Customer Information Sheet/Know Your Policy

This document provides key information about your policy. You are also advised to go through your policy document.

S. No	Title	Description	Policy Clause Number
1.	Name of the Insurance Policy	Tata AIG MediCare LITE	
2.	Policy Number	<< Policy No. >>	
3.	Type of Insurance Policy	Both indemnity & benefit, Policy has elements of both, Indemnity (which cover insured loses) and Benefit (which pays a fix amount under the policy on the occurrence of a covered event.	
4.	Sum Insured (Basis) (Along with amount)	<<Sum Insured Amount>> As per Sum Insured mentioned in Policy Schedule Sum Insured represents Our maximum, total and cumulative liability under the Policy, for all the Insured Person(s) covered in aggregate, for the respective Policy Year	
5.	Policy Coverage	**B1. In-Patient Treatment**– Covers hospitalization expenses for period more than 24 hrs. **B2. Pre-Hospitalization expenses**- Medical Expenses incurred upto 60 days prior to the date of admission to the hospital **B3. Post-Hospitalization expenses**- Medical Expenses incurred upto 180 days after the date of discharge from the hospital **B4. Day Care Treatment**– Medical expenses for Day Care Treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre. **B5. Organ Donor**- Medical Expenses towards the harvesting the organ from the donor for organ transplantation. **B6. Domiciliary Treatment**- Medical Expenses incurred for availing medical treatment at home which would otherwise have required hospitalization. **B7. Restore Benefit**- Automatically reinstate 100% of the Sum Insured, if the balance Sum Insured and accrued Cumulative Bonus is insufficient to pay an admissible claim under In-Patient Treatment, Pre-Hospitalization Expenses, Post-Hospitalization Expenses, Day Care Treatment, Organ Donor or Domiciliary Treatment cover, during the policy period. **B8. AYUSH Benefit** - Medical Expenses incurred for treatment as In-patient in an AYUSH Hospital. **B9. Ambulance Cover**– Expenses incurred on transportation of Insured Person in a registered ambulance to a hospital for admission in case of an emergency. **B10. Health Checkup-** We / Our empaneled service provider will arrange for listed medical tests every Policy Year, only on cashless basis.	Section (2)

		B11. Compassionate travel- In the event the Insured Person is Hospitalized in India for more than Five consecutive days in a place where no adult member of his immediate family is present, we will cover expenses related to a round trip economy class domestic air ticket, or first-class railway ticket, to allow the Immediate Family Member be at his bedside for the duration of his stay in the hospital, subject to a maximum limit as specified in the policy schedule during a Policy Year. **B12. Bariatric Surgery Cover-** Covers reasonable and customary expenses for Bariatric surgery if the insured person fulfills: 1. Surgery to be conducted upon the advice of the Doctor. 2. The surgery/Procedure conducted should be supported by clinical protocols. 3. The member has to be 18 years of age or older and 4. Body Mass Index (BMI) greater than or equal to 40 or 5. BMI greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss: a. Obesity-related cardiomyopathy, b. Severe sleep apnea, c. Uncontrolled Type2 Diabetes, or d. Coronary heart disease **B13. In-Patient Treatment - Dental-** Covers medical expenses incurred towards hospitalization for dental treatment under anesthesia necessitated due to an accident/injury/illness. **B14. Vaccination cover-** Covers the cost of the following vaccines: - Anti-rabies vaccine following an animal bite - Typhoid vaccination After 2 years of continuous coverage with us: - Human Papilloma Virus (HPV) vaccine - Hepatitis B Vaccine **B15. Hearing Aid-** Covers reasonable charges for hearing aid for the Insured Person, every third year, subject to a maximum limit as specified in the policy schedule per Policy. **B16. Daily Cash for choosing Shared Accommodation-** We will pay a fixed amount per day as mentioned in the policy schedule if the Insured Person is Hospitalized in Shared Accommodation in a Hospital in Our network of Valued Provider – Pan India for each continuous and completed period of 24 hours of Hospitalization. The benefit payable per day would be subject to a maximum limit as specified in the policy schedule. **B17. Daily Cash for Accompanying an Insured Child-** We will pay a fixed amount per day, as mentioned in the Policy schedule, if the Insured Person Hospitalized is a child Aged 12 years or less, for one accompanying adult for each completed period of 24 hours of Hospitalization in Our network of Valued Provider – Pan India. The benefit payable per day would be subject to a maximum limit as specified in the policy schedule. **B18. Second Opinion**- We will provide You a second opinion from Our Empaneled Service Provider, if an Insured Person is diagnosed with the mentioned Illnesses during the Policy Period. **B20. Cumulative Bonus-** We will provide Cumulative Bonus in the form of 50% of the base Sum Insured of the expiring Policy, on each Renewal of the Policy, after every claim free Policy Year, provided that the Policy is renewed with Us without a break. The total accrued Cumulative Bonus shall not exceed 100% of the base Sum Insured in any Policy Year. **B21. Wellness Services-**	

