Prospectus

1. Suitability:

a. This policy covers persons in the age group 5 years onwards (Dependent children between 91 days and 5 years can be insured only when both parents are getting insured). The maximum entry age is 65 years which is relaxed subject to following conditions:
   a. Parent/Parents-in-law above the age of 65 years will become eligible for this product provided
      i. the proposer is also an existing policyholder under any other indemnity Health Insurance of company where lives below 65years are covered
      ii. If under the same proposal lives below age of 65 years are also proposed and get accepted post underwriting

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

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

d. This policy can be issued to an individual and/or family.

e. The family includes spouse and economically dependent children and parents/parents-in-laws.

f. The policy offers coverage on family floater basis.

g. Maximum 7 members of a family are covered in one Individual Plan Policy (Self, spouse, 3 dependent children , 2 parents & 2 parents-in-laws).

h. Maximum 7 members are covered in one Family Floater Plan policy (Self, spouse, 3 dependent children (Up to the age of 25 Years) , 2 parents & 2 parents-in-law. In case of family floater, where age of the dependent child is crossing 25 years, the child can be covered under a separate policy with eligible continuity benefit.

2. Key Benefits:

i. **Range of benefits:** Indemnity based health insurance cover with range of benefits without any sub-limit unless otherwise mentioned.

ii. **Network of hospitals:** We are equipped to offer you quality health care with our strong network of 4000+ hospitals across India.

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

iv. **Global Cover:** We will cover Medical Expenses of the Insured Person incurred outside India, upto the sum insured provided that the diagnosis was made in India and the insured travels abroad for treatment.

v. **Bariatric Surgery Cover-** Covers reasonable and customary expenses for Bariatric surgery if the insured fulfills listed conditions as mentioned in the policy.

vi. **Sum Insured Restore Benefit:** If Your Sum Insured including cumulative bonus is completely utilized during the policy period, an additional amount equivalent to the base Sum Insured will be restored once during the policy period and can also be used

for admissions due to related illness/diseases after 45 days from the date of discharge of the earlier claim . This benefit cannot be carried forward to subsequent renewals.

1. **Consumables Benefit-** We will pay for expenses incurred, for specified consumables listed in 'Annexure – 1 List 1 as Optional Items (Consumables Benefit)' which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I-Optional items (Consumables Benefit) are available on our website (www.tataaig.com)

vii. **Wellness Services:** We/Our Empanelled Service Providers will provide you with the below mentioned Wellness services that are designed to assist you in maintaining and improving your health and fitness

- **Teleconsultation–General Physician**: We /Our empanelled Service Provider will arrange for 8 teleconsultations on your request through telecommunication and digital communication technologies for your health related complaints or preventive health care by a qualified Medical Practitioner.
- **Ambulance Booking facility:** We / Our empanelled Service Provider will provide a facility to book a road ambulance in India for transportation to a Hospital for admission or from one hospital to another hospital for better medical facilities and treatment.

viii. **Cumulative bonus/No Claim Discount**: You have the option to choose between Cumulative Bonus and No Claim Discount. If you choose Cumulative Bonus, sum insured will increase by 50% for every claim free policy year subject to maximum of 100% of sum insured. In case a claim is made during the policy year, the cumulative bonus would reduce by 50% in the following year. Cumulative Bonus shall be provided only if No Claim Discount has not been availed for the claim free previous Policy Year. If you Choose No Claim Discount, We will allow 1% discount on renewal premium for every claim free Policy Year, provided that the Policy is renewed with Us without break.

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

3. Discounts on premium:

i. 10% long term discount on premium in case insured opts policy term of 3 years
ii. 5% long term discount on premium in case insured opts policy term of 2 years
iii. Family floater discount on premium:
- 2 members -20%
- 3 members -28%
- > 3 members-32%

iv. 10% discount on premium in case insured opts for shared room category
v. 10% discount to all TATA Group employees

