments in full and in time and

- **We** have been provided with the documentation and information which **We** or **Our** TPA has requested to establish the circumstances of the claim, its quantum or **Our** liability for it, and
- unless **You** have complied with **Your** obligations under this **Policy**.

b. This **Policy** only covers claims incurred within India, and payments under this **Policy** shall only be made in Indian Rupees within India.

c. Medical Expenses incurred for AYUSH treatment shall be assessed only under benefit B7 of this policy and shall be admissible only if incurred within India.

Where an ailment/ **Illness**/ disease is excluded under both exclusions with waiting Periods (as specified under Section 3 (i) Sub section (1) and under any other **Policy** exclusion, then for assessment of liability, any expense related to that ailment/ **Illness**/ disease shall not be covered under this **Policy**.

ii. Sequence of applicability & Utilization

a. The sequence of assessment of claim shall be as per table given below:

Steps	**Assessment**	**Where Age specific Co-Payment is applicable**	**Where Age specific Co-Payment is not applicable**
1	Amount of Claim Intimated	√	√
2	Less Non-Payable expenses#	√	√
3	=Admissible Expenses	√	√
4	Less **Associated Medical Expenses** as defined under the **Policy** (if applicable)	√	√
5	=Admissible Claim	√	√
6^	If ***Geo Plan*** is opted: Less (**Higher Zone Co-Payment*** + **Age Linked Co-Payment**) OR **Age linked Co-Payment**;	(20%*+20%) OR 20%	20%* OR 0%

	If ***Value Plan*** is opted: Less (Out of **Our** network of **Valued Provider – Pan India Co-Payment*** as defined in **Policy** + **Age Linked Co-Payment**) OR **Age linked Co-Payment**	(30%*+20%) OR 20%	30%* OR 0%
7	=Final Assessed Amount	√	√
8	Less **Aggregate Deductible** (if Opted)**	If applicable	If applicable
9	=Final Assessed Liability	√	√
10	Claim Payable subject to applicable	Sublimit/ Voluntary Sublimit */ Balance **Sum Insured** (including accrued 5X Supercharge Bonus)/ Benefit Limit	

Deduction would vary depending upon whether optional cover 'Consumables Benefit' is opted.

^ Depending upon the opted Plan – Value Plan or Geo Plan

* If applicable

** **Aggregate Deductible**, if opted, shall be applicable on aggregate of all claims as assessed under the final assessed amount for a given **Policy Year**.

The payment of any claim under this **Policy** shall be subject to **Aggregate Deductible** (if applicable), sublimits/benefit limits, balance **Sum Insured** and accrued 5X supercharge bonus, if available.

For claims related to specific ailment/ **Surgical Procedure** where either mandatory sublimit or voluntary sublimit (if opted) are applied during claim assessment, there neither **Higher zone Co-Payment** nor outside **Our** network of **Valued Provider- Pan India Co-Payment** shall be applicable. However, the **Age linked Co-Payment** shall be applicable.

b. The sequence of utilization of benefit for a claim shall be in the following order:

1. **Sub-Limit** subject to balance **Sum Insured**/**Sum Insured** (as applicable),
2. Any accrued 5X Supercharge Bonus, if applicable (B17)
3. Restore benefit amount, if applicable (B9)
4. Restore infinity amount, if applicable (C1)

Accidental Death Benefit (C6) shall be assessed as per the **Sum Insured** of the Optional Cover.

