Section 1: Preamble

We will provide the insurance cover detailed in the Policy to the Insured Person(s) up to the Sum Insured subject to:

i. The terms, conditions and exclusions of this Policy.

ii. Statements in the proposal/enrolment form and information disclosed to Us by You or on Your behalf and on behalf of all persons to be insured which is incorporated into the Policy and is the basis of it.

Commencement of risk cover under the policy is subject to receipt of premium by Us.

While the Policy /Certificate of Insurance is in force, and if the claim is admissible under the Policy / Certificate of Insurance, then We shall pay You such Reasonable and Customary Medical Expenses incurred on treatment or pay for the listed Benefits as per the applicable limits / amount /Sum Insured. The said treatment must be on the advice of a qualified Medical Practitioner.

The insurance provided under this Policy / Certificate of Insurance is only with respect to such and so many of the Sections/Benefits as are indicated by a specific amount set opposite in the Policy Schedule/Certificate of Insurance. Notwithstanding anything to the contrary stated herein waiting periods wherever mentioned in the Policy Schedule/Certificate of Insurance shall prevail.

Our liability in aggregate at any time shall not exceed the Sum Insured / limit / amount as applicable for the Benefits as specified in the Policy Schedule/ Certificate of Insurance. In case of family floater, the Sum Insured / limit / amount shall be the maximum liability for Us for all the claims in aggregate made by any or all of the Insured Persons in the family per policy per year whereas in case of individual, this shall be applicable for all the claims made by an individual Insured Person per policy per year

In case of any other Sum Insured / limit / amount restrictions, the same shall be clearly specified in the Policy schedule/Certificate of Insurance.

The Sum Insured / Limits for all the Benefits, Extensions and Add ons are part of the Sum Insured as defined for Benefit In-patient Treatment (B1) of this Policy unless specified otherwise

Section 2 : General 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. Any one illness

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

3. 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.

4. Congenital Anomaly

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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

5. Co-Payment

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

6. Cumulative Bonus

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

7. 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.

8. 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

9. 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 before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

10. Dental Treatment

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

11. Domiciliary Hospitalization

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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.

12. 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

13. Grace Period

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

14. 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;

15. 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.

16. 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

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characteristics:

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

ii. it needs ongoing or long-term control or relief of symptoms

iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

iv. it continues indefinitely

v. it recurs or is likely to recur

17. 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.

18. In-patient Care

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.

19. 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.

20. Maternity expenses

Maternity expenses means;

a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b. expenses towards lawful medical termination of pregnancy during the policy period.

21. Medical Advice

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

22. 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.

23. 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.

24. 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

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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.

25. Migration

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

26. New Born Baby

New Born Baby means baby born during the Policy Period and is aged up to 90 days

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

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 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 means any condition, ailment or injury or disease

- That is/are diagnosed by a Physician within 48 months prior to the effective date of the Policy issued by the Insurer or its reinstatement; or
- For which medical advice or treatment was recommended by, or received from, a Physician within 48 months prior to the effective date of the Policy issued by the Insurer; or its reinstatement.

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. 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 in-patient hospitalization claim for such hospitalization is admissible by the insurance company

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33. 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.

34. 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.

35. 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.

36. Room Rent

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

37. 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.

38. 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

39. 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.

40. Associated Medical Expenses

Associated Medical Expenses shall include Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner/surgeon/ anesthetist/ Specialist conducted within the same Hospital where the Insured Person has been admitted.

41. Break in Policy

Break in Policy means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

42. Certificate Period

Certificate Period means the time during which this Cover is in effect. Such period commences from the Commencement Date and ends on the Expiry Date and specifically appears in the Certificate of Insurance against the Insured Person during which this Coverage is valid for that specific Insured Person.

43. Policy

Policy means the contract of insurance including but not limited to Policy Schedule, Certificate of Insurance, Endorsements, Annexures, Policy Wordings and Add On covers wherever opted for.

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44. 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.

45. Policy Schedule

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

46. Policy year

Policy Year means a period of twelve months beginning from the date of commencement of the policy / Certificate period and ending on the last day of such twelve-month period till the Policy Period expiry. 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 / Certificate period, as mentioned in the Policy Schedule / Certificate of Insurance

47. Policyholder

The Policyholder shall be the Employer who has taken the group insurance policy as a service benefit to his Employees or a Group Manager of a homogeneous group of persons who assemble together for a commonality of purpose and there is a clearly evident relationship between the member and group manager for services other than insurance.

48. Sub limit

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.

49. Special Conditions

Means the clauses or the conditions as mentioned in the Policy Schedule / Certificate of Insurance which shall override all other clauses as mentioned in the Policy.

50. Room Category

Room Category shall mean one of the following:

a. Single Private Room means a hospital room with one patient bed and such room must be the most economical of all accommodations available in that hospital as single occupancy.

b. Shared Accommodation means a hospital room with two or more patient beds.

c. Economy Ward means a hospital room with more than three patient beds.

This definition does not apply to Intensive Care Unit (ICU) or Intensive Critical Care Unit (ICCU).

51. Third Party Administrator (TPA)

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.

52. Waiting Period

Waiting Period means a period from the inception of this Policy / Certificate 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.

53. We/Us/Our

means TATA AIG General Insurance

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Company Limited.

54. You/Your/Yourself

means the Policy Holder and/or Insured Person(s) who is named in the Policy Schedule / Certificate of Insurance.

Section 3: Base Covers

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

B1. In-Patient Treatment

We will cover for expenses incurred during Hospitalization due to disease/illness/ Injury that requires an Insured Person's admission in a Hospital during the Policy / Cover Period as an In-Patient.

Medical expenses directly related to the hospitalization would be payable subject to the following:

i. **Limit on Room Rent/Room Category:** We will, limit Room Rent / Room Category up to the amount/ percentage of Sum Insured or room category, as specified in the Policy Schedule/ Certificate of Insurance.

ii. **Associated Medical Expenses:**

a. If the Insured Person is admitted in a room where the Room Rent expenses incurred are higher than the limit specified in the Policy Schedule/ Certificate of Insurance, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon), except pharmacy charges, diagnostic costs, costs of implants & medical devices and consumables expenses, in the proportion of the difference between the Incurred Room Rent and Eligible Room Rent to the Incurred Room Rent.

