Tata AIG MediCare Premier Policy Wording

WITH YOU ALWAYS

Policy Wordings

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

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

For **Tata AIG General Insurance Company Limited**

Authorized Signatory

Tata AIG General Insurance Company Limited
Registered Office:
Peninsula Business Park, Tower A,
15th Floor, G. K. Marg,
Lower Parel, Mumbai- 400013,
Maharashtra, India
24x7 Toll Free No. 1800 266 7780 or 1800 22 9966
(Senior Citizen)
Visit us at www.tataaig.com
IRDA of India Registration No.:108
CIN: U85110MH2000PLC128425
UIN: TATHLIP23167V032223

Preamble

While the policy is in force, if the Insured Person contracts any disease or suffers from any illness or sustains bodily injury through accident and if such event requires the insured Person to incur expenses for Medically Necessary Treatment, We will indemnify You for the amount of such Reasonable and Customary Charges or compensate to the extent agreed, upto the limits mentioned, subject to terms and conditions of the Policy. Each Benefit is subject to its Sum Insured, but Our liability to make payment in respect of any and all Benefits shall be limited to the Sum Insured unless expressly stated to the contrary.

In case of family floater policy, the sum insured for all or any of the benefits shall be on a per policy per year basis unless explicitly stated to the contrary. In case of an individual policy, the sum insured for all or any of the benefits shall be on a per insured per year basis unless explicitly stated to the contrary.

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

Section 1 – 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 third gender, 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. AYUSH Hospital

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

a. Central or State Government AYUSH Hospital or

b. Teaching hospital attached to AYUSH college recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy, or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

   i. Having atleast 5 in-patient beds;

   ii. Having qualified AYUSH Medical Practitioner round the clock;

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

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

4. Cashless facility

Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment

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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.

5. Condition Precedent

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

6. Congenital Anomaly:

Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly

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

b) External Congenital Anomaly

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

7. Cumulative Bonus

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

8. 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.

9. 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

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

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

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room in a hospital.

12. 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.

13. 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;

14. 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.

15. Illness

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

(a) Acute condition

Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

(b) Chronic condition

A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

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

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

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

iv. it continues indefinitely

v. it recurs or is likely to recur

16. 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.

17. Inpatient Care

Inpatient care means treatment for which the insured person has to stay in a hospital

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for more than 24 hours for a covered event.

18. 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.

19. Medical Advice

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

20. 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.

21. 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.

22. Medically Necessary Treatment

Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

i. is required for the medical management of the illness or injury suffered by the insured;

ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii. must have been prescribed by a medical practitioner;

iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

23. 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.

24. 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.

25. New Born Baby

Newborn baby means baby born during the Policy Period and is aged upto 90 days

26. 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

27. 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

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Insured is not admitted as a day care or in-patient.

28. Pre-Existing Disease

Pre-existing Disease means any condition, ailment, injury or disease:

a. 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

b. 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

29. 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.

30. Portability

"Portability" means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

31. Post-hospitalization Medical Expenses

Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

32. 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.

33. 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.

34. 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.

35. Room Rent

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

36. 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,

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relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

37. Unproven/Experimental treatment

Unproven/Experimental treatment means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

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

1. Age

Means the completed age of the Insured Person on his / her most recent birthday as per the English calendar, regardless of the actual time of birth.

2. Policy

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

3. Policy period

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

4. Policy Schedule

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

5. Policy year

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

6. Shared Accommodation

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

Section 2 – Benefits

Below listed benefits are payable subject to Terms and Conditions of the policy.

The company's maximum liability in aggregate for payment of any claim under Section B1, B2, B3, B4 and B7 shall not exceed the opted sum insured. However, any payment under cumulative bonus shall be over and above.

The sequence of utilization of benefits for a claim shall be as per the following:

i. Sum Insured,

ii. Any accrued Cumulative Bonus, if applicable

iii. Restore benefit amount, if applicable

B1. In-Patient Treatment

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

Medical expenses directly related to the hospitalization would be payable.

B2. Pre-Hospitalization expenses

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

The benefit is payable if We have admitted a claim under section B1 or B4 or B6 or B31 of this policy.

B3. Post-Hospitalization expenses

We will cover for expenses for Post-Hospitalization consultations, investigations and medicines incurred after

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discharge from the hospital, upto number of days as specified in the table below.

