Customer Information Sheet/know Your Policy

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

S No	Title	Description	Policy Clause No.
1.	Name of the Insurance Policy	Tata AIG Health Supercharge- Value Plan	
2.	Policy Number	<< Policy Number >>	
3.	Type of Insurance Policy	Both Indemnity and Benefit – Policy has elements of both, Indemnity (which cover insured loses) and Benefit (which pays a fix amount under the policy on the occurrence of a covered event.	
4.	Sum Insured (Basis) (Along with amount)	<<Sum Insured Amount>> As per Sum Insured mentioned in Policy Schedule Sum Insured represents Our maximum, total and cumulative liability under the Policy, for all the Insured Person(s) covered in aggregate, for the respective Policy Year	
5.	Policy Coverage (What the policy covers?)	B1. **In-Patient Treatment** - Covers medical expenses for hospitalization for period more than 24 hrs. B2. **Pre-Hospitalization expenses** - Medical Expenses incurred upto 90 days prior to the date of admission to the hospital B3. **Post-Hospitalization expenses** - Medical Expenses incurred upto 90 days after the date of discharge from the hospital B4. **Day Care Treatment** - Medical expenses for Day Care Treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre. B5. **Domiciliary Treatment** - Medical Expenses incurred for availing medical treatment at home which would otherwise have required hospitalization. B6. **Organ Donor** - Medical Expenses towards the harvesting the organ from the donor for organ transplantation. B7. **AYUSH Benefit** - Medical Expenses incurred for treatment as In-patient taken in an AYUSH Hospital subject to the maximum limit per Policy Year, as mentioned in the Policy Schedule. B8. **Road Ambulance Cover** - Expenses incurred on transportation of Insured Person in a registered ambulance to a Hospital for admission in case of an Emergency.	Section 2

		B9. **Restore benefit** - Automatically reinstate 100% of the Sum Insured, if the balance Sum Insured and accrued 5X Supercharge Bonus is insufficient to pay an admissible claim under In-Patient Treatment, Pre-Hospitalization Expenses, Post-Hospitalization Expenses, Day Care Treatment, Domiciliary Treatment or Organ Donor cover, during the policy period. B10. **Compassionate Travel** - In the event the Insured Person is Hospitalized in India for more than Five consecutive days in a place where no adult member of his immediate family is present, we will cover expenses related to a round trip economy class domestic air ticket, or first-class railway ticket, to allow the Immediate Family Member be at his bedside for the duration of his stay in the hospital, subject to a maximum limit as specified in the policy schedule during a Policy Year. B11. **Prolonged Hospitalization Benefit** - We will pay a fixed amount as specified in the Policy Schedule, in the event of Hospitalization of the Insured Person, at Our Network Provider, for a disease/illness/injury for a continuous period exceeding 10 days. B12. **Medical Devices Cover** - Expenses incurred by the Insured Person towards renting or purchase of listed medical devices during the Policy Year. B13. **Vaccination Cover** - Covers the cost of the following vaccines: -Anti-rabies vaccine following an animal bite -Typhoid vaccination B14. **Second Opinion** - We will provide You a second opinion from Our empanelled service provider in India, if an Insured Person is diagnosed with the listed Illnesses during the Policy Period. B15. **Wellness Services -** We / our Empanelled Service Provider will provide below mentioned services to Insured Person(s): a. Teleconsultation - General b. Teleconsultation – Speciality c. Ambulance Booking facility d. Emergency- Help me feature e. Redeemable voucher/Discount on services f. Health Condition Management B16. **Wellness Program** - We / our empanelled service provider will provide a wellness program to Insured Person(s), designed to promote wellness and fitness amongst the insured persons through: a. Health risk assessment b. Wellness Rewards B17. **5X Supercharge Bonus**- We will provide 5X Supercharge Bonus in the form of 50% of the base Sum Insured of the expiring Policy, on each Renewal of the Policy, irrespective of claims in	

