Policy Wordings

Section 1: Preamble

Rider can only be opted along with the base Policy and cannot be opted in isolation or as a separate product. The Riders are provided in lieu of additional premium or discount as applicable and subject to the terms, conditions and exclusions as stated in the Rider wordings in addition to the Policy Terms, Conditions and Exclusions.

These Rider(s), if selected, shall be mentioned in the Policy Schedule and will be available up to the limit specified therein, for all Insured Person(s) covered under the underlying base Policy, unless stated otherwise.

Cover(s) provided under this Rider and their limits are only with respect to such and so many as indicated in the Policy Schedule.

The Rider shall offer coverage subject to below conditions:

- Terms and conditions of the Rider are to be read in conjunction with the terms and conditions of the base Policy.
- The continuance of risk cover under the base Policy is necessary precondition for continuance of cover under Rider.
- The scope of coverage under these Riders are restricted to the geography of India, unless specified otherwise in the respective Rider cover.
- Admission of liability under any Rider shall not have any bearing on admissibility of a claim under the base Policy on any ground including non-disclosure of material fact or Pre-Existing disease.

Section 2: General Definitions

All Standard and Specific Definitions as defined in the respective base Policy shall also apply for Riders, wherever applicable.

Additional Specific Definitions:

1. **Health Care Professional:**

   A Health Care 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.

2. **Service Provider:**

   Service Provider means the providers empanelled and engaged by Us for arranging/providing services under Riders mentioned in the base Policy Schedule. The name, address and contact particulars of such service providers shall be specified by Us in the base Policy Schedule.

Section 3: Riders

Section 1: Comprehensive Riders

R1. Emergency Air Ambulance Rider

In consideration of additional premium paid for this Rider, We will reimburse cost of air ambulance for transportation of the Insured Person in an airplane or helicopter subject to the limit as specified in the Policy Schedule, per Policy Year for Emergency Care of life-threatening health conditions which require immediate and rapid transportation to a Hospital in another place for further medical management.

The Medical Evacuation should be prescribed by a Medical Practitioner and should be Medically Necessary.

This benefit shall only be payable if an in-patient Hospitalization claim for the Insured Person is admissible under In-Patient Treatment benefit of the base Policy for the related claim and the transportation is carried out within India.

This benefit has a separate limit (over and above base Sum Insured).

For Floater policies, the Sum Insured as mentioned shall be on a floater basis for all Insured Persons on a per Policy Year basis.

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

R2. Domestic Second Opinion Rider

In consideration of additional premium paid, We will provide You at your request a second medical opinion from Our Network Provider/empanelled Service Provider or Medical Practitioner in India, if an Insured Person suffers Illness/injury during the Policy Period. The expert opinion would be directly sent to the Insured Person.

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

Second Opinion will be based only on the information and documentation provided to Us which will be shared with Our empanelled Service Provider.

R3. International Second Opinion

In consideration of additional premium paid for this Rider, We will provide You at your request a second medical opinion from Our Network Provider/empanelled Service Provider or Medical Practitioner located worldwide outside India, 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
viii. Heart Valve Replacement
ix. Brain Tumors
x. End stage Lung Disease
xi. End stage Liver Failure
xii. Bone Marrow Transplant
xiii. Permanent Paralysis of Limbs
xiv. Motor Neuron Disease
xv. Parkinson's Disease

This benefit can be availed by an Insured Person once for each Illness in a Policy Year.

R4. Cumulative Bonus Shield

In consideration of additional premium paid for this Rider the Cumulative Bonus accrued under the base Policy shall not be reduced at renewals subject to the total amount of all claims made in a Policy Year, under the base Policy which impacts Cumulative Bonus under the respective base Policy, does not exceed the specified limit in the Policy Schedule for this Rider.

However, if total claims paid in the base Policy for benefits which impacts Cumulative Bonus under the respective base Policy in a Policy Year exceeds the specified limit for this Rider, then the Cumulative Bonus shall reduce at a rate as defined in the base Policy.

In policies with a tenure of more than one year, the above provisions of Cumulative Bonus Shield shall be applicable post completion of each Policy Year.

All other terms and conditions applicable to the Cumulative Bonus of base Policy shall also be applicable to this Rider.

R5. Inflation Protect

In consideration of additional premium paid for this Rider We will provide an additional increase in the Sum Insured on the basis of inflation rate (all India) in the previous calendar year for next Policy Year, irrespective of claims in preceding Policy Years, provided that:

- The Policy is renewed with Us and without a break.
- In policies with a tenure of more than one year, Inflation Protect shall accrue post completion of each Policy Year.
- The inflation rate shall be applied on the base Policy Sum Insured of the expiring Policy. In case the Sum Insured under the Policy is reduced at the time of Renewal then the accrued Inflation Protect under this benefit shall be reduced in proportion to the reduced Sum Insured.
- Unutilized accrued Inflation Protect amount will get carried forward to the next Policy Year provided the Policy is renewed with Us without any break.

- If this Rider is not renewed before Policy expiry (including the Grace Period) then all the accrued and carried forward Inflation Protect amount shall lapse.
- Any accrued Inflation Protect amount shall be utilized after the Sum Insured in the base Policy is exhausted.
- For Floater policies, the accrued Inflation Protect amount shall be available on a floater basis for all Insured Persons, who were covered under the expiring Policy, on a per Policy Year basis.

Illustration 1: Sum Insured same for subsequent Policy Year.

Base Policy Year	1st Year	2nd Year	3rd Year	4th Year	5th Year
Base Policy Sum Insured	10 Lakhs	10 Lakhs	10 Lakhs	10 Lakhs	10 Lakhs
Inflation Rate	6%	7%	8%	7%	7%
Inflation Protect Amount	60,000	70,000	80,000	70,000	70,000
Total Sum Insured	-	10,60,000	11,30,000	12,10,000	12,80,000

Illustration 2: Sum Insured Enhancement in subsequent Policy Year.

Base Policy Year	1st Year	2nd Year	3rd Year	4th Year	5th Year
Base Policy Sum Insured	10 Lakhs	10 Lakhs	20 Lakhs	20 Lakhs	20 Lakhs
Inflation Rate	6%	7%	8%	7%	7%
Inflation Protect Amount	60,000	70,000	1,60,000	1,40,000	1,40,000
Total Sum Insured	-	10,60,000	21,30,000	22,90,000	24,30,000

Illustration 3: Sum Insured reduction in subsequent Policy Year.

Base Policy Year	1st Year	2nd Year	3rd Year	4th Year	5th Year
Base Policy Sum Insured	10 Lakhs	10 Lakhs	10 Lakhs	5 Lakhs	5 Lakhs
Inflation Rate	6%	7%	8%	7%	7%
Inflation Protect Amount	60,000	70,000	80,000	35,000	35,000
Total Sum Insured	-	10,60,000	11,30,000	6,05,000	6,40,000

Illustration 4: Rider not Renewed.

Base Policy Year	1st Year	2nd Year	3rd Year	4th Year	5th Year (Rider not Renewed at the end of 4th Policy Year)

Base Policy Sum Insured	10 Lakhs	10 Lakhs	10 Lakhs	10 Lakhs	10 Lakhs
Inflation Rate	6%	7%	8%	7%	7%
Inflation Protect Amount	60,000	70,000	80,000	70,000	-
Total Sum Insured	-	10,60,000	11,30,000	12,10,000	10,00,000

For the purpose of this cover, the inflation would be computed as the change in average CPI of the entire calendar year published by the National Statistical Office (NSO), Ministry of Statistics and Program Implementation. The average CPI of the previous calendar year shall be applicable only after three months of the release of the CPI of the last month of the previous calendar year. In case inflation rate of previous calendar year is not available then the inflation rate available for penultimate calendar year shall be considered.

