PROSPECTUS

1. Suitability:

a. This policy covers persons in the age group 91 days onwards (Dependent children between 91 days and 5 years can be insured only when both parents are getting insured). The maximum entry age is 65 years.

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

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

d. This policy can be issued to an individual and/or to a family on family floater basis.

e. The family includes spouse and economically dependent children and up to 2 parents and up to 2 parent-in-laws.

Relationships covered: Self, spouse, upto 3 dependent children , upto 2 parents & upto 2 parents-in-laws. In case of family floater, where the dependent child(ren) attains 26 years of age at renewal, the child(ren) can be covered under a separate policy with eligible continuity benefit.

2. Sum Insured options (in ₹):

- 5 Lacs
- 7.5 Lacs
- 10 Lacs
- 15 Lacs
- 20 Lacs

3. Zone(s)

For the purpose of premium computation, the country is categorized in three Zones and premium payable under the policy will be calculated based on the residential location/address as provided by the proposer/insured person in the proposal form:

- Zone A: Mumbai (including Mumbai Metropolitan Region), Delhi (including National Capital Region, Faridabad, Ghaziabad), Ahmedabad, Surat & Baroda
- Zone B: Hyderabad (including Secunderabad), Bengaluru, Kolkata, Indore, Chennai, Chandigarh (including, Mohali, Punchkula, Zirakpur), Pune (including Pimpri Chinchwad) and Rajkot
- Zone C: Rest of India

4. Key Benefits:

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

b. **Network of hospitals:** We are equipped to offer you quality health care with our strong network of hospitals (Valued Provider – Pan India) across India.

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

d. **Restore Benefit:** If the balance Sum Insured and accrued Cumulative Bonus is insufficient to pay an admissible claim under In-Patient Treatment, Pre-Hospitalization Expenses, Post-Hospitalization Expenses, Day Care Treatment, Organ Donor cover or Domiciliary Treatment cover, We will automatically reinstate 100% of the Sum Insured once during the policy year. In case of Any One Illness, this benefit for related Illness/ Injury would be available to the Insured Person(s), who have claimed earlier, only for Hospitalization/ Domiciliary Hospitalization where date of admission is beyond 45 days from the date of discharge of the immediately preceding Hospitalization/ date of end of Domiciliary Hospitalization, for which claim has been paid. This unutilized Restored Sum Insured cannot be carried forward to the next Policy Year.

e. **Cumulative bonus:** Bonus in the form of 50% of the base Sum Insured of the expiring Policy, on each Renewal of the Policy, after every claim free Policy Year, The total accrued Cumulative Bonus shall not exceed 100% of the base Sum Insured in any Policy Year

f. **Wellness Services:** Teleconsultation - General

We /Our empanelled service provider will arrange for teleconsultations upon Insured Person's request through telecommunications and digital communication technologies for Insured Person's health related complaints or preventive health care by a qualified Medical Practitioner/ Health Care Professional.

g. **Tax Benefit:** The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act. This benefit is not applicable for premium amount paid towards accidental death benefit.

5. Salient Features:

i. **In-patient Treatment**: Covers Medical expenses for Medically Necessary Treatment in a Hospital, due to disease/Illness/Injury, that requires an Insured Person's admission in a Hospital for an Inpatient Care, during the Policy Period. Medical expenses directly related to the hospitalization would be payable.

ii. **Pre-Hospitalisation Expenses**: Covers Medical Expenses incurred upto 60 days prior to the date of admission to the hospital.

iii. **Post-Hospitalisation Expenses:** Covers Medical Expenses incurred upto 180 days immediately after the Insured Person was discharged post Hospitalisation.

iv. **Day Care Treatment**: Covers expenses for Day Care Treatment due to disease/illness/Injury, taken in a hospital or a Day Care Centre

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during the policy period.

v. **Organ Donor**: Covers Medical Expenses incurred by or in respect of the organ donor, for an organ transplant Surgery, solely towards the harvesting of the organ donated. The insured person must be the recipient of the organ so donated by the organ donor.

