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 by the Sum Insured set opposite such benefit in the Policy Schedule.

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-

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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** round the clock;

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

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

5. Cashless facility

Cashless Facility means a facility extended by the **Insurer** to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the **Policy** terms and conditions, are directly made to the **Network Provider** by the Insurer to the extent pre-authorization is approved.

6. Condition Precedent

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

7. 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.

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. Cumulative Bonus

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

10. Day Care Centre

A Day Care Centre means any institution established for **Day Care Treatment** of **Illness** and/or injuries or a medical setup with a **Hospital** and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified **Medical Practitioner** AND must comply with all minimum criterion as under –

i. has qualified nursing staff under its employment;

ii. has qualified **Medical Practitioner**/s in charge;

iii. has fully equipped operation theatre

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of its own where Surgical Procedure are carried out;

iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

11. 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.

12. Dental Treatment

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

13. 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**.

14. Grace Period

Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a **Policy** in force without loss of continuity benefits such as waiting periods and coverage of **Pre-Existing Disease**(s). Coverage is not available for the period for which no premium is received.

15. Hospital

A Hospital means any institution established for in-patient care and **Day Care Treatment** of **Illness** and/or injuries and which has been registered as a Hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;

ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii. has qualified **Medical Practitioner**(s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where Surgical Procedure are carried out;

v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

16. Hospitalization

Hospitalization means admission in a

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Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

17. 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

18. 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**.

19. 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.

20. 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.

21. 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.

22. Medical Advice

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

23. 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

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more than would have been payable if the **Insured Person** had not been insured and no more than other **Hospital**(s) or doctors in the same locality would have charged for the same medical treatment.

24. 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.

25. 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.

26. Migration

"Migration" means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance **Policy**), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same **Insurer**.

27. Network Provider

Network Provider means **Hospital**(s) 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**.

28. 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.

29. OPD treatment

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

30. Pre-Existing Disease

Pre-Existing Disease means any condition, ailment, **Injury** or disease:

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the **Policy** issued by the **Insurer** or its reinstatement or

b. For which **Medical Advice** or treatment was recommended by, or received from, a Physician within 48 months Prior to the effective date of the **Policy** issued by the **Insurer** or its reinstatement.

31. 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:

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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.

32. Portability

"Portability" means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one **Insurer** to another **Insurer**.

33. 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.

34. 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.

35. 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.

36. 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 Disease**(s), time-bound exclusions and for all waiting periods.

37. Room Rent

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

38. 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**.

39. 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)

40. Age

Means the completed Age of the **Insured**

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Person on his / her last birthday as on date of commencement of the **Policy** and as per the English calendar.

41. Policy

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

42. 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**.

43. Policy Schedule

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

44. 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.

45. Shared Accommodation

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

46. 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.

47. Sum Insured

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

- Upon the successful admission of a claim, the Sum Insured for the remaining **Policy Year** shall be accordingly reduced by the amount of the claim settled (inclusive of 'taxes') or admitted.
- In cases where the **Policy Period** is 2/3 years, the specified Sum Insured in the **Policy Schedule** signifies the limit for the initial **Policy Year**. This limit shall expire at the conclusion of the first year, and fresh limit up to the opted Sum Insured will become available for the subsequent second/ third year.

48. Valued Provider - Pan India

'Valued Provider - Pan India' is a specific network of **Hospital**(s), designated as such and mentioned in the **Policy Schedule**. It consists of a defined list of **Hospital**(s) or health care providers enlisted by Us, and/ or TPA to provide medical services to an **Insured Person** by a **Cashless Facility**. Reference made to '**Network Provider**' in the **Policy** wordings shall be substituted

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with 'Valued Provider - Pan India', except for Section 5(e) Claim Assessment and Payment, sub section iii (b). The updated list of Valued Provider - Pan India is available on **Our** website (www.tataaig.com).