R6. Additional Sum Insured for Accidental Hospitalization

In consideration of additional premium paid for this Rider, if the Insured Person suffers an accident during the Policy Period and this accident is the sole and direct cause for the Hospitalization of the Insured Person, then We will provide an additional Sum Insured, as specified in the Policy Schedule against this Rider, for Medical Expenses incurred towards the In-Patient Treatment of the Insured Person during such Hospitalization, subject to the following conditions:

i. For individual as well as family floater policies, this limit is individually available for each Insured Person covered under the Policy.

ii. Additional Sum Insured for Accidental Hospitalization, if applicable, shall be utilized before the Sum Insured in the base Policy.

iii. Once triggered, the total amount available under this cover shall be available for utilization for In-Patient Hospitalization expenses linked to Accident only, in a Policy Year.

iv. Any unutilized 'Additional Sum Insured for Accidental Hospitalization', shall not be carried forwarded.

v. The admissibility of claim under this Rider shall be subject to the terms, conditions and exclusions of the base Policy.

vi. Specific exclusions applicable to this Rider:

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:

- Where the Insured Person is under the influence of intoxicating liquor or drugs or other intoxicants, except where the Insured Person is not directly responsible for the injury/accident though under influence of intoxication.
- Insured Person committing or attempting to commit an illegal activity or violation of law.

R7. Supercharge Bonus Rider

i. In consideration of additional premium paid for this Rider and notwithstanding the Cumulative Bonus offered under the base Policy, We will provide Supercharge Bonus in the form of specified

irrespective of claims in preceding Policy Years, provided that the Policy is renewed with Us without a break. The total accrued Supercharge Bonus shall not exceed limit as specified in the Policy Schedule, in any Policy Year.

ii. In policies with a tenure of more than one year, Bonus shall accrue post completion of each Policy Year.

iii. The Supercharge Bonus so accrued will be available only in respect of those Insured Person(s) who were Insured Person(s) in the previous Policy Year and continue to be Insured Person(s) in the subsequent Policy Year.

iv. For the purpose of computation of Supercharge Bonus, the percentage (%) of Bonus will be applied on the base Sum Insured of the expiring Policy only. The Restore Benefit amount Sum Insured or the Restore Infinity/Restore Infinity Plus amount (if available/opted in the base Policy/Rider) or any other Cover/Rider offering Sum Insured over and above the base Sum Insured will not be taken into consideration for such computation.

v. Any accrued Supercharge Bonus can only be utilized for an admissible claim under following indemnity covers of the base Policy, as applicable:

   a. In-Patient Treatment,
   b. Pre/Post Hospitalization Expenses,
   c. Day Care Treatment/Day Care Procedure,
   d. Domiciliary Treatment,
   e. Organ Donor,
   f. AYUSH Benefit,
   g. Ambulance Cover / Road Ambulance cover,
   h. Consumables Benefit,
   i. Bariatric Surgery Cover
   j. In-Patient Treatment- Dental
   k. Home Care Treatment Cover
   l. Home Physiotherapy

vi. Any accrued Supercharge Bonus cannot be utilized for an admissible claim under following covers:

   a. Global Cover/Global Cover for Planned Hospitalization
   b. Maternity Cover
   c. Delivery Complications Cover
   d. First year Vaccinations
   e. Any cover under the base Policy or any Rider which has Sum Insured over and above the base Sum Insured

vii. In case the Sum Insured under the Policy is reduced at the time of Renewal then the accrued Supercharge Bonus under this benefit shall be reduced in proportion to the reduced Sum Insured.

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

R8. Advanced Cover Rider

In consideration of additional premium paid for this Rider, the Pre-Existing Disease Waiting Period as applicable under the base Policy should be read as "30 days" under Pre-existing Diseases Waiting Period (Code- Excl 01) for the Insured Person(s) specified in the Policy Schedule for the following named Pre-Existing Diseases only:

a) Diabetes Mellitus (Type 2),

b) Hypertension,

c) Hyperlipidemia &

d) Asthma

The above substitution shall only be applicable for such specified Insured Person(s) for whom 'Advanced Cover' has been opted and additional premium paid, which shall be specified in the base Policy Schedule.

The above would be applicable if the above-named Pre-Existing Diseases have been declared by You for the specific Insured Person for whom this coverage has been opted and the same has been accepted by Us at the time of first coverage under this Policy.

The additional premium charged under this Rider shall be a rate applied on the applicable base Policy premium for that individual at the base Policy inception or on the base Policy renewal date.

In case of portability, the "30 days" as mentioned above should be read as "0 Days" and waiver of waiting period for the above named four illnesses shall be restricted to the lower of the expiring Sum Insured or opted Sum Insured under this Policy, provided the above-named Pre-Existing Diseases had been declared by You at the time of applying for the first Policy and mentioned as accepted under the expiring ported/Our Policy.

If this Rider is availed, then it has to be mandatorily opted for all Insured Persons who have any of the above mentioned Pre-Existing Disease.

R9. Advanced Cover Plus

In consideration of additional premium paid, the Pre-Existing Disease Waiting Period as applicable under the base Policy should be read as "30 days" under Pre-existing Diseases Waiting Period (Code- Excl 01) for the Insured Person(s) specified in the Policy Schedule for the named Pre-Existing Diseases only.

The above substitution shall only be applicable for such specified Insured Person(s) for whom 'Advanced Cover Plus' has been opted and additional premium paid, which shall be specified in the base Policy Schedule.

The above would be applicable if the Pre-Existing Diseases have been declared by You for the specific Insured Person for whom this coverage has been opted and the same has been accepted by Us at the time of first coverage under this Policy.

The additional premium charged under this Rider shall be a rate applied on the applicable base Policy premium for that individual at the base Policy inception or on the base Policy renewal date.

In case of portability, the "30 days" as mentioned above should be read as "0 Days" and waiver of waiting period for the above named four illnesses shall be restricted to the lower of the expiring Sum Insured or opted Sum Insured under this Policy, provided the above-named Pre-Existing Diseases had been declared by You at the time of applying for the first Policy and mentioned as accepted under the expiring ported/Our Policy.

If this Rider is availed, then it has to be mandatorily opted for all Insured Persons who have any of the above mentioned Pre-Existing Disease.

R10. Restore Infinity Plus

In consideration of additional premium paid, notwithstanding the Restore Benefit/Restore Infinity Cover (if applicable) under the base Policy, We will provide reinstatement of base Policy Sum Insured, if the Sum Insured and Cumulative Bonus or 5X Supercharge Bonus or Supercharge Bonus or Inflation Protect or Carry Forward of Unutilized Sum Insured (if applicable) is insufficient to pay an admissible Hospitalization claim in the underlying base Policy. The reinstatement will be available for unlimited number of times during a Policy Year, subject to below conditions:

This benefit shall not be available for the first admissible Hospitalization / Domiciliary Hospitalization claim in each Policy Year.

a. This benefit shall not be available for the first admissible Hospitalization / Domiciliary Hospitalization Claim in each Policy Year. The Sum Insured will be restored for the subsequent claim in the Policy Year.
b. In case of Family Floater Policy, Reinstatement of Sum Insured will be available for all Insured Persons in the Policy on floater basis.
c. The unutilized restored Sum Insured cannot be carried forward to the next Policy Year.
d. This benefit shall also be applicable annually for policies with tenure of more than 1 year.
e. Any restored Sum Insured can only be utilized for an admissible claim under following indemnity covers of the base Policy, as applicable:
    i. In-Patient Treatment,
    ii. Pre/Post Hospitalization Expenses,
    iii. Day Care Treatment/Day Care Procedure,
    iv. Domiciliary Treatment,
    v. Organ Donor,
    vi. AYUSH Benefit,
    vii. Ambulance Cover / Road Ambulance cover,
    viii. Consumables Benefit,
    ix. Bariatric Surgery Cover
    x. In-Patient Treatment- Dental
f. Any restored Sum Insured under this benefit cannot be utilized for an admissible claim under:
    i. Any cover other than the ones mentioned in the above section or

ii. Any cover under the base Policy/Rider which has Sum Insured over and above the base Sum Insured.

g. Our maximum liability in aggregate of all claims arising out of a single Hospitalization shall not exceed the Sum Insured of the underlying base Policy.