vi. **Domiciliary Treatment**: Covers Medical Expenses related to Domiciliary Hospitalization of the Insured Person if the treatment exceeds beyond three consecutive days and is availed during the Policy Period. The treatment must be for management of an Illness and not for enteral feedings or end of life care.

vii. **Restore Benefit**: Automatically reinstate 100% of the Sum Insured , if the balance Sum Insured and accrued Cumulative Bonus is insufficient to pay an admissible claim under In-Patient Treatment, Pre-Hospitalization Expenses, Post-Hospitalization Expenses, Day Care Treatment, Organ Donor or Domiciliary Treatment cover, during the policy year.

viii. **AYUSH Benefit**: Covers medical expenses incurred for treatment as In-patient in an AYUSH Hospital.

ix. **Ambulance Cover**: Covers expenses incurred on transportation of Insured Person in a registered ambulance to a hospital for admission in case of an emergency.

x. **Health Checkup**: We / Our empaneled service provider will arrange for listed medical tests every Policy Year, only on cashless basis.

xi. **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 during a Policy Year, as mentioned in the 'Benefit Table'.

xii. **Bariatric Surgery Cover**: Covers reasonable and customary expenses for Bariatric surgery if the insured person fulfills all the following conditions:

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

ii. The surgery/Procedure conducted should be supported by clinical protocols.

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

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

v. BMI greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:

a) Obesity-related cardiomyopathy,

b) Severe sleep apnea,

c) Uncontrolled Type2 Diabetes, or

d) Coronary heart disease

xiii. **In-patient Treatment- Dental:** Covers medical expenses incurred towards hospitalization for dental treatment under anesthesia necessitated due to an accident/injury/illness

xiv. **Vaccination Cover:** Covers the cost of the following vaccines:

- Anti-rabies vaccine following an animal bite

- Typhoid vaccination

After 2 years of continuous coverage with us:

- Human Papilloma Virus (HPV) vaccine

- Hepatitis B Vaccine

xv. **Hearing Aid**: Covers reasonable charges for a hearing aid for the Insured Person, every third year, subject to a maximum limit as mentioned in the 'Benefit Table'.

xvi. **Daily cash for choosing shared accommodation**: We will pay a fixed amount per day, if the Insured Person is Hospitalized in Shared Accommodation in a Hospital in Our network of Valued Provider – Pan India, for each continuous and completed period of 24 hours of Hospitalization. The benefit payable per day would be subject to a maximum limit as mentioned in the 'Benefit Table'.

xvii. **Daily cash for accompanying an insured child**: We will pay a fixed amount per day, if the Insured Person Hospitalized is a child Aged 12 years or less, for one accompanying adult for each completed period of 24 hours of Hospitalization in Our network of Valued Provider – Pan India. The benefit payable per day would be subject to a maximum limit as mentioned in the 'Benefit Table'.

xviii. **Second Opinion**: We will provide You a second opinion from Our Empaneled Service Provider, if an Insured Person is diagnosed with the mentioned Illnesses during the Policy Period.

6. Optional Covers:

You can choose below mentioned optional cover by paying an additional premium.

- **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 in the 'Benefit Table'. This benefit is not applicable for insured children or Insured Person less than 18 years of Age as on Policy commencement date.

7. Cost Sharing

a. **Age linked Co-Payment**

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

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

If the Insured Person avails treatment outside Our network of "Valued Provider-Pan India", then a Co-Payment of 30% will be applicable for each such claim resulting from admission of the Insured Person in a Hospital/ Day Care Centre/ AYUSH Hospital. However, no Co-Payment under this sub section shall be applicable if Hospitalization is for an Injury arising from an Accident.

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Note: 'Valued Provider - Pan India' is a specific network of Hospital(s), designated as such. It consists of a defined list of Hospital(s) or health care providers enlisted by Us, and/or TPA to provide medical services to an Insured Person by a Cashless Facility. The updated list of Valued Provider - Pan India is available on Our website (www.tataaig.com).

