Important terms and conditions of various policies issued to Axis Bank covering their customers under Group MediCare product.

Please note that, selective benefits and terms and conditions shall be applicable to you, details of which are available in your respective valid Certificate of Insurance/ Policy Schedule.

In case of any further clarification, you may coordinate with our customer care team on below given contact number or approach any of your nearest Tata AIG General Insurance Company branch or the master policy holder.

In the event of any in consistency in this document and your Certificate of Insurance, the terms and condition mentioned in the Certificate of Insurance will prevail.

Please note, the following is a summary of key benefit and terms and conditions.

Preamble

We will provide the insurance cover detailed in the Policy to the Insured Persons up to the Sum Insured subject to:

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

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

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

While the policy is in force, and if the claim is admissible under the policy, then We shall pay You such Reasonable and Customary Medical Expenses incurred on treatment or pay for the listed benefit sum insured. The said treatment must be on the advice of a qualified Medical Practitioner.

Our liability at any time shall not exceed the maximum sum insured applicable for the benefit as specified in Your policy schedule or Certificate of insurance. In case of family floater, the sum insured shall be applicable for all the claims made by any or all the insured persons in the family whereas in case of individual, this shall be applicable for all the claims made by an individual insured person.

In case of any other sum insured restrictions, the same shall be clearly specified in Your Policy schedule/Certificate of Insurance.

Section 1 – Definitions

The terms defined below and at other junctures in the Policy Wording have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same:

i. Standard Definitions

1. Accident

An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. 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 Treatment

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

4. AYUSH Hospital

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

a. Central or State Government AYUSH Hospital or

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

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

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

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

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

5. Cashless facility

Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre- authorization is approved.

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. Co-Payment

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

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;

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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 which would have otherwise required hospitalization of more than 24 hours.

ii. 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 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;

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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. In-patient Care

Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

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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. 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.

24. OPD treatment

OPD treatment means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

25. Pre-Existing Disease

Pre-Existing Disease means any condition, ailment , injury or disease

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

26. 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.

27. 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

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28. 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.

29. 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.

30. 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.

31. 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.

32. Room Rent

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

33. Surgery or Surgical Procedure

Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

34. 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. Associated Medical Expenses

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

3. Policyholder

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

4. Room Category

Room Category shall mean one of the

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following:

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

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

c. Economy Ward means a hospital room with more than three patient beds. This definition does not apply to ICU or ICCU.

5. **We/Us/Our** means TATA AIG General Insurance Company Limited.

6. **You/Your/Yourself** means the Policy Holder and/or Insured Person(s) who is named in the Policy Schedule.

Section 2: Benefits

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

B1. In-Patient Treatment

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

B2. Pre-Hospitalization expenses

We will cover the Pre-Hospitalization expenses for consultations, investigations and medicines incurred upto the number of days as specified in your policy schedule/ Certificate of Insurance.

The benefit is payable if We have admitted a claim under In-patient Treatment/Day Care Procedures/Domiciliary treatment.

B3. Post-Hospitalization expenses

We will cover the Post-Hospitalization expenses for consultations, investigations and medicines incurred upto the number of days, as specified in your policy schedule/ Certificate of Insurance.

The benefit is payable if We have admitted a claim under In-patient Treatment/Day Care Procedures /Domiciliary treatment.

B4. Day Care Procedures

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

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

B5. Domiciliary 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 2-11) of this policy.

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

B6. Organ Donor

We will cover for Medical and surgical

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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 Act (Amended) , 1994 and other applicable laws and rules and the organ donated is for the use of the Insured Person, and

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

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

B7. Ambulance Cover

We will cover for expenses incurred on transportation of Insured Person in a registered ambulance to a Hospital for admission in case of an Emergency or from one hospital to another hospital for better medical facilities and treatment, subject to amount as specified on the policy schedule/Certificate of Insurance.