R11. Home Care Treatment Rider

In consideration of additional premium paid for this Rider, We will cover for reasonable and customary medical expenses incurred for treatment taken at home, which are "Equivalent Medical charges" as defined in this Rider, up to the base Policy Sum Insured for the Insured Person's medically necessary treatment at home.

Home Care Treatment means treatment availed by the Insured Person at home, which in the normal course would require Hospitalization of more than 24 hours or would have been admissible under Day Care Procedures but is actually taken at home provided that:

a. The Medical Practitioner advices the Insured Person to undergo treatment at home.

b. There is a continuous active line of treatment with monitoring of the health status by a Medical Practitioner for each day through the duration of the home care treatment.

c. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

d. Home care treatment is availed in India.

e. Home treatment services may be availed through Network Service Provider/empanelled Service Provider in select cities for select treatment procedures only. Please contact us or visit our website **(www.tataaig.com)** for updated list of treatment procedures and cities where home treatment service is provided.

f. Insured shall be permitted to avail the services as prescribed by the Medical Practitioner.

g. In case the Insured intends to avail the services of non-network provider, a prior approval from the Insurer needs to be taken before availing such services from a registered home care provider. Insurer shall respond to approval request within 1 working hour of receiving the last necessary requirement.

Specific condition under Home Care Treatment:

Pandemic Care at home will be available for a maximum period of 15 days and maximum up to 25% of the base Policy Sum Insured excluding Cumulative Bonus/Supercharge Bonus (as applicable). Pandemic as defined and declared by World Health Organization (WHO) or any equivalent healthcare authority.

In this Rider, the following shall be covered if prescribed by the treating Medical Practitioner and is related to the treatment covered under the Policy,

a. Diagnostic tests undergone at home or at diagnostics center

b. Medicines prescribed in writing

c. Consultation charges of the Medical Practitioner

d. Nursing charges related to medical staff

e. Cost incurred towards rental of medical equipment during the course of home care treatment (such as Pulse Oximeter, Oxygen cylinder, nebulizer and similar other Equipment)

For the purpose of this Rider, "Equivalent Medical charges" shall mean the charges for services or supplies, which are the standard charges for the specific provider and not more than the prevailing charges in the geographical area for identical or similar services taken on In-Patient/day care basis, considering the nature of the Illness/injury involved.

R12. Carry Forward of Unutilized Sum Insured

i. In consideration of additional premium paid, the unutilized In-Patient Treatment Sum Insured of the Policy will be carried forwarded to the next Policy at the Renewal of the Policy, provided that the Policy is renewed with Us without any break. The total accrued carried forward Sum Insured under this Rider shall not exceed 200% of the base Policy Sum Insured.

ii. In policies with a tenure of more than one year, unutilized Sum Insured shall be carried forwarded after completion of each Policy Year subject to maximum of 200% of base Policy Sum Insured.

iii. The carried forward unutilized Sum Insured so accrued will be available only in respect of those Insured Person(s) who were Insured Person(s) in the Policy in the previous year and continue to be Insured Person(s) in the subsequent Policy Year.

iv. For the purpose of computation of unutilized Sum Insured, all claims made under the Base Policy shall be considered and the unutilized Sum Insured will be added to the base Policy Sum Insured of the expiring Policy only. The Restore Benefit amount Sum Insured or the Restore Infinity/Restore Infinity Plus amount (if available/opted in the base Policy/Rider) or any other Cover/Rider offering Sum Insured over and above the base Sum Insured will not be taken into consideration for such computation.

v. Any accrued unutilized Sum Insured can only be utilized for an admissible claim under following indemnity covers of the base Policy, as applicable:

   a. In-Patient Treatment,
   b. Pre/Post Hospitalization Expenses,
   c. Day Care Treatment / Day Care Procedure,
   d. Domiciliary Treatment,
   e. Organ Donor,
   f. AYUSH Benefit,
   g. Ambulance Cover / Road Ambulance Cover,
   h. Consumables Benefit,
   i. Bariatric Surgery Cover
   j. In-Patient Treatment- Dental
   k. Home Care Treatment Cover
   l. Home Physiotherapy

vi. Any accrued unutilised Sum Insured cannot be utilized for an admissible claim under following covers:

a. Global Cover/Global Cover for Planned Hospitalization
b. Maternity Cover
c. Delivery Complications Cover
d. First year Vaccinations
e. Any cover under the base Policy or any cover under Rider which has Sum Insured over and above the base Sum Insured

vii. In case the Sum Insured under the base Policy is reduced at the time of Renewal then the accrued unutilized Sum Insured under this benefit shall be reduced in proportion to the reduced Sum Insured.

viii. Accrued unutilized Sum Insured will lapse if the Policy is not renewed before Policy expiry (including the Grace Period).

ix. If an individual Sum Insured Policy in any manner will be converted into a floater plan, then the highest of the unutilized Sum Insured of individual Insured members will be carried forward to the floater plan.

x. If a floater plan, splits into multiple policies, then the unutilized carried forward Sum Insured of floater plan will be divided in the same proportion same as the proportion of individual Sum Insureds of the split policies.

xi. For the purpose of this benefit, only In-Patient Treatment Sum Insured of the base Policy will be considered for calculating Carry Forward of Unutilized Sum Insured.

xii. Any accrued carried forward unutilized Sum Insured shall be utilized after the base Sum Insured is utilized and prior to Inflation Protect (if applicable).

R13. Voluntary Aggregate Deductible

In consideration of premium discount availed by You, Our liability under the base Policy shall be subject to Aggregate Deductible as specified in the Policy Schedule.

Voluntary Aggregate Deductible, if opted and as specified in the Policy Schedule, shall be applicable on aggregate of final assessed amount of all admissible claims in a Policy Year.

In case of multi-year base Policy (i.e. tenure more than 1 year), such Aggregate Deductible would be applicable per Policy Year.

Aggregate Deductible shall continue for all the subsequent Renewals of the base Policy, provided the base Policy is renewed with Us without any break.

Aggregate Deductible shall be applicable for all indemnity claims under following covers of the base Policy, as applicable:

a. In-Patient Treatment,
b. Pre/Post Hospitalization Expenses,
c. Day Care Procedures/Treatments (as applicable),
d. Domiciliary Treatment,
e. Organ Donor,

f. AYUSH Benefit,
g. Consumables Benefit (if Opted under Base Policy or Rider),
h. Global Cover/Global Cover for Planned Hospitalization/Global Cover,
i. Global Cover for Emergency Hospitalization (if opted under Rider)
j. Bariatric Surgery Cover,
k. In-Patient Treatment- Dental,
l. Home Care Treatment Cover (if opted under Rider)
m. Home Physiotherapy

Aggregate Deductible shall not be applicable for any claim under following covers of the base Policy, as applicable:

a. Ambulance Cover/ Road Ambulance Cover
b. Maternity Cover
c. Delivery Complications Cover
d. First year Vaccinations
e. Mental Wellbeing Rider
f. Additional Sum Insured for Accidental Hospitalization
g. OPD Rider
h. Any cover under the base Policy or any Rider which has Sum Insured over and above the base Sum Insured

For the purpose of this Rider, Aggregate Deductible is an irrevocable cost sharing requirement under this Policy which provides that We will not be liable for a specified amount in aggregate for all claims during the Policy Year.