49. We, Us, Our, Insurer

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

50. You, Your, Insured Person

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

51. Zone(s)

For the purposes of Premium calculation and payment, India has been categorized in 3 different Zone(s):

i. Zone A: Mumbai (including Mumbai Metropolitan Region), Delhi (including National Capital Region, Faridabad, Ghaziabad), Ahmedabad, Surat & Baroda

ii. Zone B: Hyderabad (including Secunderabad), Bengaluru, Kolkata, Indore, Chennai, Chandigarh (including, Mohali, Punchkula, Zirakpur), Pune (including Pimpri Chinchwad) and Rajkot

iii. Zone C: Rest of India

Please note that the above-mentioned categorization of Zone(s) is subject to change at **Our** sole discretion. Any such change made which shall impact an existing policyholder, shall be intimated under 3 months' notice and shall be applicable from the immediate next **Renewal**.

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 Medically Necessary 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 any **Co-Payment**), 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** (if accrued) specified in the **Policy Schedule**. The coverages available to a specific **Insured Person**/ **Policy** shall be as per the benefits mentioned in the **Policy Schedule**.

In case of family floater **Policy**, the sum insured for all or any of the benefits shall be on a per **Policy Year** basis unless explicitly stated to the contrary. In case of individual **Policy**, the sum insured for all or any of the benefits shall be on per **Insured Person** per **Policy Year** basis unless explicitly stated to the contrary.

Our maximum liability under the **Policy** for payment of all claims arising out of **Any one illness** in aggregate under Sections B1, B2, B3, B4, B5, B6, B7, B8, B9, B12, B13 shall not exceed the opted sum insured and accrued **Cumulative Bonus**, subject to the balance sum insured.

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**.

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

i. **Room Rent**, Boarding, Nursing Expenses as provided by the **Hospital** / Nursing Home upto the **Single Private Room** category

ii. **Intensive Care Unit** (ICU) / Intensive Cardiac Care Unit (ICCU) expenses

iii. Surgeon, Anesthetist, **Medical Practitioner**, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the **Hospital**

iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

If the **Insured Person** is admitted in a room category that is higher than the **Single Private Room**, 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 **Single Private Room** category' to 'the **Room Rent** actually incurred'.

- For the purpose of this Benefit "Associated Medical Expenses" shall include the applicable nursing charges, operation theatre charges, fees of **Medical Practitioner** including surgeon/ anesthetist/ specialist within the same **Hospital** where the **Insured Person** has been admitted. "Associated Medical Expenses" does not include cost of pharmacy & consumables, cost of implants & medical devices and cost of diagnostics.
- Proportionate deductions are not applicable for **ICU Charges**.
- Such proportionate deductions, if any, will not be applied in respect of the **Hospital**(s) 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 for expenses for Pre-Hospitalization consultations, investigations and medicines incurred upto 60 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 or B4 or B6.

B3. Post-Hospitalization expenses

We will cover for expenses for Post-Hospitalization consultations, investigations and medicines incurred upto 180 days after discharge from the **Hospital**.

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

B4. Day Care Treatment

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 shall cover the **Medical Expenses**, up to the limits as specified in the **Policy Schedule**, 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

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conditions:

Conditions

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 for 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. Restore Benefit

We will automatically reinstate 100% of the Sum Insured, if the balance Sum Insured and accrued **Cumulative Bonus** is insufficient to pay an admissible claim under B1 to B6 of this **Policy**. The Restore Benefit will be available once during the **Policy Year** but shall not be available for the first admissible **Hospitalization** / **Domiciliary Hospitalization** claim in each **Policy Year**. Notwithstanding the above, **Our** maximum liability in aggregate for all claims during a **Policy Year** under B7 'Restore benefit' shall not exceed the Sum Insured.