8. Discounts on premium:

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

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

c. Family floater discount on the base premium:

- 2 members -20%
- 3 members -28%
- 3+ members-32%

d. 10% discount to all TATA Group employees

9. Renewal Incentives:

a. **Cumulative Bonus:** We will provide Cumulative Bonus in the form of 50% of the base Sum Insured of the expiring Policy, on each Renewal of the Policy, after every claim free Policy Year, provided that the Policy is renewed with Us without a break. The total accrued Cumulative Bonus shall not exceed 100% of the base Sum Insured in any Policy Year.

10. Portability:

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

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

11. Free Look Period:

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

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

12. Waiting Period:

i. 30 days 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.

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 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

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

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

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

f. List of Specific disease/conditions/treatments:

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

II. Polycystic ovarian disease, Fibromyoma, Adenomyosis, Endometriosis

III. Prolapsed Uterus

IV. Rheumatism

V. Ligament, Tendon or Meniscal tear

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VI. Prolapsed Inter-Vertebral Disc
VII. Cholelithiasis
VIII. Pancreatitis
IX. Fissure/fistula in anus, haemorrhoids, pilonidal sinus
X. Ulcer & erosion of stomach & duodenum
XI. Gastro Esophageal Reflux Disorder (GERD)
XII. Liver Cirrhosis
XIII. Perineal Abscesses
XIV. Perianal / Anal Abscesses
XV. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.
XVI. Benign Hyperplasia of prostate
XVII. Varicocele
XVIII. Cataract, Retinal detachment, Glaucoma
XIX. Congenital Internal Diseases

List of procedure/surgeries/treatments:

XX. Adenoidectomy
XXI. Mastoidectomy
XXII. Tonsillectomy
XXIII. Tympanoplasty
XXIV. Surgery for nasal septum deviation
XXV. Nasal concha resection
XXVI. Surgery for Turbinate hypertrophy
XXVII. Hysterectomy
XXVIII. Osteoarthritis, joint replacement, osteoporosis,
XXIX. Systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid, Gout
XXX. Cholecystectomy
XXXI. Hernioplasty or Herniorraphy
XXXII. Surgery/procedure for Benign prostate enlargement
XXXIII. Surgery for Hydrocele/ Rectocele/Spermatocele
XXXIV. Surgery of varicose veins and varicose ulcers

iii. Pre-existing Diseases Waiting Period(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 36 months of continuous coverage after the date of inception of the first policy with us.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

13. General Exclusions:

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

Medical Exclusions:

i. Investigation and 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.
ii. Rest cure, rehabilitation and respite care (Code- Excl 05):
   a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
      i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
      ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
iii. Obesity/ Weight Control(Code- Excl 06)

   Expenses related to surgical treatment of obesity that does not fulfil the below conditions:
   a. Surgery to be conducted is upon the advice of the Doctor
   b. The surgery/Procedure conducted should be supported by clinical protocols
   c. The member has to be 18 years of age or older and
   d. Body Mass Index (BMI);

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i. greater than or equal to 40 or

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

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

iv. Change-of-Gender treatments: (Code- Excl07):

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

v. 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.

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

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

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

x. 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.

xi. 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

xii. Maternity (Code - Excl 18) :

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

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

xiii. Alcoholic pancreatitis or Alcoholic liver disease;

xiv. Congenital External Diseases, defects or anomalies;

xv. Stem cell therapy; however hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under this policy;

xvi. Growth Hormone Therapy;

xvii. Sleep-apnoea and Sleeping disorder;

xviii. Admission primarily for administration (via any form or mode) of immunoglobulin infusion or supplementary medications like Zolendronic Acid, etc;

xix. Venereal disease, sexually transmitted disease or illness;

xx. All preventive care, vaccination including inoculation and immunisations;

xxi. Dental treatment or Dental Surgery of any kind unless incidental to an admissible hospitalization claim where the cause of admission is accident/ illness; cost of dentures, dental implants and braces;

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

xxiii. Non payable items as mentioned in Annexure I – List I of optional items available on Our website (www.tataaig.com);

Non-Medical Exclusions:

i. Hazardous or Adventure Sports (Code- Excl 09):

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- Excl 10):

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

iii. Excluded Providers: (Code-Excl 11)

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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.

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

v. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense

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

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

viii. 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.

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

x. 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.

xi. Fitting of hearing aids, provision/fitting of spectacles or contact lenses including optometric therapy.