iii. Cost Sharing

A	The following four cost sharing methods are mandatory and inbuilt in the **Policy**		
	Cost Sharing Mechanism	**Applicability on**	
1	Age linked Co-Payment	Geo Plan & Value Plan	
2	Higher Zone Co-Payment	Geo Plan	
3	Out of **Our** network of **Valued Provider – Pan India Co-Payment**	Value Plan	
4	**Mandatory Sub-Limit**s	Geo Plan (Table I) & Value Plan (Table II)	
B	The following three cost sharing methods, are optional and applicable if opted by the policyholder in lieu of which premium discount has been provided. The Optional cost sharing method, if opted shall be mentioned in the **Policy Schedule**. Once opted, they shall mandatorily continue for all the subsequent **Renewal**s of the **Policy**, provided the **Policy** is renewed with **Us** without any break.		
	Cost Sharing Mechanism	**Available under**	**Can be availed by the policyholder/Insured**
5	**Voluntary Sub-Limits**	Geo Plan & Value Plan	At Inception of first **Policy**/coverage OR **Renewal**
6	**Aggregate Deductible**	Geo Plan & Value Plan	At Inception of first **Policy**/coverage OR **Renewal**
7	**Shared Accommodation**	Geo Plan	At Inception of first **Policy**/coverage OR **Renewal**

a. Age linked Co-Payment

If the entry **Age** of the **Insured Person** is 61 years or above at the time of first coverage under this **Policy**, then such **Insured Person** shall bear 20% of each admissible claim (over and above any other **Co-Payment**, if applicable). This shall be applicable even in **Portability** cases, irrespective of previous coverage.

This **Co-Payment** shall be applicable for all claims admitted under:

- B1, B2, B3, B4, B5, B6, B7, B8 and C3 (if opted); and
- if B9, B17 and C1 (if opted) utilized for payment of claim under aforementioned sections.

This **Co-Payment** shall not be applicable for benefits which are over and above the **Sum Insured**.

Exception to this clause:

This **Co-Payment** shall not be applicable in case of **Migration** from any active Tata AIG indemnity health **Policy** to this product provided, entry **Age** of the **Insured Person** was less than 61 years at the time of first coverage under the first indemnity health **Policy** with **Us**, subject to continuous coverage without any break in the **Policy**.

b. Higher Zone Co-Payment

Wherever, Geo Plan has been opted and the **Insured Person**(s) undergoes medical treatment at a **Hospital**/ **Day Care Centre**/ **AYUSH Hospital**/ **AYUSH Day Care Centre** in Zone A, then an additional **Co-Payment** of 20% will be applicable on each such claim.

Higher Zone Co-Payment shall be applicable for all claims except for claims for emergency **Hospitalization** due to **Injury** arising from an **Accident**. **Higher Zone Co-Payment** shall not be applicable for benefits which are over and above the **Sum Insured**.

For Clarity: This **Co-Payment** shall be applicable on claims admitted under:

- B1, B4, B6, B7 and C3 (if opted); and
- if B9, B17 and C1 (if opted) utilized for payment of claim under aforementioned sections.

c. Co-Payment for treatment availed out of Our Network of Valued Provider – Pan India

Wherever, Value Plan has been opted and the **Insured Person** avails treatment outside **Our** network of "**Valued Provider-Pan India**", then a **Co-Payment** of 30% will be applicable for each such claim resulting from admission of the **Insured Person** in a **Hospital**/ **Day Care Centre**/ **AYUSH Hospital**/ **AYUSH Day Care Centre**. However, no **Co-Payment** under this sub section shall be applicable if **Hospitalization** is for an **Injury** arising from an **Accident**.

For Clarity: This **Co-Payment** shall be applicable on claims admitted under:

- B1, B4, B6, B7 and C3 (if opted); and
- B9, B17 and C1 (if opted) if utilized for payment of claim under aforementioned sections.

d. Mandatory Sub-Limits

Our liability for any and all claims related to **Hospitalization**/ **Day Care Treatment** (including their associated Pre & Post **Hospitalization** expenses) arising out of following ailments/**Surgical Procedure**s shall be restricted to the following **Sub-Limit**s subject to availability of **Sum Insured** and other terms and conditions of the **Policy**.

