TATA AIG MediCare Plus
Policy Wording

Policy Wordings

TATA AIG General Insurance Company Limited (We, Our or Us) will provide the insurance cover, described in this Policy and any endorsements thereto, for the Insured Period, as defined in the Policy schedule. The insurance cover provided under this Policy is only with respect to such and so many of the benefits upto the Sum Insured in excess of Aggregate Deductible as mentioned in the Policy Schedule. Commencement of risk cover under the policy is subject to receipt of premium by us.

The statements contained in the Proposal signed by the Policyholder (You) shall be the basis of this Policy and are deemed to be incorporated herein. The insurance cover is governed by and subject to, the terms, conditions and exclusions of this Policy.

For **TATA AIG General Insurance Company Limited**

TATA AIG GENERAL INSURANCE COMPANY LIMITED
Authorized Signatory

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 (Senior Citizen)
Visit us at www.tataaig.com
IRDA of India Registration No.:108
CIN: U85110MH2000PLC128425
UIN: TATHLIP21253V022021

"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.

Preamble

While the policy is in force, if the Insured Person contracts any disease or suffers from any illness or sustains bodily injury through accident and if such event requires the insured Person to incur expenses for Medically Necessary Treatment, We will indemnify You 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. Each Benefit is subject to its Sum Insured and deductible as specified in the Policy Schedule, but Our liability in aggregate to make payment in respect of any and all Benefits shall be limited to the Sum Insured and will only begin when the deductible is exceeded.

In case of family floater policy, the sum insured & deductible for all or any of the benefits shall be on a per policy per year basis. In case of an individual policy, the sum insured & deductible for all or any of the benefits shall be on a per insured person per year basis.

All claims under the policy benefits shall be payable only if the aggregate of covered medical expenses, in respect to hospitalization(s) in a policy year is in excess of deductible specified in the policy schedule. In case of multi-year policy (i.e. tenure more than 1 year), such aggregate deductible would be applicable on annual basis.

The said Medically Necessary Treatment must be on the advice of a qualified Medical Practitioner.

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 include the female and references to any statutory enactment include 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. 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.

3. 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 round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has

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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.

4. AYUSH Treatment

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

5. 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.

6. 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.

7. 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.

8. Condition Precedent

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

9. Cumulative Bonus

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

10. 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 procedures are carried out;

iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

11. 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.

12. Deductible

Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply

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before any benefits are payable by the insurer.

A deductible does not reduce the Sum Insured.

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 in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;

ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

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

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

v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

17. Hospitalization

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

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

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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. Medical Advice

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

23. Medical Expenses

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

24. 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.

25. 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.

26. 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.

27. Network Provider

Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility. The updated list of Network Provider is available on Our website (www.tataaig.com).

28. 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.

29. OPD treatment

OPD treatment means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room

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for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

35. 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.

36. 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.

37. Room Rent

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

38. 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.

39. 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 most recent birthday as per the English calendar, regardless of the actual time of birth.

2. Policy

Policy means the contract of insurance including but not limited to Policy Schedule, Endorsements , Policy Wordings and Riders.

3. 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.

4. Policy Schedule

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

5. Policy year

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 Expiry date.

Section 2 – Benefits

The following benefits are payable subject to Terms and Conditions of the policy:

B1. In-Patient Treatment

We will cover for expenses for hospitalization due to disease/illness/Injury during the policy period that requires an Insured Person's admission in a hospital as an inpatient.

Medical expenses directly related to the hospitalization would be payable.

B2. Pre-Hospitalization expenses

We will cover for expenses for Pre-Hospitalization consultations, investigations and medicines incurred upto 60 days before the date of admission to the hospital.

The benefit is payable if We have admitted a claim under B1 or B4 or B6.

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 or B4 or B6.

B4. Day Care Procedures

We will cover expenses for listed Day Care Treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre. The list of such day care procedures covered is available on our website (www.tataaig.com).

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

B5. Organ Donor

We will cover for Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs (Amendment) Bill, 2011 and the organ donated is for the use of the Insured Person, and

ii. We have accepted an inpatient Hospitalization claim for the insured member under In Patient Hospitalization Treatment (section B1).

B6. Domiciliary Treatment

We will cover for expenses related to Domiciliary Hospitalization of the insured person if the treatment exceeds beyond three days. 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

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(Section 1) of this Policy.

B7. AYUSH Benefit

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 60 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. 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 Rs. 3000 per Hospitalization.

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

B9. Health Checkup

We will cover for expenses for a Preventive Health Check-up upto 1% of previous sum insured subject to a maximum of Rs. 10,000/- per policy. The limit is the maximum per policy and more than one insured can utilize the amount.

The benefit is payable once after block of every two continuous claim free policy years with us. This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus. Deductible shall not be applicable for this benefit.

