

TATA AIG MediCare Reserve Policy Wordings

TATA AIG General Insurance Company Limited (**We, Our or Us**) will provide the insurance, described in this **Policy** and any endorsements thereto, for the **Policy Period**, as defined in the **Policy** to the **Insured Person(s)** named in the **Policy Schedule** based on the Disclosure to Information Norm, including in reliance upon the statements contained in the Proposal Form or any other mode of communication which shall be the basis of this **Policy** and are deemed to be incorporated herein in return for the receipt of the required premium in full and compliance with all the applicable terms, conditions and exclusions of this **Policy**. The insurance provided under this **Policy** is only in force for the **Insured Person** with respect to such and so many of the benefits as indicated in the **Policy Schedule** and up to the **Sum Insured**, in excess of **Aggregate Deductible**.

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 includes other genders and references to any statutory enactment includes 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 Day Care Centre

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH **Medical Practitioner** (s) on day care basis without in-patient services and must comply with all the following criterion:

- i. Having qualified registered AYUSH **Medical Practitioner(s)** in charge;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where **Surgical Procedures** are to be carried out;
- iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. AYUSH Hospital

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

- a. Central or State Government AYUSH **Hospital** or
- b. Teaching **Hospital** attached to AYUSH college recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy, or
- c. AYUSH **Hospital**, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH **Medical Practitioner** and must comply with all the following criterion:
 - i. Having atleast 5 in-patient beds;
 - ii. Having qualified AYUSH **Medical Practitioner** 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. AYUSH Treatment

AYUSH Treatment refers to the medical and / or **Hospitalization** treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

6. Break in Policy

Break in Policy means the period of gap that occurs at the end of the existing **Policy** term/installment premium due date, when the premium due for **Renewal** on a given **Policy** or installment premium due is not paid on or before the premium **Renewal** date or **Grace Period**.

7. 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.

8. 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**.

9. Condition Precedent

Condition Precedent means a **Policy** terms or condition upon which the **Insurer's** liability under the **Policy** is conditional upon.

10. 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.

11. Cumulative Bonus

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

12. 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 in India, wherever applicable, and is under supervision of a registered and qualified **Medical Practitioner** AND must comply with all minimum criterion as under –

- i. has qualified nursing staff under its employment;

- ii. has qualified **Medical Practitioner/s** in charge;
- iii. has fully equipped operation theatre of its own where **Surgical Procedures** are carried out;
- iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

13. Day Care Treatment

Day Care Treatment means medical treatment, and/or **Surgical Procedure** which is:

- i. undertaken under General or Local Anesthesia in a **Hospital/Day Care Centre** in less than 24 hrs because of technological advancement, and
- ii. which would have otherwise required **Hospitalization** of more than 24 hours.

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

14. Dental Treatment

Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and **Surgery**.

15. 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**.

16. Emergency Care

Emergency Care means management for an **Illness or Injury** which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a **Medical Practitioner** to prevent death or serious long term impairment of the **Insured Person's** health.

17. Grace Period

"**Grace Period**" means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a **Policy** in force without loss of continuity benefits pertaining to waiting periods and coverage of **Pre-Existing Diseases**. For single premium payment policies, coverage is not available during the period for which no premium is received. However, If the premium is paid in instalments during the **Policy Period**, coverage will be available during the **Grace Period**, within the **Policy Period**. The **Grace Period** for payment of the premium shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

18. Hospital

A **Hospital** means any institution established for **Inpatient 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) of the said act Or complies with all minimum criteria as under:

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Registered Office : Peninsula Business Park, Tower A, 15th Floor, G.K.Marg, Lower Parel, Mumbai - 400 013, Maharashtra, India. CIN: U85110MH2000PLC128425. IRDA of India Regn. No. 108. 24*7 Customer Support Number: 022 6489 8282 / 1800 267 1955 (only for senior citizen policy holders). • Email Id – customersupport@tataaig.com. • Website: www.tataaig.com IRDA of India Registration

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- 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;

19. Hospitalization

Hospitalization means admission in a **Hospital** for a minimum period of 24 consecutive 'Inpatient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

20. 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

21. 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**.

22. Inpatient 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.

23. Intensive Care Unit:

Intensive Care Unit means an identified section, ward or wing of a **Hospital** which is under the constant supervision of a dedicated **Medical Practitioner(s)**, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

24. ICU Charges:

ICU (**Intensive Care Unit**) Charges means the amount charged by a **Hospital** towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

25. Medical Advice

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

26. 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.

27. Medical Practitioner

Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

28. 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.

29. Migration

“**Migration**” means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for **Pre-Existing Diseases** and specific waiting periods from one health insurance **Policy** to another with the same **Insurer**.

30. 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**.

The updated list of **Network Provider** is available on **Our** website (www.tataaig.com).

31. New Born Baby

New Born Baby means baby born during the **Policy Period** and is aged upto 90 days.

32. Non-Network Provider

Non-Network means any **Hospital, Day Care Centre** or other provider that is not part of the network.

33. Notification of Claim

Notification of Claim means the process of intimating a claim to the **Insurer** or TPA through any of the recognized modes of communication.

34. Pre-Existing Disease

“**Pre-Existing Disease (PED)**” means any condition, ailment, **Injury** or disease:

- a. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the **Policy** issued by the **Insurer**; or
- b. for which **Medical Advice** or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the **Policy**.

35. 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.

36. Portability

“**Portability**” means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, **Pre-Existing Diseases** and specific waiting periods from one **Insurer** to another **Insurer**.

37. 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.

38. 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.

39. 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.

40. 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.

41. Room Rent

Room Rent means the amount charged by a **Hospital** towards Room and Boarding expenses and shall include the **Associated Medical Expenses**.

42. 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**.

43. 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 last birthday as on date of commencement of the **Policy** and as per the English calendar.

2. Aggregate Deductible

Aggregate Deductible is a cost sharing requirement under this **Policy** which provides that **We** will not be liable for a specified amount in aggregate for all claims during the per **Policy Year**. A deductible does not reduce the **Sum Insured**.

3. Associated Medical Expenses (AME)

AME shall include nursing charges, operation theatre charges, fees of **Medical Practitioner**/surgeon/ anesthetist/ specialist (excluding cost of pharmacy and consumables, cost of implants and medical devices, cost of diagnostics) conducted within the same **Hospital** where the **Insured Person** has been admitted. It shall not be applicable for **Hospitalization** in ICU. **Associated Medical Expenses** shall be applicable for covered expenses, incurred in Hospitals which follow differential billing based on the room category.

4. Family

Family may comprise of You, Your Spouse, Dependent Children. Dependent Child(ren) refers to a child (natural or legally adopted) who is financially dependent on the **Policyholder** and does not have his or her independent sources of income. For the purpose of this policy child upto 25 years is considered as Dependent Child(ren).

5. Modern Treatment Methods and Advancement in Technologies

The following Procedures shall be considered for **Modern Treatment Methods and Advancement in Technologies**:

- A. Uterine Artery Embolization and HIFU
- B. Balloon Sinuplasty
- C. Deep Brain stimulation
- D. Oral chemotherapy
- E. Immunotherapy-Monoclonal Antibody to be given as injection
- F. Intra vitreal injections
- G. Robotic surgeries
- H. Stereotactic radiosurgeries
- I. Bronchical Thermoplasty
- J. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- K. IONM - (Intra Operative Neuro Monitoring)
- L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

6. Multi-Sharing Accommodation

Multi-Sharing Accommodation means a Hospital room with three or more patient beds. This definition does not apply to ICU or ICCU.

