Prospectus

1. Suitability:

a. This policy covers persons in the age group 61 years onwards. The maximum entry age is 85 years.

b. There is no maximum cover ceasing age under this policy.

c. The policy will be issued for a period 1/2/3 years.

d. This policy can be issued to an individual and/or family.

e. The family includes spouse

f. The policy offers coverage on family floater basis.

g. Maximum 2 members of a family are covered in one Individual Plan Policy (Self, spouse, parent, parent-in-law, grandparent

h. Maximum 2 members are covered in one Family Floater Plan policy (Self and spouse or one set of parents/parent-in-laws/grandparents)

2. Key Benefits:

a. **Range of benefits:** Indemnity based health insurance cover with range of benefits.

b. **Network of hospitals:** We are equipped to offer you quality health care with our strong network of 7000+ hospitals across India.

c. **Lifelong renewal:** We offer you a lifelong renewal for your policy provided premium is paid without any break. Your premiums will be basis the age, sum insured and plan. Your renewal premium will be basis your age on renewal and there will be no extra loadings based on your individual claim.

d. Post Operative Care:

- We will arrange for a qualified nurse at home within India, wherever available, within the city you reside through our empanelled service provider and for a maximum period of 7 days per person in a policy year. In locations where we do not have empanelled service providers to offer this service, We will reimburse up to ₹1000 Per day for a maximum period of 7 days per person in a policy year.
- Telephonic assistance of a personalized health manager, who will assist in booking appointments of the insured person and coordinating with providers for below services, through our network as a part of post operative care:
  - i. Physiotherapy at home
  - ii. Nursing at home

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iii. Compassionate Care attendant at home

iv. Home Assessment for Elderly Care/ Disability

v. Appointment at Hospital / Diagnostic Center

e. **Compassionate Care:** We will arrange for a compassionate caregiver to assist the insured person in 'Activities of Daily Living' at the insured person's home within India, wherever applicable, through our empanelled service provider and for a maximum period of 14 days per person in a policy year. In locations where we do not have empanelled service providers to offer this service, We will reimburse up to ₹750 Per day for a maximum period of 14 days per person in a policy year.

f. **Consumables Benefit** - We will pay for expenses incurred, for specified consumables which are listed in 'annexure 1 – List 1 as optional items' under 'Master Circular on Standardization of Health Insurance Products, 2020" & 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).

g. **Cumulative bonus:** 10% increase in cumulative bonus for every claim free year. In the case a claim is made during the policy year, the cumulative bonus would reduce by 10% in the following year.

h. **High End Diagnostics -** We will pay the insured for the listed diagnostic tests on OPD basis if required as part of a treatmentsubject to coverage sum insured.

i. **Home Care Treatment Cover -** We will cover for reasonable and customary medical expenses incurred for treatment taken at home for below specified conditions/ illness, for maximum up to 10% of the sum insured (excluding accrued cumulative bonus):

- Dialysis at home
- Chemotherapy at home
- Pandemic Care at home

j. **Wellness Services -** We / our Empanelled Service Provider will provide below mentioned wellness services:

a. Teleconsultation – General

b. Diet and Nutrition Consultation

c. Discounts from Network Providers

k. **Tax Benefit:** The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

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3. Discounts on premium:

a. 10% long term discount on premium in case insured opts policy term of 3 years

b. 5% long term discount on premium in case insured opts policy term of 2 years

c. Family floater discount on premium:

- 2 members -20%

4. Salient Features:

1. **In-patient Treatment:** We will cover 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 in a single private room would be payable

2. **Pre-Hospitalisation Expenses:** The Medical Expenses incurred in 30 days immediately before the Insured Person was hospitalized.

3. **Post-Hospitalisation Expenses:** The Medical Expenses incurred in 60 days immediately after the Insured Person was discharged post Hospitalisation.

4. **Home Physiotherapy:** We will provide upto 10 physiotherapy sessions at home within India, wherever applicable, within the city you reside through our empanelled service providers only. Benefit is available for claim under Joint replacement surgery, stroke or paralysis and as a part of the Post hospitalization period.