B10. Consumables Benefit

We will pay for expenses incurred, for specified consumables listed in 'Annexure I – List I of Optional Items (Consumables Benefit)' which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I-Optional items (Consumables Benefit) are available on our website (www.tataaig.com).

However the following items shall be excluded from scope of this coverage:

- Items of personal comfort, toiletries, cosmetics and convenience shall be excluded from scope of this coverage.
- External durable devices like Bilevel Positive Airway Pressure (BIPAP) machine, Continuous Positive Airway Pressure (CPAP) machine, Peritoneal Dialysis (PD) equipment and supplies, Nimbus/water/air bed, dialyzer and other medical equipments.
- Any item which is neither a medical consumable nor medically necessary nor prescribed by doctor.

  For this claim to be paid, the main claim must be admissible under section B1 or B4 of this policy.

B11. In-Patient Treatment - Dental

We will cover for medical expenses incurred towards hospitalization for dental treatment under anesthesia necessitated due to an accident/injury/illness.

B12. Second Opinion

We will provide You a second opinion from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with the below mentioned Illnesses 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

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vii. Organ failure requiring transplant

viii. Heart Valve replacement

ix. Brain tumors

This benefit can be availed by an Insured Person once during a Policy Year.

B13. Global Cover (Optional Cover)

We will cover for Medical Expenses of the Insured Person incurred outside India, upto the sum insured, provided that the diagnosis was made in India and the insured travels abroad for treatment.

The Medical Expenses payable shall be limited to Inpatient and daycare Hospitalization only on reimbursement basis. Cashless facility may be arranged on case to case basis. Insured person can contact us for any claim assistance.

The payment of any claim under this benefit will be in Indian Rupees based on the rate of exchange as on the date of invoice, published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for claims payment. If these rates are not published on the date of invoice, the exchange rate next published by RBI shall be considered for conversion.

We shall require the following additional documents of the insured person for supporting the claim under this benefit:

- Proof of diagnosis in India
- Insured's Passport and Visa

B14. Cumulative Bonus

i. 50% cumulative bonus will be applied on the Sum Insured for next policy year under the Policy after every claim free Policy Year, provided that the Policy is renewed with Us and without a break. The maximum cumulative bonus shall not exceed 100% of the Sum Insured in any Policy Year.

ii. If a Cumulative Bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the Cumulative Bonus by 50% of the Sum Insured in that following Policy Year. There will be no impact on the Inpatient Sum Insured, only the accrued Cumulative Bonus will be decreased.

iii. In policies with a tenure of more than one year, the above guidelines of Cumulative Bonus shall be applicable post completion of each policy year.

iv. In relation to a Family Floater, the Cumulative Bonus so applied will only be available in respect of those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

v. Cumulative Bonus shall not be applicable for newly added members in the year of addition.

vi. For purpose of computation of Cumulative Bonus, the percentage (%) of Cumulative Bonus will be applied on the Inpatient Sum Insured only.

vii. Cumulative Bonus shall be provided only if No Claim Discount has not been availed for the claim free previous Policy Year.

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, unless expressly stated to the contrary in this Policy.

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.

f. List of Specific Diseases/ procedures as furnished below:

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

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The following treatments are covered after a waiting period of two years irrespective of the illness for which it is done:

XXVII. Adenoidectomy
XXVIII. Mastoidectomy
XXIX. Tonsillectomy
XXX. Tympanoplasty
XXXI. Surgery for nasal septum deviation
XXXII. Nasal concha resection
XXXIII. Surgery for Turbinate hypertrophy
XXXIV. Hysterectomy
XXXV. Joint replacement surgeries Eg: Knee replacement, Hip replacement
XXXVI. Cholecystectomy
XXXVII. Herniorraphy or Herniorraphy
XXXVIII. Surgery/procedure for Benign prostate enlargement
XXXIX. Surgery for Hydrocele/ Rectocele
XL. 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

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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- 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.

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 -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) :**

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

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

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.

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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 mentioned under Section 3 (i) above)

1. Medical Exclusions

i. Alcoholic pancreatitis;

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 benefit B1 or B4 of this policy;

iv. Growth hormone therapy;

v. Sleep-apnoea;

vi. Admission primarily for administration of Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid;

vii. Venereal disease, sexually transmitted disease or illness;

viii. All preventive care, vaccination including inoculation and immunisations;

ix. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization & any dental treatment other than specified in 'Inpatient Treatment – Dental';

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

2. Non-Medical Exclusions

i. War or any act of war, invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.

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

iii. Intentional self- injury or attempted suicide while sane or insane.

iv. 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.

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

vi. 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.

vii. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy.

viii. Any treatment and associated expenses for alopecia,

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baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

ix. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.

x. Crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively and explicitly stated and covered in the policy).

xi. 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.

xii. Any claim within the deductible limit as specified in the policy schedule.