R14. Waiver of Co-Payment for treatment availed out of Our Network of Valued Provider – Pan India:

In consideration of additional premium paid, Co-Payment applicable for treatment availed out of Our Network of Valued Provider - Pan India, specified in the base Policy shall stand deleted and will not be applicable on the admissible claim under the base Policy.

R15. Voluntary Co-Payment

In consideration of premium discount availed for this Rider, the Insured Person will bear specified Co-Payment as mentioned in the Policy Schedule, for each admissible claim made under the base Policy/Rider which utilizes basic Sum Insured.

Our liability shall be restricted to the balance amount after deducting the applicable Co-payment amount.

For the purpose of this benefit, Co-payment shall be applicable for any and all claims made under following benefits, if covered under the base Policy/Rider or any of the Policy/Rider benefit(s) is utilized towards the claim under the Policy for any of the following:

a. In-Patient Treatment,
b. Pre/Post Hospitalization Expenses,
c. Day Care Procedures/Treatments (as applicable),
d. Domiciliary Treatment,
e. Organ Donor,
f. AYUSH Benefit,
g. Consumables Benefit,
h. Bariatric Surgery Cover
i. Home Care Treatment Cover
j. In-Patient Treatment- Dental
k. Global Cover/Global Cover for Planned Hospitalization
l. Global Cover for Emergency Hospitalization

R16. Sub-Limit on Specified Ailment/Surgical Procedure/Treatment

In consideration of premium discount availed for this Rider, Our liability for any and all claims related to Hospitalization/Day Care Treatment (including their associated Pre & Post Hospitalization expenses) arising out of following ailments/Surgical Procedures shall be restricted to the following Sub-Limits subject to availability of Sum Insured and other terms and conditions of the base Policy.

(Ailment/ Surgical Procedure/Treatment)	Sub limit, as applicable to each Insured Person based on the Sum Insured for Zone A, as defined in the base Policy				
	5 Lacs	7.5 Lacs	10 Lacs	15 Lacs	>=20 Lacs
Cataract Surgery (per eye)	45,000	60,000	90,000	130,000	175,000
Balloon Sinuplasty/FESS	30,000	40,000	55,000	85,000	110,000
Oral chemotherapy	85,000	115,000	165,000	250,000	330,000
Immunotherapy-Monoclonal Antibody all forms	140,000	195,000	275,000	415,000	550,000
Robotic surgeries	140,000	195,000	275,000	415,000	550,000
Stem cell therapy for Hematopoietic stem cells for bone marrow transplant for hematological conditions	140,000	195,000	275,000	415,000	550,000

Total Knee Replacement (per knee)	165,000	175,000	180,000	215,000	230,000
Any type of Hernia Surgery	70,000	75,000	75,000	95,000	100,000
Any type of Hysterectomy	70,000	75,000	75,000	95,000	100,000
Benign Prostate Hypertrophy	70,000	75,000	75,000	95,000	100,000
Stones of Renal System	70,000	75,000	75,000	95,000	100,000
Cerebrovascular & Cardiovascular	275,000	300,000	330,000	360,000	385,000
Cancer	275,000	300,000	330,000	360,000	385,000
Renal Complications & Disorders (excluding Stones of Renal System)	275,000	300,000	330,000	360,000	385,000
Breakage of Bones requiring Surgery under general anesthesia	275,000	300,000	330,000	360,000	385,000

(Ailment/ Surgical Procedure/Treatment)	Sub limit, as applicable to each Insured Person based on the Sum Insured, for Zone B and C, as defined in the base Policy				
	5 Lacs	7.5 Lacs	10 Lacs	15 Lacs	>=20 Lacs
Cataract Surgery (per eye)	40,000	56,000	80,000	120,000	160,000
Balloon Sinuplasty/FESS	25,000	35,000	50,000	75,000	100,000
Oral Chemotherapy	75,000	105,000	150,000	225,000	300,000
Immunotherapy-Monoclonal Antibody all forms	125,000	175,000	250,000	375,000	500,000
Robotic Surgeries	125,000	175,000	250,000	375,000	500,000
Stem cell therapy for Hematopoietic stem cells for Bone Marrow Transplant for hematological conditions	125,000	175,000	250,000	375,000	500,000

Total Knee Replacement (per knee)	150,000	157,000	165,000	195,000	210,000
Any type of Hernia Surgery	65,000	68,000	70,000	85,000	90,000
Any type of Hysterectomy	65,000	68,000	70,000	85,000	90,000
Benign Prostate Hypertrophy	65,000	68,000	70,000	85,000	90,000
Stones of Renal System	65,000	68,000	70,000	85,000	90,000
Cerebrovascular & Cardiovascular	250,000	275,000	300,000	325,000	350,000
Cancer	250,000	275,000	300,000	325,000	350,000
Renal Complications & Disorders (excluding Stones of Renal System)	250,000	275,000	300,000	325,000	350,000
Breakage of Bones requiring Surgery under general anesthesia	250,000	275,000	300,000	325,000	350,000

For the purpose of this Rider, Sub-limit means a cost sharing requirement under a health Insurance Policy in which We would not be liable to pay any amount in excess of the pre-defined limit.
Mandatory/Voluntary Co-payment, as applicable under the base Policy shall not be applicable on claim incurred for these surgical procedures.

In case more than one Sub-Limit is applicable to an ailment/procedure, covered under the Policy, then the highest of applicable Sub-Limits, shall be considered.

In case of any Sub-Limit on Specified Disease is also applicable for the same Ailment/Surgical Procedure/Treatment under the base Policy, then the lowest of applicable Sub-Limits shall be considered.

R17. Introduction of Higher Zone Co-Payment

If the Insured Person(s) undergoes medical treatment at a Hospital / Day Care Centre / AYUSH Hospital in Zone A as defined in the base Policy, then an additional Co-Payment as specified in the Policy Schedule will be applicable on each such claim.

Higher Zone Co-Payment shall be applicable for all claims except for claims for emergency Hospitalization due to Injury arising from an Accident. Higher Zone Co-Payment shall not be applicable for benefits which are over and above the Sum Insured in the underlying base Policy.

R18. Preventive Annual Health Check-Up Rider

In consideration of additional premium paid and notwithstanding the exclusion mentioned under base Policy with respect to all preventive care including Health Check-ups, vaccination including inoculation and immunizations, and at the request of the Insured Person, We/Our empanelled Service Provider will arrange for the medical tests as specified in the Policy Schedule every Policy Year provided the Policy is in force with Us. The Health Check-Ups shall be arranged by Us only on cashless basis either at Our empanelled service providers or at Insured Person's residence, as per availability. Health Check-Up will be available for all Insured Persons covered under the Policy irrespective of claim. Check-ups under this benefit can be availed once in a Policy Year.

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

R19. Emergency Assistance Services

In consideration of additional premium paid for this Rider and in the event Insured Person suffers an injury due to an accident during the Policy Period, then We/Our empanelled Service Provider will arrange for the below mentioned emergency services as a part of emergency assistance service to the Insured Person.

a) First Aid Services – On the Spot
b) Ambulance Service/Transportation to hospital
c) Tele/Video consultation – On the Spot
d) Resuscitation aid – On the Spot
e) Assistance for appointment booking at hospital
f) Assistance to coordinate with insurance for claim processing
g) Accommodation assistance after first aid services, if required.
h) Location alert to an immediate family member
i) Assistance in case of Medical Legal Case
j) Emergency Medical Payments assistance - Arrangement of cash advancement
k) Investigation/diagnostic test assistance – Arranging Emergency Diagnostics Logistics
l) Emergency Pharmacy Delivery
m) Assistance in Repatriation of mortal remains

The cost of the service will be borne by the Insured Person.

R20. Reduction in Pre-Existing Disease Waiting Period

In consideration of additional premium paid and notwithstanding anything to the contrary in the base Policy, the applicable waiting period as mentioned in the base Policy under 'Pre-existing Diseases Waiting Period (Code- Excl 01)', shall be modified to the time period as specified in the Policy.