Restore Benefit will be available once during the **Policy Year** subject to the following conditions:

a. The reinstated sum insured can be used by the **Insured Person**(s) for any claim (related or unrelated **Illness**/ **Injury**) under B1 to B6 of the **Policy**.

b. However, in case of **Any one illness**, this benefit for related **Illness**/ **Injury** would be available to the **Insured Person**(s), who have claimed

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earlier, only for **Hospitalization**/ **Domiciliary Hospitalization** where date of admission is beyond 45 days from the date of discharge of the immediately preceding **Hospitalization**/ date of end of **Domiciliary Hospitalization**, for which claim has been paid.

c. In a floater **Policy**, the Reinstated Sum Insured will be available for all **Insured Person**(s) in the **Policy** on floater basis.

d. The unutilized restored sum insured cannot be carried forward to the next **Policy Year**.

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

f. Restore will not trigger or be available for utilization for the first claim under each **Policy Year**.

g. Accrued Bonus, if any, will not be reinstated.

B8. AYUSH Benefit^

We will cover for Medical Expenses incurred for treatment as In-Patient or Day Care Treatment in an **AYUSH Hospital/ AYUSH day care** centre, for a room category maximum up to **Single Private Room** and applicability of Associated Medical Expenses.

This benefit shall also cover Pre-Hospitalization medical expenses for a period of upto 60 days before the date of admission to the **AYUSH hospital/ AYUSH day care centre** and Post-Hospitalization Medical Expenses for a period upto 180 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 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).

B9. Ambulance Cover

We will cover for expenses incurred on transportation of **Insured Person** in a registered ambulance to a **Hospital** for admission in case of an Emergency or from one **Hospital** to another **Hospital** for better medical facilities and treatment, subject to a maximum limit as specified in the **Policy Schedule** per **Hospitalization**.

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

B10. Health Checkup

At the request of the **Insured Person**, **We**/ **Our** empaneled service provider will arrange for below listed medical tests every **Policy Year** provided the **Policy** is in force with **Us**. The health check-ups shall be arranged by **Us** only on cashless basis at **Our** empanelled service providers or at **Insured Person**'s residence, as per availability.

Health Check Up will be available for all **Insured Person**(s) covered under the **Policy** irrespective of claim. Check-ups under this benefit can be availed once in a **Policy Year**.

List of tests:

a. Complete Blood Count with Erythrocyte Sedimentation Rate (CBC with ESR) test

b. Fasting Blood Sugar Test

c. Hemoglobin A1C Test (Hba1c)

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d. Lipid Profile Test

e. Liver Function Test

f. Electrocardiogram (ECG) Test

g. Urine Routine Analysis

For the purpose of this benefit, Preventive Health Check-up means the above medical test(s) undertaken for general assessment of health status and does not include any diagnostic or investigative medical tests for evaluation of **Illness** or a disease.

Utilization of this benefit by **Insured Person** shall not affect **Cumulative Bonus**.

B11. Compassionate travel

In the event the **Insured Person** is Hospitalized in India for more than Five consecutive days in a place where no adult member of his immediate family is present, **We** will cover for expenses related to a round trip economy class domestic air ticket, or first-class railway ticket, to allow the Immediate Family Member be at his bedside for the duration of his stay in the **Hospital**, subject to a maximum limit as specified in the **Policy Schedule** during a **Policy Year**.

This benefit shall be payable if **We** have accepted an inpatient **Hospitalization** claim for the **Insured Person**(s) under In Patient Treatment (B1).

This benefit has a separate limit (over and above base sum insured).

We shall require additional documents as proof of travel for supporting the claim under this benefit.

B12. Bariatric Surgery Cover

We will cover for reasonable and customary expenses for Bariatric **Surgery** if the insured fulfills all of the following conditions:

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

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

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

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

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

   a. Obesity-related cardiomyopathy

   b. Coronary heart disease

   c. Severe sleep apnea

   d. Uncontrolled Type2 Diabetes

The coverage and claim assessment and terms & conditions applicable shall be as per the Section 2 Benefit B1 of this **Policy**.

B13. In-Patient Treatment - Dental

We will cover for **Medical Expenses** incurred towards **Hospitalization** for **Dental Treatment** under anesthesia necessitated due to an **Accident**/**Injury**/**Illness**.