Basic Sum insured	Number of days
Upto Rs. 50 Lacs	90 days
Rs.75 Lacs to Rs.3 Crore	200 days

In case the insured person has opted sum insured Rs. 75 Lacs and above, then We will arrange up to 15 physiotherapy sessions at home within India, wherever available, within the city in which you reside through our empanelled service provider subject to following conditions:

- This limit on physiotherapy sessions is applicable to each insured person, per post-hospitalization event
- Availing the services for physiotherapy at home under this Benefit is at insured person's sole discretion and risk. We do not assume any liability towards quality of service rendered, any immediate or consequential loss arising out of or in relation to these services rendered by the empanelled service provider.
- The said physiotherapy must be advised in writing by the treating medical practitioner.
- The above services may be provided by the company /network providers or other empaneled hospitals / service providers. Any additional expenses other than the eligible expenses shall be borne by the insured person which shall not be covered under this policy unless specified otherwise
- This facility may be availed through our website or our mobile application or through calling our call centre on the toll free number specified in the policy schedule. Alternatively, details of our empanelled service provider are available on our website (www.tataaig.com)
- In case we or the empanelled 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 service provider services suspended, curtailed or limited performance shall not constitute breach of contract and the company or the empanelled service provider shall have no liability whatsoever including but not limited to any immediate or consequential loss resulting therefrom.

The benefit is payable if We have admitted a claim under section B1 or B4 or B6 or B31 of this policy.

B4. Day Care Procedures

We will cover expenses for Day Care Treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre.

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

B5. Organ Donor

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

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

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the Insured Person, and

ii. We have accepted an inpatient Hospitalization claim for the insured member under section B1 of this policy.

B6. Domiciliary Treatment

We will cover for expenses related to Domiciliary Hospitalization of the insured person if the treatment exceeds beyond three days. The treatment must be for management of an illness and not for enteral feedings or end of life care.

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

B7. Restore benefit

We will automatically restore the Basic Sum Insured if the Sum Insured and accrued Cumulative Bonus is insufficient to pay a claim during the policy year. This benefit can be availed once during the policy year subject to the following conditions:

a. The restored sum insured can be used for all claims made by the insured person(s) who have not claimed earlier under Sections B1 to B4. In case the insured 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.

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

c. For policy with Basic Sum Insured less than or Equal to Rs. 50 Lacs: This benefit shall be applicable annually for policies with tenure of more than 1 year.

For policy with Basic Sum Insured Rs. 75 Lacs and above:

This benefit shall be applicable annually for multiyear policies. However, for single premium multiyear policies, the insured shall have the right to utilize the available restorations anytime during the policy period, except for the first claim, for e.g. a policy with tenure of 2 years where entire premium is paid upfront, the insured is eligible for a total of 2 restorations anytime during the policy period except for the first claim in each policy year.

d. The unutilized restored sum insured cannot be carried forward to the next policy year.

e. Restore will not trigger for the first claim under each policy year.

f. The maximum liability under a single claim under this benefit shall be the sum Insured.

This benefit shall not be available for section B13 and B31 of this policy.

B8. AYUSH Benefit

We will cover for expenses incurred for treatment as in-patient in an Ayush Hospital.

B9. 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 limited as specified in the table below.

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Basic Sum Insured	Limit
Up to Rs. 50 Lacs	Upto Rs. 5000 per hospitalization
Rs. 75 Lacs	Upto Rs. 7500 per hospitalization
Rs. 1 Crore	Upto Rs. 10000 per hospitalization
Rs. 2 Crore	Upto Rs. 20000 per hospitalization
Rs. 3 Crore	Upto Rs. 30000 per hospitalization

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

B10. Health Checkup

We will cover for expenses for a Preventive Health Check-up upto 1% of policy sum insured subject to a maximum limit as specified in the table below. The limit is the maximum per policy in case of floater policy and per insured person in case of individual policy

The benefit is payable every year irrespective of claims under the policy. This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

Basic Sum Insured (Rs.)	Limit
Up to Rs. 50 Lacs	Upto Rs. 10000
Rs. 75 Lacs	Upto Rs. 15000
Rs. 1 Crore	Upto Rs. 20000
Rs. 2 Crore	Upto Rs. 25000
Rs. 3 Crore	Upto Rs. 25000

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

B11. Compassionate travel

a) Domestic

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 for expenses related to a round trip economy class 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.

The benefit shall be payable if an inpatient Hospitalization claim for the insured member is admissible under section B1 of this Policy.

b) Global (Applicable for sum insured above Rs. 50 Lacs):

In the event the Insured person is hospitalized outside India and claim is admissible under section B13 (Global cover for Planned Hospitalization) of this policy, We will cover expenses related to round trip economy class air ticket, to allow the Immediate Family Member to accompany the Insured person for the purpose of planned treatment outside India.

This benefit has a separate limit (over and above base sum insured) as specified in the policy schedule and does not affect cumulative bonus.