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

B8. Family Transportation Benefit

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

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

B9. Hospital Daily Cash Benefit

We will pay the Hospital Daily Cash Benefit as specified in the Policy Schedule/ Certificate of Insurance for each continuous and completed 24 Hours of Hospitalisation during the Policy Year, provided that:

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

ii. Any claim shall be payable under this Benefit after applying the opted number of days of deductible as specified in the Policy Schedule/ Certificate of Insurance.

iii. All Benefits will be available up to the maximum number of coverage days selected per Policy Year.

iv. In case of Hospitalisation << in Intensive Care Unit and/or due to accident >>, the Daily Cash Benefit will be twice the Hospital Daily Cash Benefit amount specified in the Policy Schedule/ Certificate of Insurance under cover for which the claim qualifies.

v. For this claim to be paid, the main claim must be admissible under sections - Inpatient Treatment or Day care procedures of this policy.

vi. The Benefit under this cover will

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be << over and above inpatient sum insured/within inpatient sum insured>>

B10. Inclusion of Nursing Allowance

We will pay for expenses related to the services of a registered nurse attending to the Insured Person at the Insured Person's home immediately following his discharge from Hospital up to the limit as specified in the policy schedule/Certificate of Insurance, provided that:

i. the Medical Practitioner treating the Insured Person recommends the provision of such care for medical reasons,

ii. We have accepted an inpatient Hospitalisation claim under Benefit In-patient Treatment

iii. This benefit payable shall be part of in-patient sum insured

B11. Inclusion of AYUSH Cover

Coverage:

Subsequent to this endorsement, Section 3 –General Exclusions (2-21) stands deleted and modified coverage wordings are as below:

We will cover for expenses incurred on in-patient treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines during each Policy Year up to the limit of Sum Insured as specified in the Policy Schedule / Certificate of Insurance subject to Sub limit if applicable in any Ayush Hospital

This benefit shall be applicable to <<All insured persons/Primary Insured Person/ Dependents of Primary insured person>> for an amount as specified on the policy schedule/Certificate of insurance.

The Benefit under this cover shall be part of inpatient sum insured.

All other policy terms and conditions remain unaltered.

B12. Inclusion of Restore Sum Insured Benefit

We will automatically restore the Inpatient Sum Insured upon exhaustion of the Sum Insured during the policy period. This benefit can be availed once during the policy period subject to the following conditions:

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

ii. The restored sum insured can be used for all claims made by the insured person(s) who have not claimed earlier under Sections – Inpatient Treatment, Pre/post Hospitalization expenses and day care procedures. 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.

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

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

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

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B13. Inclusion of Health-Check up

We will pay the reasonable and customary Charges incurred, in respect of health check up, during the Policy Year in, up to the limit specified in the Policy Schedule/ Certificate of Insurance, provided that:

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

ii. The eligibility of the Insured Person, frequency of heath check ups and dependency of health check ups on claim status will be as defined in the Policy Schedule/ Certificate of Insurance.

iii. The benefit payable would be << over and above/within outpatient>> and <<over and above/within inpatient>> sum insured.

B14. Inclusion of Personal Accident cover

The Benefit under Personal Accident Covers have a separate sum insured.

1) Accidental Death

If an Insured Person suffers an accident during the policy period and this is the proximate cause of his death within 365 days from the date of accident then We will pay to Insured person's beneficiary or legal representative the benefit Sum Insured specified in the Policy schedule/ Certificate of insurance.

Disappearance

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

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

In addition to the claim documents mentioned under Section 5 (4-iv) of base cover policy wordings, following claim documents would be required for this benefit:

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

2) Permanent Total Disability

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

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

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

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following:

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

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

In addition to the claim documents mentioned under Section 5 (4-iv) of base cover policy wordings, we would require certificate from Civil Surgeon or Medical Superintendent/Dean of government hospital/medical board,, confirming the Disability percentage / period and prognosis.