The benefit is payable (notwithstanding exclusion under Section 3.ii.sub-section 1.ix).

The coverage and claim assessment and terms & conditions applicable shall be as per the Section 2 Benefit B1 of this **Policy**.

B14. Vaccination cover

We will cover the cost of the following vaccines if the **Insured Person**(s) is

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vaccinated during the **Policy Year**:

- Anti-rabies vaccine following an animal bite
- Typhoid vaccine

After 2 years of continuous coverage with Us:

- Human Papilloma Virus (HPV) vaccine
- Hepatitis B Vaccine

The benefit is payable (notwithstanding the exclusion as per Section 3.ii.sub-section 1.viii) subject to a maximum limit as specified in the **Policy Schedule** per **Policy Year** and this benefit has a separate limit (over and above the base sum insured) and does not affect **Cumulative Bonus**. Expenses related to the doctor, nurse or any incidental expenses are not payable.

B15. Hearing Aid

We will cover for reasonable charges for a hearing aid for the **Insured Person**, every third year provided there is continuous coverage under this **Policy**, without any break and is subject to a maximum limit as specified in the **Policy Schedule** per **Policy**. This benefit has a separate limit (over and above the base sum insured) and does not affect **Cumulative Bonus**.

The items must be prescribed by a specialized **Medical Practitioner** as medically necessary.

B16. Daily Cash for choosing Shared Accommodation

We will pay a fixed amount per day, if the **Insured Person** is Hospitalized in **Shared Accommodation** in a **Hospital** in **Our** network of **Valued Provider** - **Pan India**, for each continuous and completed period of 24 hours of **Hospitalization**. The benefit payable per day would be subject to a maximum limit as specified in the **Policy Schedule**.

For this claim to be paid, the main claim must be accepted under B1 of this **Policy**. This benefit has a separate limit (over and above base sum insured).

B17. Daily Cash for Accompanying an Insured Child

We will pay a fixed amount per day, if the **Insured Person** Hospitalized is a child Aged 12 years or less, for one accompanying adult for each completed period of 24 hours of **Hospitalization** in **Our** network of **Valued Provider** - **Pan India**. The benefit payable per day would be subject to a maximum limit as specified in the **Policy Schedule**.

For this claim to be paid, the main claim must be accepted under B1 of this **Policy**.

This benefit has a separate limit (over and above base sum insured).

B18. Second Opinion

At **Your** request, **We** will provide **You** a second medical opinion in India from **Our** Empaneled Service Provider, if an **Insured Person** is diagnosed with the below mentioned **Illnesses** during the **Policy Period**. The expert opinion would be directly sent to the **Insured Person**.

i. Cancer
ii. Kidney Failure
iii. Myocardial Infarction
iv. Angina
v. Coronary bypass Surgery
vi. Stroke/Cerebral hemorrhage
vii. Organ failure requiring transplant

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viii. Heart Valve replacement

ix. Brain tumors

This benefit can be availed by an **Insured Person** once during a **Policy Year**.

Second Opinion will be based only on the information and documentation provided to **Us** which will be shared with **Our** empaneled service provider. Conditions as mentioned under Disclaimer Clause (applicable to B18 & B21) in the **Policy** shall apply.

B19. Accidental Death Benefit (Optional Cover)

If an **Insured Person** suffers an **Accident** during the **Policy Period** and this is the sole and direct cause of his death within 365 days from the date of **Accident**, then **We** will pay the Sum Insured as mentioned against the respective **Insured Person** in the **Policy Schedule**.

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

Benefit under optional cover (if opted) shall be available to the **Insured Person**, only if the particular benefit/optional cover is specifically mentioned in the **Policy Schedule**. This benefit has a separate limit (over and above base sum insured).

