Preamble

This Policy is a contract of insurance issued by TATA AIG General Insurance Company Ltd. (hereinafter called the 'Company') to the proposer mentioned in the Schedule (hereinafter called the 'Insured') to cover the person(s) named in the Schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

Operative Clause

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.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definition contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule

Section 1 –Definitions

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

i. Standard Definitions

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Any One Illness** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.

3. **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 at least 5 in-patient beds;

      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

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4. **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.

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

6. **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** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person 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** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

9. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

   - **Internal Congenital Anomaly**

     Congenital anomaly which is not in the visible and accessible parts of the body.

   - **External Congenital Anomaly**

     Congenital anomaly which is in the visible and accessible parts of the body.

10. **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. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

12. **Day Care Centre** means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

    i. has qualified nursing staff under its employment;

    ii. has qualified medical practitioner (s) in charge;

    iii. has a fully equipped operation theatre of its own where surgical

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procedures are carried out

iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

13. **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 twenty four hours because of technological advancement, and

ii. which would have otherwise required a hospitalisation of more than twenty four hours.

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

14. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

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

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

17. **"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.

18. **Hospital** means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under 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 ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;

iii. has qualified medical practitioner (s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out

v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

19. **Hospitalisation** means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

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20. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

i. **Acute Condition** means a disease, illness or injury that is likely to response 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.

ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics

a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

b) it needs ongoing or long-term control or relief of symptoms

c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it

d) it continues indefinitely

e) it recurs or is likely to recur

21. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

22. **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

23. **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.

24. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

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

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

27. **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 the scope and jurisdiction of the licence.

28. **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 illness or injury suffered by the insured;

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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.

29. **"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.

30. **Network Provider** means hospitals enlisted by 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).

31. **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

32. **Out-Patient (OPD) Treatment** means treatment 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.

33. **"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.

34. **Pre-hospitalisation Medical Expenses** means medical expenses incurred during the period of 30days preceding the hospitalisation of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

35. **Post-hospitalisation Medical Expenses** means medical expenses incurred during the period of 60days 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 hospitalisation was required, and

ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

36. **"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.

37. **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.

38. **Renewal:** Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a

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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** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

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

41. **Third Party Administrator (TPA)** means a Company registered with the Authority,and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

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

1. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

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

   i. legally wedded spouse.

   ii. Parents and Parents-in-law.

   iii. dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals)

3. **Insured Person** means person(s) named in the schedule of the Policy.

4. **Non- Network Provider** means any hospital that is not part of the network.

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

6. **Policy period** means period of one policy year as mentioned in the schedule for which the Policy is issued

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

8. **Policy year** means a period of twelve 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, till the policy period, as mentioned in the schedule

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

10. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

11. **Waiting Period** means a period from

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the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

Section 2 – Benefits

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

1. Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.

ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.

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.

1.1 Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits

ii. Dental treatment, necessitated due to disease or injury

iii. Plastic surgery necessitated due to disease or injury

iv. All the day care treatments

v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment

2. **In case of admission to a room/ICU/ ICCU at rates exceeding the aforesaid limits, the** reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ ICCU charges.

2. AYUSH Treatment

We will cover Medical Expenses incurred for treatment as In-Patient or Day Care Treatment in an AYUSH Hospital/ AYUSH day care centre.

This benefit shall also cover Pre-Hospitalization medical expenses for a period of upto 30 days before the date of admission to the AYUSH hospital/ AYUSH day care centre and Post-Hospitalization Medical Expenses for a period upto 60 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).

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For your reference, the document has been uploaded on Our website under "Annexure B for AYUSH Benefit" (www.tataaig.com).

3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs. 40,000/-, whichever is lower, per each eye in one policy year.

4. Pre Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

5. Post Hospitalisation

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

6. The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

B. Balloon Sinoplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy- Monoclonal Antibody to be given as injection

F. Intra vitreal injections

G. Robotic surgeries

H. Stereotactic radio surgeries

I. BronchialThermoplasty

J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

K. ION M - (Intra Operative Neuro Monitoring)

L. Stem Cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

7. The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

8. Cumulative Bonus (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the Company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year. Cumulative Bonus shall be provided only if No Claim Discount has not been availed for the claim free previous Policy Year.