5. **Post Operative Care:**

a. **Home Nursing Service:** If an insured person requires to be attended by a qualified nurse after the discharge from the hospital to avail post-operative care, We will arrange for a qualified nurse at home within India, wherever applicable, within the city you reside through our empanelled service providers only for a maximum period of 7 days per person in a policy year within post hospitalization period. In locations where we do not have empanelled service providers to offer this service, We will reimburse up to ₹1000 Per day for a maximum period of 7 days per person in a policy year.

b. **Personalized Health Manager:** We/our empanelled service provider will offer telephonic assistance of a personalized health manager, who will assist in booking appointments of the insured person and coordinating with providers for the services listed in the policy.

6. **Compassionate Care:** We will arrange for a compassionate caregiver to assist the insured person in the 'Activities of Daily Living' post discharge from the hospital at insured person's home within India, wherever available through our empanelled service providers for a maximum period of 14 days per person per policy year within post

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hospitalization period. In locations where we do not have empanelled service providers to offer this service, We will reimburse up to ₹750 Per day for a maximum period of 14 days per person in a policy year

7. **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.

8. **AYUSH benefit -** Medical Expenses incurred for In-patient treatment taken in AYUSH hospital, subject to maximum of 50% of the sum insured.

9. **Road Ambulance cover –** For utilizing ambulance service for transporting insured person to hospital in case of an emergency, subject to a maximum of ₹5000 per Hospitalization

10. **Preventive Health Check-up -** We will arrange for a Preventive Health Check-up for tests specified in the policy, through our empanelled network providers after block of every two continuous claim free policy years with us.

11. **Annual Preventive Health Consultation:** We will arrange for an Annual health consultation for preventive dental check-up, eye check-up and orthopedic consultation.

12. **Consumables Benefit -** We will pay for expenses incurred, for specified consumables which are listed in 'annexure 1 – List 1 as optional items' under 'Master Circular on Standardization of Health Insurance Products, 2020" & 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).

13. **Cumulative Bonus:** 10% increase in cumulative bonus for every claim free year. In the case a claim is made during the policy year, the cumulative bonus would reduce by 10% in the following year.

14. **Medical Second Opinion -** We will provide You a second opinion from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with any of the illnesses specified in the policy.

15. **High End Diagnostics -** We will pay the insured for the following diagnostic tests on OPD basis if required as part of a treatment subject to a maximum of ₹20,000 per policy year:

    a. Brain Perfusion imaging

    b. CT guided Biopsy

    c. CT Urography

    d. Digital Subtraction Angiography (DSA)

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e. Liver Biopsy

f. Magnetic Resonance Cholangiography Scan

g. PET CT

h. PET MRI

i. Renogram

16. **Home care treatment cover -** We will cover for reasonable and customary medical expenses incurred for treatment taken at home for mentioned conditions/ illness, for maximum up to 10% of the sum insured.

17. **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.

    a. Teleconsultations – General: Maximum 12 consultations per policy year.

    b. Diet and Nutrition Consultation: Consultations through telecommunication and digital communication technologies.

    c. Discount from network providers: Discounts on diagnostic tests, medicines, medical devices, health supplements and other health related services offered through our empanelled service provider.

18. **Home Assessment and Modification for Elderly Care/Disability:** We/ our empanelled service provider will arrange for home assessment to evaluate and recommend the modifications required in home to suit the mobility needs for elderly care/disability. In addition, a fixed amount of ₹5000 will be paid to undertake home alteration, if recommended by the home assessor.