7. Non-Resident Indian (NRI)

Non-Resident Indian (NRI) shall have the meaning assigned to it under the Income-tax Act, 1961, as amended from time to time.

8. Overseas Citizen of India (OCI)

Overseas Citizen of India (OCI) shall have the meaning assigned to it under the Citizenship Act, 1961, as amended from time to time.

9. Policy

Policy means the contract of insurance including but not limited to **Policy Schedule**, Endorsements, **Policy** Wordings (inbuilt covers & optional covers, if opted), Riders, Annexures etc., as applicable.

10. Policy Period

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

11. Policy Schedule

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

12. Policy Year

Policy Year means a period of twelve consecutive months beginning from the date of commencement of the **Policy Period** and ending on the last day of such twelve-month period. For the purpose of subsequent years, **Policy Year** shall mean a period of twelve months commencing from the end of the previous **Policy Year** and lapsing on the last day of such twelve-month period, or the **Policy Expiry** date whichever is earlier.

13. Single Private Room

Single Private Room means an air-conditioned room in a **Hospital** where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a single occupancy room in that **Hospital**. This does not include a deluxe room or a suite or a VIP room. Any room that offers services or incurs charges greater than those of the **Single Private Room** shall be classified as a room category higher than the **Single Private Room**.

14. Sum Insured

"**Sum Insured**" refers to the amount specified in the **Policy Schedule** at the inception of a **Policy Year**. **Sum Insured** represents **Our** maximum, total and cumulative, liability in aggregate under the **Policy**, for all the **Insured Person(s)** covered, for the respective **Policy Year**.

- Upon settlement of a claim under the **Policy**, the **Sum Insured** for the remaining **Policy Year** shall be accordingly reduced by the amount of the claim settled or admitted.
- In cases where the **Policy Period** exceeds one year, the **Sum Insured** specified in the **Policy Schedule** shall apply separately to each **Policy Year**. Any unutilized **Sum Insured** at the end of a **Policy Year** shall lapse and shall not be carried forward to the subsequent **Policy Year**. A fresh **Sum Insured**, up to the opted limit, shall become available at the commencement of each subsequent **Policy Year**.

15. Shared Accommodation

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

16. Twin Sharing Accommodation

Twin Sharing Accommodation means a Hospital room with two patient beds. This definition does not apply to ICU or ICCU. Such room type shall be the most basic and the most economical of all accommodations available as twin sharing room in that Hospital

17. We, Us, Our, Insurer

means The TATA AIG General Insurance Company Limited that has provided Insurance Cover under this **Policy**.

18. You, Your, Insured Person

means the person whose name specifically appears in the **Policy Schedule** as an **Insured Person/** Policyholder.

19. Zone(s)

For the purpose of premium computation, the country is segmented into following three **Zones** and premium payable under this **Policy** will be computed based on the **Zone** as applicable for the 'Address' of the proposer/**Insured Person**:

- **Zone A:** Mumbai (including Mumbai Metropolitan Region), Delhi (including National Capital Region, Faridabad, Ghaziabad), Ahmedabad, Surat, Baroda and Hisar
- **Zone B:** Hyderabad (including Secunderabad), Sangareddy, Bengaluru, Kolkata (including Kolkata Metropolitan Area, Howrah, Hoogly), Indore, Gwalior, Chennai, Chandigarh (including, Mohali, Panchkula, Zirakpur), Pune (including Pimpri Chinchwad), Rajkot, Gandhinagar, Patan, Mahesana, Sabarkantha, Banaskantha, Junagadh, Navsari, Kheda, Arvalli, Mahisagar, and Surendranagar
- **Zone C:** Rest of India

Here 'Address' implies the residential location/address where Insured Person(s) ordinarily resides in India. In case proposed prospect(s) reside at multiple addresses, then address of the person residing in the highest **Zone** will be considered for premium computation.

Section 2 – Benefits

If during the **Policy Period** one or more **Insured Person(s)** is required to be hospitalized for treatment of an **Illness** or **Injury** at a **Hospital / Day Care Centre**, following **Medical Advice** of a duly qualified **Medical Practitioner**, the Company shall indemnify Medical expenses towards the coverage mentioned in the **Policy Schedule** for the amount of such **Reasonable and Customary charges** or compensate to the extent agreed, upto the limits mentioned, subject to terms and conditions of the **Policy**. Provided further that, any amount payable under the **Policy** shall be subject to the terms of coverage (including but not limited to **Aggregate Deductible**, exclusions, conditions and definition contained herein). Maximum liability of the Company under all such Claims during each **Policy Year** shall be the **Sum Insured** opted and **Cumulative Bonus**, as specified in the **Policy Schedule**. In case of multi year Policy (i.e. tenure more than 1 year), such aggregate deductible would be applicable on annual basis and separately on each policy year. All benefits under this Policy are restricted to the geography of India.

In case of family floater **Policy**, the **Sum Insured, Cumulative Bonus & Aggregate Deductible**, shall be available for all **Insured Persons** on an aggregate basis, on a per **Policy Year** basis.

After completion of five continuous years of coverage under this Policy with Us and payment of applicable premium, the Policyholder will have the option to opt for waiver of the Aggregate Deductible on subsequent renewal(s). Please note that no credit for portability/migration shall be considered while calculating the five continuous Policy Years of coverage.

B1. In-Patient Treatment

We will cover **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**.

The Company shall indemnify **Medical Expenses** as listed below:

TATA AIG General Insurance Company Limited

Registered Office : Peninsula Business Park, Tower A, 15th Floor, G.K.Marg, Lower Parel, Mumbai - 400 013, Maharashtra, India. CIN: U85110MH2000PLC128425. IRDA of India Regn. No. 108. 24*7 Customer Support Number: 022 6489 8282 / 1800 267 1955 (only for senior citizen policy holders). • Email Id – customersupport@tataaig.com. • Website: www.tataaig.com IRDA of India Registration

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- i. **Room Rent**, Boarding, Nursing Expenses as provided by the **Hospital** / Nursing Home, up to the room category specified in the **Policy Schedule**.
- ii. **Modern Treatment Methods and Advancement in Technologies**
 - a. Each Claim under **Modern Treatment Methods and Advancement in Technologies** shall be subject to written clarification from the treating medical practitioner, justifying the requirement for such procedure(s).
- iii. **Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU)** expenses
- iv. Surgeon, Anesthetist, **Medical Practitioner**, Consultants, Specialist Fees
- v. Anesthesia, **Qualified Nurse** charges, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

If the **Insured Person** is admitted in a room whose category is higher than the one that is specified in the **Policy Schedule**, then the **Insured Person** shall bear a rateable proportion of the **Room Rent** and the total **Associated Medical Expenses**, including surcharge or taxes thereon in the proportion of the 'difference between the **Room Rent** actually incurred & the **Room Rent** of the entitled room category' to 'the **Room Rent** actually incurred'.