R21. Reduction in Specific Disease/Procedure Waiting Period

In consideration of additional premium paid and notwithstanding anything to the contrary in the base Policy, the applicable waiting period as mentioned in the base Policy, under 'Specific Disease/Procedure Waiting Period (Code-Excl 02) shall be modified to the time period as specified in the Policy.

R22. Increase in Pre-Existing Disease Waiting Period

In consideration of premium discount availed and notwithstanding anything to the contrary in the base Policy, the applicable waiting period as mentioned in the base Policy under 'Pre-existing Diseases Waiting Period (Code- Excl 01)', shall be modified to the time period as specified in the Policy.

R23. Increase in Specific Disease/Procedure Waiting Period

In consideration of premium discount availed and notwithstanding anything to the contrary in the base Policy, the applicable waiting period as mentioned in the base Policy, under 'Specific Disease/Procedure Waiting Period (Code-Excl 02) shall be modified to time period as specified in the Policy.

R24. Room Eligibility Modification

In consideration of premium discount availed, the Room entitlement in the base Policy stands modified to the limit/category as specified in the Policy Schedule under this Rider.

However, if the Insured Person is admitted in a room which is of higher category than entitled Room, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon), except pharmacy charges, diagnostic costs, costs of implants & medical devices and consumables expenses, in the proportion as specified below:

Expenses to be borne by Insured Person = {(Associated Medical Expenses) X (Incurred Room Rent– Eligible Room Rent of the Eligible Room Category)} / Incurred Room Rent.

For the purpose of this Rider, "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 Hospitals which do not follow differential billing or for those Associated Medical Expenses in respect of which differential billing is not adopted based on the room category.

R25. Premium Waiver Benefit

In consideration of additional premium paid and in case, the Policyholder who is also an Insured Person under the base Policy suffers Death due to an injury caused by an Accident, within 365 days from the date of the accident or if he/she is diagnosed with a Cancer of Specified Severity, then We will pay the premium (including Optional covers, Riders and Taxes as opted in the expiring Policy) for a Policy Year at subsequent renewal, and the Policy shall be renewed for a Policy tenure of 1 year. The premium shall be paid only towards the other Insured Persons covered under the expiring base Policy in the year of the above-mentioned event. In case of any change in base Policy benefits or new member addition (other than new born baby or newly wedded spouse), the difference in premium will be borne by the Policyholder.

Once a claim has been accepted and paid under this Rider, this cover will automatically terminate in respect of that Insured Person.
Any claim under this Rider will not impact the Sum Insured, Cumulative Bonus/Supercharge Bonus (As applicable and if opted), accrued Inflation Protect Sum Insured (if opted), and Carry forward of unutilized Sum Insured (if opted).

The cover is available subject to below conditions:

- If only one person is covered under the base Policy, the Policy shall terminate in case of death of the Policyholder.
- There is no change in covers or Sum Insured enhancement or benefit structure or limits or conditions applicable under the base Policy, at the time of renewal.
- In case of a base Policy with existing tenure of 2 or 3 years, it will be renewed only for one year, provided all covers, optional covers, Riders' terms and conditions, benefits and coverage limits remain same.

For the purpose of this cover, 'Cancer of Specified Severity' is defined as the following:

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
II. The following are excluded –
    i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or noninvasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.
    ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
    iii. Malignant melanoma that has not caused invasion beyond the epidermis;
    iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
    v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
    vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs.

R26. Health Condition Management Program

In consideration of additional premium paid, We/Our empanelled Service Provider will arrange for consultative services related to health conditions/Illnesses with the objective of maintaining good health and improving it through various health condition management programs including but not limited to nutrition management, weight management, chronic condition management, cancer care assistance program, stress management, health coach offered by Us.

Consultative services will be provided through various specified modes of communication including in-person, audio, video, online portal, chat, digital customer application or any other digital mode.

R27. Waiver of Age-Linked Co-Payment

In consideration of additional premium paid the Age-Linked Co-Payment applicable in the base Policy shall stand deleted and will not be applicable on the admissible claim under the base Policy.

R28. Extension of Pre-Hospitalization Expenses Cover

In consideration of additional premium paid the expenses for Pre-Hospitalization consultations, investigations and medicines incurred under the base Policy shall be extended up to the number of days as specified in the Policy Schedule.

R29. Extension of Post-Hospitalization Expenses Cover

In consideration of additional premium paid the Post-Hospitalization Expenses consultations, investigations and medicines incurred under the base Policy shall be extended upto the number of days as specified in the Policy Schedule.

R30. Instalment Facility

In consideration of additional premium paid, the premium payment frequency shall be modified to the frequency as specified in the Policy Schedule.

The following conditions shall apply (notwithstanding any terms contrary elsewhere in the base Policy):

a. The Grace Period for payment of the premium during the Policy Period, for instalment premium shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases (Annually (for multi-year Policy) / Half-Yearly / Quarterly)

b. Coverage during such Grace Period:
   - Within the Policy Period coverage will be available from the due date of instalment premium till the date of receipt of premium by Company within the Grace Period.
   - At the end of the Policy Period - the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in Policy. Coverage is not available during the Grace Period after the end of the Policy Period.

c. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.

d. No interest will be charged if the instalment premium is not paid on due date.

e. In case of instalment premium due but not received within the Grace Period, the Policy will get cancelled.

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

g. The Company has the right to recover and deduct all the pending instalments from the claim amount due under the Policy.

This Rider endorsement will form part of Your base Policy. Rest of the terms/conditions of the base Policy shall remain unchanged.

R31. Limited Payment Facility

In consideration of additional premium paid, the premium payable for the Policy Period shall be allowed to be paid for a specific duration of the Policy tenure in parts as specified in the Policy Schedule. However, this does not affect the coverage period of the Policy.

The following conditions shall apply (notwithstanding any terms contrary elsewhere in the base Policy):

a. The Grace Period for payment of the premium during the Policy Period, for limited payment facility shall be fifteen days.

b. Coverage during such Grace Period:
   i. Within the Policy Period - coverage will be available from the due date of such premium till the date of receipt of premium by Company within the Grace Period.
   ii. At the end of the Policy Period - the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in Policy. Coverage is not available during the Grace Period after the end of the Policy Period.

c. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.

d. No interest will be charged if the such premium is not paid on due date.

e. In case of such premium due but not received within the Grace Period, the Policy will get cancelled and premium will be refunded on pro rata basis and after deducting administrative costs (if any), subject to no claims under the Policy.

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

g. The company has the right to recover and deduct all the pending payments from the claim amount due under the Policy.

This Rider endorsement will form part of Your base Policy. Rest of the terms and conditions of the base Policy shall remain unchanged.

R32. Reduction of Maternity Benefit Waiting Period

In consideration of additional premium paid and notwithstanding anything to the contrary in the base Policy, the applicable Maternity Cover Waiting Period as mentioned in the base Policy shall be modified to the time period as specified in the Policy Schedule.

R33. Double Sum Insured for Maternity Cover

In consideration of additional premium paid, the 'Maternity Cover' limit specified under the base Policy shall be applicable to each baby when more than one baby is born in a single event of delivery.

Illustration:

Policy Sum Insured: ₹ 10 Lakhs
Maternity Cover: ₹ 50,000 (₹ 60,000 for Girl Child)
In case of delivery of twins, the Maternity Cover limit: ₹ 50,000 per child i.e., ₹ 1,00,000 (In case of two girl child: ₹ 1,20,000 or in case of one boy and one girl child: ₹ 1,10,000)

R34. Introduction of Valued Provider Network

If this Rider is opted, then We shall offer discount in premium of the base Policy subject to a condition that the Insured Person shall avail treatment within Our network of "Valued Provider-Pan India".