We shall require the following additional documents (proof of travel) supporting the claim under this benefit: Copy of Passport (in case of Global), Boarding Pass, or Railway ticket or any other document to show proof of travel.

B12. Consumables Benefit

We will pay for expenses incurred, for specified consumables which are listed in

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'Annexure I – List I- Optional Items' under 'Guidelines on Standardization in Health Insurance, 2016' and its amendments, which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I-Optional items are available on our website (www.tataaig.com)

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

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

For this claim to be paid, the main claim must be admissible under section B1 or B4 or B31 of this policy.

B13. Global Cover for Planned Hospitalization

a. Global Cover for Planned Hospitalization (Medical Expenses)

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

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

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

Only basic sum insured along with Cumulative Bonus can be used for this and not the restored sum insured.

We shall require the following additional documents supporting the claim under this benefit:

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

b. Visa Services Fees (Applicable only for Sum Insured above Rs.50 Lacs)

We will cover for reasonable and customary expenses incurred towards obtaining visa for medical treatment of the insured person travelling abroad upto the sum insured subject to claim being admissible under section B13 (a – Global Cover for Planned Hospitalization (Medical Expenses)) of this policy.

- We shall require valid receipts/bills of visa fee services supporting the claim under this benefit.

B14. Bariatric Surgery Cover

We will cover for reasonable and customary expenses for Bariatric Surgery if the insured fulfills all of the following conditions:

i. Surgery to be conducted is upon the advice of the Doctor

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ii. The member has to be 18 years of age or older and

iii. Body Mass Index (BMI) greater than or equal to 40 or

iv. BMI is 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:

a. Obesity-related cardiomyopathy

b. Coronary heart disease

c. Severe sleep apnea

d. Uncontrolled Type2 Diabetes

In view of this coverage getting extended, exclusion code (Code-Excl06) of this policy stands deleted.

B15. In-Patient Treatment - Dental

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

B16. Vaccination cover

We will cover for expenses related to the cost of the following vaccines only:

Basic Sum Insured	Vaccines covered
Up to Rs. 50 Lacs	Without any waiting period: - 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
Rs. 75 Lacs to Rs. 3 Crore.	Without any waiting period: - Anti-rabies vaccine following an animal bite - Typhoid vaccination After 2 years of continuous coverage with Us: - Human Papilloma Virus (HPV) vaccine - Hepatitis A Vaccine - Hepatitis B Vaccine - Tetanus, Diphtheria, Pertussis - Pneumococcal

Expenses related to the doctor, nurse or any incidental expenses are not payable. This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B17. Hearing Aid

We will cover for reasonable charges for a hearing aid every third year. The maximum amount payable is 50% of actual cost or Rs. 10,000/- per policy, whichever is lower.

The items must be prescribed by a specialized Medical Practitioner as medically necessary.

This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B18. 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 Network Hospital for each continuous and completed period of 24 hours. The benefit payable per day

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would be 0.25% of base sum insured and a maximum of Rs. 2000 per day.

For this claim to be paid, the main claim must be admissible under section B1 of this policy. This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B19. 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 complete period of 24 hours. The benefit payable per day would be 0.25% of base sum insured and a maximum of Rs.2000 per day.

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

This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B20. Second Opinion

We will provide You a second opinion from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with the below mentioned Illnesses during the Policy Period. The expert opinion would be directly sent to the Insured Person.

i. Cancer
ii. Kidney Failure
iii. Myocardial Infarction
iv. Angina
v. Coronary bypass surgery
vi. Stroke/Cerebral hemorrhage
vii. Organ failure requiring transplant
viii. Heart Valve replacement
ix. Brain tumors

This benefit can be availed by an insured person once during a Policy Year.

B21. Maternity Cover

We will cover for Maternity Expenses, upto limits as specified in the table below, per policy subject to a waiting period of 4 years of continuous coverage under this policy.

Basic Sum Insured	Limit
Up to Rs. 50 Lacs	A maximum of upto Rs 50,000/-. In case of birth of a girl child, the maximum limit under this coverage would be upto Rs 60,000/- per policy
Rs.75 Lacs to Rs.3 Crore	A maximum of upto Rs 1,00,000/-. In case of birth of a girl child, the maximum limit under this coverage would be upto Rs 1,20,000/- per policy

We will not cover ectopic pregnancy under this benefit (although it shall be covered under section B1).

Expenses incurred for following shall be excluded from the scope of this coverage:

- Expenses incurred for pre/post natal care
- Pre/Post hospitalization benefit (Section B2 and B3 of this policy)

In view of this coverage getting extended, maternity exclusion code 18 stands deleted. However, no coverage is available for voluntary termination of pregnancy during the policy period under this policy.