		Teleconsultation– General We /Our empanelled Service Provider will arrange for teleconsultations for Insured Person’s through telecommunication and digital communication technologies for insured person’s health related complaints or preventive health care by a qualified Medical Practitioner/ Health Care Professional. **Optional Cover:** You can choose optional cover list below by paying an additional premium: **B19. Accidental Death Benefit-**If an Insured Person suffers an accident during the policy period and this is the sole and direct cause of his death within 365 days from the date of accident, then we will pay the Sum Insured as mentioned against the respective insured person in the Policy schedule.	
6.	Exclusions	**Standard Exclusion** **1. Medical Exclusions** II. Investigation and evaluation (Code- Excl 04) III. Rest cure, rehabilitation and respite care (Code- Excl 05) IV. Obesity/ Weight Control (Code- Excl 06) V. Change-of-Gender treatments: (Code- Excl07) VI. Cosmetic or Plastic Surgery (Code- Excl 08) VII. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code- Excl 12). VIII. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code- Excl13) IX. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. (Code-Excl14) X. Refractive error (Code- Excl 15) XI. Unproven treatments (Code- Excl 16) XII. Sterility and Infertility (Code- Excl 17) XIII. Maternity (Code - Excl 18)	Section 3

		2. **Non-Medical Exclusions** I. Hazardous or Adventure Sports (Code- Excl 09) II. Breach of law (Code- Excl 10) III. Excluded Providers: (Code-Excl 11) **Specific Exclusions (Exclusions other than as those mentioned above)** 1. **Medical Exclusions** I. Alcoholic pancreatitis or Alcoholic liver disease; II. Congenital External Diseases, defects or anomalies; III. Stem cell therapy; however hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under this Policy IV. Growth Hormone Therapy V. Sleep-apnoea and Sleeping disorder; VI. Admission primarily for administration (via any form or mode) of immunoglobulin infusion or supplementary medications like Zolendronic Acid, etc; VII. Venereal disease, sexually transmitted disease or Illness; VIII. All preventive care, vaccination including inoculation and immunisations; IX. Dental Treatment or Dental Surgery of any kind unless incidental to an admissible Hospitalization claim where the cause of admission is Accident/ Illness; cost of dentures, dental implants and braces X. Any existing disease specifically mentioned as Permanent exclusion in the Policy Schedule. XI. Non payable items as mentioned in Annexure I – List I of optional items available on Our website (www.tataaig.com) **2.Non-Medical Exclusions** I. War or any act of war, invasion, act of foreign enemy, war like operations. II. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event.	

		III. Any Insured Person's participation or involvement in naval, military or air force operation. IV. Intentional self-Injury or attempted suicide while sane or insane. V. Items of personal comfort and convenience. VI. Treatment rendered by a Medical Practitioner which is outside his discipline. VII. Doctor's fees charged by the Medical Practitioner sharing the same residence as an Insured Person or who is an immediate relative of an Insured Person's family. VIII. Fitting of hearing aids, Provision/fitting of spectacles or contact lenses including optometric therapy. IX. Any treatment and associated expenses for alopecia, baldness, wigs or toupees, medical supplies. X. Any treatment or part of a treatment that does not form part of 'Reasonable and Customary Charges', nor is medically necessary; XI. Expenses which are either not supported by a prescription of a Medical Practitioner or are not related to Illness or disease for which claim is admissible under the Policy. XII. Any external appliance and/or device used for diagnosis or treatment except when used intra-operatively. XIII. Any Illness diagnosed or Injury sustained or where there is change in health status of the member after date of proposal and before commencement of Policy and the same is not communicated and accepted by Us. This is summary of exclusions. For detailed exclusions, please refer Policy wordings (Section 3)	
7.	Waiting period	I. Initial waiting period of 30 days for all illnesses (not applicable for accidents or on renewals) II. Specified Waiting periods (Not applicable for claims arising due to an accident) of 24 months for 34 listed Diseases/procedure III. Pre-existing disease covered after 36 months	Section 3
	Financial limits of coverage	The policy will pay only up to the limits specified hereunder for the following diseases/procedures	Section 2 &