3) Transportation of mortal remains

If we have accepted a claim under Accidental Death benefit, then we will in addition pay fixed amount as specified in the policy schedule/Certificate of insurance towards transporting the mortal remains of the insured from the place of the accident or the hospital to his residence.

4) Funeral Expenses

If we have accepted a claim under Accidental Death benefit, then we will in addition pay fixed amount as specified in the policy schedule/Certificate of insurance towards funeral expenses.

5) Education benefit

If we have accepted a claim under Accidental Death benefit, then we will in addition pay an amount as specified in policy schedule/Certificate of insurance towards child education. The benefit is payable for each child who has not reached the age of 23 years and is enrolled as a full time student in an educational institution recognized by the Government of India. This would be a onetime payment irrespective of no. of dependent children. In case the child is a minor, the benefit will be given to the joint account of the legal guardian and the minor child.

In addition to the claim documents mentioned under Section 5 (4-iv) of base cover policy wordings, following claim documents would be required for this benefit:

- Copy of admission form with identity card for child/children at the time of date of loss.
- Copy of Birth Certificate or any other valid document establishing age.
- Copy of Family card or Ration card reflecting the name of child/children.

Specific Exclusions Applicable to Personal Accident Cover

The following exclusions will be applicable in addition to the exclusions under – Section 3:

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

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

iii. Arising out of or resulting from or in connection with any act of terrorism.

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

B15. Inclusion of Deductible

1) Per Claim Deductible

The Deductible amount specified in the Policy Schedule/ Certificate of Insurance as the Per Claim Deductible shall be applicable on all claims made by an Insured Person during the Policy Year, as specified on the policy schedule/Certificate of insurance, provided that:

i. The Per Claim Deductible will be applied on all claims under indemnity based coverages on the admissible claim amount in respect of <<All insured persons/Primary Insured Person/Dependent of Primary Insured person>>.

ii. The Deductible amount will be applicable on the basis of the admissible claim amount after applying the Sub Limits of the Policy.

2) Annual Aggregate Deductible

The Deductible amount specified in the Policy Schedule/ Certificate of Insurance shall be applicable on the aggregate of all claims made by an Insured Person if covered under the Policy on an Individual basis or by the family if covered under the Policy on a Floater basis during the Policy Year, provided that:

i. The Annual Aggregate Deductible will be applied on all claims under indemnity based coverages on the admissible claim amount.

ii. The consumption of the Deductible amount will be on the basis of the admissible claim amount after applying the Sub Limits of the Policy.

Section 3 – Exclusions

i. Standard Exclusions

1. Exclusions with Waiting Period

i. 30 day Waiting Period(Code- Excl 03)

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

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

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

All other policy terms and conditions remain unaltered.

ii. Specified disease / procedure waiting period: (Code- Excl 02)

a) Expenses related to the treatment of the listed Conditions, surgeries/ treatments shall be excluded until the expiry of << as specified under the Policy Schedule/Certificate of Insurance>> months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

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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:

a. Tumors, Cysts, polyps including breast lumps (benign)
b. Polycystic ovarian disease
c. Fibromyoma
d. Adenomyosis
e. Endometriosis
f. Prolapsed Uterus
g. Non-infective arthritis
h. Gout and Rheumatism
i. Osteoporosis
j. Ligament, Tendon or Meniscal tear (due to injury or otherwise)
k. Prolapsed Inter Vertebral Disc (due to injury or otherwise)
l. Cholelithiasis
m. Pancreatitis
n. Fissure/fistula in anus, haemorrhoids, pilonidal sinus
o. Ulcer & erosion of stomach & duodenum
p. Gastro Esophageal Reflux Disorder (GERD)
q. Liver Cirrhosis
r. Perineal Abscesses
s. Perianal / Anal Abscesses
t. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.
u. Benign Hyperplasia of prostate
v. Varicocele
w. Cataract
x. Retinal detachment
y. Glaucoma
z. Congenital Internal Diseases
aa. Adenoidectomy
bb. Mastoidectomy
cc. Tonsillectomy
dd. Tympanoplasty
ee. Surgery for nasal septum deviation
ff. Nasal concha resection
gg. Surgery for Turbinate hypertrophy
hh. Hysterectomy
ii. Joint replacement surgeries Eg: Knee replacement, Hip replacement
jj. Cholecystectomy