Table I : Mandatory **Sub-Limit**s applicable for Ailment/**Surgical Procedure** for Geo Plan

(in INR)

(Ailment/Surgical Procedure)	Sub limit, as applicable to each **Insured Person** based on the **Sum Insured**				
	5 Lacs	**7.5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**
Cataract **Surgery** (per eye)	40,000	56,000	80,000	120,000	160,000
Balloon Sinuplasty/ FESS	25,000	35,000	50,000	75,000	100,000
Oral chemotherapy	75,000	105,000	150,000	225,000	300,000
Immunotherapy- Monoclonal Antibody all forms	125,000	175,000	250,000	375,000	500,000
Robotic surgeries	125,000	175,000	250,000	375,000	500,000
Stem cell therapy for Hematopoietic stem cells for bone marrow transplant for hematological conditions	125,000	175,000	250,000	375,000	500,000

Table II: Mandatory **Sub-Limit**s applicable for Ailment/**Surgical Procedure** for Value Plan
(in INR)

(Ailment/ Surgical Procedure)	Sub limit, as applicable to each **Insured Person** based on the **Sum Insured**				
	5 Lacs	**7.5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**
Cataract **Surgery** (per eye)	45,000	60,000	90,000	130,000	175,000
Balloon Sinuplasty/ FESS	30,000	40,000	55,000	85,000	110,000
Oral chemotherapy	85,000	115,000	165,000	250,000	330,000
Immunotherapy- Monoclonal Antibody all forms	140,000	195,000	275,000	415,000	550,000
Robotic surgeries	140,000	195,000	275,000	415,000	550,000

Stem cell therapy for Hematopoietic stem cells for bone marrow transplant for hematological conditions	140,000	195,000	275,000	415,000	550,000
Total Knee Replacement (per knee)	165,000	175,000	180,000	215,000	230,000
Any type of Hernia **Surgery**	70,000	75,000	75,000	95,000	100,000
Any type of Hysterectomy	70,000	75,000	75,000	95,000	100,000
Benign Prostate Hypertrophy	70,000	75,000	75,000	95,000	100,000
Stones of Renal System	70,000	75,000	75,000	95,000	100,000

e. Voluntary Sub-Limits

In lieu of premium discount opted by **You**, the following **Sub-Limit**s shall be applicable in addition to the Mandatory **Sub-Limit**s. **Our** liability for any and all claims related to **Hospitalization**/ **Day Care Treatment** (including their associated Pre & Post **Hospitalization** expenses) arising out of following ailments/**Surgical Procedure**s shall be restricted to the following **Sub-Limit**s subject to availability of **Sum Insured** and other terms and conditions of the **Policy**.

This voluntary **Sub-Limit** cover, if opted, shall continue for all the subsequent **Renewal**s of the **Policy**, provided the **Policy** is renewed with **Us** without any break.

Table A : Voluntary **Sub-Limit**s applicable for Ailment/**Surgical Procedure** for Geo Plan

(in INR)

(Ailment/ Surgical Procedure)	Sub limit, as applicable to each **Insured Person** based on the **Sum Insured**				
	5 Lacs	**7.5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**
Total Knee Replacement (per knee)	150,000	157,500	165,000	195,000	210,000
Any type of Hernia **Surgery**	65,000	68,000	70,000	85,000	90,000
Any type of Hysterectomy	65,000	68,000	70,000	85,000	90,000
Benign Prostate Hypertrophy	65,000	68,000	70,000	85,000	90,000
Stones of Renal System	65,000	68,000	70,000	85,000	90,000
Cerebrovascular & Cardiovascular	250,000	275,000	300,000	325,000	350,000
Cancer	250,000	275,000	300,000	325,000	350,000
Renal Complications & Disorders (excluding Stones of Renal System)	250,000	275,000	300,000	325,000	350,000

Breakage of Bones requiring **Surgery** under general anesthesia	250,000	275,000	300,000	325,000	350,000

Table B: Voluntary **Sub-Limit**s applicable for Ailment/**Surgical Procedure** for Value Plan