	i. Sub-limit (it is a pre-defined limit and the insurance company will not pay any amount in excess of this limit) ii. Co-payment (it is a specified amount/percentage of the admissible claim amount to be paid by policy holder/insured) iii. Deductible (it is a specified amount: - Up to which an insurance company will not pay any claim, and - Which will be deducted from total claim amount (if claim amount is more than the specified amount) Any other limit (as applicable)	**Sub-limit** <u>Benefit Specific Sub-limit</u>: • Ambulance Cover Upto Rs. 3000 per Hospitalization. • Room category- Upto Single private room **Co-payment:** a. **Age linked Co-payment** If the entry Age of the Insured Person is 61 years or above at the time of first coverage under this Policy, then such Insured Person shall bear 20% of each admissible claim b. **Co-payment for treatment availed out of Our Network of Valued Provider – Pan India** If the Insured Person avails treatment outside Our network of "Valued Provider-Pan India", then a Co-Payment of 30% will be applicable for each such claim resulting from admission of the Insured Person in a Hospital/ Day Care Centre/ AYUSH Hospital. However, no Co-Payment under this sub section shall be applicable if Hospitalization is for an Injury arising from an Accident. *Note: 'Valued Provider - Pan India' is a specific network of Hospital(s), designated as such and mentioned in the Policy Schedule. It consists of a defined list of Hospital(s) or health care providers enlisted by Us, and/or TPA to provide medical services to an Insured Person by a Cashless Facility. Reference made to 'Network Provider' in the Policy wordings shall be substituted with 'Valued Provider - Pan India', except for Section 5(e) Claim Assessment and Payment, sub section iii (b) of the Policy Wordings. The updated list of Valued Provider - Pan India is available on Our website (www.tataaig.com).* **Any Other limit**: • In-Patient Treatment: Upto Sum Insured • Pre-Hospitalisation expenses: Upto 60 days, Upto Sum Insured • Post-Hospitalisation Expenses: Upto 180 days, Upto Sum Insured • Day Care Procedures: Upto Sum Insured • Organ Donor: Upto Sum Insured • Domiciliary Treatment: Upto Sum Insured • AYUSH Benefit: Upto Sum Insured • Compassionate Travel: Upto ₹20,000 per policy year (over and above base sum insured)	Section 4

		• Bariatric Surgery Cover: Upto Sum Insured • In-Patient Treatment - Dental: Upto Sum Insured • Vaccination cover: Upto ₹5,000 per policy (over and above base sum insured) • Hearing Aid: Upto 50% of actual cost or ₹10,000/- per policy, whichever is lower (over and above base sum insured) • Daily Cash for choosing Shared Accommodation: Upto 0.25% of base sum insured and a maximum of ₹2000 per day (over and above base sum insured). • Daily Cash for Accompanying an Insured Child: Upto 0.25% of base sum insured and a maximum of ₹2000 per day (over and above base sum insured). Optional Cover (**For cover applicable to you, please refer your Policy Schedule)**: • Accidental Death Benefit: 100% of the base Sum insured.	
9.	Claims/Claims Procedure	**Claim procedure:** • For Cashless Service: 1. If any planned treatment, consultation or procedure for which a claim may be made then the insured must notify us at least 48 hours before the planned Hospitalization. 2. If any treatment, consultation or procedure for which a claim may be made, requiring emergency Hospitalization, then the insured must notify us within 24 hours after the treatment or Hospitalization 3. 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. • For Reimbursement of Claim: 1. Please intimate our TPA/Us within 7 days of completion of treatment, consultation or procedure. 2. Please submit claim documents to our TPA/Us within 15 days of occurrence of incident. 3. Kindly send the claim documents to: Tata AIG General Insurance Company Limited, 5th and 6th Floor, Imperial Towers, H.No 7-1-6-617/A, GHMC No - 615,616, Ameerpet, Hyderabad – 500016, Telangana, Phone-040-66864900	Section 5

		Turn Around Time (TAT) for claims settlement: i. TAT for preauthorization of cashless facility: 2 hours ii. TAT for cashless final bill authorization: 4 hours **Assistance**: 1. Please refer to our website <www.tataaig.com> or call us on our toll free number at <1800-266-7780> to get details on our empanelled hospitals and list of Excluded providers/ Blacklisted Hospitals. 2. Helpline number: Toll Free: <1800 266 7780> or <1800 22 9966> (only for Senior Citizen policyholders) 3. Please refer our website < www.tataaig.com> to download claim form	
10.	Policy Servicing	Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders)	Section 4
11.	Grievances/Complaints	**Redressal of Grievance** ○ In case of any grievance the insured person may contact the company through • Website: www.tataaig.com • Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders) • Email: customersupport@tataaig.com • Courier: Customer Support, Tata AIG General Insurance Company Limited, 7 and 8 Floor, Romell Tech Park, Cama Industrial Estate, Western Express Highway, Goregaon(E), Mumbai, Maharashtra 400063 ○ Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. **Escalation level 1:** ○ 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.	Section 4

		○ For updated details of grievance officer, kindly refer the link (https://www.tataaig.com/grievance-redressal-policy) **Escalation level 2:** 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 (details as mentioned in the Annexure A of this policy) 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/)	
12.	Things to remember	**Free Look Period** The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look 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 has not made any claim during the Free Look Period, the insured shall be entitled to • 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 • 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 Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period. **Policy renewal** The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.	Section 4

		▪ The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal. ▪ Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years. ▪ Request for renewal along with requisite premium shall be received by the Company before the end of the policy period. ▪ At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period. No loading shall apply on renewals based on individual claims experience. **Migration** The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines 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/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof. **Portability** The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. For Detailed Guidelines on Portability, kindly refer Guidelines issued IRDAI(Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref:	

		IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof. **Change in Sum Insured** Sum Insured can be enhanced only at the time of renewal subject to underwriting guidelines of the company. **Moratorium Period** After completion of eight continuous years under the policy no look back to 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 8 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.	
13.	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid and termination of Your policy.	