- Proportionate deductions are not applicable for **ICU Charges**.
- Such proportionate deductions, if any, will not be applied in respect of the Hospitals which do not follow differential billing or for those **Associated Medical Expenses** in respect of which differential billing is not adopted based on the room category.

B2. Pre-Hospitalization expenses

We will cover expenses for pre-hospitalization consultations, investigations and medicines incurred upto 90 days prior to the date of admission to the **Hospital**. Any pre-hospitalization expenses incurred prior to **Policy Period** shall not be covered.

The benefit is payable if **We** have admitted a claim under B1, B4, or B6.

B3. Post-Hospitalization expenses

We will cover expenses for post-hospitalization consultations, investigations and medicines incurred upto 90 days after discharge from the **Hospital**.

The benefit is payable if **We** have admitted a claim under B1, B4, or B6.

B4. Day Care Procedures

We will cover expenses for **Day Care Treatment**, due to disease/**Illness/Injury**, taken in a **Hospital** or a **Day Care Centre**, during the **Policy Period**.

B5. Organ Donor

We will cover the **Medical Expenses**, incurred by or in respect of the organ donor, for an organ transplant **Surgery**, solely towards the harvesting of the organ donated subject to the following conditions:

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- i. The organ donation conforms to the Transplantation of Human Organs (Amendment) Bill, 2011 and the organ is for the use of the **Insured Person**;
- ii. The **Insured Person** is the recipient of the organ so donated by the organ donor and the claim of such **Surgery** is accepted by **Us** under B1 of this **Policy**;
- iii. The organ transplant is medically necessary for the **Insured Person** as certified by a **Medical Practitioner**
- iv. Claim under this section shall be assessed as per the claim of the recipient **Insured Person**

What is not covered

- i. **Pre-hospitalization Medical Expenses** or **Post hospitalization Medical Expenses** of the organ donor
- ii. Screening Expenses of the organ donor
- iii. Any other medical expense as a result of harvesting from the organ donor
- iv. Costs directly or indirectly associated with the acquisition of the donor's organ
- v. Transplant of any organ/tissue where the transplant is experimental or investigational
- vi. Expenses related to organ transportation or preservation
- vii. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

B6. Domiciliary Treatment

We will cover 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.

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

B7. AYUSH Benefit

We will cover **Medical Expenses** incurred for treatment as In-Patient or Day Care in an **AYUSH Hospital/ AYUSH Day Care Centre**, for a room category, as specified in the **Policy Schedule** and applicability of **Associated Medical Expenses**.

This benefit shall also cover **Pre-hospitalization Medical Expenses** for a period of upto 90 days before the date of admission to the **AYUSH Hospital/ AYUSH Day Care Centre** and **Post-hospitalization Medical Expenses** for a period upto 90 days, subject to AYUSH In-Patient **Hospitalization** or AYUSH **Day Care Treatment** claim being admissible under this benefit.

Claims under this section shall be assessed as per the applicable insurance guidelines related to AYUSH and benchmark rates as available on Ministry of AYUSH website (<https://ayushnext.ayush.gov.in/site/insurance-guidelines-related-to-ayush>).

For reference, please refer the document "Annexure B for AYUSH Benefit" available on **Our** website (www.tataaig.com)

B8. Ambulance Cover

We will cover expenses incurred for the transportation of the **Insured Person** in a registered road ambulance, within a radius of 50 kilometers, for the following:

- i. In case of an emergency, from site of incident to the nearest **Hospital** for admission
- ii. If medically necessary and prescribed by the treating practitioner, from **Insured Person's** residence to **Hospital**
- iii. From one **Hospital** to another **Hospital** for better medical facilities and treatment or from one **Hospital** to diagnostic center for advanced diagnostic treatment, where such facility is not available at the existing **Hospital**.
- iv. If medically necessary and prescribed by the treating practitioner, from **Hospital** to **Insured Person's** residence

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

B9. Pocket Protect

We will pay an amount as specified in the **Policy Schedule** in the event of the **Insured Person(s)** being hospitalized for a disease/**Illness/Injury** for a continuous period exceeding 7 days, subject to the conditions mentioned below:

- i. The benefit is payable for disease/illness/injury as per the coverage provided under the benefits B1, B5 or B7
- ii. Notwithstanding to the contrary stated the **Aggregate Deductible** is not applicable to the benefit payable under this benefit.
- iii. Claim under this benefit shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first **Policy** with **Us**.
- iv. This benefit can be availed up to 5 **Hospitalizations** in a **Policy Year**.
- v. This benefit will not be applicable after the **Insured Person(s)** has opted Waiver of **Aggregate Deductible**

B10. Wellness Services

We / Our will provide below mentioned wellness services designed to assist **Insured Persons** in maintaining and improving good health and fitness. These Wellness Services will be available for the **Insured Person** during the **Policy Period** and as specified in the **Policy Schedule**. Any claim under this cover can be made only on cashless basis through our Empanelled Service Provider.

We do not assume any liability towards and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner and / or Network Provider / Empanelled Service Provider or in any service under this Benefit or for any consequences of actions taken or not taken, in reliance thereon.

a. Teleconsultation - General

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

TATA AIG General Insurance Company Limited

Registered Office : Peninsula Business Park, Tower A, 15th Floor, G.K.Marg, Lower Parel, Mumbai - 400 013, Maharashtra, India. CIN: U85110MH2000PLC128425. IRDA of India Regn. No. 108. 24*7 Customer Support Number: 022 6489 8282 / 1800 267 1955 (only for senior citizen policy holders). • Email Id – customersupport@tataaig.com. • Website: www.tataaig.com IRDA of India Registration

No.: 108 • CIN: U85110MH2000PLC128425 • TATA AIG MediCare Reserve UIN: TATHLIP27059V012627

This service can only be availed subject to condition below:

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

b. Teleconsultation - Speciality

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

This service can only be availed subject to conditions below:

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

c. Diet and Nutrition Consultation

With an objective of maintaining good health, **We/Our** empanelled service provider will arrange for a consultation with a nutritionist/dietitian during the **Policy Period**.

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

d. Discount from Network Providers

We will facilitate the **Insured Person** in availing discounts on diagnostic tests, medicine, medical devices, health supplements and other health related services offered through our empanelled service providers. Home delivery of pharmacy will also be offered upon the request of the **Insured Person**, wherever available.

B11. Waiver of Aggregate Deductible

The **Insured Person** will have the option to waive off **Aggregate Deductible** on **Renewal**, upon completion of five continuous Policy Years under this policy with **Us**, including **Grace Period**, on payment of applicable premium.

The **Policy** shall not require underwriting at the time of availing this option, up to the **Sum Insured** as opted by the **Insured Person** at inception.

Subject to the following conditions:

- Once waiver of **Aggregate Deductible** option is availed, the **Policy** shall continue without any **Aggregate Deductible** for all subsequent **Renewals**.
- Once waiver of **Aggregate Deductible** option is availed, it would be applicable for all **Insured Person(s)**.

Addition of Insured Persons

Spouse and/or **New Born Baby** can be added as an **Insured Person(s)** in the **Family** to this **Policy** on payment of appropriate premium. Newly added **Insured Person** shall be subject to underwriting and shall be admissible only for the applicable **Policy Sum Insured** and **Aggregate Deductible**, subject to the terms and conditions specified below:

- Spouse and/or **New Born Baby** can be added only within 3 months of the marriage/birth or at subsequent renewal, whichever is earlier.
- For such newly added **Insured Person**, the eligibility for the Waiver of Aggregate Deductible benefit will be calculated from the first inception date of this **Policy**.