Any treatment availed outside Our network of "Valued Provider-Pan India" shall attract a Co-Payment of 30% for each such claim, resulting from admission of the Insured Person in a Hospital / Day Care Centre / AYUSH Hospital. This Co-payment shall only be applicable for claims under covers which utilizes base Sum Insured (in-patient treatment Sum Insured) of the base Policy. 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:

- In-Patient Treatment, Day Care Treatment, Organ Donor, AYUSH Benefit, Bariatric Surgery Cover, In-Patient Treatment- Dental, Maternity Cover, Delivery Complications Cover, First year Vaccinations and Consumables Benefit as applicable in the base Policy; and
- Cumulative Bonus, Restore Benefit, Restore Infinity, Restore Infinity Plus, Inflation Protect, Supercharge Bonus, Carry forward of unutilized Sum Insured benefits as applicable in the base Policy, if utilized for payment of claim under aforementioned sections.

For the Purpose of this Rider, 'Valued Provider - Pan India' is a specific network of Hospitals, designated as such and mentioned in the Policy Schedule. It consists of a defined list of Hospitals or health care providers enlisted by Us, and/or TPA to provide medical services to an Insured Person by a Cashless Facility. Where the Policyholder has selected this Rider, You shall be eligible only for 'Valued Provider -Pan India' and reference made to 'Network Provider' in the base Policy wordings shall be substituted with 'Valued Provider - Pan India. The updated list of Valued Provider – Pan India is available on Our website **(www.tataaig.com)**.

R35. Accidental Death Benefit Rider

In consideration of additional premium paid for this Rider, if this Rider is opted and in case 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 100% of the Sum Insured as mentioned under this Rider against the respective Insured Person in the base Policy Schedule. This benefit is not applicable for Insured Children or Insured Person less than 18 years of Age as on base Policy commencement date. This benefit has a separate limit (over and above base Sum Insured).

Once a claim has been accepted and paid under this Rider then all opted Riders/optional covers and the base Policy will automatically terminate in respect of that Insured Person.

Specific exclusions applicable to this Rider:

- Where the Insured Person is under the influence of intoxicating liquor or drugs or other intoxicants, except where the Insured Person is not directly responsible for the injury/accident though under influence of intoxication
- Insured Person committing or attempting to commit an illegal activity or violation of law

Claim Documentation:

a. Duly completed claim form
b. Nominee-attested copy of Death Certificate
c. Nominee-attested copy of Post Mortem Report, wherever applicable and conducted
d. Duly completed claim form Nominee-attested copy of Death Certificate
e. Nominee-attested copy of Death Summary or all Medical records, if treated in hospital
f. Nominee-attested copy of news paper cutting, if any
g. Nominee-attested copy of KYC documents with NEFT details of nominee and CKYC form (attached)

R36. Permanent Total Disability Benefit Rider

In consideration of additional premium paid, if an Insured Person suffers an Accident during the Policy Period and this accidental injury results in You suffering Permanent Total Disability, then We will pay the 100% of the Sum Insured as mentioned under this Rider against the respective Insured Person in the Policy Schedule provided:

- The Functional Loss is within 365 days from the date of Accident which caused the Injury.
- This clause is however not applicable for immediate Dismemberment cases.
- Permanent Total Disability is certified by a Medical Practitioner and has continued for a period of 365 days and is total, continuous and permanent at the end of this period.

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

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

With respect to the above, loss means physical separation of the body part, or the total loss of functional use provided this has continued for at least twelve (12) months from the onset of such disablement and provided further that We are satisfied based on a written confirmation by a Medical Practitioner at the expiry of the twelve (12) months that there is no reasonable medical hope of improvement.

Specific conditions applicable to this benefit:

- Once a claim has been accepted and 100% of the Sum Insured as specified in the Policy Schedule has been paid under this Rider, then this Rider shall immediately and automatically cease in respect of that Insured Person.
- This benefit is not applicable for Insured Children or Insured Person less than 18 years of Age as on base Policy commencement date.
- This benefit has a separate limit (over and above base Sum Insured).

Specific Exclusions applicable to this Rider

This Rider does not provide benefits for any loss resulting from:

i. An accident that do not occur within the Policy Period
ii. Ionising radiation or contamination by radioactivity from any nuclear waste from combustion of nuclear fuel; or the radioactive, toxic, explosive or other hazardous properties of any explosion nuclear assembly or nuclear component, thereof
iii. Asbestosis or other related sickness or disease resulting from the existence, production, handling, processing, manufacture, sale, distribution of asbestos or other products thereof.
iv. Participation in any Professional Sports which remunerates in excess of 50% of the Insured Person's annual income as a means of their livelihood
v. Being under the influence of intoxicating liquor or drugs or other intoxicants except where the insured is not directly responsible for the injury / accident though under influence of intoxication
vi. Whilst engaging in Adventure Sports, where Adventure Sports means Recreational activities perceived as involving a high degree of risk. These activities involve speed, height, a high level of physical exertion, and highly specialized gear.
vii. Whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or traveling in any balloon or aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world
viii. Infections (except pyogenic infections which shall occur through an Accidental cut or wound) or any other kind of Disease;
ix. Insured Person committing or attempting to commit an illegal activity or violation of law

Claim Documentation

a. Completed Claim Form.
b. Competent Medical Authority / Doctor like Civil Surgeon, confirming the Disability percentage / period and prognosis for Permanent Total Disability.
c. Self-attested copy of FIR, if filed / Police Panchnama, if conducted.
d. Self-attested copy of Discharge Summary or all Medical records Self-attested copy of news paper cutting, if any.
e. Self-attested copy of KYC documents with NEFT details of nominee and KYC form.

R37. In-Patient Hospital Cash Rider

In consideration of additional premium paid We will pay a Fixed Daily Cash Benefit subject to deductible (number of days) as specified in the Policy Schedule for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person due to an Illness or injury during the Policy Year, provided that:

i. This benefit will be available up to the number of days specified in the Policy Schedule.
ii. On the day of discharge, when Insured Person is discharged before completion of consecutive 24 hours of Hospitalization but after the completion of 12 hours, We shall pay 50% of daily cash benefit.
iii. The Hospitalization claim is payable under in-patient treatment cover of the base Policy for the same Hospitalization.
iv. This benefit has a separate limit (over and above base Sum Insured).

R38. Worldwide Hospital Cash Benefit Rider

In consideration of additional premium paid if an Insured Person avails treatment outside India, during the Policy Period, We will pay a fixed daily cash amount, subject to deductible (number of days) as specified in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalization provided that:

i. The In-Patient Hospitalization claim is admissible under Global Cover for Planned Hospitalization/Global Cover (as applicable in the base Policy), for the same Hospitalization.
ii. This benefit will be available up to the number of days specified in the Policy Schedule.
iii. On the day of discharge, when Insured Person is discharged before completion of consecutive 24 hours of Hospitalization but after the completion of 12 hours, We shall pay 50% of daily cash benefit.
iv. This benefit has a separate limit (over and above base Sum Insured).

R39. ICU Cash Benefit Rider

In consideration of Additional premium paid, if the Insured Person is hospitalized in an Intensive Care Unit (ICU), We will pay a daily cash benefit for each continuous and completed 24 Hours of Hospitalization in an Intensive Care Unit (ICU), for Medically necessary treatment of the Insured Person provided that:

i. This benefit will be available up to the number of days specified in the Policy Schedule.

ii. On the day of discharge/transfer from ICU, when Insured Person is discharged/transferred from ICU before completion of consecutive 24 hours of Hospitalization but after the completion of 12 hours, We shall pay 50% of daily cash benefit.

iii. The Hospitalization claim is payable under In-Patient Treatment Cover of the base Policy for the same Hospitalization.

iv. This benefit has a separate limit (over and above base Sum Insured).