		preceding Policy Years. The total accrued 5X Supercharge Bonus shall not exceed 500% of the base Sum Insured in any Policy Year. **Optional Covers (For covers applicable to you, please refer your Policy Schedule):** **C1.Restore Infinity -** We will provide reinstatement of sum insured unlimited number of times during a Policy Year post exhaustion of the Restore Benefit. **C2.Emergency Air Ambulance Cover -** We will reimburse cost of air ambulance for transportation of the Insured Person in an airplane or helicopter subject to maximum of limit as specified in the policy schedule per Policy Year for Emergency Care of life-threatening health conditions which require immediate and rapid ambulance transportation to a Hospital for further medical management. **C3.Consumables benefit -** We will pay for expenses incurred, for specified consumables, subject to balance sum insured, which are mentioned in Annexure I – List I of optional items available on Our website (www.tataaig.com) which are consumed during the period of Hospitalization directly related to the Insured Person's medical or surgical treatment of Illness/disease/Injury. **C4.Preventive Annual Health Check-Up -** We/ Our empanelled service provider will arrange for listed medical tests, once in a Policy Year, only on cashless basis. **C5.Advanced Cover -** In lieu of the policyholder opting for this Advanced Cover and paying additional premium for the specific Insured Person(s), the word "48 months" should be read as "30 days" under 'Pre-existing Diseases Waiting Period (Code- Excl 01)'only for the following named pre-existing diseases: a. Diabetes Mellitus (Type 2), b. Hypertension, c. Hyperlipidemia & d. Asthma **C6.Accidental Death Benefit** - If an Insured Person suffers an accident during the policy period and this is the sole and direct cause of his death within 365 days from the date of accident, then we will pay the Sum Insured as mentioned against the respective insured person in the Policy schedule.	
6.	Exclusions	Standard **Exclusions**	Section 3

1. Medical Exclusions

I. Investigation and evaluation (Code- Excl 04)
II. Rest cure, rehabilitation and respite care (Code- Excl 05)
III. Obesity/ Weight Control (Code- Excl 06)
IV. Change-of-Gender treatments: Code- Excl07
V. Cosmetic or Plastic Surgery (Code- Excl 08)
VI. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code- Excl 12).
VII. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code- Excl13)
VIII. 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)
IX. Refractive error (Code- Excl 15)
X. Unproven treatments (Code- Excl 16)
XI. Sterility and Infertility (Code- Excl 17)
XII. Maternity (Code - Excl 18)

2. Non-Medical Exclusions

I. Hazardous or Adventure Sports (Code- Excl 09)
II. Breach of law (Code- Excl 10)
III. Excluded Providers: (Code-Excl 11)

Specific Exclusions (Exclusions other than as those mentioned above)

1. Medical Exclusions

I. Alcoholic pancreatitis or Alcoholic liver disease;
II. Congenital External Diseases, defects or anomalies;
III. Stem cell therapy;
IV. Growth Hormone Therapy;
V. Sleep-apnoea and Sleeping disorder;
VI. Admission primarily for administration (via any form or mode) of immunoglobulin infusion or supplementary medications
VII. Venereal disease, sexually transmitted disease or Illness;
VIII. All preventive care

		IX. Cost of dentures, dental implants and braces X. Any existing disease specifically mentioned as Permanent exclusion in the Policy Schedule. XI. Non payable items as mentioned in Annexure I – List I of optional items available on Our website (www.tataaig.com) **2. Non-Medical Exclusions** I. War or any act of war, invasion, act of foreign enemy, war like operations. II. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event III. Any Insured Person's participation or involvement in naval, military or air force operation. IV. Intentional self-Injury or attempted suicide while sane or insane. V. Items of personal comfort and convenience. VI. Treatment rendered by a Medical Practitioner which is outside his discipline. VII. Doctor's fees charged by the Medical Practitioner sharing the same residence as an Insured Person or who is an immediate relative of an Insured Person's family. VIII. Hearing aids, spectacles or contact lenses, etc. IX. Any treatment and associated expenses for alopecia, baldness, wigs or toupees, medical supplies. X. Any treatment or part of a treatment that does not form part of 'Reasonable and Customary Charges', nor is medically necessary; XI. Expenses which are either not supported by a prescription of a Medical Practitioner or are not related to Illness or disease for which claim is admissible under the Policy. XII. Any external appliance and/or device used for diagnosis or treatment except when used intra-operatively. XIII. Any Illness diagnosed or Injury sustained or where there is change in health status of the member after date of proposal and before commencement of Policy and the same is not communicated and accepted by Us. This is summary of exclusions. For detailed exclusions, please refer Policy wordings (Section 3)	