Not applicable

Expenses to be borne by Insured Person =

{(Associated Medical Expenses) X (Incurred Room Rent– Eligible Room Rent)} / Incurred Room Rent

b. If the Insured Person is admitted in a room which is of higher category than the limit specified in the Policy Schedule/ Certificate of Insurance, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon), except pharmacy charges, diagnostic costs, costs of implants & medical devices and consumables expenses, in the proportion of the difference between the Incurred Room Rent and the Room Rent as applicable to the eligible Room Category in that Hospital to the Incurred Room Rent.

Expenses to be borne by Insured Person =

{(Associated Medical Expenses) X (Incurred Room Rent– Eligible Room Rent of the Eligible Room Category)} / Incurred Room Rent

iii. **Co-pay on Higher Room Category**

If the Insured Person is admitted in a hospital where the room category opted is higher than the category specified in the Policy Schedule/ Certificate of Insurance, then the Insured Person shall bear such percentage of the admissible

Not applicable

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claim amount as mentioned in the Policy Schedule / Certificate of Insurance

Not applicable

In case of unavailability of specified room category, the person is eligible for next available hospital room category provided that necessary documented proof for unavailability of such hospital room category is furnished to us.

iv. Limit on Treatment of/ Illness/ Surgery/Procedure / Medical Condition

We will cover the Medical Expenses incurred towards treatment of/ Illness/ Surgery/Procedure / Medical Condition upto the amount of Sub-Limit applicable per claim during the Policy Year as specified in the Policy Schedule / Certificate of Insurance. All expenses related to Any One Illness including its Pre-Hospitalisation expenses and Post-Hospitalisation expenses are considered as one Single Claim.

Not applicable

B2. Pre-Hospitalization expenses

We will cover the Pre-Hospitalization expenses for medical expenses incurred up to the number of days or the limit as specified in the Policy Schedule/Certificate of Insurance.

The benefit is payable if We have admitted a claim under In-patient Treatment(B1)/ Day Care Procedures(B4) /Domiciliary Hospitalisation(B5).

B3. Post-Hospitalization expenses

We will cover the Post-Hospitalization expenses for medical expenses incurred upto the number of days or the limit as specified in the Policy Schedule/Certificate of Insurance.

The benefit is payable if We have admitted a claim under In-patient Treatment(B1)/ Day Care Procedures (B4) /Domiciliary Hospitalisation(B5).

B4. Day Care Procedures

We will cover Medical expenses for listed Day Care Procedures due to disease/ illness/Injury during the Policy / Certificate 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) or shall be attached along with the Policy.

This benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance. Treatment normally taken on out-patient basis is not included in the scope of this cover.

B5. Domiciliary Hospitalisation

We will cover for expenses related to Domiciliary Hospitalization of the Insured Person during the Policy / Certificate Period 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 (Section 2.i.11) of this policy and this does not include Home Care Expenses (A23).

This benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance.

B6. 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:

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i. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act (Amended), 1994 and other applicable laws and rules and the organ donated is for the use of the Insured Person, and

ii. We have accepted an In-patient Hospitalization claim for the insured Person under In-Patient Treatment (B1).

This benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance.

B7. 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 Sub limit as specified in the Policy Schedule/Certificate of Insurance.

For this claim to be paid, the claim must be admissible under section In-patient Treatment(B1) or Day Care Procedures(B4) of this policy.

B8. Maternity Cover

Not applicable

We will cover for maternity expenses for the delivery of a child and/or maternity expenses related to a Medically Necessary Treatment and lawful medical termination of pregnancy, during the Policy Year, subject to the Sub-Limits and maternity waiting period as specified in the Policy Schedule. Medical expenses incurred for resuscitation of newborn baby shall form part of the maternity Sub imit.

We will not cover ectopic pregnancy under this benefit (although it shall be covered under section In-patient Treatment (B1) of this Policy

Expenses incurred for pre/post natal care shall be excluded from the scope of this coverage.

If this benefit is opted for under the Policy and the same has been specified by mentioning a Sum Insured /Limit under the Policy Schedule / Certificate of Insurance then Exclusion clause in Section 3 – General Exclusions under Medical Exclusions No. m. Maternity Expenses (Code - Excl 18) stands deleted.

B9. Pre/Post Natal Cover

Not applicable

We will cover for medical expenses incurred during the Policy Year on out-patient basis, in respect of pre- natal check-ups, since confirmation of pregnancy, post-natal check-ups for a period up to six weeks from date of delivery, prescribed pre- natal medicines and diagnostic tests up to the limit specified in the Policy Schedule/ Certificate of Insurance provided that:

i. The [illegible]

ii. The maternity claim is admissible by Us under Maternity Cover (B8)

The Sum Insured applicable for pre/ post natal cover on out-patient basis shall be part of Maternity limit.

We will not be liable to make any payment in respect of any Pre-hospitalization Expenses or Post – hospitalization Expenses under the Base Cover.

B10. Baby day one Cover

Not applicable

We will cover for Medical Expenses incurred within [illegible] the date of Birth of the baby, during the Policy Year, towards the In-patient treatment (B1) of

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the New Born Baby within the limit as specified in the Maternity Cover (B8), as specified in the Policy Schedule/ Certificate of Insurance.

New Born Baby can be covered under the Policy as an Insured Person only by way of an endorsement or at the next Renewal, whichever is earlier, on payment of the requisite premium.

Not applicable

B11. Family Transportation Benefit

If We have accepted a claim under Benefit In-patient Treatment(B1), then We will reimburse the actual expenses incurred in transporting one Immediate Family Member from the Insured Person's residence to the Hospital where the Insured Person is admitted, provided that such Hospital is located at least 200 kms away from the Insured Person's residence up to the limit as specified in the Policy Schedule/Certificate of Insurance.

For the purpose of this benefit, Immediate Family Member means the Insured Person's legal spouse, children, parents, parents-in-law, legal guardian, ward, step child or adopted child.