B12. Restore benefit

We will automatically restore the basic **Sum Insured** if the **Sum Insured** and accrued **Cumulative Bonus** is insufficient to pay a claim during the **Policy Year**. This benefit shall trigger only once during the **Policy Year**, subject to the following conditions:

- a. The restored sum insured can be used for any admissible claim under Sections B1 to B4 for the insured person(s) who have not claimed earlier under these Sections. In case the insured has claimed under these sections, then this automatic restoration benefit is available for admissions due to unrelated illness/diseases. However, this benefit for related illness/diseases would be available, in case of claimed insured person(s), for admissions after 45 days from the date of discharge of the earlier claim.
- b. In case of Family Floater policy, restoration of Sum Insured will be available for all Insured Persons in the Policy on floater basis.
- c. This benefit shall be applicable annually for policies with tenure of more than 1 year.
- d. The unutilized restored sum insured cannot be carried forward.
- e. Restore will not trigger for the first claim under each **Policy Year/Policy period**.
- f. Our maximum liability in aggregate of all claims arising out of a single **Hospitalization** shall not exceed the **Sum Insured** of the underlying **Policy**.
- g. The Restore Benefit will be available in the Policy after the insured has opted for waiver of **Aggregate Deductible**.

B13. No Claim Bonus

Under this benefit, the Policyholder, at the time of first claim free Policy renewal, can opt for either Cumulative Bonus or Discount in Renewal Premium. Once opted, the option cannot be changed at subsequent renewals.

1) Cumulative Bonus

- i. 50% **Cumulative Bonus** will be applied on the **Sum Insured** of the expiring **Policy**, on each **Renewal** after every claim free **Policy Year**, provided that the **Policy** is renewed with **Us** and without a break. The maximum **Cumulative Bonus** shall not exceed 100% of the **Sum Insured** in any **Policy Year**.
- ii. If a **Cumulative Bonus** has been applied and a claim is made, then in the subsequent **Policy Year**, **We** will automatically decrease the **Cumulative Bonus** by 50% of the **Sum Insured** in that following **Policy Year**. There will be no impact on the base **Sum Insured**, only the accrued **Cumulative Bonus** will be decreased.
- iii. In policies with a tenure of more than one year, the above guidelines of **Cumulative Bonus** shall be applicable post completion of each **Policy Year**
- iv. In relation to a Family Floater, the **Cumulative Bonus** so applied will only be available in respect of those **Insured Person(s)** who were **Insured Person(s)** in the claim free **Policy Year** and continue to be **Insured Person(s)** in the subsequent **Policy Year**.
- v. For the purpose of computation of **Cumulative Bonus**, the percentage (%) of **Cumulative Bonus** will be applied on the base **Sum Insured** of the expiring **Policy** only. The Restore Benefit amount will not be taken into consideration for such computation.
- vi. Reduction of **Sum Insured**: In case the **Sum Insured** under the **Policy** is reduced at the time of **Renewal** then the accrued **Cumulative Bonus** under this benefit shall be reduced in proportion to the reduced **Sum Insured**.
- vii. **Cumulative Bonus** will lapse if the **Policy** is not renewed before **Policy** expiry (including the **Grace Period**).

2) Discount in Renewal Premium

The No Claim Bonus will be available in the **Policy** after the insured has opted for waiver of **Aggregate Deductible**.

Optional Covers

The Optional Cover(s) can only be opted only at the first inception of the **Policy**, along with the base covers under the **Policy** and cannot be opted in isolation or as a separate product. The Optional cover(s) are provided on payment of additional premium or discounts and subject to the terms and conditions and exclusions as stated in the **Policy** Terms and Conditions and Exclusions. These Optional Cover(s), if selected, should be opted for all eligible **Insured Persons** to be covered under the **Policy** unless stated otherwise and shall be available only if the same are specifically mentioned in the **Policy Schedule**.

The insurance provided under these Optional cover(s) are only with respect to such and so many of the coverages as are indicated in the **Policy Schedule**.

C1 Consumables Benefit

In consideration of additional premium paid and notwithstanding the exclusion mentioned under Section 3.ii (Specific Exclusions).A.(xii), if this optional cover has been opted, **We** will cover expenses incurred for specified consumables, subject to balance **Sum Insured**, which are mentioned in Annexure I – List I of optional items

(Consumables Benefit) 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**.

Conditions applicable for claim to be admissible under this cover:

- Item is a medical consumable and is medically necessary;
- prescribed by the treating **Medical Practitioner** and
- the **Hospitalization** claim is admissible under B1 or B4 of this **Policy**.

The assessment of payout under this Optional Cover shall follow the assessment of claim done under B1 and B4 except for application of **Associated Medical Expenses**.

C2 TransiCare Wallet

In consideration of payment of additional premium, We will cover **Medical Expenses** for **Medically Necessary Treatment** in a **Hospital**, for benefits admissible under section B1 or B4 of this **Policy**, arising due to **Illness, Disease or Injury**, up to the limit specified in **the Policy schedule**.

Conditions specific to this benefit:

- i. This benefit can be availed once during the **Policy Year**.
- ii. The opted **Aggregate Deductible** will not be applicable under this benefit.
- iii. This Cover will be applicable only to the **Insured Person(s)** specifically covered under Employer-Employee Group Health Insurance Policy, as per the declaration and verified submitted supporting document(s).
- iv. This benefit will be available for hospitalization occurring during ninety (90) consecutive days from the termination date of the Employer-Employee Group Health Insurance Policy.
- v. This cover will remain in force for ninety (90) consecutive days from the effective start date or till the insured person gets covered under a separate Employer-Employee Group Health Insurance Policy, whichever is earlier, subject to this **Policy** being in force.
- vi. Mid-term endorsement of any existing Insured Person under the TransiCare Wallet Benefit shall not be permitted. Such endorsement, if any, shall be allowed only at the time of Policy Renewal, subject to the terms and conditions of the Policy.
- vii. Room category applicable under this cover shall be as per the room category opted and mentioned in the Policy Schedule
- viii. This benefit will have a separate limit over and above the base **Sum Insured** and shall not impact eligibility for No Claim Bonus
- ix. In case of family floater policies, the TransiCare Wallet limit shall apply on floater basis.
- x. In case of multi-individual policies, the TransiCare Wallet limit shall apply individually for each **Insured Person**.
- xi. In the event of any misrepresentation, misdescription, or fraud in relation to the information or documents submitted for availing the TransiCare Wallet Benefit, the Company shall have the right, at its sole discretion, to recover, adjust, or retain any amounts payable under the Policy.
- xii. The declaration of above details and its verification shall be required at the time of claim of the TransiCare Wallet benefit and also at each policy renewal, including all subsequent renewals, for the continued applicability of TransiCare Wallet.
- xiii. All terms, conditions, exclusions, and definitions of the **Policy** shall apply to this Cover unless expressly stated otherwise herein.

- xiv. The TransiCare Wallet will not be available in the Policy after the insured has opted for waiver of Aggregate Deductible.