B22. Delivery Complications Cover

We will cover for medical expenses

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incurred for the medically necessary treatment of the new born baby upto limits as specified in the table below, for complications related to delivery if claim is admitted under the maternity benefit (B21) of this policy.

Basic Sum Insured	Limit
Up to Rs.50 Lacs	Upto Rs. 10000
Rs. 75 Lacs to Rs. 3 Crore	Upto Rs. 25000

B23. First year Vaccinations

We will pay for vaccination expenses for up to one year after the birth of the child subject to a limit of Rs. 10,000/- provided the child is covered with Us. In case of girl child, applicable limit under this coverage would be Rs.15,000/-.

For the claim to be paid under this benefit, the expenses related to maternity should be admissible under section B21 of this policy. The limit of Rs.10,000 (Rs.15,000 in case of girl child) is a lifetime limit and not a policy limit which will be applicable for each child.

B24. Prolonged Hospitalization Benefit

We will pay a fixed amount of 1% of sum insured, in the event of insured hospitalized for a disease/illness/injury for a continuous period exceeding 10 days.

This benefit will be triggered provided that the hospitalization claim is accepted under section B1 of this policy.

This benefit shall not be applicable for section B6 / B 31 of this policy.

This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B25. High End Diagnostics

We will cover for reasonable charges incurred for the following diagnostic tests only on OPD basis if required as part of a medically necessary treatment subject to limits as specified in the table below, per policy year:

i. Brain Perfusion imaging

ii. Computed Tomography (CT) guided Biopsy

iii. Computed Tomography (CT) Urography

iv. Digital Subtraction Angiography (DSA)

v. Liver Biopsy

vi. Magnetic Resonance Cholangiography Scan

vii. Positron Emission Tomography Computed Tomography (PET CT)

viii. Positron emission tomography Magnetic Resonance Imaging (PET MRI)

ix. Renogram

Basic Sum Insured	Limit
Up to Rs.50 Lacs	Up to Rs. 25,000 per policy year
Rs. 75 Lacs to Rs. 3 Crore	Up to Rs. 50,000 per policy year

This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B26. OPD Treatment

Once the insured has completed two years of continuous coverage with Us, We will pay for expenses related to consultations and pharmacy up to limits specified in the table below, per policy year annually subject to policy terms and conditions.

Basic Sum Insured	Limit
Up to Rs.50 Lacs	Upto Rs. 5,000/-
Rs.75 Lacs	Upto Rs. 7,500/-
Rs. 1 Crore	Upto Rs. 10,000/-

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Rs. 2 Crore	Upto Rs. 15,000/-
Rs. 3 Crore	Upto Rs. 20,000/-

This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B27. OPD Treatment - Dental

Once the Insured has completed two years of continuous coverage with Us, we will pay for expenses related to the following dental treatments only subject to a maximum of limit specified in the table below, per policy year annually:

- Root Canal Treatment (single or multiple sittings)
- Tooth extraction(s)
- Filling

Basic Sum Insured	Limit
Up to Rs. 50 Lacs	Upto Rs. 10,000/-
Rs. 75 Lacs	Upto Rs. 12,500/-
Rs.1 Crore	Upto Rs. 15,000/-
Rs.2 Crore	Upto Rs. 20,000/-
Rs.3 Crore.	Upto Rs. 25,000/-

This benefit has a separate limit (over and above base sum insured) and does not affect Cumulative Bonus.

In view of this coverage getting extended, dental exclusion (General Exclusions ii. 1. ix) is not applicable for this particular coverage.

B28. Emergency Air Ambulance Cover

We will pay for ambulance transportation of the Insured Person in an airplane or helicopter subject to maximum of limit specified in the table below, for emergency life threatening health conditions which require immediate and rapid ambulance transportation to the hospital/medical centre for further medical management.

The Medical Evacuation should be prescribed by a Medical Practitioner and should be Medically Necessary.

This benefit shall only be payable if We have accepted an inpatient Hospitalization claim for the Insured member under section B1 of this policy.

Basic Sum Insured	Limit
Up to Rs.50 Lacs	Up to Rs. 500,000
Rs.75 Lacs to Rs. 3 Crore	Up to Rs. 500,000 for Non Network; Upto Sum Insured for Network Provider

This benefit has a separate limit (over and above base sum insured) and does not affect Cumulative Bonus.

B29. 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 a fixed amount of 100% of the base Sum Insured, maximum up to Rs 50 Lakhs.

This benefit is not applicable for dependent children covered in the policy.