B20. Cumulative Bonus

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

ii. If a **Cumulative Bonus** has been applied and a claim is made, then in the subsequent **Policy Year We** will automatically decrease the accrued **Cumulative Bonus** by 50% of the Base Sum Insured in that following **Policy Year**.

iii. In policies with a tenure of more than one year, Bonus shall accrue 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 purpose of computation of **Cumulative Bonus**, the percentage (%) of **Cumulative Bonus** will be applied on the base Sum Insured of the expiring **Policy** only. Restore Benefit amount will not be taken into consideration for such computation.

vi. Any accrued **Cumulative Bonus** can only be utilized for an admissible claim under B1, B2, B3, B4, B5, B6, B8, B9, B12 & B13 of this **Policy**.

vii. 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.

viii. **Cumulative Bonus** will lapse if the **Policy** is not renewed before **Policy** expiry (including the **Grace Period**).

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B21. Wellness Services

Teleconsultation– General

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

This service can only be availed subject to condition below:

- Consultation will be provided through various specified modes of communication like audio, video, online portal, chat, digital customer application or any other digital mode.

Definition: For the purpose of section B 21 of this **Policy**, a Healthcare Professional is a person who holds a valid qualification from regulatory body as set up by the Government of India or a State Government or any other relevant authority and is engaged in actions with an objective of maintaining and improving individual's good health.

Disclaimer Clause (applicable to B18 & B21)

1. Availing the services under this benefit is purely upon the Insured's sole discretion and risk.
2. For services that are provided through empanelled service providers, **We** are acting as a facilitator; hence **We** would not be liable for any incremental costs or the services. Any additional services availed, or expenses incurred on such services or benefits which are other than those covered under this **Policy** and explicitly excluded by this **Policy**, shall not be covered under this **Policy** and all expenses incurred shall be borne by the **Insured Person**.
3. **We** shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which **Insured Person** claims to have suffered, sustained or incurred, by way of and / or on account of the benefit. **We** shall not be liable for any deficiency or discrepancy in the services provided by empanelled service provider under this **policy**.
4. **Insured Person** may consult any medical professional at any empanelled service provider at its sole discretion. The cost of service arising out of **Insured Person** choice of medical professional at any empanalled service provider shall completely be borne by the **Insured Person** unless covered otherwise. However, the services under this **Policy** should not be construed to constitute **Medical Advice** and/ or substitute the **Insured Person**'s visit/ consultation to an independent **Medical Practitioner**/Healthcare professional.
5. The **Medical Practitioner** may suggest/recommend/prescribe over the counter medications based on the information provided, if required on a case-to-case basis. Provided that any recommendation under this **Policy** shall not be valid for any medico legal purposes.
6. The **Insured Person** is free to choose whether or not to act on

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the recommendation after seeking consultation.

7. Any advice, recommendations or suggestions made by any medical professional shall be solely based on the information and documentation provided by the **Insured Person** to such medical professional. **We** shall not be liable towards any loss or damage (immediate or consequential) arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the medical professional from whom **We** have availed services or taken benefit or for any consequence of any act or omission in reliance thereon.

8. Above mentioned services are non-portable, annual contracts, independent of **Policy** contract and not lifelong renewable. The Services provided may be added / deleted / modified at **Our** discretion and the same shall be notified to the policyholders in advance prior to change effective date.

9. Provision of these services is subject to availability as per the duration specified by **Us**/the empanelled service provider. Details are available on **Our** website (www.tataaig.com)

10. Any service availed by the **Insured Person** under this Benefit will not impact **Cumulative Bonus** if applicable.

11. **We** reserve the right to change any empanelled service provider during the currency of the **Policy** or at **Renewal**. The same shall be intimated to the insured atleast 15 days prior to the effective date of change.

12. In case **We** or the assistance service provider fails to provide any of the services as mentioned in this **Policy** or is unable to implement, in whole or in part due to force majeure, non-availability of services, change in law, rule or regulations which affects the services, or if any regulatory or governmental agency having jurisdiction over a party takes a position which affects the services, then the assistance services' suspended, curtailed or limited performance shall not constitute breach of contract and the company or the assistance service provider shall have no liability whatsoever including but not limited to any loss or damage resulting therefrom.