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<td>7.</td>
<td>Waiting period</td>
<td>I. Initial waiting period of 30 days for all illnesses (not applicable for accidents or on renewals)
II. Specified Waiting periods (Not applicable for claims arising due to an accident) of 24 months for 34 listed Diseases/procedure
III. Pre-existing disease covered after 48 months</td>
<td>Section 3</td>
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<td>8.</td>
<td>Financial limits of coverage
i. Sub-limit (it is a pre-defined limit and the insurance company will not pay any amount in excess of this limit)
i. Co-payment (it is a specified amount/ percentage of the admissible claim amount to be paid by policy holder/insured)
i. Deductible (it is a specified amount:
- Up to which an insurance</td>
<td>The policy will pay only up to the limits specified hereunder for the following diseases/procedures

Sub-limit

<u>Benefit Specific Sub-limit</u>:
• AYUSH Benefit Upto ₹50,000 per policy year
• Road Ambulance Cover Upto ₹1,000 per hospitalization
• Room Rent- Upto ₹5,000 per day

<u>Disease Specific Sub-limit</u>:
Mandatory Sub-Limits
Our liability for any and all claims related to Hospitalization/ Day Care Treatment (including their associated Pre & Post Hospitalization expenses) arising out of listed ailments/surgical procedures shall be restricted to the Sub-Limits mentioned in Table II, as applicable to your opted Sum Insured, of cost sharing as per policy wordings.
<table>
<tr><td>(Ailment/ Surgical Procedure)</td><td colspan="5">Sub limit, as applicable to each Insured Person based on the Sum Insured</td></tr>
<tr><td></td><td>5 Lacs</td><td>7.5 Lacs</td><td>10 Lacs</td><td>15 Lacs</td><td>20 Lacs</td></tr>
<tr><td>Cataract Surgery (per eye)</td><td>45,000</td><td>60,000</td><td>90,000</td><td>130,000</td><td>175,000</td></tr>
<tr><td>Balloon Sinuplasty/ FESS</td><td>30,000</td><td>40,000</td><td>55,000</td><td>85,000</td><td>110,000</td></tr>
<tr><td>Oral chemotherapy</td><td>85,000</td><td>115,000</td><td>165,000</td><td>250,000</td><td>330,000</td></tr>
<tr><td>Immunotherapy-Monoclonal Antibody all forms</td><td>140,000</td><td>195,000</td><td>275,000</td><td>415,000</td><td>550,000</td></tr>
<tr><td>Robotic surgeries</td><td>140,000</td><td>195,000</td><td>275,000</td><td>415,000</td><td>550,000</td></tr>
<tr><td>Stem cell therapy for Hematopoietic stem cells for bone marrow transplant for hematological conditions</td><td>140,000</td><td>195,000</td><td>275,000</td><td>415,000</td><td>550,000</td></tr>
<tr><td>Total Knee Replacement (per knee)</td><td>165,000</td><td>175,000</td><td>180,000</td><td>215,000</td><td>230,000</td></tr>
<tr><td>Any type of Hernia Surgery</td><td>70,000</td><td>75,000</td><td>75,000</td><td>95,000</td><td>100,000</td></tr>
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<td>Section 2
&
Section 5</td>
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company will not pay any claim, and

- Which will be deducted from total claim amount (if claim amount is more than the specified amount)

Any other limit (as applicable)