B30. Cumulative Bonus

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

ii. If a Cumulative Bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the Cumulative Bonus by 50% of the

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Sum Insured in that following Policy Year. There will be no impact on the Inpatient Sum Insured, only the accrued Cumulative Bonus will be decreased.

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

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

v. For purpose of computation of Cumulative Bonus, the percentage (%) of Cumulative Bonus will be applied on the base Sum Insured only. Restored sum insured will not be taken into consideration.

B31. Home Care Treatment Cover (Applicable only for Sum Insured Rs.75 Lacs and above)

We will cover for reasonable and customary medical expenses incurred for treatment taken at home, which are "Equivalent Medical charges" as defined in this policy, for below specified conditions/ illness upto the sum insured (excluding accrued cumulative bonus) for the Insured Person's medically necessary treatment at home. Restore benefit sum insured is not applicable for this benefit.

Home Care Treatment means treatment availed by the Insured Person at home for below listed conditions/ illness/ procedures, which in normal course would require hospitalization of more than 24 hours or would have been admissible under Day Care Procedures but is actually taken at home provided that:

a. The medical practitioner advices the insured person to undergo treatment at home.

b. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.

c. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

d. Home care treatment is availed in India.

e. Home treatment services may be provided through network service provider/ empanelled service provider in select cities for select treatment procedures only. Please contact us or visit our website (www.tataaig.com) for updated list of treatment procedures and cities where home treatment service is provided

f. Insured shall be permitted to avail the services as prescribed by the medical practitioner.

g. In case the insured intends to avail the services of non-network provider, claim shall be subject to reimbursement, a prior approval from the insurer needs to be taken before availing such services from a registered home care provider. Insurer shall respond to approval request within 4 working hours of receiving the last necessary requirement.

Specified conditions/ illness covered under Home care treatment:

a. Dialysis at home

b. Chemotherapy at home

c. Pandemic Care at home for a

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maximum period of 15 days and maximum upto 25% of the base sum insured excluding cumulative bonus (Pandemic as defined and declared by World Health Organization (WHO) or any equivalent healthcare authority)

In this benefit, the following shall be covered if prescribed by the treating medical practitioner and is related to treatment covered under the policy,

a. Diagnostic tests undergone at home or at diagnostics center

b. Medicines prescribed in writing

c. Consultation charges of the medical practitioner

d. Nursing charges related to medical staff

e. Medical procedures limited to parenteral administration of medicines

f. Including but not limited to cost of Pulse Oximeter, Oxygen cylinder and nebulizer wherever applicable

For the purpose of this cover, "Equivalent Medical charges" shall mean the charges for services or supplies, which are the standard/equivalent charges for the specific provider and not more than the prevailing charges in the geographical area for identical or similar services taken on inpatient/day care basis, considering the nature of the illness / injury involved.

B32. Wellness Services

We / our Empanelled Service Provider will provide below mentioned wellness services designed to assist insured persons in maintaining and improving good health and fitness. These Wellness Services will be available for the insured person during the policy period and as specified in the Policy schedule.

i. Teleconsultation - General

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

This service can only be availed subject to condition below:

- Consultation will be provided through various specified modes of communication (including but not limited to) like audio, video, online portal, chat, digital customer application or any other digital mode.

ii. Teleconsultation - Speciality

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

This service can only be availed subject to conditions below:

- Consultation will be provided through various specified modes of communication (including but not limited to) like audio, video, online portal, chat, digital customer application or any other digital mode.

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iii. Ambulance Booking facility

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

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

iv. Emergency - Help me feature

In case of an emergency, insured person will have an option to share his/her location with the 'designated caregiver' through our customer application provided the insured person has registered on our App.

The app will trigger a message and call to the designated caregiver informing about the emergency and sharing the location of the Insured Person.

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

Please note

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

v. Redeemable voucher/Discount on services

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

vi. Health Condition Management

We / our empanelled service provider will provide consultative services related to health conditions/ illnesses with the objective of maintaining good health and improving it through various health condition management programmes including but not limited to nutrition management, weight management, chronic condition management, stress management, health coach (as approved by the regulator from time to time) and offered by us.

Consultative services will be provided through various specified modes of communication (including but not limited to) audio, video, online portal, chat, digital customer application or any other digital mode.

Definition:

For the purpose of section B 32 of this policy, a Health Care Professional is a person who holds a valid qualification from regulatory body as set up by the Government of India or a State Government or any other relevant authority and is engaged in actions with an objective of maintaining and improving individual's good health.