Section 4 – General Terms and Clauses

Standard General Terms and 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

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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 the 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 established fraud, misrepresentation or non-disclosure of material facts.

8. Migration

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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.

Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud, non-disclosure or misrepresentation.

i. Renewal shall not be denied on the ground that the insured person 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 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 (Anually/ Half-Yearly/Quarterly/ Limited Premium Payment 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.

c. 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.

vi. No loading shall apply on renewals based on individual claims experience.

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

11. 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.

12. 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.

13. 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 has not made any claim during the Free Look Period, the insured shall be entitled to

i. 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.

14. 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 6489 8282/ 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**.

15. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under

the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/ Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

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

16. Premium Payment

i. Premium to be paid for the Policy Period before Policy Commencement date as opted by You in the proposal form.

ii. Long term premium discount of 5% and 10% is applicable for policy with tenure of 2 and 3 years respectively.

17. Insured Person

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

ii. Any person may be added during the Policy Period after his application 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.

iii. We will be offering continuous renewal with no exit age subject to regular premium payment and compliance with all provisions and terms & conditions of this policy by the Insured Person.

18. Loadings

i. We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance).

ii. The maximum risk loading applicable for an individual shall not exceed 100% of premium per diagnosis / medical condition and an overall risk loading of over 150% of premium per person.

iii. The loading shall only be applied basis an outcome of Our medical underwriting.

iv. 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.

v. 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. Sum Insured Enhancement and Change in deductible

i. Sum Insured and/or Deductible can be changed only at the time of renewal subject to underwriting guidelines of the company.

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ii. In case of increase in the Sum Insured waiting period and exclusions will apply afresh in relation to the amount by which the Sum Insured has been enhanced. For claims arising in respect of accident, injury or illness contracted or suffered during a preceding Policy period, liability of the Company shall be only to the extent of the Sum Insured under the Policy in force at the time when it was contracted or suffered.

21. Change of Policyholder

The change of Policyholder is permitted only at the time of renewal.

If the Insured Person is no longer eligible on grounds of age or dependency, the insured member will be eligible to apply for a new policy and enjoy continuity benefits upto Sum Insured.

22. 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 Persons 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.

Section 5 – Claims Procedure and Claims Payment

This section explains about the procedures involved to file a valid claim by the insured member and processes related in managing the claim by TPA or Us. 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

	Treatment, Consultation or Procedure:	We or Our TPA* must be informed:
1	If any treatment for which a claim may be made and that treatment requires planned Hospitalisation:	At least 48 hours prior to the Insured Person's admission.
2	If any treatment for which a claim may be made and that treatment requires emergency Hospitalisation	Within 24 hours of the Insured Person's admission to Hospital.

Failure to furnish such intimation 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 of such delay within such time. The Company may relax these timelines only in special circumstances and for the reasons beyond the control of the insured.

**TPA as mentioned in the policy schedule*

2. Cashless Service

Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:

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If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	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 treatment or Hospitalisation
If any treatment, consultation or procedure for which a claim may be made, requiring emergency hospitalisation	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation

3. Procedure for Cashless Service

i. Cashless Service is only available at Network Hospitals.

ii. In order to avail of 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. For any emergency Hospitalisation, our designated TPA/We must be informed no later than 24 hours of the start of Your hospitalization/ treatment.

c. For any planned hospitalization, our designated TPA/We must be informed atleast 48 hours prior to the start of your hospitalization/treatment.

d. 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.

e. 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**.

f. In case the ailment /treatment is not covered under the policy or cashless is rejected due to insufficient documents submitted, a rejection letter would be sent to the **Hospital/ You** by TPA/**Us**

- **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.

g. 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.

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

i. 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

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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) 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. Stickers and invoice of implants used during surgery.

j. 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.

k. 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.

l. Legal heir/succession certificate, if required;

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m. PM report (wherever applicable and conducted);

n. If the original claim documents mentioned above are submitted to any other insurer, we would require:

- Self –attested copies of the claim documents
- Certificate / Claim settlement letter from other insurer or TPA

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 an independent 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 Payment

i. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and We have been provided with the documentation and information We or Our TPA has requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

ii. 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.^

iii. This Policy only covers medical treatment taken within India (except in case of benefit B13- Global cover, if opted), and payments under this Policy shall only be made in Indian Rupees within India.

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

1. 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.

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Annexure A
NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES

SN	Centre	Address & Contact	Jurisdiction of Office Union Territory, District
1	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
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	Bhubaneswar	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	Tamil 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

SN	Centre	Address & Contact	Jurisdiction of Office Union Territory, District
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

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SN	Centre	Address & Contact	Jurisdiction of Office Union Territory, District
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

SN	Centre	Address & Contact	Jurisdiction of Office Union Territory, District
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

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.

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