Section 4 – General Exclusions

i. Standard Exclusions

1. Waiting Period

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 << as specified under the Policy Schedule/Certificate of Insurance>> months of continuous coverage after the date of inception of the first policy with insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) 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 << as specified under the Policy Schedule/ Certificate of Insurance>> months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

Explanation: The waiting period as applicable, not exceeding 48 months, shall be specified in the Policy Schedule/ Certificate of Insurance and shall be applicable to << all Pre-existing diseases / specified Pre-existing diseases>> in relation to <<Insured persons/Dependents of Primary Insured person>>

In the event of no waiting period being mentioned in the Policy Schedule/ Certificate of Insurance then it shall mean that this exclusion has been waived off

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 << as specified under the Policy Schedule/ Certificate of Insurance>> 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

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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

a. Tumors, Cysts, polyps including breast lumps (benign)

b. Polycystic ovarian disease

c. Fibromyoma

d. Adenomyosis

e. Endometriosis

f. Prolapsed Uterus

g. Non-infective arthritis

h. Gout and Rheumatism

i. Osteoporosis

j. Ligament, Tendon or Meniscal tear (except for those arising out of Injury during Policy Period)

k. Prolapsed Inter Vertebral Disc (except for those arising out of Injury during Policy Period)

l. Cholelithiasis

m. Pancreatitis

n. Fissure/fistula in anus, haemorrhoids, pilonidal sinus

o. Ulcer & erosion of stomach & duodenum

p. Gastro Esophageal Reflux Disorder (GERD)

q. Liver Cirrhosis

r. Perineal Abscesses

s. Perianal / Anal Abscesses

t. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.

u. Benign Hyperplasia of prostate

v. Varicocele

w. Cataract

x. Retinal detachment

y. Glaucoma

z. Congenital Internal Diseases

aa. Adenoidectomy

bb. Mastoidectomy

cc. Tonsillectomy

dd. Tympanoplasty

ee. Surgery for nasal septum deviation

ff. Nasal concha resection

gg. Surgery for Turbinate hypertrophy

hh. Hysterectomy

ii. Joint replacement surgeries Eg: Knee replacement, Hip replacement

jj. Cholecystectomy

kk. Hernioplasty or Herniorraphy

ll. Surgery/procedure for Benign prostate enlargement

mm. Surgery for Hydrocele/ Rectocele

nn. Surgery of varicose veins and varicose ulcers

Explanation: The waiting period as applicable to each of these illnesses/ conditions/surgeries shall be as specified in

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the Policy Schedule/Certificate of Insurance and shall be applicable to <<Insured persons/Dependents of Primary insured person>>

In the event of no waiting period being mentioned in the Policy Schedule/ Certificate of Insurance then it shall mean that this exclusion has been waived off.

30 day Waiting Period (Code- Excl 03)

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

Explanation:

a. The waiting period as applicable, not exceeding 30 days, shall be specified in the Policy Schedule/Certificate of Insurance and shall be applicable to <<Insured persons/Dependents of Primary insured person>>

b. In the event of a Pandemic or epidemic, the Company may at its discretion reduce the above mentioned waiting period and the same shall be specified in the Policy Schedule/Certificate of Insurance along with the name of the Pandemic / Epidemic for which it is applicable

c. In the event of no waiting period being mentioned in the Policy Schedule/ Certificate of Insurance then it shall mean that this exclusion has been waived off.

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:

a. Investigation & Evaluation(Code- Excl 04)

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

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

b. Rest Cure, rehabilitation and respite care(Code- Excl 05)

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.

c. 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

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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

d. 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.

e. 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.

f. 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.

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

h. 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)**

i. 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)**

j. Refractive Error:(Code- Excl 15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

k. Unproven Treatments:(Code- Excl 16)

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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.

l. 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

m. Maternity (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

a. 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.

b. 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.

ii. Specific Exclusions

4. Medical Exclusions

a. Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the Insured Person.

b. Congenital External Diseases, defects or anomalies.

c. Stem cell therapy, however Hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under Benefit B1 and B4 of this Policy.

d. Growth hormone therapy.

e. Sleep-apnoea.

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

g. Venereal disease, sexually transmitted disease or illness.

h. All preventive care, vaccination including inoculation and immunisations (except in case of post- bite treatment and other vaccines explicitly covered).

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i. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization.

j. Circumcisions unless as a result of Illness/Accidental Bodily Injury and forming part of the treatment.

k. Any non-allopathic treatment.

l. Alcoholic pancreatitis.

m. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

n. The expenses incurred by the Insured Person on organ donation.

o. Home Care expenses unless explicitly stated and covered in the policy.

p. 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 Home care treatment

5. Non-Medical Exclusions

a. 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.

b. 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.

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

d. 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.

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e. 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.

f. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

g. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy unless explicitly stated and covered in the policy.

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

i. 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.

j. 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).

k. Any illness diagnosed or injury sustained or where there is change in health status of the member after date of proposal/enrolment form and before commencement of Policy/Certificate of Insurance and the same is not communicated to us and accepted by Us.

l. Treatment / Diagnosis outside India.

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

n. Expenses as specified in Annexure I are excluded from this Policy.

Section 5 : General Conditions

i. Standard General Terms and Clauses

1. 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.

2. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of mis-representation, mis-description or non-disclosure of any material fact by the 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)

3. 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.

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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 mis-statement of or suppression of material fact are within the knowledge of the insurer.

4. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.

iii. If the amount to be claimed exceeds the sum insured under a single Policy, the Insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

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

5. Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

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

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. 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

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benefits without Break in Policy. Coverage is not available during the grace period.

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

6. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

7. 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.

8. Cancellation

The Policyholder / Certificate of Insurance holder may cancel this policy/Certificate, as applicable, by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy / cover period as detailed below.

<<The Company will incorporate the refund table in the Policy wordings as per the rules defined below.

Pro-rata refund grid

In case of Employer / Employee Policy– where the deletion of members is on account of the following reasons premium shall be refunded on pro-rata basis

Not applicable

i. Cessation of Employment

ii. Death of Employee

Short Rate Table:

In case of Non-Employer / Employee Policy– premium shall be refunded on short scale basis as defined below in case of any cancellation by the Policyholder/ Insured

	Year				
Length of time Policy in force	1	2	3	4	5
Upto 1 Month	85.00%	87.50%	91.50%	96%	98%
>1 month & Upto 3 Months	70.00%	75.00%	88.50%	93%	95%
>3 months & Upto 6 Months	50.00%	62.50%	75%	78%	80%
>6 months & Upto 12 Months	Nil	50.00%	66.50%	70%	72%

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>12 months & Upto 15 Months	Not Applicable	30%	50%	52%	54%
>15 months & Upto 18 Months	Not Applicable	20%	41.50%	43%	44%
>18 months & Upto 24 months	Not Applicable	Nil	33%	35%	36%
>24 months & Upto 30 months	Not Applicable	Not Applicable	15%	20%	30%
> 30 months & Up to 36 months	Not Applicable	Not Applicable	Nil	15%	25%
> 36 months & up to 42	Not Applicable	Not Applicable	Not Applicable	Nil	20%
Exceeding 42 months	Not Applicable	Not Applicable	Not Applicable	Nil	Nil

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Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or any Benefit (including those provided under A21. Wellness Services / A22. Wellness Program) has been availed by the Insured Person under the Policy.