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.

ii. In case where the policy is on floater basis,

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the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.

iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons

v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy

vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.

vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.

viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

Section 3 –Exclusions

i. Standard Exclusions

1. Exclusions with waiting periods

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

I. Pre-Existing Diseases(Code- Excl 01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 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. Specific Waiting Period: (Code- Excl 02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum

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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.

i. 24 Months waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

ii. 36 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

III. First Thirty Days Waiting Period(Code-Excl 03)

i. 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.

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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2. Medical Exclusions

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

i. Investigation & Evaluation(Code-Excl 04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

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 the surgical treatment of obesity that does not fulfill all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor

2) The surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

b) 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:

I. Obesity-related cardiomyopathy

II. Coronary heart disease

III. Severe Sleep Apnea

IV. Uncontrolled Type2 Diabetes

iv. Change-of-Gender treatments: (Code- Excl 07)

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

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

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

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

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- Excl 14)**

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 1VF, Z1FT, GIFT, ICS1

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

xii. Maternity Expenses (Code - Excl 18):

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. 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

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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 mentioned under Section 3 (i) above)

1. Medical Exclusions

i. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

ii. Treatment taken outside the geographical limits of India

iii. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule(based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

2. Non-Medical Exclusions

i. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

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:

a) 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.

b) 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.

c) 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.

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 mis-description or non-disclosure of any material fact.

2. 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.

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ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest 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 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 at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

3. Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. Multiple Policies

1. In case of multiple policies taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder 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 if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

2. Policyholder 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(s) shall independently settle the claim subject to the terms and conditions of this policy.

3. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount and we will assist the insured person in facilitating the same.

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

5. Cancellation

a) The Policyholder may cancel this Policy by giving 7days' 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**.

b) 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

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on cancellation on grounds of established fraud, misrepresentation or non disclosure of material facts.

6. 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 affected.

7. 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 returns the same if not acceptable.

i. If the insured person has not made any claim during the Free Look Period, the insured person shall be entitled to a a 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.

8. 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. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

9. 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.

10. 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 If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Migration benefit will be offered

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to the extent of sum of previous sum insured and 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.

Policyholder should initiate action to approach the insurer to exercise migration option well before the renewal date to avoid any break in the policy coverage

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.

11. Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as Under:

i. The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Portability benefit will be offered to the extent of sum of previous sum insured and 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 there

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

12. Condition Precedent to Admission of Liability

The due observance and fulfillment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

13. 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer

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to issue a 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 policy 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 mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

14. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud misrepresentation or non-disclosure by the insured person.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years

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 during the Grace Period, the Policy shall terminate at the end of the Grace period.

15. Premium Payment in Installments

If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly, Monthly or Limited Premium Paying Term as mentioned in Your Policy Schedule/ Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. 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 Terms).

ii. 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.

iii. 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.

iv. No interest will be charged If the installment premium is not paid on due date.

v. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

16. Automatic change in Coverage under the policy

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The coverage for the Insured Person(s) shall automatically terminate:

1. In the case of his/ her (Insured Person) demise.

   However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. 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. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

17. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

18. Material Change

The insured shall notify the Company in writing of any material change in the riskin relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

19. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

20. Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

21. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

22. Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

ii. The policyholder may be changed only at the time of renewal. The

   new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her

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demise or him/her moving out of India.

23. Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

24. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

25. 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 **022 64898282 or 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**.

Nodal Officer

Please visit our website at www.tataaig.com to know the contact details of the Nodal Officer for your servicing branch.