13. **We** shall not accept any liability towards quality of the services made available by service provider. The service provider is responsible for providing the availed services and **We** are not liable for any defects or deficiencies on the part of the service provider.

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.

i. Standard Exclusions

1. 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

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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 24 months of continuous coverage after the date of inception of the first **Policy** with **Us**. This exclusion shall not be applicable for claims arising due to an **Accident**.

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

c. If any of the specified disease/ procedure falls under the waiting period specified for **Pre-Existing Disease**(s), 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)

II. Polycystic ovarian disease, Fibromyoma, Adenomyosis, Endometriosis

III. Prolapsed Uterus

IV. Rheumatism

V. Ligament, Tendon or Meniscal tear

VI. Prolapsed Inter-Vertebral Disc

VII. Cholelithiasis

VIII. Pancreatitis

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

X. Ulcer & erosion of stomach & duodenum

XI. Gastro Esophageal Reflux Disorder (GERD)

XII. Liver Cirrhosis

XIII. Perineal Abscesses

XIV. Perianal / Anal Abscesses

XV. Calculus diseases of Urogenital system Example: Kidney stone,

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Urinary bladder stone.

XVI. Benign Hyperplasia of prostate

XVII. Varicocele

XVIII. Cataract, Retinal detachment, Glaucoma

XIX. Congenital Internal Diseases

List of procedure/surgeries/ treatments:

XX. Adenoidectomy

XXI. Mastoidectomy

XXII. Tonsillectomy

XXIII. Tympanoplasty

XXIV. **Surgery** for nasal septum deviation

XXV. Nasal concha resection

XXVI. **Surgery** for Turbinate hypertrophy

XXVII. Hysterectomy

XXVIII. Osteoarthritis, joint replacement, osteoporosis,

XXIX. Systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid, Gout

XXX. Cholecystectomy

XXXI. Hernioplasty or Herniorraphy

XXXII. **Surgery**/procedure for Benign prostate enlargement

XXXIII. **Surgery** for Hydrocele/ Rectocele/Spermatocele

XXXIV. **Surgery** of varicose veins and varicose ulcers

iii. 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.

2. 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

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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. For this to be considered a medical necessity, it must be certified by the attending **Medical Practitioner**.

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

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

viii. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a **Medical Practitioner** as part of **Hospitalization** claim or day care procedure. **(Code-Excl14)**

ix. Refractive error (Code- Excl 15): Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

x. Unproven treatments (Code- Excl 16):

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

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

Expenses related to Sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services

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including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

iv. Reversal of sterilization

xii. Maternity (Code - Excl 18):

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

b. Expenses towards miscarriage (unless due to an **Accident**) and lawful medical termination of pregnancy during the **Policy Period**.

3. Non-Medical Exclusions

i. Hazardous or Adventure Sports (Code-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 1, 2 &3 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.

1. 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, vaccination including inoculation and immunisations;

ix. **Dental Treatment** or Dental **Surgery** of any kind unless incidental to an admissible **Hospitalization**

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claim where the cause of admission is **Accident**/ **Illness**; cost of dentures, dental implants and braces

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

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

2. Non-Medical Exclusions

i. War or any act of war, invasion, act of foreign enemy, war like operations (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 naval, military or air force operation.

iv. Intentional self-Injury or attempted suicide while sane or insane.

v. 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.

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

vii. Doctor's fees charged by the **Medical Practitioner** sharing the same residence as an **Insured Person** or who is an immediate relative of an **Insured Person**'s family.

viii. Fitting of hearing aids, Provision/ fitting of spectacles or contact lenses including optometric therapy.

ix. Any treatment and associated expenses for alopecia, baldness,

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wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

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

xi. Expenses which are either not supported by a prescription of a **Medical Practitioner** or are not related to **Illness** or disease for which claim is admissible under the **Policy**.