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

xiii. Any treatment or part of a treatment that does not form part of 'Reasonable and Customary Charges' nor is Medically Necessary.

xiv. 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

xv. Any external appliance and/or device used for diagnosis or treatment except when used intra-operatively.

xvi. 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.

14. Claim Procedure:

The final decision on all claims is taken by Tata AIG General Insurance Company Limited. We may have a Specified Third Party Administrator (TPA) duly licensed by IRDAI to administer all claims under this policy.

a. Notification of claim & Assistance:

Every claim needs to be notified to Us.

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

We may waive off this condition in extreme cases of hardship where it is proved to Our satisfaction that under the circumstances in which the Policyholder/Insured Person were placed, it was not possible for the Policyholder/Insured Person or any other person to give notice or file claim within the prescribed time limit.

b. Claim Related Information:

For any claim related query, intimation of claim and submission of claim related documents, the Policyholder/Insured Person can contact us through:

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

  TATA AIG General Insurance Co. Ltd.

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

Any change in TPA by Us shall be communicated to You 30 days before such effect of change.

c. Procedure for reimbursement claims:

- Please send the duly signed claim form and all the information/documents mentioned therein to our TPA/Us within 15 days of the occurrence of the Incident.
- Please refer to claim form for complete documentation.
- If there is any deficiency in the documents/information submitted by the Policyholder/Insured Person, our TPA/We will send the deficiency letter within 7 working days of receipt of the claim documents.
- On receipt of the complete set of claim documents, We will send the payment for the admissible amount, along with a settlement statement within 30 days.
- The payment will be sent in the name of the proposer/ Nominee in case of death of Proposer

d. Procedure for Cashless Service at Our network of Valued Provider – Pan India

i. Insured person is entitled for cashless coverage only in our network of Valued Provider – Pan India .

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

- Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, the Policyholder/Insured Person must call our designated TPA/Us and request pre-authorization.
- Our designated TPA/We will check your coverage as per the eligibility and send an authorization letter to the provider.
- 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.

Note:

- Please refer to our website (www.tataaig.com) or call us on our toll free number at 1800-266-7780 or 1800-22-9966 (for Senior Citizens) for updated list of Valued Provider – Pan India.
- Rejection of cashless facility in no way indicates rejection of the claim.

e. Claim settlement (provision for Penal Interest):

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

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.

f. Claim Procedure and management of Health Checkup & Wellness Services:

Service may be availed through Our website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule. Alternatively, details of Our empanelled service provider are available on Our website (www.tataaig.com).

g. Supporting Documentation & Examination

Insured Person or someone booking services on Your behalf shall provide Us with identification documentation, medical records and information We may request to establish the circumstances of the claim.

15. Renewal of Policy:

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

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

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

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

16. 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.

17. Migration:

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

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

18. Withdrawal of the policy:

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.

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.

19. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

20. Nomination:

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

representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

21. Requirement:

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

22. Pre-policy medical check-up:

Pre-policy medical examination gird:

Age/Sum Insured	All Sum Insured Options
Upto 17 Years	Tele MER/ Video MER (only if positive medical declaration)
18 Years – 45 Years	Individual: Tele MER/ Video MER Family Floater: Tele MER / Video MER (only if positive medical declaration)
46 Years and above	Tele MER/ Video MER/PPC (Applicable for all plans)

- In case of adverse medical declaration, we may call for additional medical tests. We may conduct medical tests at diagnostic centre based on medical disclosure wherever applicable.
- 100% of TeleMER cost would be borne by the Company, in case of proposal acceptance.
- At least 50% of pre-policy medical checkup cost would be borne by Tata AIG in case where proposal is accepted.
- Pre-Policy Check-up(PPC) at our network, if required. The medical reports are valid for a period of 90 days from the date of Pre-Policy Checkup.

The Company may conduct Tele MER / Video MER / Pre – Policy Check – up based on age / Sum Insured medical declaration or any other underwriting criteria.

23. Premium Rates:

a. The premium will be charged on the completed age of the Insured Person and as per applicable zone.