Any type of Hysterectomy	70,000	75,000	75,000	95,000	100,000
Benign Prostate Hypertrophy	70,000	75,000	75,000	95,000	100,000
Stones of Renal System	70,000	75,000	75,000	95,000	100,000

Optional Sub-limit opted:

Voluntary Sub-limits:

In lieu of premium discount opted by You, the specified sub-limits shall be applicable in addition to the Mandatory Sub-limits. Our liability for any and all claims related to Hospitalization/ Day Care Treatment (including their associated Pre & Post Hospitalization expenses) arising out of listed ailments/surgical procedures shall be restricted to the specified **Sub-Limits mentioned in Table B, as applicable to your opted Sum Insured, of cost sharing as per policy wordings** (subject to availability of Sum Insured and other terms and conditions of the policy).

(Ailment/ Surgical Procedure)	Sub limit, as applicable to each **Insured Person** based on the **Sum Insured**				
	5 Lacs	**7.5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**
Cerebrovascular & Cardiovascular	275,000	300,000	330,000	360,000	385,000
Cancer	275,000	300,000	330,000	360,000	385,000
Renal Complications & Disorders (excluding Stones of Renal System)	275,000	300,000	330,000	360,000	385,000
Breakage of Bones requiring **Surgery** under general anesthesia	275,000	300,000	330,000	360,000	385,000

Co-payment :

- **Age linked Co-Payment** If the entry Age of the Insured Person is 61 years or above at the time of first coverage under this Policy, then such Insured Person shall bear 20% of each admissible claim.

- **Co-Payment for treatment availed out of Our Network of Valued Provider – Pan India**

Wherever, Value Plan has been opted and the Insured Person avails treatment outside Our network of "Valued Provider-Pan India", then a Co-Payment of 30% will be applicable for each such claim resulting from

admission of the insured person in a Hospital/ Day Care Centre/ AYUSH Hospital except for Hospitalization for an Injury arising from an Accident.
Note: 'Valued Provider - Pan India' is a specific network of Hospitals, designated as such and mentioned in the Policy Schedule. It consists of a defined list of Hospitals or health care providers enlisted by Us, and/or TPA to provide medical services to an insured person by a Cashless Facility. Where the Policyholder has selected Value Plan, You shall be eligible only for 'Valued Provider -Pan India'. The updated list of Valued Provider – Pan India is available on Our website (www.tataaig.com).

Aggregate Deductible:
In lieu of premium discount opted by the policyholder/ insured person, Our liability under this Policy shall be subject to application of Aggregate Deductible as opted by the the policyholder/ insured person.

Sum Insured (in ₹)	Deductible Options (in ₹)
5 Lacs	25,000/ 50,000
7.5 Lacs	37,500/ 75,000
10 Lacs	50,000/ 100,000
15 Lacs	75,000/ 150,000
20 Lacs	100,000/ 200,000

For Aggregate Deductible applicable to you, please refer your policy schedule.

Any Other limit:

- In-Patient Treatment- Upto Sum Insured
- Pre-Hospitalization expenses- Upto 90 days Upto Sum Insured
- Post-Hospitalization expenses- Upto 90 days Upto Sum Insured
- Day Care Treatment- Upto Sum Insured
- Domiciliary Treatment- Upto Sum Insured
- Organ Donor- Upto Sum Insured
- Compassionate Trave-l Upto ₹10,000 per policy year (over and above base Sum Insured)
- Prolonged Hospitalisation Benefit- ₹10,000 per policy year (over and above base Sum Insured)
- Medical Devices Cover- Upto ₹5,000 per policy year (over and above base Sum Insured)
- Vaccination Cover- Upto ₹10,000 per policy year (over and above base Sum Insured)

Optional Covers(**For covers applicable to you, please refer your Policy Schedule)**:

		• Emergency Air Ambulance Cover Upto ₹5,00,000 per policy year (over and above base Sum Insured) • Consumables benefit Upto Sum Insured • Accidental Death benefit- 100% of Sum insured(over and above base Sum Insured)	
9.	Claims/Claims Procedure	**Claim procedure:** • <u>For Cashless Service</u>: 1. If any planned treatment, consultation or procedure for which a claim may be made then the insured must notify us at least 48 hours before the planned Hospitalization. 2. If any treatment, consultation or procedure for which a claim may be made, requiring emergency Hospitalization, then the insured must notify us within 24 hours after the treatment or Hospitalization 3. You have to provide the ID card issued to You along with any other information or documentation that is requested by the TPA/Us to the Network Hospital. • <u>For Reimbursement of Claim</u>: 1. Please submit claim documents to our TPA/Us within 15 days of occurrence of incident. 2. Kindly send the claim documents to: 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 **Turn Around Time (TAT) for claims settlement:** i. TAT for preauthorization of cashless facility: 2 hours ii. TAT for cashless final bill authorization: 4 hours **Assistance**: 1. Please refer to our website <www.tataaig.com> or call us on our toll free number at <1800-266-7780> to get details on our empanelled hospitals and list of Excluded providers/ Blacklisted Hospitals. 2. Helpline number: Toll Free: <1800 266 7780> or <1800 22 9966> (only for Senior Citizen policyholders) 3. Please refer our website < www.tataaig.com> to download claim form	Section 5

10.	Policy Servicing	Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders)	Section 4
11.	Grievances/ Complaints	**Redressal of Grievance** If the Insured Person is not satisfied with our services and wish to lodge a complaint, he/ she may contact our 24X7 Toll free number <<1800-266-7780 or 022-66939500>> (tolled) or email to the customer service desk at customersupport@tataaig.com. **Escalation Level 1:** For lack of a response or if the resolution still does not meet expectations, the Insured Person can write to manager.customersupport@tataaig.com. **Escalation Level 2:** For lack of a response or if the resolution still does not meet expectations, the Insured Person can write to the Head - Customer Services at head.customerservices@tataaig.com **Escalation to Insurance Ombudsman** Within 30 days of lodging a complaint with us, if the Insured Person does not get a satisfactory response from us and wish to pursue other avenues for redressal of grievances, the Insured Person may approach Insurance Ombudsman appointed by IRDAI under the Insurance Ombudsman Scheme. Website: www.tataaig.com Toll Free: <<1800 266 7780>> or <<1800 22 9966>> (only for Senior Citizen policyholders) Email: <<customersupport@tataaig.com>> Courier: <<>>	Section 4
12.	Things to remember	**Free Look Period** The Free Look Period shall be applicable on new individual health insurance policies and not on **Renewal**s 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 Person** has not made any claim during the Free Look Period, the **Insured Person** shall be entitled to i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the **Insured Person** and the stamp duty charges or ii. where the risk has already commenced and the option of return of the **Policy** is exercised by the **Insured Person**, a deduction towards the proportionate risk premium for period of cover or	Section 4

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

Policy renewal

The **Policy** shall ordinarily be renewable except on grounds of fraud, misrepresentation by the **Insured Person**.

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 Year**s.
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 **Renewal**s based on individual claims experience.

Migration

The **Insured Person** will have the option to migrate the **Policy** to other health insurance products/plans offered by the company by applying for **Migration** of the **Policy** at least 30 days before the **Policy Renewal** date as per IRDAI guidelines on **Migration**.

For Detailed Guidelines on **Migration**, kindly refer Guidelines issued by IRDAI (Insurance Regulatory and Development Authority of India) on 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.

Portability

The **Insured Person** will have the option to port the **Policy** to other insurers by applying to such **Insurer** to port the entire **Policy** along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the **Policy Renewal** date as per IRDAI guidelines related to **Portability**.

For Detailed Guidelines on **Portability**, kindly refer Guidelines issued by 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.

Moratorium Period

After completion of eight continuous years under the **Policy** no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first

		Policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the **Policy** contract. The policies would however be subject to all limits, sub limits, **Co-Payment**s, **Aggregate Deductible**s as per the **Policy** contract.	
13.	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid and termination of Your policy.	