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

9. Claim settlement (provision of Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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.

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("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)

10. 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.

11. Moratorium Period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, Sub limits, co-payments, deductibles as per the policy contract.

ii. Specific terms and clauses

12. 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.

13. Condition Precedent

i. The premium for the policy will remain the same for the policy period as mentioned in the Policy Schedule / Certificate of Insurance

ii. No change in this Policy / Certificate of Insurance shall be valid unless a valid endorsement has been done in the Policy / Certificate.

iii. In case of master policy, the Policy Period would be 1 year however the period of Certificate of Insurance would be from 1 year to 5 years (in case of credit linked). Details of the policy term applicable to individual Certificate of Insurance would be clearly stated in Your Certificate of Insurance.

14. Insured Person

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

ii. Mid-term addition of Primary Insured and Dependants:

Mid-term addition of Primary insured and dependents shall be allowed in the event of following:

1. Intimation is given to Us by a defined & agreed date and shall be subject to Guidelines on Group Insurance Policies,

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dated 14th July 2005 issued by Insurance Regulatory and Development Authority of India and any subsequent amendments as published from time to time

2. Requisite premium has been received by Us.

3. All existing dependants must be covered, as permitted in the Policy, along with the Primary Insured and the addition of dependants shall be allowed only in the event of:

   - Children in the event of childbirth
   - Spouse in the event of marriage

If any of the conditions (1) & (2) above are not met, coverage will commence only from the date of intimation to Us or premium received date whichever is later.

iii. Mid-term deletion of Primary Insured and Dependants:

   a. In case of Employer-Employee Policies:

      - The coverage for existing Primary Insured and his dependants will automatically expire from date of cessation of employment.
      - Pro-rata refund of premium would be made on intimation provided such intimation is made by a defined date and no claim is made by the Primary Insured or his dependants.

   b. In case of non-Employer-Employee Policies, the coverage shall automatically expire from the date the Insured Person exits the scheme or no longer qualifies the criteria as mentioned in the Policy Schedule / Certificate of Insurance

15. Group Policyholder

The Group Policyholder shall take all reasonable steps to cover their members for whom coverages have been offered by the Company and ensure timely receipt of premium by the Company in respect of each of the members covered. The Group Policyholder will neither charge more premium nor alter the scope of coverage offered under this Policy.

This Policy will be issued to the Group Policyholder and Certificates will be issued to individual members wherever applicable.

The Company reserves the right to inspect the record at any time to ensure that terms and condition of Group policy and provisions of IRDAI group guidelines and any amendments thereto are being adhered. The Company may also require submission of Certificate of compliance from the Auditors of Group Policyholder

The Group Policyholder will ensure compliance of Guidelines as prescribed by IRDAI from time to time including but not limited to - Circular Ref: 015/IRDA/Life / Circular / GI Guidelines / 2005

16. Entire Contract

i. This Policy, its Schedule, endorsement(s), proposal/enrolment form constitutes the entire contract of insurance. No change in this policy shall be valid unless approved by

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Us and such approval be endorsed hereon.

ii. This Policy and the Policy Schedule/ Certificate of insurance 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.

17. Migration

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

For Detailed Guidelines on Migration, kindly refer Guidelines issued by IRDAI (Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: IRDAI/ HLT/ REG/ CIR/ 003/ 01/2020 dated 01/01/20.

18. Notices

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

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

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

19. Policy Review period

The insured person shall be allowed policy review period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured person has not made any claim during the policy review period, the insured person shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

20. Termination

In case of master policy, each Certificate of Insurance will get terminated on the earliest of the following dates:

a. The date You or We cancel the

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Certificate of Insurance

b. The member opts out of the scheme or no longer qualifies the criteria as mentioned in the Policy Schedule / Certificate of Insurance unless otherwise which shall be agreed at proposal/quote stage.

c. Foreclosure/closure of loan availed (wherever applicable)

- The Insured Person has an option to continue the cover till the expiry of the Certificate of Insurance in case of condition 20.c as mentioned above.
- Otherwise, In the event of foreclosure/closure of entire loan where Certificate of Insurance is terminated, We shall refund proportionate premium provided there are no claims under the policy. In case of prepayment of the entire loan and upon making any refund of premium under this Policy in accordance with the terms and conditions hereof in respect of the Insured person, the Cover in respect of the Insured person shall forthwith terminate and We shall not be liable hereunder

21. Arbitration

If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.

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

22. 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.

Section 6 : 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.

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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 /Home Care Expenses wherever opted	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

Leaflet_MotorInsurance_TAGIC	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:
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 / Home Care expenses (whereever opted)	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.

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

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

b. For any emergency Hospitalization, 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, the same shall be communicated to the hospital by TPA/Us within 6 hours of receipt of the documents.

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 within 6 hours.

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 accordingly coverage will be determined according to the terms and conditions of this Policy.

4. Supporting Documentation & Examination

i. You or someone claiming on Your behalf shall provide Us with documentation, medical records and information We or Our TPA may request 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 Hospitalisation or completion of treatment.

ii. 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

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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. Discharge Certificate from medical practitioner specifying date of start and completion of home care treatment. (If Home care expenses opted).

e. A precise diagnosis of the treatment for which a claim is made.

f. 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.

g. 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.

h. 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.

i. 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

j. A certificate from hospital regarding non-unavailability of bed in the hospital and advising treatment at home or consent from the insured person on availing home care benefit (If Home care expenses opted).

k. Copy of settlement letter from other insurance company or TPA

l. Stickers and invoice of implants used during surgery

m. 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.

n. Regulatory requirements as amended from time to time, currently mandatory NEFT (to

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enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements

o. Legal heir/succession certificate , if required

p. PM report (wherever applicable and conducted)

v. Note: In case You are claiming for the same event under an indemnity based policy of another insurer and are required to submit the original documents related to Your treatment with that particular insurer, then You may provide Us with 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.

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

5. Claims Payment

i. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full and on 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. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Interests Regulation), 2017.