C3 Inbound Emergency Hospitalization

(Applicable for Non-Resident Indian (NRI) or Overseas Citizen of India (OCI) Insured Person(s))

In consideration of the additional premium paid, **We** will cover the **Medical Expenses** incurred towards an emergency arising out of an **Accident** of the **Non-Resident Indian (NRI) or Overseas Citizen of India (OCI) Insured Person** whilst on a trip to India up to the limit specified in the **Policy schedule**. This Cover will be available only for benefits admissible under section B1 or B4 of this **Policy**, subject to the conditions specified below:

- This Cover will be applicable only to the **Insured Person(s)** as mentioned in the **Policy Schedule** at the inception of the **Policy**, up to the limit specified in the **Policy Schedule**.
- The opted Aggregate Deductible will not be applicable under this benefit.
- The Medical Condition necessitating emergency **Hospitalization** must first be diagnosed in India, during the same trip in which the **Hospitalization** occurs.
- We will indemnify **Medical Expenses** incurred towards **Medically Necessary Treatment for Emergency Care** until such time as the **Insured Person's** medical condition is stabilized, as certified by the treating **Medical Practitioner**. Any planned **Hospitalizations** will not be covered.
- We shall not be liable to make any payment under this Cover for any claim arising out of, caused by, or attributable to any Pre-Existing Disease, complication, or consequence thereof.
- This benefit will have a separate limit over and above the base **Sum Insured** and shall not impact eligibility for No Claim Bonus.
- The Inbound Emergency Hospitalization will not be available in the Policy after the insured has opted for waiver of Aggregate Deductible.

C4 Room Category Select

If this optional cover is availed, the room category entitlement in the **Policy** shall be replaced to the room category as specified in the **Policy Schedule**.

However, if the **Insured Person** is admitted in a room whose category is higher than the one that is specified in the **Policy Schedule**, then the **Insured Person** shall bear a rateable proportion of the **Room Rent** and the total **Associated Medical Expenses**, including surcharge or taxes thereon in the proportion of the 'difference between the **Room Rent** actually incurred & the **Room Rent** of the entitled room category' to 'the **Room Rent** actually incurred'.

- Proportionate deductions are not applicable for **ICU Charges**.
- Such proportionate deductions, if any, will not be applied in respect of the **Hospitals** which do not follow differential billing or for those **Associated Medical Expenses** in respect of which differential billing is not adopted based on the room category.
- The cover can be selected only at the inception of the **Policy**. Once opted, the cover has to be opted continuously under the **Policy**.

Section 3 – 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. All the waiting periods shall be applicable individually for each **Insured Person**.

i. Standard Exclusions

A. Exclusions with waiting periods

i. *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**.

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 36 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.

List of Specific disease/conditions/treatments:

- I. Tumors, Cysts, polyps including breast lumps (benign) (*Arbud, Granthi, including arbud in Sthana*)
- II. Polycystic ovarian disease (*garbhashaya granthi*), Fibromyoma (*Aartav dushti (Sowmya arbudham)*), Adenomyosis, Endometriosis (*Udavarthani yoni vyaazpt*)
- III. Prolapsed Uterus (Yoni bhramsha)
- IV. Gout and Rheumatism (*Vaathraktha and Aamvaat / Aadhya vata*), Rheumatoid arthritis, Non-infective arthritis (*Sandhi shool {Dhatukshay janya or Avrodhjanya, both, Sandhigata vata, Vata roga}*)

- V. Ligament, Tendon or Meniscal tear (*Sira, kandara, maams gat vaat janya shool, sandhi shola*)
- VI. Prolapsed Inter-Vertebral Disc (*Katishool, Greevashool, Grudhrasi vata*) and Spinal Diseases including spondylitis/spondylosis unless arising from **Accident**
- VII. Cholelithiasis (*yakrut roga*)
- VIII. Pancreatitis
- IX. Fissure/fistula in anus, haemorrhoids, pilonidal sinus (*Arsha, Parikartika, bhagandar, gudagat vranshoth, nadi vrana*)
- X. Ulcer & erosion of stomach & duodenum
- XI. Gastro Esophageal Reflux Disorder (GERD) (*Parinamshool, annadravakhya shool, Amlapitta, Grahani*)
- XII. Liver Cirrhosis
- XIII. Perineal Abscesses (*bhagandhara*)
- XIV. Perianal / Anal Abscesses
- XV. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone (*Ashmari of all types*)
- XVI. Benign Hyperplasia of prostate (*Asththila vrudhhi*)
- XVII. Varicocele (*Vrudhhi, Vrushanshoth*)
- XVIII. Cataract (*avrana Shukla*), Retinal detachment, Glaucoma (*abhishyandha*)
- XIX. Congenital Internal Diseases
- XX. Osteoarthritis and osteoporosis (*Astrikshay/ asti gata vata*)
- XXI. Systemic connective tissue disorders, inflammatory polyarthropathies

List of procedure/surgeries/treatments:

- XXII. Adenoidectomy
- XXIII. Mastoidectomy
- XXIV. Tonsillectomy
- XXV. Tympanoplasty
- XXVI. **Surgery** for nasal septum deviation and Nasal concha resection
- XXVII. **Surgery** for Turbinate hypertrophy
- XXVIII. Hysterectomy
- XXIX. Joint replacement (for example: Knee replacement, Hip replacement)
- 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
- XXXV. Obesity / Weight control procedures including Gastric bypass surgeries

iii. 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.

B. 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);
 - 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 Person**. 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 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):** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
- 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):**
 1. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during **Hospitalization**) except ectopic pregnancy;
 2. Expenses towards miscarriage (unless due to an **Accident**) and lawful medical termination of pregnancy during the **Policy Period**.

C. 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):

Expenses incurred towards treatment in any **Hospital** or by any **Medical Practitioner** or any other provider specifically excluded by the **Insurer** and disclosed in its website / notified to the Policyholders are not admissible. However, in case of life-threatening situations or following an **Accident**, expenses up to the stage of stabilization are payable but not the complete claim.

ii. Specific Exclusions (Exclusions other than as those mentioned under Section 3 (i) subsection A, B & C above)

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.

A. Medical Exclusions

- i. Alcoholic pancreatitis or Alcoholic liver disease;
- ii. Congenital External Diseases, defects or anomalies;
- iii. Stem cell therapy; however, hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under this **Policy**,
- 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 like Zolendronic Acid, etc;
- vii. Venereal disease, sexually transmitted disease or **Illness**;
- viii. All preventive care including Health Check-ups, vaccination including inoculation and immunisations;
- ix. Cost of dentures, dental implants and braces; **Dental Treatment** or Dental **Surgery** of any kind unless incidental to an admissible **Hospitalization** claim where the cause of admission is **Accident**;
- x. Any form of Non-Allopathic treatment (except AYUSH Benefit), Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.
- xi. Any existing disease specifically mentioned as Permanent exclusion in the **Policy Schedule**.
- xii. Non payable items as mentioned in Annexure I – List I of optional items available on **Our** website (www.tataaig.com)

B. Non-Medical Exclusions

- i. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not) or caused during service in the armed forces of any country, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.
- ii. 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. For the purpose of this exclusion:
 - Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any **Illness**, incapacitating disablement or death

- Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any **Illness**, incapacitating disablement or death.
 - Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any **Illness**, incapacitating disablement or death.
- iii. Any **Insured Person's** participation or involvement in armed forces or related operation.
 - iv. Intentional self-**Injury** or attempted suicide while sane or insane.
 - v. If the **Insured Person** is under the influence of intoxicating liquor or drugs or other intoxicants, except where the **Insured Person** is not directly responsible for the **Injury/Accident** though under influence of intoxication.
 - vi. Items of personal comfort and convenience like television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service.
 - vii. Treatment rendered by a **Medical Practitioner** which is outside his discipline.
 - viii. Doctor's fees charged by the **Medical Practitioner** sharing the same residence as an **Insured Person** or who is an immediate relative of an **Insured Person's** family.
 - ix. Hearing aids, spectacles or contact lenses, etc. including optometric therapy.
 - x. Any treatment and associated expenses for alopecia, baldness, wigs or toupees, medical supplies including elastic stockings, diabetic test strips and similar products.
 - xi. Any treatment or part of a treatment that does not form part of '**Reasonable and Customary charges**', nor is medically necessary;
 - xii. 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**.
 - xiii. Any external appliance and/or device used for diagnosis or treatment except when used intra-operatively.
 - xiv. 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**.
 - xv. Any claim within the deductible limit, as applicable and specified in the policy schedule.

Section 4 – General Terms and Clauses

i. Standard General Terms & Clauses

1. Disclosure of Information

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

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

2. Condition Precedent to Admission of Liability

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

3. Claim Settlement (provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 15 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. All claims will be settled in accordance with the applicable guidelines issued by IRDAI.
 (Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).

4. Complete Discharge

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

5. Multiple Policies

- i. In case of multiple policies taken by an **Insured Person** during a period from one or more insurers to indemnify treatment costs, the **Insured Person** shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the **Insurer** chosen by the **Insured Person** shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen **Policy**.
- ii. **Insured Person** having multiple policies shall also have the right to prefer claims under this **Policy** for the amounts disallowed under any other **Policy** / policies even if the **Sum 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 and **We** will assist the **Insured Person** in facilitating the same.
- iv. Where an **Insured Person** has policies from more than one **Insurer** to cover the same risk on indemnity basis, the **Insured Person** shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen **Policy**.

6. Fraud

If any claim made by the **Insured Person**, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the **Insured Person** or

anyone acting on his/her behalf to obtain any benefit under this **Policy**, all benefits under this **Policy** and the premium paid shall be forfeited.

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the **Insured Person** or by his agent or the **Hospital/doctor/any other party** acting on behalf of the **Insured Person**, with intent to deceive the **Insurer** or to induce the **Insurer** to issue an insurance **Policy**:

- a. the suggestion, as a fact of that which is not true and which the **Insured Person** does not believe to be true;
- b. the active concealment of a fact by the **Insured Person** having knowledge or belief of the fact;
- c. any other act fitted to deceive; and
- d. any such act or omission as the law specially declares to be fraudulent.

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

7. Cancellation

The policyholder may cancel this **Policy** by giving 7 days written notice and in such an event, the Company shall refund proportionate premium for unexpired **Policy Period**. No refunds of premium shall be made in respect of Cancellation where any claim has been admitted or has been lodged or any benefit under this **Policy** has been availed by the **Insured Person**.

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

8. Migration

The **Insured Person** will have the option to migrate the **Policy** to other health insurance products/plans offered by the company by applying for **Migration** of the **Policy** at least 30 days before the **Policy Renewal** date per IRDAI guidelines. 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 to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy, as applicable.

For Detailed Guidelines on **Migration**, kindly refer

Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and subsequent amendments thereof.

For the purpose of this product, Migration, wherever permitted, shall be allowed only within similar health insurance product categories offered by Us, such as Top-up to Top-up products. On completion of one year of coverage after availing the waiver of the Aggregate Deductible option, the Policyholder shall have the option to migrate to a suitable base product offered by Us, subject to applicable terms, conditions, and underwriting guidelines.

9. Portability

The **Insured Person** will have the option to port the **Policy** to other insurers by applying to such **Insurer** to port the entire **Policy** along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the **Policy Renewal** date per IRDAI guidelines. 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 to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the existing Insurer to the acquiring Insurer in the previous policy, as applicable.

For Detailed Guidelines on **Portability**, kindly refer

Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and their subsequent amendments thereof.

However, after porting into this product, the option of Waiver of Aggregate Deductible under benefit B11 will be available after completion of 5 continuous years under this **Policy**.

10. Renewal of Policy

The **Policy** shall ordinarily be renewable except on grounds of established fraud, non-disclosure or misrepresentation by the **Insured Person**.

- i. **Renewal** shall not be denied on the ground that the **Insured Person** had made a claim or claims in the preceding **Policy Years**.
- ii. Request for **Renewal** along with requisite premium shall be received by the Company before the end of the **Policy Period**.
- iii. Single premium payment mode **Policy** 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** after the end of the **Policy Period**. If not renewed under the **Grace Period**, the **Policy** shall terminate at the end of the **Grace Period**.
- iv. The **Grace Period** for payment of the premium during the **Policy Period**, for instalment premium shall be fifteen days where premium payment mode is monthly and thirty days in all other cases (Annual/ Half-Yearly/ Quarterly/Limited Premium paying term).
- v. Coverage during such **Grace Period** (in case of instalment premium):
 - a. Within the **Policy Period** - coverage will be available from the due date of instalment premium till the date of receipt of premium by Company within the **Grace Period**.
 - b. 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** after the end of the **Policy Period**.

TATA AIG General Insurance Company Limited

Registered Office : Peninsula Business Park, Tower A, 15th Floor, G.K.Marg, Lower Parel, Mumbai - 400 013, Maharashtra, India. CIN: U85110MH2000PLC128425. IRDA of India Regn. No. 108. 24*7 Customer Support Number: 022 6489 8282 / 1800 267 1955 (only for senior citizen policy holders). • Email Id – customersupport@tataaig.com. • Website: www.tataaig.com IRDA of India Registration

No.: 108 • CIN: U85110MH2000PLC128425 • TATA AIG MediCare Reserve UIN: TATHLIP27059V012627

- vi. The **Insured Person** will get the accrued continuity benefit to the extent of Sum Insured, No Claim Bonus, Specified Waiting Periods, waiting periods for pre-existing diseases, Moratorium period, as applicable, in the event of payment of premium within the stipulated **Grace Period**.
- vii. No loading shall apply on **Renewals** based on individual claims experience.

11. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the **Insured Person** about the same 90 days prior to expiry of the **Policy**.
- ii. **Insured Person** will have the option to migrate to similar health insurance product available with the Company at the time of **Renewal** with all the accrued continuity benefits such as No Claim Bonus, waiver of waiting period as per IRDAI guidelines, provided the **Policy** has been maintained without a break.
- iii. In the event of withdrawal of this Product, **We** shall continue to offer coverage under this Product to existing Policyholders until they become eligible to opt for waiver of the **Aggregate Deductible**, thereby enabling eligible Policyholders to avail the mentioned option under this Product upon payment of applicable premium and subject to other terms and conditions of the **Policy**.

12. Moratorium Period

After completion of five continuous years of coverage (including **Portability** and **Migration**) in health insurance **Policy**, no **Policy** and claim shall be contestable by the **Insurer** on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This continuous period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first **Policy**. Wherever the **Sum Insured** is enhanced, completion of five continuous years would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, **Co-Payments**, **Aggregate Deductibles** as per the **Policy** contract.