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

c. Monthly/Quarterly/Half-Yearly instalment options would be allowed and following loadings shall be applicable as per the selected installment option and Policy Tenure:

Installments	Policy Tenure		
	1 Year	2 Year	3 Year
Monthly	5.00%	9.00%	13.00%
Quarterly	4.00%	8.00%	11.50%
Half-Yearly	3.00%	7.00%	10.50%

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

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

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

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

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

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

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

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

(Annual Per Person Rates in ₹)

Zone A					
Age (in years)/ Sum Insured	**5 Lakhs**	**7.5 Lakhs**	**10 Lakhs**	**15 Lakhs**	**20 Lakhs**
91 Days -17	5,162	5,496	5,604	6,282	6,496
18-35	7,937	8,359	8,521	9,511	10,158
36-40	9,642	10,044	10,440	11,549	12,210
41-45	10,397	10,832	11,255	12,456	13,171
46-50	14,556	15,058	15,585	17,572	17,939

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IRDA of India Registration No: 108 | CIN: U85110MH2000PLC128425 | Tata AIG MediCare LITE UIN: TATHLIP24132V012324

51-55	19,222	20,173	20,715	22,989	23,517
56-60	23,465	24,589	24,701	27,199	28,589
61-65	29,541	30,988	31,059	34,563	35,935
66-70^	45,939	48,847	48,970	55,088	57,075
71+^	57,384	60,484	61,848	69,472	71,197

(Exclusive of taxes)

(Annual Per Person Rates in ₹)

Zone B					
Age (in years)/ Sum Insured	**5 Lakhs**	**7.5 Lakhs**	**10 Lakhs**	**15 Lakhs**	**20 Lakhs**
91 Days -17	4,812	5,236	5,276	6,007	6,219
18-35	6,851	7,330	7,990	8,998	9,417
36-40	8,267	8,816	9,761	11,081	11,413
41-45	8,912	9,507	10,520	11,949	12,308
46-50	13,342	14,186	14,683	16,530	17,029
51-55	17,017	18,057	18,367	20,496	21,379
56-60	20,767	21,943	22,068	24,959	25,659
61-65	25,918	27,940	28,101	31,021	32,676
66-70^	40,227	43,964	44,171	49,756	51,669
71+^	50,822	53,256	55,524	61,152	64,902

(Exclusive of taxes)

(Annual Per Person Rates in ₹)

Zone C					
Age (in years)/ Sum Insured	**5 Lakhs**	**7.5 Lakhs**	**10 Lakhs**	**15 Lakhs**	**20 Lakhs**
91 Days -17	4,050	4,310	4,377	4,951	5,098
18-35	6,273	6,506	6,742	7,632	7,786
36-40	7,575	7,991	8,097	9,244	9,594
41-45	8,160	8,611	8,719	9,961	10,340
46-50	11,306	11,849	12,071	13,456	14,196
51-55	15,284	15,577	15,767	17,888	18,486
56-60	18,241	19,160	19,479	21,303	22,140
61-65	22,905	24,183	24,238	27,154	28,358
66-70^	35,391	37,360	37,552	41,610	44,115
71+^	44,959	46,577	47,759	54,191	55,598

(Exclusive of taxes)

Accidental Dealth Benefit (Optional Cover)

(Annual Per Person Rates in ₹)

All Zones					
Age (in years)/ Sum Insured	**5 Lakhs**	**7.5 Lakhs**	**10 Lakhs**	**15 Lakhs**	**20 Lakhs**
All Ages	279	418	558	836	1,115

(Exclusive of taxes)

^ Premium rates for age above 65 is for renewal.

24. Loadings:

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

ii. The loading shall be applied basis outcome of Our underwriting.