Section 7 : Redressal of Grievance

In case of any grievance the Insured Person may contact through

Website: www.tataaig.com

Call us 24X 7 toll free helpline 1800 266 7780 or 1800 22 9966 (Senior Citizen) Email us at customersupport@tataaig.com

Write to us at: Customer Support, Tata AIG General Insurance Company Limited

A-501 Building No. 4 IT Infinity Park, Dindoshi, Malad (E), Mumbai - 400097

Visit the Servicing Branch mentioned in the policy document

The insured person may also approach the grievance cell at any of the Company's branches with details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured person may contact the grievance officer at manager.customersupport@tataaig.com. For updated details of grievance officer, kindly refer the link IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms. irda.gov.in/

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List of Insurance Ombudsman

SN	Centre	Address & Contact
1	Ahmedabad	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in
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
3	Bhopal	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in
4	Bhubaneswar	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in
5	Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
6	Chennai	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in
7	New Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in

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SN	Centre	Address & Contact
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
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
10	Jaipur	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in
11	Ernakulam	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in
12	Kolkata	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in
13	Lucknow	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in
14	Mumbai	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/ 27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in
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

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SN	Centre	Address & Contact
16	Patna	Office of the Insurance Ombudsman, 2nd Floor, North wing, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
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.: 020-41312555 Email: bimalokpal.pune@cioins.co.in

List of excluded expenses (non-medical) under indemnity policy are uploaded on our website. Please login to: https://www.tataaig.com / downloads/ Others/Annexure-I-List of Optional Items.

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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Appendix II: Endorsements

A. Inclusion of Covers Endorsements (Additional Covers)

It is hereby agreed that any and all endorsements issued under this Policy or endorsed thereon shall be expressly subject to the terms and conditions and exclusions of this Policy, except to the extent expressly varied by the endorsement and shall become applicable only upon endorsement and after receipt of requisite additional premium by Us. All other Policy terms, conditions and exclusions shall remain unchanged.

A1 Inclusion of Critical Illness Cover

A1.2 Inclusion of Critical Illness Cover on Indemnity basis

If an Insured Person is diagnosed with any of the Critical Illnesses which have been specified in the Policy Schedule / Certificate of Insurance and defined as below during the Policy Year, We will pay the expenses incurred in relation to In-patient Treatment, Pre-Hospitalisation Expenses, Post-hospitalisation Expenses, Day Care Procedures, Domiciliary Hospitalisation and Organ Donor expenses upto the Sum Insured specified in the Policy Schedule/ Certificate Of Insurance, provided that:

i. This cover shall be applicable to <<All Insured Persons/ Primary Insured Person /Dependents of Primary Insured Person>>.

ii. Where this Benefit under the Policy / Certificate has been issued on

- an Individual basis, our total and aggregate liability in respect of an Insured Person under this Benefit will be limited to the Critical Illness Sum Insured opted; or
- a Floater basis, our total and aggregate liability in respect of all the Insured Persons under this Benefit will be limited to the Critical Illness Sum Insured opted.

iii. Our total and aggregate liability during the Policy Year under this cover will be limited to the Critical Illness Sum Insured opted over and above the In-patient Treatment (B1) Sum Insured and Corporate Floater (if opted).

iv. This Benefit payable will be on an indemnity basis for treatment taken within India

v. Any Restored Sum Insured will not be available for coverage under this Section. Restored Sum Insured shall mean the In-patient treatment (B1) Sum Insured reinstated upon exhaustion of the Sum Insured during the policy period.

vi. If a Claim has been admitted under A.1.2 Inclusion of Critical illness Cover on Indemnity Basis for a specified Critical illness then coverage for the same. Critical illness upto the Sum Insured as specified in the Policy Schedule /Certificate of insurance shall be provided even under the continuous renewal of this policy with us.

Definitions Specific to this Coverage – A1

A. Activities of Daily Living- The Activities of Daily Living are:

I. Washing : the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

II. Dressing: the ability to put on, take

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off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

III. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

IV. Mobility: the ability to move indoors from room to room on level surfaces;

V. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

VI. Feeding: the ability to feed oneself once food has been prepared and made available.

B. Permanent Neurological Deficit- Permanent Neurological Deficit means Symptoms of dysfunction in the nervous system that is present on clinical examination and expected to last throughout the insured person's life. Symptoms that are covered include numbness, increased sensitivity, paralysis, localized weakness difficulty with speech, inability to speak, difficulty in swallowing, visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma.

C. "Critical Illness" shall mean any of the following critical illness with specific meaning as defined below and provided the same has been specifically covered under the Policy Schedule / Certificate of Insurance and under the respective Add-ons A1.2 :

List-1		List-2 = List – 1+ following:-	
1	Cancer of Specified Severity	7	Kidney Failure Requiring Regular Dialysis
2	Stroke resulting in permanent symptoms	8	Major organ Transplant / Bone Marrow Transplant
3	End Stage Liver Failure	9	Coma of Specified Severity
4	End Stage Lung Failure	10	Permanent Paralysis of Limbs
5	Myocardial Infarction (First Heart Attack of specific severity)	11	Muscular dystrophy
6	Major Brain Surgery	12	Myasthenia gravis
		13	Motor Neuron Disease with permanent symptoms
		14	Severe Progressive Supranuclear Palsy
		15	Third Degree Burns

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List 1		
1	Cancer of Specified Severity	I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma. II. The following are excluded – i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3. ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond; iii. Malignant melanoma that has not caused invasion beyond the epidermis; iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0 v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below; vi. Chronic lymphocytic leukaemia less than RAI stage 3 vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification, viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
2	Stroke resulting in permanent symptoms	i. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. ii. The following are excluded: a. Transient ischemic attacks (TIA) b. Traumatic injury of the brain c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

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3	End Stage Liver Failure	I. Permanent and irreversible failure of liver function that has resulted in all three of the following: i. Permanent jaundice; and ii. Ascites; and iii. Hepatic encephalopathy. II. Liver failure secondary to drug or alcohol abuse is excluded.
4	End Stage Lung Failure	End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following: i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and iv. Dyspnea at rest.
5	Myocardial Infarction (First Heart Attack of specific severity)	i. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria: a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain) b. New characteristic electrocardiogram changes c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. ii. The following are excluded: a. Other acute Coronary Syndromes b. Any type of angina pectoris c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.
6	Major Brain Surgery	The actual undergoing of Surgery to the brain arising from a disease process under general anesthesia during which a craniotomy / craniectomy is performed. Exclusion: Burr hole Surgery / brain Surgery on account of an Accident.
List 2= List – 1+ following:-		
7	Kidney Failure Requiring Regular Dialysis	End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