Grievance may also be lodged on the Bima Bharosa Grievance Redressal Portal of IRDAI (https://bimabharosa.irdai.gov.in/)

Insurance Ombudsman - The insured person may also approach the office of Insurance Ombudsman of the respective area/region for Redressal of grievance. The contact details of the Insurance Ombudsman Offices have been provided as Annexure -B

No loading shall apply on renewals based on individual claims experience. Insurance is the subject matter of solicitation

Section 5 – Claims Procedure and Claims Payment

1. Procedure for Cashless Claims:

(i) Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA. (ii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/ TPA for authorization. (iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification. (iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible

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expenses. (v) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details. (vi)In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

2. Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable) /Company within the prescribed time limit as specified hereunder.

Sl No	Type of Claim	Prescribed Time limit
1	Reimbursement of hospitalization, day care and pre ho s p ita liz a tio n expenses	Within thirty days of date of discharge from hospital
2	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

3. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

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

4. Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form

ii. Photo Identity proof of the patient

iii. Medical practitioner's prescription advising admission

iv. Original bills with itemized break-up

v. Payment receipts

vi. Discharge summary including complete medical history of the patient along with other details.

vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner

viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).

ix. Sticker/Invoice of the Implants, wherever applicable.

x. MLR(Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.

xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque

xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines

xiii. Legal heir/succession certificate, wherever applicable

xiv. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept bills/ invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted

2. In the event of a claim lodged under the Policy and the original documents having

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been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company

3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

5. Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

6. Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;

ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

7. Payment of Claim

1 All claims under the policy shall be payable in Indian currency only.

2 Medical Expenses incurred for AYUSH treatment shall be assessed only under benefit 2 of this policy and shall be admissible only if incurred within India.

Section 6 - Dispute Resolution

Table of Benefits

Name	Arogya Sanjeevani Policy, TATA AIG General Insurance Company Ltd.
Product Type	Individual/ Floater
Category of Cover	Indemnity
Sum insured	INR On Individual basis – SI shall apply to each individual family member On Floater basis – SI shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Policy can be availed for Self and the following family members i. legally wedded spouse. ii. Parents and Parents-in-law. iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	For monthly premium payment mode, Grace Period shall be 15 days during the policy period and 30 days in all other cases (Annually {multi-year policies} / Half-Yearly / Quarterly) during the policy period.

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Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Centre.
Pre Hospitalisation	For 30 days prior to the date of hospitalisation
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/doctors fee	1. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/- per day. 2. Intensive Care Unit (ICU) charges / Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs.10,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or Rs.40,000/-, whichever is lower, per eye, under one policy year.
AYUSH	We will cover Medical Expenses incurred for treatment as In-Patient or Day Care Treatment in an AYUSH Hospital/ AYUSH day care centre. This benefit shall also cover Pre-Hospitalization medical expenses for a period of upto 30 days before the date of admission to the AYUSH hospital/ AYUSH day care centre and Post-Hospitalization Medical Expenses for a period upto 60 days, subject to AYUSH In-Patient hospitalization or AYUSH day care treatment claim being admissible under this benefit.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 4 years
Cumulative bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate. Cumulative Bonus shall be provided only if No Claim Discount has not been availed for the claim free previous Policy Year.
Co Pay	5% co pay on all claims

Annexure-A

List I – Items for which coverage is not available in the policy

Sl No	*Item*
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES

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4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
43	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUSBEDORWATERORAIRBEDCHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHO KIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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List II – Items that are to be subsumed into Room Charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/ INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

Sl No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES

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18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

Sl No	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	& PAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT1 DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES-DIETICIAN CHARGES-DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

Annexure- B

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES

Centre	Address & Contact	Jurisdiction of Office Union Territory, District
Ahemdabad	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahemdabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
Bengaluru	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka

TATA AIG GENERAL INSURANCE COMPANY LIMITED
Regd Office: 15th Floor, Tower A, Peninsula Business Park, G. K. Marg, Lower Parel, Mumbai - 400 013
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Centre	Address & Contact	Jurisdiction of Office Union Territory, District
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
Bhubaneswar	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
Chandigarh	Office Of The Insurance Ombudsman, 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
Chennai	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet,CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
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
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

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Centre	Address & Contact	Jurisdiction of Office Union Territory, District
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
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
Kolkata	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
Lucknow	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
Mumbai	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, 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)

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