R40. Accidental Hospitalization Cash Benefit Rider

In consideration of additional premium paid if an Insured Person is hospitalized due to an injury, We will pay a daily cash benefit for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person provided that:

i. This benefit will be available up to the number of days specified in the Policy Schedule.

ii. On the day of discharge, when Insured Person is discharged before completion of consecutive 24 hours of Hospitalization but after the completion of 12 hours, We shall pay 50% of daily cash benefit.

iii. The Hospitalization claim is payable under In-Patient Treatment Cover of the base Policy for the same Hospitalization.

iv. This benefit has a separate limit (over and above base Sum Insured).

R41. Accidental Hospitalization ICU Cash Benefit Rider

In consideration of additional premium paid if an Insured Person is hospitalized due to an injury, We will pay a daily cash benefit for each continuous and completed 24 Hours of Hospitalization in an Intensive Care Unit (ICU), for Medically necessary treatment of the Insured Person provided that:

i. This benefit will be available up to the number of days specified in the Policy Schedule.

ii. On the day of discharge/transfer from ICU, when Insured Person is discharged/transferred from ICU, before completion of consecutive 24 hours of Hospitalization but after the completion of 12 hours, We shall pay 50% of daily cash benefit.

iii. The Hospitalization claim is payable under in-patient treatment cover of the base Policy for the same Hospitalization.

iv. This benefit has a separate limit (over and above base Sum Insured).

R42. Prolonged Hospital Cash Benefit Rider

In consideration of additional premium paid We will pay a fixed amount as specified in the Policy Schedule, subject to below conditions:

- The Insured Person is admitted in a hospital at Our Network Provider, during a Policy Year, and
- Purpose of admission is to avail Medically Necessary Treatment for a disease/illness/injury covered under the Policy, and
- Hospitalization is for a continuous period exceeding 10 days.

This benefit is over and above the base Sum Insured and can be availed only once per Policy Year, provided that the Hospitalization claim is admissible under In-Patient Treatment Cover of the base Policy.

R43. Health Risk Assessment Rider

We/Our empanelled Service Provider will arrange for a Health Risk Assessment (HRA) questionnaire, which is an online tool for evaluation of status of health and quality of the Insured Person's life. This Health Risk Assessment will enable Insured Person(s) to review their lifestyle practices for improving their health.

You may also log into your account on our Customer Application for undertaking Health Risk Assessment. You will get assessment report on completion of Health Risk Assessment.

R44. Wellness Program Rider

We/Our empanelled Service Provider will provide a wellness program designed to promote wellness and fitness amongst the Insured Person(s). This wellness program is structured to reward the Insured Person in the form of measurable wellness score for the prescribed physical efforts/fitness activity undertaken by such Insured Person during the Policy Period. This is a voluntary program available for Insured with age above 18 years, at the start of the Policy Year. It is advisable to the Insured Person to consult his/her physician before starting any physical exercise/activity.

It is a pre-condition for enrolment under this wellness programme, that the Insured Person should have undergone the health risk assessment as specified below and depending on the outcome from health risk assessment, the wellness reward and its scoring should be administered. The earnings under the wellness program are linked to your wellness category and shall be valid for one year from the date of credit of daily score in Insured Person's wellness account, provided the Rider is renewed within the Grace Period. Daily score will be credited after the completion of a healthy day.

For the purpose of understanding if the daily score is credited on 1st Jan 2023, it will be valid up to 31st Dec 2023.

1) **Health Risk Assessment:**

   We/Our empanelled Service Provider will provide a Health Risk Assessment (HRA) questionnaire, which is an online tool for evaluation of status of health and quality of the Insured Person's life. This tool helps Insured Persons to review their lifestyle practises which may impact their health status.

   To undertake the health risk assessment, you can log into your account on our customer application. This can be undertaken once a Policy Year.

   On completion of the health risk assessment and based on the Insured Person's assessment results, We/Our empanelled Service Provider will identify the wellness category in which the Insured Person falls in.

   Wellness categories for this purpose are defined as below:

   - Green - Low risk for developing lifestyle disease as compared to peers in the same age and gender group.
   - Yellow - Moderate risk for developing lifestyle disease as compared to peers in the same age and gender group.

- Red - Higher risk for developing lifestyle disease as compared to peers in the same age and gender group.

The overall wellness category is valid till the expiry of the Policy Year in which the Insured undergoes the assessment and will be updated based on HRA results of subsequent assessment undergone by the Insured Person in each consecutive Policy Year, subject to renewal of the Rider within the Grace Period. In the event of a long-term Policy (greater than 1 year) the Insured has to undergo HRA in each Policy Year to be eligible for wellness rewards. If the Insured does not undergo assessment in the consecutive Policy Year, henceforth no rewards will be earned for any physical activity undertaken. However, earned rewards will be carried forward till its validity and will be available for utilisation.

2) Wellness Rewards:

Mechanism to Earn Wellness Reward:

We will encourage physical exercise and fitness and recognise the effort by rewarding the Insured Person on daily basis for each healthy day.

A healthy day can be earned by undertaking below activity on a calendar day:

1. Recording 10,000 steps / day# in the activity tracking apps or fitness tracker devices as prescribed by the company or our Empanelled Service Provider: or
2. Burning 500 calories or more in a day through activity as measured by fitness tracker devices.

The Company may at its discretion change the above criteria and the same would be mentioned in the Policy Schedule/Customer Application.

Wellness reward will be earned depending on the wellness category of the Insured Person and as per the grid below:

	Wellness category		
	Green	**Yellow**	**Red**
Rewards per Healthy Day	10	7	5

Note:

- HRA registration will be allowed anytime during the Policy Year and healthy activities will be tracked throughout the Policy Year, however, for each Policy Year, activities completed in first 300 days of the Policy Year will be considered for reward in the same year, activities completed on or after 301st day of the Policy Year will be carried forward to the next Policy Year and will be available for utilisation in the next year provided the Policy has been inforce or renewed with Us without any break within the Grace Period.
- In case of individual Policy, each Insured Person would be tracked separately and shall earn wellness reward based on one's own individual performance/physical activity as per the grid above.

- In case of family floater Policy, each Insured Person, with age above 18 years, at the start of the Policy Year, would be tracked separately and shall earn wellness reward based on one's own individual performance/physical activity as per the grid above. In order to compute the wellness reward for such Policies, average of individual performance rewards would be considered for computation of wellness reward.
- #The Company may also use alternative measurement criteria in lieu of steps and calories burnt and the same shall be mentioned on the Policy Schedule.
- Data entered manually in the fitness tracking apps or devices will not be considered for tracking healthy day.
- Calories burnt during basic metabolism shall not be considered for tracking healthy day (here basic metabolism refers to activities done while at rest to maintain vital functions such as breathing and keeping warm etc.)

Mechanism to Utilize Wellness Reward:

Wellness Reward accumulated through fitness activities can be converted into monetary value as per method defined below and can be utilized towards the payment of services/items under below categories, available through our Network / empanelled Service Provider:

- OPD Consultation/Treatment
- Pharmaceuticals
- Health Check-ups/Diagnostics
- Health Supplements
- Coverage of cost of treatment of any admissible claim in respect of non-payable items that are specified under the terms and conditions of the base Policy
- Or any other items as prescribed by the Company or Our empanelled Service Provider as approved by the Regulator as a redeemable item from time to time

Note:

- Wellness Reward can be converted into a monetary value after every Healthy Day, during the Cover Period.
- Monetary value of the Wellness score earned is equivalent to the:

  Wellness score earned X (Per year Policy Premium without Taxes/ 10,000).

  - In case of Policy with tenure more than one year, 'per year Policy Premium without Taxes' = (Total Policy premium without tax, for the tenure/Policy tenure).
  - In case of family floater Policy, reward will be calculated on average premium per person which is equivalent to the Total Policy premium without tax/number of Insured Persons covered in the Policy on floater basis.