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8	Major organ Transplant / Bone Marrow Transplant	The actual undergoing of a transplant of: a. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. The following are excluded: o Other stem-cell transplants o Where only Islets of Langerhans are transplanted
9	Coma of Specified Severity	I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: i. no response to external stimuli continuously for at least 96 hours; ii. life support measures are necessary to sustain life; and iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.
10	Permanent Paralysis of Limbs	Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

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11	Muscular dystrophy	A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following 4 conditions: a. Family history of muscular dystrophy; b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction; c. Characteristic electromygram; or d. Clinical suspicion confirmed by muscle biopsy. The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living (as mentioned in Definitions under A1)as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months.
12	Myasthenia gravis	An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatigability, where all of the following criteria are met Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and The Diagnosis of Myasthenia Gravis and categorization are confirmed by a registered Medical Practitioner who is a neurologist. Myasthenia Gravis Foundation of America Clinical Classification: • Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere. • Class II: Eye muscle weakness of any severity, mild weakness of other muscles. • Class III: Eye muscle weakness of any severity, moderate weakness of other muscles. • Class IV: Eye muscle weakness of any severity, severe weakness of other muscles. • Class V: Intubation needed to maintain airway.

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13	Motor Neuron Disease with permanent symptoms	Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.
14	Severe Progressive Supranuclear Palsy	A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days and progressive nature evident.
15	Third Degree Burns	There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

Specific Conditions Applicable to Critical Illness Cover

i. Waiting Period as specified in the Policy Schedule /Certificate of Insurance shall be applicable to each Insured Person for this benefit from the later of Policy / Certificate commencement date or date of enrollment / Cover Start date of the Insured Person

ii. Survival Period as specified in the Policy Schedule /Certificate of Insurance shall be applicable for this benefit from the date of diagnosis.

Specific Exclusions Applicable to Critical Illness Cover

In addition to the policy exclusions, following exclusions shall be applicable for this critical illness cover. We will not pay for critical illness benefits for any loss resulting in whole or in part from, or expenses incurred, in respect of:

i. Any Pre-existing Condition, or its related conditions arising from it, or

ii. Any Critical Illness resulting from a physical condition which existed prior to first risk inception date which was not disclosed , or

iii. Any Critical Illness/Disability based on a Diagnosis made by the Insured or his/her Immediate Family Member or anyone who is living in the same household as the Insured or by a herbalists, acupuncturist or any other non-traditional health care provider.

A3 Inclusion of Nursing Allowance

i. We will pay per day allowance up to the number of days and the limit as specified in the Policy Schedule/ Certificate of Insurance and subject to deductible if applicable, related to the services of a registered nurse attending to the Insured Person at the Insured Person's home immediately following his discharge from Hospital, provided that the Medical Practitioner treating the Insured Person recommends the provision of such care for medical reasons provided,

ii. We have accepted an in-patient

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Hospitalisation claim under Benefit In-patient Treatment and

iii. This benefit payable would be within In-Patient Treatment (B1)Sum Insured

A7 Inclusion of Health-Check up

We will pay the Reasonable and Customary Charges incurred, in respect of health checkup as specified in the Policy Schedule/ Certificate of Insurance, during the Policy Year, up to the limit specified in the Policy Schedule/ Certificate of Insurance, subject to Sub limit if applicable provided that:

i. This benefit shall be applicable to <<All Insured Persons/Primary Insured Person/Dependents of Primary insured person>>

ii. The eligibility of the Insured Person and frequency of heath checkups will be as defined in the Policy Schedule/ Certificate of Insurance.

iii. The benefit payable would be over and above In-patient Treatment (B1) Sum Insured and does not affect Cumulative Bonus if opted.

A9 Inclusion of Restore Sum Insured Benefit

We will automatically restore the In-patient Treatment (B1) Sum Insured upon exhaustion of the Sum Insured during the policy period. This benefit can be availed once during the Policy Period subject to the following conditions:

i. This benefit shall be applicable to <<All Insured Persons/Primary Insured Person/Dependents of Primary insured person>>

ii. The restored Sum insured can be used for all claims made by the Insured Person(s) who have not claimed earlier under Sections – In-patient Treatment (B1), Pre/post Hospitalization expenses (B2 & B3) and Day Care Procedures(B4). In case the Insured Person has claimed under these sections, then this automatic restoration benefit is available for admissions due to unrelated illness/ diseases. However, this benefit for related illness/diseases would be available, in case of claimed insured person(s), for admissions after 45 days from the date of discharge of the earlier claim.

iii. In case of Family Floater policy, Reinstatement of Sum Insured will be available for all Insured Persons in the Policy on floater basis

iv. This benefit shall be applicable annually for policies with tenure of more than 1 year.

v. The unutilized restored sum insured cannot be carried forward.

vi. The Restore Benefit will be available only for those illnesses / Injury which are covered under In-patient Treatment (B1) and Day Care Procedures (B4)

A11 Inclusion of Personal Accident cover

The Benefit under Personal Accident Covers have a separate sum insured. The Company's total liability for all Claims admissible in aggregate under A11.1 Accidental Death (if opted) and A11.2 Permanent Total Disability (if opted) shall not exceed the Sum Insured as mentioned in the Policy Schedule / Certificate of Insurance.

A11.1 Accidental Death

If an Insured Person suffers an accident during the policy period and this is the

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proximate cause of his death within 365 days from the date of accident then We will pay to Insured person's nominee or legal heir the benefit Sum Insured specified in the Policy schedule/Certificate of insurance.

We will pay, the Sum Insured less any other amount paid/payable under Coverage: A11.2. Extension - Permanent Total Disability, of this Policy, if these Coverages are opted under this Policy, as a result of the same Accident.

Once a Claim has been accepted then this Coverage shall immediately and automatically cease in respect of that Insured Person.

Disappearance

We will pay the benefit for Loss of Life occurring within policy period if Insured person's body cannot be located within 365 Days after the forced landing, stranding, sinking or wrecking of a conveyance in which You were a passenger or as a result of any Acts of God, subject to all other terms and provisions of the Policy.

This benefit shall be applicable to <<All Insured Persons/Primary Insured Person/ Dependents of Primary insured person>>.

In addition to the claim documents mentioned under Section 6 (4-iv) of base cover policy wordings, following claim documents would be required for this benefit:

- Original \Attested copy of Death Certificate
- In case of disappearance where death certificate is not issued, missing complaint report filed with the police authorities or police inquest/ investigation report
- Copy of death summary,
- All previous medical records, if hospitalised / treatment given.