B33. Wellness Program

We / our empanelled service provider will provide a wellness program designed to promote wellness and fitness amongst the insured persons. This wellness program is structured to reward the insured person in the form of measurable wellness score for the prescribed physical efforts/fitness activity undertaken by such insured person during the policy period. This is a voluntary program available for insured with age

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above 18 years, at the start of the policy year. It is advisable to the insured person to consult his/her physician before starting any physical exercise/ activity.

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

For the purpose of understanding if the daily score is credited on 1st Jan 2022 it will be valid up to 31st Dec 2022.

i) Health risk assessment

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

To undertake the health risk assessment, you can log into your account on our customer application. This can be undertaken once a policy year.

On completion of the health risk assessment and based on the insured person's assessment results, we / our empanelled service provider will identify the wellness category in which the insured person falls in.

Wellness categories for this purpose are defined as below:

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

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

ii) Wellness Rewards

Mechanism to earn Wellness Reward:

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

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

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

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fitness tracker devices.

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

Wellness reward will be earned depending on the wellness category of the insured person and as per the grid below:

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

Note:

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

Mechanism to Utilise Wellness Reward:

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

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

Note:

- Wellness Reward can be converted

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into a monetary value after every Healthy Day, during the Cover Period

- Monetary value of the Wellness score earned is equivalent to the:

  Wellness score earned X (Per year Policy Premium without Taxes/ 10,000).

  - o In case of policy with tenure more than one year, 'per year policy Premium without Taxes' = (Total Policy premium without tax, for the tenure/ policy tenure).
  - o In case of family floater policy, reward will be calculated on average premium per person which is equivalent to the Total Policy premium without tax/ number of Insured persons covered in the policy on floater basis

Illustration

Age of the Insured Person (Years)	40
Sum Insured opted under the Policy (Rs.)	5 Lacs
Plan Type	Individual
Policy Tenure (years)	1
Total number of members covered under the policy	1
Net Premium paid (without Tax)	7931
Wellness Category (post Health Risk Assessment)	Green

Healthy Day	Wellness Reward earned (per day)	Wellness Reward converted to Monetary Value (per day)	Wellness Reward credited after Healthy Day	Wellness Reward valid up to 365 days (provided the policy is active and insured is covered)
1 to 300 day	10	7.931	Date of credit of Wellness score	365 days from the Date of credit of Wellness score
301 day onwards	10	7.931	Date of Policy Anniversary - in case of Multi year policy Date of renewal - in case of 1 yr policy	365 days from: - Date of Policy Anniversary - in case of Multi year policy - Date of renewal - in case of 1 yr policy, as applicable
Maximum Total in a Policy Year		2894.82		

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

Step 1. Register yourself on customer application

- The insured person will download Tata AIG customer application on your device and complete registration process by providing policy and insured person's details.

Step 2. Complete health risk assessment

- Submit response to the online health questionnaire on your device.
- On completion of the health risk assessment, a Wellness category will be assigned to the insured person for the policy year and will be updated based on the latest health risk assessment in next policy year.

Step 3. Comply with mechanism to earn Wellness Rewards

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

Step 4. Convert Healthy Day into monetary value and spend

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

Disclaimer (applicable to section B32 & B33)

1. Availing the services under this benefit is purely upon the Insured's sole discretion and risk.
2. For services that are provided through empanelled Service Providers, we are acting as a facilitator; hence would not be liable for any incremental costs or the services. Any additional services availed, or expenses incurred on such services or benefits which are other than those covered under this policy and explicitly excluded by this policy 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 be completely borne by the insured person unless covered otherwise. However, the services under this policy should not be construed to constitute medical advice and/or substitute the insured person's visit/ consultation to an independent medical practitioner/healthcare professional
5. The medical practitioner may suggest/ recommend/prescribe over the counter medications based on the information provided, if required on a case-to-case basis. Provided that any recommendation

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under this policy shall not be valid for any medico legal purposes.

6. The insured person is free to choose whether or not to act on the recommendation after seeking consultation.

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

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

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

10. For Ambulance Booking facility–

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

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

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

11. Above mentioned services are non-portable, annual contracts, independent of policy contract and not lifelong renewable. The Services provided may be added / deleted / modified at our discretion and the same shall be notified to the policyholders in advance prior to change effective date.

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

13. Any service availed by the Insured Person under this Benefit will not impact 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.