19. **Cost Sharing:**

    a. Mandatory Co-Payment: This policy will be subject to a mandatory co-payment of 20% and You shall be liable to pay 20% of the admissible claim amount of each and every claim. Co-payment shall be applicable for all claim under in-patient hospitalization, pre/post hospitalization, day care procedures, Ayush benefit, consumable benefit, high end diagnostic and home care treatment covers.

    b. Sub-Limits on Specified Surgical Procedure: The expense payable during the entire policy year for following surgical procedure, either as Day care or In-patient is limited to the amount mentioned in the table below:

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a. Cataract (per eye per insured person)

	Annual Sum Insured		
Zone of the insured (Premium Payment Zone, as specified in the policy schedule)	₹5Lacs	₹10Lacs	₹25Lacs
Zone A	₹50,000	₹75,000	₹1,00,000
Zone B	₹47,500	₹70,000	₹95,000
Zone C	₹40,000	₹60,000	₹80,000

b. Joint Replacement Surgery (per insured person)

	Annual Sum Insured		
Zone of the insured (Premium Payment Zone, as specified in the policy schedule)	₹5Lacs	₹10Lacs	₹25Lacs
Zone A	₹2,00,000	₹3,00,000	₹5,00,000
Zone B	₹1,90,000	₹2,85,000	₹4,75,000
Zone C	₹1,60,000	₹2,50,000	₹4,00,000

Sub-limits will also include the expenses incurred on pre hospitalisation and post hospitalisation expenses. Mandatory co-payment of 20% shall not be applicable on claim incurred for these surgical procedures (i.e. Cataract/joint replacement).

5. Sum Insured options (₹):

- 5 Lacs
- 10 Lacs
- 25 Lacs

6. Renewal Incentives:

a. Cumulative Bonus: We will offer Cumulative Bonus of 10% of the Sum Insured for every claim free year accumulating up to 100% of sum insured. In the event of a claim, the cumulative bonus shall be reduced by 10% at the time of renewal.

b. Preventive Health Check-up - We will arrange a Preventive Health Check-up, for listed tests, through our empanelled network providers after a block of every two continuous claim free policy year with us.

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7. 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 Consolidated Guidelines on Product Filing in Health Insurance Business– Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof.

8. 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

9. Waiting Period:

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

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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/48 months (as applicable), 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 conditions furnished below are covered after a waiting period of 24 months:

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

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XII. Cholelithiasis

XIII. Pancreatitis

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

XV. Ulcer & erosion of stomach & duodenum

XVI. Gastro Esophageal Reflux Disorder (GERD)

XVII. Liver Cirrhosis

XVIII. Perineal Abscesses

XIX. Perianal / Anal Abscesses

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

XXI. Benign Hyperplasia of prostate

XXII. Varicocele

XXIII. Cataract

XXIV. Retinal detachment

XXV. Glaucoma

XXVI. Congenital Internal Diseases

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. Cholecystectomy

XXXVI. Hernioplasty or Herniorraphy

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XXXVII. Surgery/procedure for Benign prostate enlargement

XXXVIII. Surgery for Hydrocele/ Rectocele

XXXIX. Surgery of varicose veins and varicose ulcers

48 months waiting period will be applicable for joint replacement surgeries Eg: Knee replacement, Hip replacement

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.

10. 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.

Medical Exclusions:

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

ii. Alcoholic pancreatitis

iii. 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 by clinical protocols

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

d. Body Mass Index (BMI);

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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

iv. Congenital External Diseases, defects or anomalies;

v. Stem cell therapy ; however hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under benefit In-Patient Treatment or Day Care Procedures of this policy;

vi. Growth hormone therapy;

vii. Sleep-apnoea

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

ix. 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.

x. Venereal disease, sexually transmitted disease or illness;

xi. 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

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

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xiii. 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

xiv. 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.

xv. 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.

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

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

xvii. 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.

xviii. Dental treatment or surgery of any kind

xix. 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

xx. 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

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domestic reasons. (Code -Excl13)

xxi. 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)

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

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. 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

IV. 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.

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

VI. 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

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

VIII. 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.

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

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

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XI. Any treatment or part of a treatment that is not a part of 'Reasonable and Customary charges', not medically necessary; drugs or treatments which are not supported by a prescription.