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kk. Hernioplasty or Herniorraphy

ll. Surgery/procedure for Benign prostate enlargement

mm. Surgery for Hydrocele/ Rectocele

nn. Surgery of varicose veins and varicose ulcers

All other policy terms and conditions remain unaltered.

iii. Pre-Existing Diseases(Code- Excl 01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of << as specified under the Policy

Schedule/Certificate of Insurance>> months of continuous coverage after the date of inception of the first policy with insurer.

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

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

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

All other policy terms and conditions remain unaltered.

2. Medical 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 connection with or in respect of:

1. Investigation & Evaluation(Code- Excl 04)

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

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

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

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

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

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

3. Obesity/ Weight Control(Code- Excl 06)

Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor

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2) The surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMI);

   a) greater than or equal to 40 or

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

      I. Obesity-related cardiomyopathy

      II. Coronary heart disease

      III. Severe Sleep Apnea

      IV. Uncontrolled Type2 Diabetes

4. 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.

5. Cosmetic or plastic Surgery: (Code- Excl 08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

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

7. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code- Excl 13)

8. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure (Code- Excl 14)

9. Refractive Error:(Code- Excl 15)

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

10. Unproven Treatments:(Code- Excl 16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

11. Sterility and Infertility: (Code- Excl 17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

iv. Reversal of sterilization

12. Maternity (Code - Excl 18):

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

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

3. Non Medical Exclusions

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. 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 **(Code – Excl11)**

ii. <u>Specific Exclusions (Exclusions other than as mentioned under Section 3 (i) above)</u>

1. Medical Exclusions

i. Congenital External Diseases, defects or anomalies.

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

iii. Growth hormone therapy.

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

v. Venereal disease, sexually transmitted disease or illness.

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

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

viii. Any non-allopathic treatment.

2. Non-Medical Exclusions

i. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or notor 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.

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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 claim incurred after date of proposal/enrolment form and before issuance of policy/Certificate of Insurance where there is change in health status of the member and the same is not communicated to us.

Section 4 – General Terms and Clauses

i. Standard General Terms and Clauses

1. Condition Precedent to Admission of Liability

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

2. Disclosure of Information

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

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

3. Fraud

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

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

4. Multiple Policies

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

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

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

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

5. Renewal of Policy

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

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

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

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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.

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

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

7. Migration

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

For Detailed Guidelines on Migration, kindly refer Guidelines issued by IRDAI(Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof.

8. 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.

9. 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

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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

10. 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.

11. Claim settlement (provision of Penal Interest)

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

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

("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)

12. 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.

13. Moratorium Period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for

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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.

14. 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.

Short Rate Table:

	Year				
Length of time Policy in force	1	2	3	4	5
Upto 1 Month	85.00%	87.50%	91.50%	96%	98%
>1 month & Upto 3 Months	70.00%	75.00%	88.50%	93%	95%
>3 months & Upto 6 Months	50.00%	62.50%	75%	78%	80%
>6 months & Upto 12 Months	Nil	50.00%	66.50%	70%	72%
>12 months & Upto 15 Months	Not Applicable	30%	50%	52%	54%
>15 months & Upto 18 Months	Not Applicable	20%	41.50%	43%	44%
>18 months & Upto 24 months	Not Applicable	Nil	33%	35%	36%
>24 months & Upto 30 months	Not Applicable	Not Applicable	15%	20%	30%
> 30 months & Up to 36 months	Not Applicable	Not Applicable	Nil	15%	25%
> 36 months & up to 42	Not Applicable	Not Applicable	Not Applicable	Nil	20%
Exceeding 42 months	Not Applicable	Not Applicable	Not Applicable	Nil	Nil

Not with standing 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 has been availed by the Insured Person under the Policy.