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

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

14. Free look period

The insured person shall be provided a free look period of thirty days beginning from the date of receipt of the policy document, whether received electronically or otherwise, 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 a refund of the premium paid subject to deduction of proportionate risk premium for the period of cover and the expenses, if any, incurred by **Us** on medical examination of the proposer and stamp duty charges.

15. Redressal of Grievance

At TATA AIG, **We** strive to provide the best service to **Our** customers. If **You're** not satisfied and wish to lodge a complaint, please call **Our** 24*7 Customer Support Number: 022 6489 8282 / 1800 267 1955 (only for senior

citizen policy holders) or email **Us** at customersupport@tataaig.com. **We** will investigate and respond within the regulatory turnaround time (TAT).

Escalation Level 1

If **You** do not receive a response or are not satisfied with the resolution, please contact **Us** at manager.customersupport@tataaig.com.

Escalation Level 2

If **You** still need assistance, reach out to the Head of Customer Services at head.customerservices@tataaig.com. **We** will provide **Our** final response within the regulatory TAT.

If **You're** still not satisfied after this process, **You** may approach the Insurance Ombudsman of concerned jurisdiction.

You can also lodge a grievance on the Bima Bharosa Grievance Redressal Portal: <https://bimabharosa.irdai.gov.in>

The name and address of the Insurance Ombudsman of competent jurisdiction is provided under Annexure A of this **Policy**.

16. Nomination

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

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

17. Insured Person

- i. Only those persons named as an **Insured Person** in the Schedule shall be covered under this **Policy**.
- ii. Any eligible person may be added during the **Policy Period** after his proposal has been accepted by **Us**, additional premium has been paid and **We** have issued an endorsement confirming the addition of such person as an **Insured Person**.

18. 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** and on the applicable **Sum Insured** for each **Policy Year** including increased **Sum Insured**, if any.
 - 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/ release the amount 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.

19. NRI Discount

Availability of NRI discount shall be subject to below mentioned conditions:

- i. The **Insured Person(s)** shall submit a declaration and supporting document(s) confirming that they qualify as a **Non-Resident Indian (NRI) / Overseas Citizen of India (OCI)** for the entire Policy Year and at each subsequent Renewal.
- ii. In the event the **Insured Person(s)** cease(s) to qualify as a **Non-Resident Indian (NRI) / Overseas Citizen of India (OCI)** or fail(s) to submit the required documents for verification of residency status, the applicable discount shall cease to exist.
- iii. Such **Non-Resident Indian (NRI) / Overseas Citizen of India (OCI) Policyholder** must have an Indian bank account for the purpose of premium/claims payment.

20. Entire Contract

- i. This **Policy**, its Schedule, endorsement(s), proposal constitutes the entire contract of insurance. No change in this **Policy** shall be valid unless approved by **Us** and such approval be endorsed hereon.
- ii. This **Policy** and the Schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this **Policy** or of the Schedule shall bear such meaning wherever it may appear.

21. Notices

- i. Any notice, direction or instruction under this **Policy** shall be in writing and if it is to:
 - a. Any **Insured Person**, then it shall be sent to **You** at **Your** address specified in the Schedule to this **Policy** and **You** shall act for all **Insured Persons** for these purposes.
 - b. **Us**, it shall be **delivered to Our address specified in the Schedule to this Policy. No insurance agents, brokers or other person or** entity is authorised to receive any notice, direction or instruction on **Our** behalf unless **We** have expressly stated to the contrary in writing.

22. Premium Payment Zone

For the purpose of premium computation, the country is segmented into three **Zones** {as mentioned in Section 1: ii. Specific Definitions. 15. **Zone(s)**} and the premium payable under this **Policy** will be computed based on the residential location/address in India, as provided by the proposer/**Insured Person** in the proposal form. In cases where the Proposer/**Insured Person** does not have a residential address within the territory of India as on the policy inception date or **Renewal** date, as applicable, the Premium payable under the **Policy** shall be determined basis Zone A.

Here 'Address' implies the residential location/address where Insured Person(s) ordinarily resides in India. In case proposed prospect(s) reside at multiple addresses, then address of the person residing in the highest **Zone** will be considered.

The Policyholder/Proposer has the option to choose Zone A for premium payment, irrespective of Insured Person(s) location /address, which shall be designated as Pan India. This would entail that Co-payment for Treatment in Higher Zone would not be applicable. However once Zone A/Pan-India premium payment option has been selected then the Policyholder/Proposer will not have the option to shift to other premium payment zones at renewals

23. Co-Payment for Treatment in Higher Zone

In the event that the **Insured Person** undergoes medical treatment at a **Hospital / Day Care Centre / AYUSH Hospital / AYUSH Day Care Centre** in a **Zone** higher than the **Zone** as opted by the **Insured Person** at the time of Policy inception or **Renewal**, a **Co-payment** as mentioned in the table below shall be applicable on the admissible claim amount.

Opted Zone	Treatment Zone	Co-Pay Applicable
B	A	10%
C	B	10%
C	A	20%

The Proposer/**Insured Person** may, at the time of Policy inception or **Renewal**, opt to pay an additional premium equivalent to the premium applicable for the higher Zone in order to upgrade the **Zone** that was basis the residential location/address in India as provided by the proposer/**Insured Person** in the proposal form. Where such **Zone** upgrade is opted for and the corresponding premium is paid, no **Co-payment** shall be applicable for treatment availed within the upgraded **Zone**.

The Higher Zone **Co-Payment** shall be applicable for:

- all claims except for claims for emergency **Hospitalization** due to Injury arising from an **Accident**.
- all claim under section B1, B2, B3, B4, B5, B6, B7, B8, C1 (if opted) and C2 (if opted) of this **Policy**.

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

The coverage for the **Insured Person(s)** shall automatically terminate in case of his/ her (**Insured Person**) demise. However, the cover shall continue for the remaining **Insured Persons** till the end of **Policy Period**. Provided no claim has been made and deletion from **Policy** takes place on account of death of the **Insured Person** during the **Policy Period**, pro-rata refund of premium of the deceased **Insured Person** for the balance period of the **Policy** will be made.

- Refund will be made to the **Policy** holder in case of demise of the insured person(s).
- Refund will be made to the nominee in case of demise of the **Policy** holder.

We would require death certificate of the Deceased **Insured Person** for processing of the refund amount.

The other **Insured Persons** may also apply to renew the **Policy**. In the event of change of Proposer, all relevant particulars in respect of such person (including his/her relationship with the **Insured Person**) must be submitted to the company along with the application.

Section 5 – Claims Procedure and Claims Payment

This section explains about the procedure involved to file a valid claim by the **Insured Person** and processes related to assessment, cost sharing and management of the claim. 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.

a. Notification of Claim

Every claim needs to be notified to **Us** either in writing or email or through a call to **Our** tollfree number, as mentioned in the **Policy Schedule**, within the stipulated timelines as mentioned below.