(in INR)

(Ailment/ Surgical Procedure)	Sub limit, as applicable to each **Insured Person** based on the **Sum Insured**				
	5 Lacs	**7.5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**
Cerebrovascular & Cardiovascular	275,000	300,000	330,000	360,000	385,000
Cancer	275,000	300,000	330,000	360,000	385,000
Renal Complications & Disorders (excluding Stones of Renal System)	275,000	300,000	330,000	360,000	385,000
Breakage of Bones requiring **Surgery** under general anesthesia	275,000	300,000	330,000	360,000	385,000

Special condition applicable for above-mentioned Mandatory Sub-Limits and Voluntary Sub-Limits

In case more than one **Sub-Limit** is applicable to an ailment/ procedure, covered under the **Policy**, then the highest of applicable **Sub-Limit**s, shall be considered.

f. Aggregate Deductible

In lieu of premium discount opted by **You**, **Our** liability under this **Policy** shall be subject to application of **Aggregate Deductible** as mentioned in the **Policy Schedule**.

The **Aggregate Deductible** amount as specified in the **Policy Schedule** shall be first deducted from the aggregate of Final Assessed Amount (s) for all claims, during the **Policy Year** and **Our** liability shall be restricted to the balance amount, subject to availability of **Sum Insured** and applicability of **Sub-Limit**s.

In case of multi-year **Policy** (i.e. tenure more than 1 year), such **Aggregate Deductible** would be applicable on annual basis.

Aggregate Deductible shall continue for all the subsequent **Renewal**s of the **Policy**, provided the **Policy** is renewed with **Us** without any break.
Aggregate Deductible shall not be applicable to claims under B13, B14, B15, B16, C4 (if opted) and C6 (if opted) of this **Policy**.

iv. Claims Procedure and management of services (B15, B16 &C4)

Service may be availed through **Our** website or **Our** mobile application or through calling **Our** call centre on the toll free number specified in the **Policy Schedule**. Alternatively, details of **Our** empanelled service provider are available on **Our** website (www.tataaig.com).

Supporting Documentation & Examination
Insured Person or someone booking services on **Your** behalf shall provide **Us** with identification documentation, medical records and information **We** may request to establish the circumstances of the claim.

Your claim will be processed including cashless and final bill authorization as prescribed by the Regulator under the Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 and its subsequent amendments thereof.

Section 6 - Dispute Resolution

Dispute Resolution Clause

Any and all disputes or differences under or in relation to this **Policy** shall be determined by the Indian Courts and subject to Indian law.

Annexure A

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES

Sr.No.	Centre	Address & Contact	Jurisdiction of Office Union Territory, District
1	AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu

2	BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
3	BHOPAL	Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh
4	BHUBHANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
5	CHANDIGARH	Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.

6	CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	amil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)
7	DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
8	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@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
9	HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
10	JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan

11	KOCHI	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
12	KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
13	LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar

14	MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)
15	NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
16	PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand

17	PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)

For updated list and details of Insurance Ombudsman Offices, please visit website http://www.cioins.co.in/ombudsman.html

Section 64VB of the Insurance Act, 1938 - Commencement of risk cover under the **Policy** is subject to receipt of premium by Tata AIG General Insurance Company Limited.

Prohibition of Rebates - Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the **Policy**, nor shall any person taking out or renewing or continuing a **Policy** accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the **Insurer**.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Tata AIG General Insurance Company Limited

Registered Office: Peninsula Business Park, Tower A, 15th Floor, G.K. Marg, Lower Parel,

Mumbai 400013, Maharashtra, India

24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For Senior Citizens)

Email:customersupport@tataaig.com Website: www.tataaig.com IRDA of India Registration No: 108

CIN: U85110MH2000PLC128425

"Insurance is the subject matter of solicitation". For more details on risk factors, terms and conditions, please read **Policy** document carefully before concluding a sale.