A11.2 Permanent Total Disability

We will pay the Sum Insured as specified in the Policy Schedule/Certificate of Insurance if injury to you results in you suffering Permanent Total Disability. The injury must occur within the policy period as mentioned in the Policy Schedule/ Certificate of insurance and the disability should continue for 365 days from the date of accident which caused the injury. This waiting period of 365 days is not applicable for severance or amputation cases.

If the Insured Person suffers more than one below mentioned loss as a result of the same accident, our liability shall be restricted to the sum insured mentioned on the Policy Schedule/Certificate of Insurance.

Once a Claim has been accepted and 100% Sum Insured has been paid then this Coverage shall immediately and automatically cease in respect of that Insured Person.

For the purpose of this cover, Permanent Total Disability shall mean either of the following:

- Irrecoverable Loss of sight of both eyes
- Physical Separation of or the irrecoverable loss of ability to use both hands or both feet
- Physical Separation of or the irrecoverable loss of ability to use one hand and one foot
- Irrecoverable Loss of sight of one eye and the physical separation of or the irrecoverable loss of ability to use

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either one hand or one foot.

This benefit shall be applicable to <<All Insured Persons/Primary Insured Person/Dependents of Primary insured person>>.

In addition to the claim documents mentioned under Section 6 (4-iv) of base cover policy wordings, we would require certificate from Civil Surgeon or Medical Superintendent/Dean of government hospital/medical board, confirming the Disability percentage / period and prognosis.

Specific Exclusions Applicable to Personal Accident Cover

The following exclusions will be applicable in addition to the exclusions under the Base Cover –Section 4 – General Exclusions:

i. Any existing injury/disability, or any complication arising from it, or

ii. Any physical disability which existed prior to first risk inception date which was not disclosed , or

iii. Claim which arises out of an Accident connected with the operation (including Flying, mounting, dismounting) of an aircraft or which occurs during parachuting except when the Insured Person is flying as a Fare Paying passenger in a multiengine, commercial aircraft.

A15 Cumulative Bonus

A15.1 Inclusion of Cumulative Bonus on existing renewals

Subsequent to this endorsement all the Insured Persons in the policy shall be entitled to cumulative bonus as follows:

i. Cumulative bonus as a percent as specified in the Policy Schedule / Certificate of Insurance shall be applied on the In-Patient Treatment (B1) Sum Insured for next policy year under the Policy after every claim free Policy Year, provided that the Policy is renewed with Us without a break. The maximum cumulative bonus shall not exceed <<Percentage as specified in the Policy Schedule / Certificate of Insurance >> In-Patient Treatment (B1) Sum Insured in any Policy Year.

ii. If a Cumulative Bonus has been applied and a claim is made, We will automatically decrease the Cumulative Bonus by the percentage of the Sum Insured as specified in the Policy Schedule / Certificate of Insurance in that following Policy Year. There will be no impact on the In-patient Treatment (B1) 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. For purpose of computation of Cumulative Bonus, the percentage (%) of Cumulative Bonus will be applied on the base In-Patient Treatment (B1) Sum Insured only. Restored sum insured will not be taken into consideration.

vi. For a claim to be admissible under Cumulative Bonus, it should be admissible under Benefit In-patient Treatment (B1) .

A21. Wellness Services

Definitions specific to this coverage:

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

Only those Coverages which have been specified on your Policy schedule / Certificate of Insurance shall be provided

Coverage:

We / Our Empanelled Service Provider will provide wellness services designed to assist insured persons in maintaining and improving good health and fitness. These Wellness Services will be available for the insured person during the cover period, as specified in the Policy schedule / Certificate of Insurance.

i.	Teleconsultation-General	We /Our empanelled Service Provider will arrange for consultations upon insured person's request through telecommunications and digital communication technologies for insured person's health related complaints or preventive health care by a qualified Medical Practitioner/ Health Care Professional, as per the limit specified in your Policy Schedule / Certificate of Insurance. This service can only be availed subject to conditions below: - Consultation will be provided through various specified modes of communication (including but not limited to) audio, video, online portal, chat, customer application or any other digital mode. **Claim procedure and management** Services are only available at Network. To avail the same, following procedure must be followed: Insured Person can gain access to tele/video/digital consultation with a general physician/ Specialist/Psychiatrist as per the eligibility, using Our Customer application.

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ii.	Emergency - Help me feature	In case of an emergency, insured person will have an option to share his/her location with the 'designated caregiver' through our customer application provided the insured person has registered on our App. The app will trigger a message and call to the designated caregiver informing about the emergency and sharing the location of the Insured Person. For the purpose of this benefit, 'designated caregiver' shall mean that individual who has been specified as a caregiver at the time of registration in the customer App. Please note **Not applicable** The service will be available subject to suitable infrastructure, connectivity, device restrictions and device functionality **Claim procedure and management** In case of an emergency, insured person can use Our Customer application to alert designated caregiver, at a push of a button. An alert message will be sent to the designated caregiver, informing him/her about the emergency. By opting this feature, the insured person authorizes us/our empanelled service provider to share their geo-location with the designated caregiver. This service will be offered on best effort basis and does not have a legal binding on us.
iii.	Health Condition Management	**Not applicable** We / Our empanelled Service Provider will provide consultative services related to health conditions with the objective of maintaining good health by providing [illegible] through various health condition management programmes including but not limited to nutrition management, weight management, stress management, health coach. (as approved by the Regulator IRDAI from time to time).

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iv.	Teleconsultation – Speciality	We /Our empanelled Service Provider will provide for consultations upon insured person's request through telecommunications and digital communication technologies for insured person's health related complaints or preventive health care by a qualified & specialist Medical Practitioner/ Health Care Professional, as per the limit/ speciality specified in your Policy Schedule / Certificate of Insurance **Not applicable** [illegible] ns below: [illegible] specified modes of communication (including but not limited to) like audio, video, online portal, chat, customer application or any other digital mode. **Claim procedure and management** Services are only available at Network. To avail the same, following procedure must be followed: Insured Person can gain access to tele/video/digital consultation with a general physician/ Specialist/Psychiatrist as per the eligibility, using Our Customer application.
v.	Redeemable voucher/Dis[illegible] on services	**Not applicable** We / Our Empanelled Service Provider will provide redeemable [illegible] IRDAI from time to time, [illegible] mote wellness and fitness of the insured person.
vi.	Emergency -24*7 Ambulance Booking	We / Our empanelled Service Provider will provide a facility to book a road ambulance in India, in case of an Emergency, for transportation of an Insured Person to a Hospital for admission or from one hospital to another hospital for better medical facilities and treatment. This booking service can be availed at Our Network subject to an [illegible] **Not applicable** - The transportation of the Insured Person will be offered to the nearest Hospital **Claim procedure and management** In case of an emergency, insured person can use Our Customer application to book an ambulance. This service will be offered on best effort basis and does not have a legal binding on us.