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

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

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

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

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

25. Cancellation:

You may terminate this Policy at any time by giving Us written notice, and the Policy shall terminate when such written notice is received. The cancellation shall be from the date of receipt of such notice.If and only if no claim has been made under the Policy, then We will refund premium in accordance with the table below:

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

Length of time Policy in force	Policy Period		
	1 Year	2 Year	3 Year
Upto 1 Month	75.00%	87.50%	91.5%
>1 month & Upto 3 Months	50.00%	75.00%	88.5%
>3 months & Upto 6 Months	25.00%	62.50%	75%
>6 months & Upto 12 Months	Nil	50.00%	66.5%
>12 months & Upto 15 Months	NA	25%	50%
>15 months & Upto 18 Months	NA	12.5%	41.5%
>18 months & Upto 24 months	NA	Nil	33%
>24 months & Upto 30 months	NA	NA	8%
Exceeding 30 months	NA	NA	Nil

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

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the Policyholder/insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

26. Redressal of Grievance:

The Company is committed to extend the best possible services to its customers. However, if you are not satisfied with our services and wish to lodge a complaint, please feel free to call our 24X7 Toll free number 1800-266-7780 or 022-66939500 (tolled) or you may email to the customer service desk at customersupport@tataaig.com. After investigating the matter internally and subsequent closure, we will send our response within a period of 10 days from the date of receipt of the complaint by the Company or its office in Mumbai. In case the resolution is likely to take longer time, we will inform you of the same through an interim reply.

Escalation Level 1

For lack of a response or if the resolution still does not meet your expectations, you can write to manager.customersupport@tataaig.com. After investigating the matter internally and subsequent closure, we will send our response within a period of 8 days from the date of receipt at this email id.

Escalation Level 2

For lack of a response or if the resolution still does not meet your expectations, you can write to the Head - Customer Services at head.customerservices@tataaig.com After examining the matter, we will send you our final response within a period of 7 days from the date of receipt of your complaint on this email id. Within 30 days of lodging a complaint with us, if you do not get a satisfactory response from us and you wish to pursue other avenues for redressal of grievances, you may approach Insurance Ombudsman appointed by IRDA under the Insurance Ombudsman Scheme.

Benefit Table

Benefit Name	**Coverage Limit**
In-Patient Treatment	Upto Sum Insured
Pre-Hospitalization expenses	Upto 60 Days
Post-Hospitalization expenses	Upto 180 Days
Day Care Treatment	Upto Sum Insured
Organ Donor	Upto Sum Insured
Domiciliary Treatment	Upto Sum Insured

Benefit Name	Coverage Limit
Restore Benefit	Available
AYUSH Benefit	Upto Sum Insured
Ambulance Cover	Upto ₹3,000 per hospitalization
Health Checkup	Once every policy year for listed tests, only on Cashless basis
Compassionate Travel	Upto ₹20,000 per policy year, over and above base Sum Insured
Bariatric Surgery Cover	Upto Sum Insured
In-Patient Treatment - Dental	Upto Sum Insured
Vaccination Cover	Upto ₹5,000 per policy year as per the list, over and above base Sum Insured
Hearing Aid	50% of actuals; maximum ₹10,000 per policy, every third year of continuous coverage under this Policy, over and above base Sum Insured
Daily Cash for choosing Shared Accommodation	0.25% of base Sum Insured; maximum ₹2000 per day, over and above base Sum Insured Benefit applicable only if hospitalization is in Our network of Valued Provider – Pan India
Daily Cash for Accompanying an Insured Child	0.25% of base Sum Insured; maximum ₹2000 per day, over and above base Sum Insured Benefit applicable only if hospitalization is in Our network of Valued Provider – Pan India
Second Opinion	Covered for listed illnesses
Cumulative Bonus	50% of the base Sum Insured of the expiring Policy, on each Renewal of the Policy after every claim free Policy Year, maximum upto 100% of the base Sum Insured in any Policy Year
Accidental Death Benefit (Optional Cover)	100% of base Sum Insured
Wellness Services	Teleconsultation – General: Available
Room Category	Single Private Room*
Cost Sharing	
Age Linked Co-Payment	20% co-payment for each admissible claim applicable if the entry Age of the Insured Person is 61 years or above at the time of first coverage under this Policy
Co-payment for treatment availed out of Our Network of Valued Provider – Pan India	30% co-payment for each such admissible claim applicable where the Insured Person avails treatment outside Our network of "Valued Provider-Pan India".

*Note: Proportionate deduction of Associated Medical Expenses applicable in case insured person is admitted in a room category that is higher than the Single Private Room

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

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

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

Disclaimer:

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

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

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

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