S.No.	Event	We or Our TPA* must be informed:
1	If any treatment for which a claim may be made and that treatment requires planned Hospitalization/ Day Care Treatment/ AYUSH/ Domiciliary Treatment :	At least 48 hours prior to the Insured Person's admission/ start of treatment.
2	If any treatment for which a claim may be made and that treatment requires emergency Hospitalization/ Day Care Treatment	Within 24 hours of the Insured Person's admission to Hospital or at the time of discharge, whichever is earlier.

*TPA as mentioned in the **Policy Schedule**, if applicable.

Timely intimation of claim in **Our** prescribed format is a pre-condition for admission of liability.

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

b. Cashless Service

Treatment, Consultation or Procedure:	Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to avail cashless service accompanied by full particulars:
If any planned treatment, consultation or procedure for which a claim may be made:	Network Provider	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 Hospitalization

If any treatment, consultation or procedure for which a claim may be made, requiring emergency Hospitalization	Network Provider	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital .	Within 24 hours of the Hospitalization and prior to discharge
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c. Procedure for Cashless Service

- i. Cashless Service is only available at **Our Network Provider**.
- 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 Provider**, **You** must notify **Our** designated TPA/**Us** and request pre-authorization.
 - b. **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 Provider**.
 - c. In case of deficiency in the documents sent to TPA/**Us** for cashless authorization or the ailment /treatment is not covered under the **Policy**, the same shall be communicated to the **Hospital/You** by TPA/**Us**.
 - d. **We/TPA will respond** within turn around time as prescribed by the Regulator under the Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 and its subsequent amendments thereof.
 - e. 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.
 - f. If the cashless is approved, the original bills and evidence of treatment in respect of the same shall be left with the **Network Provider**.
 - g. 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**.

d. Supporting Documentation & Examination

- i. **We** or **Our** TPA may require documentation, medical records and information 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 **Hospitalization** or completion of treatment.
- ii. In case the delay is at **Your** end, failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if **You** can satisfy **Us** that it was not reasonably possible for **You** to give proof within such time.
- iii. **We** may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the **Insured Person**.
- iv. Such documentation will include the following:

- a. **Our** claim form, duly completed and signed for on behalf of the **Insured Person. We**, upon receipt of a notice of claim, will furnish **Your** representative with such forms as **We** may require for filing proofs of loss or **You** may download the claim form from **Our** Web site.
- b. Original Bills (pharmacy purchase bill, consultation bill, diagnostic bill, medical devices) 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
- n. PM report (wherever applicable)
- o. The Company reserves the right to call for additional documents wherever required.
- p. The documents validating the residential status of NRI/OCI at the time of claim.
- q. Claims under 'TransiCare Wallet' cover will be admissible only upon termination of the Employer-Employee Group Health Insurance Policy of the **Insured Person(s)**. We reserve the right to call for and verify supporting documents, including but not limited to a resignation letter, termination letter, or any other documentary evidence establishing unemployment status.
 - The **Insured Person(s)** shall also be required to submit a declaration confirming that he/she was unemployed at the time of occurrence of the claim event. In the event such declaration, we shall retain the right to call and validate additional supporting documents, including but not limited to the appointment letter, joining letter, or any other proof of employment.
- v. **Note:** In case **You** are claiming for the same event under an indemnity-based **Policy** with **Us** and with another **Insurer** and are required to submit the original documents related to **Your** treatment with that particular **Insurer**, then **We** will require 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.

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

e. **Claims Assessment and Payment**

i. **General**

- a. **We** shall be under no obligation to make any payment under this **Policy** unless:
- **We** have received all premium payments in full and in time and
 - **We** have been provided with the documentation and information which **We** or **Our** TPA has requested to establish the circumstances of the claim, its quantum or **Our** liability for it, and
 - unless **You** have complied with **Your** obligations under this **Policy**.
- b. This **Policy** only covers claims incurred within India, and payments under this **Policy** shall only be made in Indian Rupees within India.
- c. **Medical Expenses** incurred for **AYUSH Treatment** shall be assessed only under benefit B7 of this **Policy** and shall be admissible only if incurred within India.

Where an ailment/ **Illness**/ disease is excluded under both exclusions with waiting Periods (as specified under Section 3 (i) Sub section (A) and under any other **Policy** exclusion, then for assessment of liability, any expense related to that ailment/ **Illness**/ disease shall not be covered under this **Policy**.

Claim assessment for policies with instalment Premium Payment Mode:

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

ii. **Sequence of applicability & Utilization**

- a. The sequence of assessment of claim shall be as per table given below:

Steps	Assessment	Applicability
1	Amount of Claim Intimated	√
2	Less Non-Payable expenses	√
3	=Admissible Expenses	√
4	Less Associated Medical Expenses as defined under the Policy (if applicable)	√
5	=Final Assessed Amount	√
6	Less Aggregate Deductible *	√
7	=Final Assessed Liability	√
Claim Payable subject to applicable Balance Sum Insured (including accrued Cumulative Bonus)/ Benefit Limit		

Deduction may vary subject to applicability of 'Pocket Protect/Consumables Benefit' .

* **Aggregate Deductible**, shall be applicable on aggregate of all claims as assessed under the final assessed amount for a given **Policy Year**.

The payment of any claim under this **Policy** shall be subject to **Aggregate Deductible**, benefit limits, balance **Sum Insured** and accrued **Cumulative Bonus**, if available.

b. The sequence of utilization of benefit for a claim shall be in the following order:

1. Balance **Sum Insured**,
2. Any accrued **Cumulative Bonus**
3. Restore Benefit

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.

Your claim will be processed including cashless and final bill authorization as prescribed by the Regulator under the Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 and its subsequent amendments thereof.

Section 6 - Dispute Resolution

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.

Annexure A

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES

Sr.No.	Centre	Address & Contact	Jurisdiction of Office Union Territory, District
1	AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: oio.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
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, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: oio.bengaluru@cioins.co.in	Karnataka
3	BHOPAL	Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202/ 2769203 Email: oio.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh

TATA AIG General Insurance Company Limited

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4	BHUBHANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/ 2596429/ 2596003 Email: oio.bhubaneswar@cioins.co.in	Odisha
5	CHANDIGARH	Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 2706468 Email: oio.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
6	CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: oio.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)
7	DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 – 46013992/ 23213504/ 23232481 Email: oio.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh
8	GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Near Pan bazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205/ 2631307 Email: oio.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
9	HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 – 23312122/ 23376991 / 23376599 / 23328709 / 23325325 Email: oio.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
10	JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: oio.jaipur@cioins.co.in	Rajasthan
11	KOCHI	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: oio.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry

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12	KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: oio.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
13	LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: oio.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
14	MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: oiol.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N, S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
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.: 0120-4027589 Email: oio.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

16	PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: oio.patna@cioins.co.in	Bihar, Jharkhand
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.: 020-24471175 Email: oio.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
18	THANE	Office of the Insurance Ombudsman, Jeevan Chintamani Building, 2 nd Floor, Near New RTO Office, Louis Wadi, Vasanttrao Naik Mahamarg, Thane (West) - -400604Tel.: 022- 20812868/69 Email: oio.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."

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

Section 64VB of the Insurance Act, 1938 - Commencement of risk cover under the **Policy** is subject to receipt of premium by Tata AIG General Insurance Company Limited.

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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“Insurance is a subject matter of solicitation”. For more details on risk factors, terms and conditions, please read **Policy** document carefully before concluding a sale.