Supporting Documentation & Examination

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

Disclaimer

1. Availing the services under this benefit is purely upon the Insured's sole discretion and risk.
2. For services that are provided through empaneled Service Providers, we are acting as a

facilitator; hence would not be liable for any incremental costs or the services. Any additional services availed, or expenses incurred on such services or benefits which are other than those covered under this policy and explicitly excluded by this Policy Schedule, shall not be covered under this Policy and all expenses incurred shall be borne by the Insured Person.

3. We shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which Insured Person claims to have suffered, sustained or incurred, by way of and / or on account of the benefit. We shall not be liable for any deficiency or discrepancy in the services provided by empanelled service provider/network provider under this policy.

4. Insured Person may consult any medical professional at any network provider/ empanelled service provider at its sole discretion. The cost of service arising out of insured Person choice of medical professional at any network provider/ emplaned service provider shall completely borne by the Insured Person unless covered otherwise. However, the services under this policy should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional

5. The Medical Practitioner may suggest/ recommend/prescribe over the counter medications based on the information provided, if required on a case-to-case basis. Provided that any recommendation under this Policy shall not be valid for any medico legal purposes.

6. The Medical Practitioner may offer Mental Health Services which will render general support for issues concerning stress, anxiety and depression. This will not include support for clinically established mental health conditions like bipolar disorder, schizophrenia, dementia, Alzheimer's disease and/or any other pre diagnosed condition. The Insured Person is free to choose whether or not to act on the recommendation after seeking consultation.

7. Any advice, recommendations or suggestions made by any medical professional shall be solely based on the information and documentation provided by the Insured Person to such medical professional. We shall not be liable towards any loss or damage (immediate or consequential) arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the medical professional from whom we have availed services or taken benefit or for any consequence of any act or omission in reliance thereon.

8. We at our discretion may provide discounts on any of the above services which may vary from time to time subject to IRDAI Regulations

9. Any discount offered under Redeemable voucher/Discount on services by our empanelled service providers are subject to modification or withdrawal. We do not assume any liability towards the quantum of discount, quality of product/services and timeline within which the product/service is rendered.

10. For Emergency -24*7 Ambulance Booking –

    a. These services are provided through our empanelled service provider in select cities. Please contact us / refer to our customer application for more details on this service.

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b. The cost of availing such a service shall be solely borne by the insured person

c. We do not assume any liability towards quality and turnaround times of service rendered, any loss or damage arising out of or in relation to these services rendered by the empanelled service provider.

d. This facility may be availed through Our customer application or through calling Our call centre on the tollfree number specified in the Policy Schedule.

11. Above mentioned services are non-portable, annual contracts, independent of policy contract and not lifelong renewable. The Services provided may be added / deleted / modified at our discretion.

12. Provision of these services is subject to availability as per the duration specified by Us/the empanelled service provider. Details are available on our website (www.tataaig.com)

13. Any service availed by the Insured Person under this Benefit will not impact Cumulative Bonus if applicable.

14. We reserve the right to change any service provider during the currency of the policy or at renewal. The same shall be intimated to the insured atleast 15 days prior to the effective date of change. During such change, all the credits earned by the insured Person shall be transferred to the new service provider.

15. In case We or the Assistance Service Provider fails to provide any of the services as mentioned in this Policy or is unable to implement, in whole or in part due to Force Majeure , non-availability of Services, change in law, rule or regulations which affects the Services, or if any regulatory or governmental agency having jurisdiction over a party takes a position which affects the services , then the Assistance Services' suspended, curtailed or limited performance shall not constitute Breach of Contract and the Company or the Assistance Service Provider shall have no liability whatsoever including but not limited to any loss or damage resulting therefrom

C. Inclusion of Exclusions

C6 Inclusion of AYUSH cover

Definitions specific to this coverage:

1. AYUSH Treatment refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

2. 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;

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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.

Coverage:

Notwithstanding anything to the contrary stated herein coverage under In-patient Treatment (B1) is extended to cover for expenses incurred on in-patient treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines during each Policy Year within the limit of Sum Insured as specified in the Policy Schedule / Certificate of Insurance.

This benefit shall be applicable to <<All Insured Persons/Primary Insured Person/Dependents of Primary Insured Person>> for an amount as specified on the Policy Schedule/Certificate of insurance.

All other policy terms and conditions remain unaltered.

D. Deletion of Base Covers

D1 Deletion of Limit on Room rent/Room Category

Subsequent to this endorsement, Section 3 –Base covers (B1-i) stands deleted for <<Primary Insured Person/Dependents of Primary insured person as specified >>.

All other policy terms and conditions remain unaltered.

D2 Deletion of Associated Medical Expenses – B1-ii-a

Subsequent to this endorsement, Section 3 –Base covers (B1-ii-a) stands deleted for << Primary Insured Person/Dependents of Primary insured person as specified>>.

All other policy terms and conditions remain unaltered.

D4 Deletion of Co-Payment on Higher room category

Subsequent to this endorsement, Section 3 –Base covers (B1-iii) stands deleted for << Primary Insured Person/Dependents of Primary insured person as specified>>.

All other policy terms and conditions remain unaltered.

D5 Deletion of Limit on Treatment of / Illness/Surgery/Procedure / Medical Condition

Subsequent to this endorsement, Section 3 –Base covers (B1-iii) stands deleted for <<Primary Insured Person/Dependents of Primary insured person as specified>>.

All other policy terms and conditions remain unaltered.

D11 Deletion of Pre/Post Natal cover

Subsequent to this endorsement, Section 3 –Base covers (B9) stands deleted.

All other policy terms and conditions remain unaltered.

D12 Deletion of Baby Day one cover

Subsequent to this endorsement, Section 3 –Base covers (B10) stands deleted.

All other policy terms and conditions remain unaltered.

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