Illustration:

Age of the Insured Person (Years)	40
Sum Insured opted under the Policy (₹)	5 Lacs
Plan Type	Individual
Policy Tenure (years)	1
Total number of members covered under the Policy	1
Net Premium paid (without Tax)	7931
Wellness Category (post Health Risk Assessment)	Green

Healthy Day	Wellness Reward earned (per day)	Wellness Reward converted to Monetary Value (per day)	Wellness Reward credited after Healthy Day	Wellness Reward valid up to 365 days (provided the Policy is active and Insured is covered)
1 to 300 day	10	7.931	Date of credit of Wellness score	365 days from the Date of credit of Wellness score
301 day onwards	10	7.931	Date of Policy Anniversary - in case of Multi year Policy Date of renewal - in case of 1 yr Policy	365 days from: - Date of Policy Anniversary - in case of Multi year Policy - Date of renewal - in case of 1 yr Policy, as applicable
Maximum Total in a Policy Year		2894.82		

Steps to register for Wellness Program and earn & spend Wellness Rewards

Step 1. Register yourself on customer application

- The Insured Person will download TATA AIG customer application on your device and complete registration process by providing Policy and Insured Person's details.

Step 2. Complete health risk assessment

- Submit response to the online health questionnaire on your device.
- On completion of the health risk assessment, a Wellness category will be assigned to the Insured Person for the Policy Year and will be updated based on the latest health risk assessment in next Policy Year.

Step 3. Comply with mechanism to earn Wellness Rewards

- We will track the physical exercise and fitness activities completed by the Insured Person, through the customer app.
- Activities completed on a calendar day will be considered as a Healthy Day and reward will be credited to Insured Person's wellness account.

Step 4. Convert Healthy Day into monetary value and spend

- Insured Person will have an option to convert the accumulated rewards into the monetary value and spend it on items/services offered under the Policy.
- The unutilized rewards will be carried forward to next Policy Year till this Policy is renewed with us within Grace Period and is in force subject to validity period of the reward point

R45. Rider for Discounts from Network Providers

We will offer discounts on diagnostic tests, medicine, medical devices, health supplements and other health related services offered through our empanelled Service Providers. Home delivery of pharmacy will also be offered upon the request of the Insured Person, wherever available.

R46. Global Cover for Emergency Hospitalization

In consideration of additional premium paid, We will cover for Reasonable and Customary Charges in respect of the covered Medical Expenses of the Insured Person while the Insured Person is travelling outside India and suffers an Injury or is diagnosed with an Illness leading to an Emergency condition that require Medically Necessary Hospitalization in Emergency Care outside India, upto the Sum Insured & subject to waiting period as specified in the Policy and following conditions:

i. Insured Person must be resident of India and travel outside India must commence after the Policy inception date supported by passport, visa and other travel documents.

ii. Any claim under this benefit shall be payable only if the treatment is Medically Necessary and has been certified as an Emergency by a Medical Practitioner, where such treatment cannot be postponed until the Insured Person has returned to India. The Medical Expenses payable shall be limited to In-Patient and Day Care Hospitalization.

iii. The treatment for these emergency measures would be paid till the Insured Person becomes medically stable. All further medical cost(s) to maintain medically stable condition or to prevent the onset of acute pain would be borne by the Insured Person.

iv. Expenses incurred for Pre and Post Hospitalization Expenses, Out-Patient Treatment or any other base Covers / Optional Cover(s) / Riders under the Policy shall be excluded from the scope of this cover.

v. Only the balance base Policy Sum Insured will be available for claim under this benefit. Any accrued bonus and/or Sum Insured accrued under Inflation Protect Rider and/or any restored Sum Insured, cannot be utilized for claim under this benefit.

vi. Any claim under this cover can be made only on reimbursement basis. Cashless facility may be arranged on case-to-case basis. Insured person may contact us for claim assistance.

vii. The treatment should be taken in a registered Hospital, as per law, rules and/or regulations applicable to the country, where the treatment is taken.

viii. The payment of claim under this benefit will be in Indian Rupees based on the rate of exchange published by Reserve Bank of India (RBI), as on the date of invoice and shall be used for conversion of foreign currency into Indian Rupees for claims payment. If these rates are not published on the date of invoice, the exchange rate next published by RBI shall be considered for conversion.

ix. The coverage is available for 45 consecutive days from the date of travel from India in a single trip and 90 days on a cumulative basis in a Policy Year. Any expenses incurred beyond 45 days from date of travel shall not be covered in any case.

x. There is no separate Sum Insured for this Rider and any claim triggered under this Rider shall reduce the Sum Insured of the base Policy.

xi. Specific Exclusions Applicable to this Rider:

a. Any planned treatment or where the Insured Person is travelling for the purpose of obtaining treatment.

b. Treatment or part of treatment for any condition which is not life threatening in nature and can be safely postponed till the Insured Person's return to India.

c. Where the Insured Person is travelling against the advice of a Physician/Medical Practitioner or receiving or on a waiting list for receiving specified medical treatment or has received a terminal prognosis for a medical condition.

d. The Insured Person whilst being under the influence of intoxicating liquor or drugs or other intoxicants, suffers Injury / Accident, except where the Insured Person is not directly responsible for the Injury / Accident though under influence of intoxication.

e. Where the Insured Person is operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft or the Scheduled Airline.

f. Any treatment of Orthopaedic Diseases or conditions except for fractures, dislocations and/or Injuries suffered during the Policy Period.

g. Treatment towards Oncological (Cancer) diseases.

h. Any claim under this benefit due to the pregnancy of the Insured Person including resulting childbirth, miscarriage, abortion or complication of any of these.

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

j. In case of any territorial restriction laid by the Government of India, We will not pay the expenses incurred for such Hospitalization.

k. Expenses incurred in connection with weak, strained, or flat feet, corns, calluses, or toenails.

l. Surgical treatment undertaken for correction of Deviated nasal septum, including sub mucous resection and/or other surgical correction thereof, except as the result of Accident.

m. Child care including general medical examination and immunizations.

n. Any expenses incurred in India unless specifically covered elsewhere in the Policy.

o. Bone marrow transplants in blood disorders.

p. Stem cell implantation/Surgery, harvesting, storage or any kind of treatment using stem cells.

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

Disclaimer Clause

1) Availing the services under this Rider is upon the Insured Person's sole discretion and risk.
2) For services that are provided through empanelled Service Providers, We are acting as a facilitator; hence 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 action, claim, demand, loss, damage, cost, 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/Network Provider under this Policy.
4) Insured Person may consult any medical/ service professional at any Network Provider/empanelled Service Provider at his/her sole discretion. The cost of service arising out of insured Person choice of medical professional at any Network Provider/empanelled Service Provider shall be completely 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/service 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 the recommendation after seeking consultation.
7) Any advice, recommendation or suggestion made by any medical/service professional shall be solely based on the information and documentation provided by the Insured Person to such medical/service 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/service professional from whom We have availed services or taken benefit or for any consequence of any act or omission in reliance

thereon.

8) Any discount offered under Redeemable voucher/Discount on services by our empanelled Service Providers are subject to modification or withdrawal. We do not assume any liability towards the quantum of discount, quality of product/services and timeline within which the product/service is rendered.

9) 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.

10) 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**).

11) Any service availed by the Insured Person under these Benefits will not impact Cumulative Bonus under the Base Policy, if applicable.

12) We reserve the right to change any Service Provider during the currency of the Policy or at renewal. The same shall be intimated to the Insured Person atleast 15 days prior to the effective date of change. During such change, all the credits earned by the insured Person shall be transferred to the new Service Provider.

13) 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.

14) 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.

15) The above-mentioned assistance services are purely on referral or arrangement basis, We/Our empanelled Service Provider shall not be responsible for any third party expenses incurred and it shall be the responsibility of the Insured Person.