XII. 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).

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

XIV. 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.

11. Claim Procedure:

The final decision on all claims is taken by Tata AIG General Insurance Company Limited.

a. Intimation & Assistance:

Please contact our designated TPA/Us atleast 48 hours prior to an event which might give rise to a claim. For any emergency situations, kindly contact our TPA within 24 hours of the event.

b. Claim Related Information:

For any claim related query, intimation of claim and submission of claim related documents, You can contact us through:

- Name of Claims Administrator: TAGIC Health Claims
- Website : www.tataaig.com
- Email : general.claims@tataaig.com
- Toll Free : 1800 266 7780
  : 1800 22 9966 (for Senior Citizens)
- Submit claim: A&H Claims Department

  Tata AIG General Insurance Co. Ltd.

  5th and 6th Floor, Imperial Towers, H.No 7-1-6-617/A, GHMC No - 615,616, Ameerpet, Hyderabad – 500016, Telangana, Phone-040-66864900

c. Procedure for reimbursement claims:

- Our TPA/We must be informed within 7 days of completion of such treatment, consultation or procedure using the Claim Intimation Form.
- Please send the duly signed claim form and all the information/documents mentioned therein to our TPA/Us within 15 days of the occurrence of the Incident.
- Please refer to claim form for complete documentation.
- If there is any deficiency in the documents/information submitted by you, our TPA/ We will send the deficiency letter within 7 working days of receipt of the claim documents.
- On receipt of the complete set of claim documents, We will send the payment for the admissible amount, along with a settlement statement within 30 days.
- The payment will be sent in the name of the proposer/ Nominee in case of death of Proposer.

d. Procedure for availing cashless facility:

- For any emergency Hospitalisation, our TPA/We must be informed within 24 hours after hospitalization.
- For any planned hospitalization, kindly seek cashless authorization from our TPA/ Us atleast 48 hours prior to the hospitalization.
- TPA/We will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 6 hours of receipt of documents.
- In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 6 hours.

Note:

- Insured person is entitled for cashless coverage only in our empanelled hospitals.
- Please refer to our website(www.tataaig.com) or call us on our toll free number at 1800-266-7780 for empaneled hospital list.
- Rejection of cashless facility in no way indicates rejection of the claim.

e. 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.

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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)

f. Claim procedure and management of Services

Service 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). This is applicable for availing services under the benefits B4, B5, B6, B10, B11, B17, B18 of the policy.

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.

12. 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 preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company

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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

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. 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 Consolidated Guidelines on Product Filing in Health Insurancre Business– Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof.

15. Withdrawal of the policy:

a. 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.

b. 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.

16. 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

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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.

17. Nomination:

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

18. Requirement:

- Completed proposal form,
- Supporting Medical papers (wherever applicable),
- Previous policy copies, IRDAI portability form (as applicable)

19. Pre-policy medical check-up:

Pre-Policy Check-up at our network is required. The medical reports are valid for a period of 90 days from the date of Pre-Policy Checkup.

Pre-policy medical examination gird: Age (Years)	Pre Policy Check up tests*
61-70 Years	MER, CBC ESR, HbA1c, Lipid Profile, Sr. Creat, SGOT, SGPT, Urine Routine, ECG
71 Years & above	MER, CBC ESR, HbA1c, Lipid Profile, Sr. Creat, SGOT, SGPT, Urine Routine, 2 D Echo, USG

- In case of adverse medical declaration, we may call for additional medical tests
- *At least 50% of pre-policy medical checkup cost would be borne by Tata AIG in case where proposal is accepted.

20. Premium Rates & Payment Zones:

a. The premium will be charged on the completed age of the Insured Person.

b. Premium rates are subject to change with prior approval from IRDAI.