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IRDA of India Registration No.:108 | CIN: U85110MH2000PLC128425
Tata AIG MediCare Premier UIN: TATHLIP23167V032223

Section 3 –Exclusions

General Exclusions

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

i. Standard Exclusions

1. Exclusions with waiting periods

i. 30 Days Waiting Period (Code-Excl03):

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.

ii. Specified Disease/Procedure Waiting Period (Code-Excl02):

a. Expenses related to the treatment of the listed Conditions, surgeries/ treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

c. If any of the specified disease/ procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

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

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

II. Polycystic ovarian disease

III. Fibromyoma

IV. Adenomyosis

V. Endometriosis

VI. Prolapsed Uterus

VII. Non-infective arthritis

VIII. Gout and Rheumatism

IX. Osteoporosis

X. Ligament, Tendon or Meniscal tear

XI. Prolapsed Inter Vertebral Disc

XII. Cholelithiasis

XIII. Pancreatitis

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

XV. Ulcer & erosion of stomach & duodenum

XVI. Gastro Esophageal Reflux Disorder (GERD)

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XVII. Liver Cirrhosis

XVIII. Perineal Abscesses

XIX. Perianal / Anal Abscesses

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

XXI. Benign Hyperplasia of prostate

XXII. Varicocele

XXIII. Cataract

XXIV. Retinal detachment

XXV. Glaucoma

XXVI. Congenital Internal Diseases

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

XXVII. Adenoidectomy

XXVIII. Mastoidectomy

XXIX. Tonsillectomy

XXX. Tympanoplasty

XXXI. Surgery for nasal septum deviation

XXXII. Nasal concha resection

XXXIII. Surgery for Turbinate hypertrophy

XXXIV. Hysterectomy

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

XXXVI. Cholecystectomy

XXXVII. Hernioplasty or Herniorraphy

XXXVIII. Surgery/procedure for Benign prostate enlargement

XXXIX. Surgery for Hydrocele/ Rectocele

XL. Surgery of varicose veins and varicose ulcers

iii. Pre-existing Diseases Waiting Period (Code-Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us.

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

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. Medical Exclusions

i. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof .(Code-Excl12)

ii. Expenses related to surgical treatment of obesity that does not fulfil the below conditions (Code-Excl06):

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported

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by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

i. greater than or equal to 40 or

ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

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

iii. Investigation and evaluation (Code-Excl04):

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.

iv. Expenses related to Sterility and infertility (Code-Excl17). 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

v. Refractive error (Code -Excl15): Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

vi. 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

vii. Cosmetic or Plastic Surgery (Code – Excl08) : 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.

viii. Rest cure, rehabilitation and respite care (Code-Excl05):

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

ix. Unproven treatments (Code-Excl16) : 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.

x. Maternity (Code - Excl18):

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

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

xi. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code -Excl13)

xii. 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)

3. Non-Medical Exclusions

i. Hazardous or Adventure Sports (Code Excl09) : Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving

ii. Breach of law (Code Excl10): Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

iii. Excluded Providers (Code-Excl11):Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

1. Medical Exclusions

i. Alcoholic pancreatitis

ii. Congenital External Diseases, defects or anomalies;

iii. Stem cell therapy ; however hematopoietic stem cells for bone marrow transplant for

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haematological conditions will be covered under benefit B1 or B4 of this policy;

iv. Growth hormone therapy;

v. Sleep-apnoea

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

vii. Venereal disease, sexually transmitted disease or illness;

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

ix. Dental treatment or surgery of any kind except as specified in 'Inpatient Treatment – Dental'.

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

2. Non-Medical Exclusions

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

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

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

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

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

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

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

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

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

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

xi. Any illness diagnosed or injury sustained or where there is change in health status of the member after date of proposal and before commencement of policy and the same is not communicated and accepted by us

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Section 4 – General Terms and Clauses

i. Standard General Terms and Clauses

1. Disclosure of Information

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

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

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 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.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).The Clause shall be suitably modified by the insurer based on the amendment(s), if any to the relevant provisions of Protection of Policyholder's Interests Regulations, 2017)

4. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5. Multiple Policies

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

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum

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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 treatment costs in accordance with the terms and conditions of the chosen policy.

6. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/ doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. Cancellation

i. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

Length of time Policy in force	Tenure (Years)		
	1	2	3
Upto 1 Month	75.00%	87.50%	91.5%
>1 month & Upto 3 Months	50.00%	75.00%	88.5%
>3 months & Upto 6 Months	25.00%	62.50%	75%
>6 months & Upto 12 Months	Nil	50.00%	66.5%
>12 months & Upto 15 Months	Not Applicable	25%	50%

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>15 months & Upto 18 Months	Not Applicable	12.5%	41.5%
>18 months & Upto 24 months	Not Applicable	Nil	33%
>24 months & Upto 30 months	Not Applicable	Not Applicable	8%
Exceeding 30 months	Not Applicable	Not Applicable	Nil

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit (including those provided under B 32. Wellness Services/ B 33. Wellness Program of this policy) has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation 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 misrepresentation, non-disclosure of material facts or fraud.

8. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines 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/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof.

9. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on 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.

10. 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 person had made a claim or claims in the

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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 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

11. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

12. 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. 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.

14. 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

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

15. Redressal of Grievance

In case of any grievance the insured person may contact the company through

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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, 7th and 8th 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.

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 (https://www.tataaig.com/grievance-redressal-policy)

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/)

16. Nomination

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

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

17. Premium Payment

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

ii. If you have opted to pay premium in full (lumpsum) upfront then the entire premium for the policy period shall be paid before the policy commencement date with an option of policy tenure 1/2/3 years.

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

18. Insured Person

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

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

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

19. Loadings

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

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

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

iv. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

a. We will inform You about the applicable risk loading through a counter offer letter.

b. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter.

c. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 10 days subject to deduction of the Pre-Policy Check up charges, as applicable.

v. Please note that We will issue Policy only after getting Your consent.

20. Entire Contract

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

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

21. Change of Policyholder

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

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

22. Notices

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

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

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

23. Premium Payment Zone

For the purpose of premium computation, the country is divided into following three Zones and premium payable under the

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policy will be computed based on the residential location/address as provided by the proposer/insured person in the proposal form:

a. Zone A: Mumbai including MMR/ Thane, Delhi NCR/Faridabad/ Ghaziabad, Ahmedabad, Surat and Baroda

b. Zone B: Hyderabad, Bengaluru, Kolkata, Indore, Chennai, Chandigarh/ Mohali/ Punchkula/ Zirakpur, Pune/ Pimpri Chinchwad and Rajkot

c. Zone C: Rest of India

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

The coverage for the Insured Person(s) shall automatically terminate in case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/ her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be made.

Refund will be made to the Policy holder or the nominee in case of demise of the Policy holder. We would require death certificate of the Deceased Insured Person for processing of the refund amount.

Section 5 – Claims Procedure and Claims Payment

This section explains about the procedures involved to file a valid claim by the insured member and processes related in managing the claim by TPA or Us. All the procedures and processes such as notification of claim, availing cashless service, supporting claim documents and related claim terms of payment are explained in this section.

1. Notification of Claim

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

**TPA as mentioned in the policy schedule, if any*

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2. Cashless Service

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

3. Procedure for Cashless Service

i. Cashless Service is only available at Network Hospitals.

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

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

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

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

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

e. In case of deficiency in the documents sent to TPA/Us for cashless authorization, 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

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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 after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person.

iv. **Such documentation will include the following:**

a. Our claim form, duly completed and signed for on behalf of the Insured Person.We, upon receipt of a notice of claim, will furnish Your representative with such forms as We may require for filing proofs of loss or you may download the claim form from our Web site.

b. Original Bills (pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

c. All medical reports, case histories, investigation reports, indoor case papers/ treatment papers (in reimbursement cases, if available), discharge summaries.

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

e. A detailed list of the individual medical services and treatments provided and a unit price for each in case not available in the submitted hospital bill.

f. Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. In case of pre/ post hospitalization claim Prescriptions must be submitted with the corresponding Doctor/ hospital invoice.

g. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being

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made, if and where applicable.

h. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident, if available

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

j. Stickers and invoice of implants used during surgery

k. Copy of MLC (Medico legal case) records, if carried out and FIR (First information report) if registered, in case of claims arising out of an accident and available with the claimant.

l. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements

m. Legal heir/succession certificate, if required

n. PM report (wherever applicable)

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 persons through Our Authorised Medical Practitioner whose details will be notified to insured person when and as often as We may reasonably require during the pendency of a claim hereunder.

5. Claims Payment

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

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

6. Claim procedure and management of Wellness Services & Wellness Program (Section B32 & B33)

i. Utilise Wellness Points:

Utilisation of Wellness points is only available at network service providers. To avail products or services, Insured Person must visit our Customer application and buy the required product/ services. On successful purchase, an amount equivalent to the monetary value of the Earned Wellness points will be deducted from Your policy.

ii. Avail services under Benefits:

Services are only available at network. To avail the same, following procedure must be followed:

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- Teleconsultation:

  Insured person can gain access to tele/video/digital consultation with a general physician/ specialist/psychiatrist, using our digital customer application.

- Ambulance booking facility:

  Insured person can use our digital customer application to book an ambulance. This service will be offered on best effort basis and does not have a legal binding on us.

- Emergency - Help me feature:

  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. 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.

Section 6 - Dispute Resolution

1. Dispute Resolution Clause

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

2. 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.

3. 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.

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Annexure A

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES

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
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

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SN	Centre	Address & Contact
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
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

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

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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