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

xiii. Any **Illness** diagnosed or **Injury** sustained or where there is change in health status of the member after date of proposal and before commencement of **Policy** and the same is not communicated and accepted by **Us**.

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 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 30 days from the date of receipt of last necessary document.

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

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

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

(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

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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.

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**

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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

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

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

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit (including those provided under B21-Wellness Services of this **Policy**) has been availed by the **Insured Person** under the **Policy**.

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

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 as per IRDAI guidelines on **Migration**. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on **Migration**.

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

9. Portability

The **Insured Person** will have the option to port the **Policy** to other **Insurers** by applying to such **Insurer** to port the

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entire **Policy** along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the **Policy Renewal** date as per IRDAI guidelines related to **Portability**. If such person is presently covered and has been continuously covered without any lapses under any health insurance **Policy** with an Indian General/Health **Insurer**, the proposed **Insured Person** will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on **Portability**.

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

10. Renewal of Policy

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

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

ii. **Renewal** shall not be denied on the ground that the **Insured Person** had made a claim or claims in the preceding **Policy Years**.

iii. Request for **Renewal** along with requisite premium shall be received by the Company before the end of the **Policy Period**.

iv. At the end of the **Policy Period**, the **Policy** shall terminate and can be renewed within the **Grace Period** of 30 days to maintain continuity of benefits without break in **Policy**. Coverage is not available during the **Grace Period**.

v. No loading shall apply on **Renewal**(s) 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 **Cumulative Bonus**, waiver of waiting period as per IRDAI guidelines, provided the **Policy** has been maintained without a break.

12. Moratorium Period

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

13. Possibility of Revision of Terms of the

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Policy Including the Premium Rates

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

14. Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on **Renewal**(s) or at the time of porting/migrating the **Policy**.

The **Insured Person** shall be allowed free look period of fifteen days from date of receipt of the **Policy** document to review the terms and conditions of the **Policy**, and to return the same if not acceptable.

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

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

ii. where the risk has already commenced and the option of return of the **Policy** is exercised by the **Insured Person**, a deduction towards the proportionate risk premium for period of cover or

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

15. Redressal of Grievance

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

Escalation Level 1

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

Escalation Level 2

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

16. Nomination

The policyholder is required at the inception of the **Policy** to make a nomination for the purpose of payment

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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. Risk Loadings

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

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

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

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

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

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

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

19. 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.

20. 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**

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address specified in the Schedule to this **Policy** and **You** shall act for all **Insured Person**(s) for these purposes.

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

21. Zone

Premium payable under the **Policy** will be computed based on the residential location/address as provided by the proposer/**Insured Person** in the proposal form.

Premium to be received by Company before **Policy** Commencement date.

22. 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 Person**(s) 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 Policyholder or the nominee as the case may be in case of demise of the Policyholder. **We** would require death certificate of the Deceased **Insured Person** for processing of the refund amount.

The other **Insured Person**(s) 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:

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	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:	**Our** network of **Valued Provider** - **Pan India**	**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**	**Our** network of **Valued Provider** - **Pan India**	**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

c. Procedure for Cashless Service at Our network of Valued Provider - Pan India

i. Cashless Service is only available at **Our** network of **Valued Provider** - **Pan India**.

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

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Network **Hospital**, **You** must call **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 **Hospital**.

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

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

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 **Hospital**.

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

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

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** Website.

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

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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.

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

vi. **We** at **Our** own expense, shall have the right and opportunity to examine **Insured Person**(s) through **Our** Authorised **Medical Practitioner** whose details will be notified to **Insured Person** when

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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 (except B19, wherever applicable), 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 B8 of this policy and shall be admissible only if incurred within India.^

d. Where an ailment/ **Illness**/ disease is excluded under both exclusions with waiting Periods (as specified under Section 3 (i) Sub section (1) 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**.

ii. Sequence of applicability & Utilization:

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

Steps	Assessment	Where Age specific Co-Payment is applicable	Where Age specific Co-Payment is not applicable
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	=Admissible Claim	√	√
6	Less (Out of **Our** network of **Valued Provider - Pan India Co-Payment*** as defined in **Policy** + **Age** Linked **Co-Payment**) OR **Age** linked Co-Payment	(30%*+20%) OR 20%	30%* OR 0%

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7	=Final Assessed Liability	√	√
8	Claim Payable subject to applicable	Balance Sum Insured (including accrued **Cumulative Bonus**)/ Benefit Limit	

* If admission is outside **Our** network of **Valued Provider - Pan India**

The payment of any claim under this **Policy** shall be subject to benefit limits, balance sum insured and accrued **Cumulative Bonus**, as available

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

1. Balance Sum Insured/Sum Insured (as applicable),
2. Any accrued **Cumulative Bonus**, if applicable (B20)
3. Restore benefit amount, if applicable (B7)

Accidental Death Benefit (B19) shall be assessed as per the Sum Insured of the Optional Cover.

iii. Cost Sharing

a. Age linked Co-Payment

If the entry **Age** of the **Insured Person** is 61 years or above at the time of first coverage under this **Policy**, then such **Insured Person** shall bear 20% of each admissible claim (over and above any other **Co-Payment**, if applicable). This shall be applicable even in **Portability** cases, irrespective of previous coverage.

This **Co-Payment** shall be applicable for all claims admitted under

- B1, B2, B3, B4, B5, B6, B8, B9, B12 and B13 of this **Policy**; and
- if B7 and B20 of this **Policy** is utilized for payment of claim under aforementioned sections.

Exception to this clause:

This **Co-Payment** shall not be applicable in case of **Migration** from any active TATA AIG indemnity health **Policy** to this product provided, entry **Age** of the **Insured Person** was less than 61 years at the time of first coverage under the first indemnity health **Policy** with **Us**, subject to continuous coverage without any break in the **Policy**.

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

"**Valued Provider - Pan India**" network list is different from **Our** standard list of "**Network Provider**". Cashless services shall be available only in those **Hospitals** or health care providers which have been specifically enlisted under '**Valued Provider - Pan India**'.

The standard list of **Network Provider** shall not be available to the **Insured Person** under this **Policy**. List of **Valued Provider - Pan India** will be updated from time to time and will be available on **Our** website www.tataaig.com

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

For Clarity: This **Co-Payment** shall be applicable on claims admitted under

- B1, B4, B5, B8, B12 & B13 of this **Policy**; and

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Email: customersupport@tataaig.com | IRDA of India Registration No: 108 | website: www.tataaig.com
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- if B7 and B20 of this **Policy** is utilized for payment of claim under aforementioned sections.

iv. Claims Procedure and management of Wellness Services (Section B10 & B21)

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

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.

Section 6 - Dispute Resolution

1. Dispute Resolution Clause

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

^Note: In compliance with IRDAI circular dated 31.01.2024, on 'Guidelines on providing AYUSH coverage in Health Insurance policies' (Ref: IRDAI/HLT/CIR/GDL/31/01/2024), policy wordings have been modified.

Annexure A

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES

Centre	Address & Contact	Jurisdiction of Office Union Territory, District
Ahemdabad	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahemdabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
Bengaluru	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
Bhopal	Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh

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Centre	Address & Contact	Jurisdiction of Office Union Territory, District
Bhubaneswar	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh
Chennai	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet,CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
Guwahati	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
Hyderabad	Office of the Insurance Ombudsman, 6-2-46, 1st floor, “Moin Court”, Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
Jaipur	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan

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Centre	Address & Contact	Jurisdiction of Office Union Territory, District
Ernakulam	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College,M.G.Road, Ernakulam - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
Kolkata	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
Lucknow	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, 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
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: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)

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Centre	Address & Contact	Jurisdiction of Office Union Territory, District
Noida	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	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
Patna	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
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: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)

For updated list and details of Insurance Ombudsman Offices, please visit website http://www.cioins.co.in/ombudsman.html

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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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