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c. The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.

d. For family floater, premium is calculated by adding the premium of respective individual members and applying family floater discount.

e. Monthly instalment option would be allowed and following loadings shall be applicable:

Term of Policy	Loading%
1 year Policy	5%
2 year Policy	9%
3 year Policy	13%

If the insured person has opted for Payment of Premium on an installment basis i.e. Monthly, as mentioned in the policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

I. Grace Period of 15 days would be given to pay the installment premium due for the policy.

II. During such grace period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.

III. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

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

V. In case of installment premium due not received within the grace period, the policy will get cancelled.

VI. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

VII. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Premium Payment Zones:

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

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

c. Zone C: Rest of India

Zone A (Annual)Per Person Rates(Rs.) (Exclusive of taxes)

Age\Sum Insured(Rs.)	5 Lacs	10 Lacs	25 Lacs
61-65 Years	27,844	35,000	50,840
66-70 Years	34,940	44,023	64,210
71-75 Years	49,127	61,669	90,035
76-80 Years	73,664	91,295	1,33,729
81-85 Years	86,132	1,07,558	1,57,911
86-90 Years	1,03,359	1,29,165	1,89,809
91-95 Years	1,24,030	1,55,091	2,28,084
96+ Years	1,48,836	1,86,202	2,74,015

Zone B (Annual)Per Person Rates(Rs.) (Exclusive of taxes)

Age\Sum Insured(Rs.)	5 Lacs	10 Lacs	25 Lacs
61-65 Years	25,274	31,686	45,886
66-70 Years	31,653	39,792	57,888
71-75 Years	44,479	55,718	81,147
76-80 Years	66,530	82,331	1,20,370
81-85 Years	77,749	96,951	1,42,089
86-90 Years	93,263	1,16,389	1,70,754
91-95 Years	1,11,878	1,39,714	2,05,148
96+ Years	1,34,216	1,67,703	2,46,422

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Zone C (Annual)Per Person Rates(Rs.) (Exclusive of taxes)

Age\Sum Insured(Rs.)	5 Lacs	10 Lacs	25 Lacs
61-65 Years	22,640	28,292	40,814
66-70 Years	28,284	35,458	51,416
71-75 Years	39,717	49,625	72,048
76-80 Years	59,223	73,153	1,06,697
81-85 Years	69,163	86,091	1,25,895
86-90 Years	82,922	1,03,309	1,51,250
91-95 Years	99,431	1,23,970	1,81,673
96+ Years	1,19,242	1,48,763	2,18,181

21. 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.

22. 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.

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Length of time Policy in force	Year		
	1	2	3
Upto 1 Month	75%	87.5%	91.5%
>1 month & Upto 3 Months	50%	75%	88.5%
>3 months & Upto 6 Months	25%	62.5%	75%
>6 months & Upto 12 Months	Nil	50%	66.5%
>12 months & Upto 15 Months	NA	25%	50%
>15 months & Upto 18 Months	NA	12.5%	41.5%
>18 months & Upto 24 months	NA	Nil	33%
>24 months & Upto 30 months	NA	NA	8%
Exceeding 30 months		NA	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 Wellness Services) 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.

23. Redressal of Grievance:

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

- Website: www.tataaig.com
- Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders)
- Email: customersupport@tataaig.com
- Courier: Customer Support

  Tata AIG General Insurance Co. Ltd.

  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/)

24. Section 41 of Insurance Act1938 (Prohibition of Rebates):

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 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 prospectus or tables of the insurer.
2. Any person making default in complying with the provision of this section shall be liable for penalty which may extend to ten lakh rupees.

IRDAI REGULATION: This policy is subject to IRDAI (Protection of Policyholder's Interests) Regulations,2017.

Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDAI.

Disclaimer:

This is only a summary of the product features. The actual benefits available are as described in the policy, and will be subject to the policy terms, conditions and exclusions. Please seek the advice of your insurance advisor if you require any further information or clarification.

"Insurance is the subject matter of the solicitation". For more details on benefits, exclusions, limitations, terms & conditions, please refer sales brochure/ policy wordings carefully, before concluding a sale."

Commencement of risk cover under the policy is subject to receipt of premium by Tata AIG General Insurance Company Limited.

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