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

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non-disclosure of material facts or fraud.

15. Redressal of Grievance

In case of any grievance the Insured Person may contact through Website: www.tataaig.com

Call us 24x7 toll free helpline 1800 266 7780 or 1800 22 9966 (Senior Citizen) Email us at 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

Visit the Servicing Branch mentioned in the policy document

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured person may contact the grievance officer at manager.customersupport@tataaig.com. For updated details of grievance officer, kindly refer the link (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 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/

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

16. Condition Precedent

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

ii. No change in this Policy shall be valid unless a valid endorsement is passed in the policy.

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

17. Insured Person

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

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

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

1. Intimation is given to Us by a defined & agreed date and shall be subject to Guidelines on Group Insurance Policies, dated 14th July 2005 issued by Insurance Regulatory and Development Authority of India and any subsequent amendments as published from time to time
2. Requisite premium has been paid to Us.
3. All existing dependents must be covered along with the Primary

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Insured and the addition of **Dependents** shall be allowed only in the event of:

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

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

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

a. In case of Employer-Employee Policies:

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

b. In case of non Employer-Employee Policies, the coverage shall automatically expire from the date the insured person exits the scheme.

c. In case of refund of premium being generated on the Policy due to deletion of Insured Persons, the same will be refunded or adjusted accordingly against the future premium installments due on the Policy.

18. Entire Contract

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

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

19. Notices

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

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

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

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20. Termination

i. You may terminate this Policy / Certificate of Insurance at any time by giving Us written notice, and the Policy/Certificate of Insurance shall terminate when such written notice is received.

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

a. The date You or We cancel the Certificate of Insurance

b. The member opts out of the scheme

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

21. Arbitration

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

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

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

22. Dispute Resolution Clause

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

Section 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.

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2	If any treatment for which a claim may be made and that treatment requires emergency Hospitalisation	Within 24 hours of the Insured Person's admission to Hospital.

Failure to furnish such intimation within the time required shall not invalidate nor reduce any claim if You can satisfy us that it was not reasonably possible for You to give proof of such delay within such time. The Company may relax these timelines only in special circumstances and for the reasons beyond the control of the insured.

*TPA as mentioned in the policy schedule

2. Cashless Service

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken	Cashless Service is Available:	We must be given notice that the Insured Person
		at:		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.

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

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

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

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

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

e. In case of deficiency in the documents sent to TPA/Us for cashless authorization, the same shall be communicated to the hospital by TPA/Us within 6 hours of receipt of the documents.

f. In case the ailment /treatment is not covered under the policy or cashless is rejected due to insufficient documents submitted, a rejection letter would be sent to the hospital within 6 hours.

g. Rejection of cashless in no way indicates rejection of the claim. You are required to submit the claim along with required documents for us to decide on the admissibility of the claim.

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

i. Pre-authorization does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.

4. Supporting Documentation & Examination

i. You or someone claiming on Your behalf shall provide Us with documentation, medical records and information We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days or earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment.

ii. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if you can satisfy us that it was not reasonably possible for you to give proof within such time.

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iii. We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person.

iv. Such documentation will include the following:

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

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

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

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

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

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

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

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

i. 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

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n. PM report (wherever applicable and conducted)

v. Note: In case You are claiming for the same event under an indemnity based policy of another insurer and are required to submit the original documents related to Your treatment with that particular insurer, then You may provide Us with the attested copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

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

5. Claims Payment

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

ii. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Interests Regulation), 2017.

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

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SN	Centre	Address & Contact
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
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

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SN	Centre	Address & Contact
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 http://www.cioins.co.in/ombudsman.html

Prohibition of Rebates - Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

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