4. Salient Features:

2. **In-patient Treatment:** We will cover expenses for hospitalization due to disease/illness/Injury during the policy period that requires an Insured Person's admission in a hospital as an inpatient. Medical expenses directly related to the hospitalization would be payable
3. **Pre-Hospitalisation:** The Medical Expenses incurred in 60 days immediately before the Insured Person was hospitalized.
4. **Post-Hospitalisation:** The Medical Expenses incurred in the 90 days immediately after the Insured Person was discharged post Hospitalisation.
5. **Day Care Procedures:** We will cover expenses for listed Day Care Treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre. The list of such day care procedures covered is available on our website (www.tataaig.com)
6. **Organ Donor:** The Medical and surgical Expenses of the organ donor for harvesting the organ where an insured person is the recipient.
7. **Domiciliary Treatment:** The Medical Expenses incurred by an Insured Person for availing medical treatment at his home which would otherwise have required Hospitalisation. We will also cover pre and post hospitalization expenses in case of domiciliary hospitalization.
8. **Global Cover:** We will cover Medical Expenses of the Insured Person incurred outside India, upto the sum insured provided that the diagnosis was made in India and the insured travels abroad for treatment. The Medical Expenses payable shall be limited to Inpatient and daycare Hospitalization only on reimbursement basis.
9. **Bariatric Surgery Cover-** Covers reasonable and customary expenses for Bariatric surgery if the insured fulfills:
    i. Surgery to be conducted upon the advice of the Doctor
    ii. The member has to be 18 years of age or older and
    iii. BMI greater than or equal to 40 or
    iv. BMI greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
        a) Obesity-related cardiomyopathy,
        b) Severe sleep apnea,
        c) Uncontrolled Type2 Diabetes, or
        d) Coronary heart disease
10. **In-patient Dental Treatment-** Covers expenses incurred towards hospitalization for dental treatment under anesthesia necessitated due to an accident/injury/illness
11. **Restore benefit**- Automatically restore the Basic Sum Insured upon exhaustion of the Sum Insured and accrued Cumulative Bonus, during the policy period.
12. **AYUSH benefit** - Medical Expenses incurred for In-patient/Day care treatment taken in an AYUSH hospital/AYUSH day care centre, including pre and post hospitalization expenses.
13. **Ambulance cover**–For utilizing ambulance service for transporting insured person to hospital in case of an emergency.
14. **Health Check-up-** Expenses for a Preventive Health Check-up upto 1% of previous year policy sum insured subject to a maximum of Rs. 10,000/- per policy in the event of every two continuous claim free policy years with us.

15. **Second Opinion-** We will provide You a second opinion from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with the mentioned Illnesses during the Policy Period.
16. **Vaccination cover-** We will cover for expenses related to the cost of the following vaccines:
    a. **Without any waiting period:**
        i. Anti-rabies vaccine following an animal bite
        ii. Typhoid vaccination
    b. **After 2 years of continuous coverage with us:**
        i. Human Papilloma Virus (HPV) vaccine
        ii. Hepatitis B Vaccine
17. **Hearing Aid-** We will cover reasonable charges for hearing aid, every third year. The maximum payable is 50% of actual cost or Rs. 10,000/- per policy, whichever is lower.
18. **Daily cash for choosing shared accommodation-** We will pay a fixed amount per day as mentioned in the policy schedule if the Insured Person is Hospitalized in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours. The benefit payable per day would be 0.25% of base sum insured and max. Rs. 2000 per day. This benefit is applicable only for those cases where shared accommodation category is not opted by the policy holder in the policy.
19. **Daily cash for accompanying an insured child-** We will pay a fixed amount per day, as mentioned in the schedule, if the Insured Person Hospitalized is a child Aged 12 years or less, for one accompanying adult for each complete period of 24 hours. The benefit payable per day would be 0.25% of base sum insured and max. Rs. 2000 per day.
20. **Compassionate travel-** In the event the Insured Person is Hospitalized for more than Five consecutive days in a place where no adult member of his immediate family is present, we will cover expenses related to a round trip economy class 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. The expenses must be incurred within India and shall not exceed Rs. 20,000 during a policy year**.**
21. **Consumables Benefit-** We will pay for expenses incurred, for specified consumables listed in 'Annexure – 1 List 1 as Optional Items (Consumables Benefit) ' which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I-Optional items (Consumables Benefit) are available on our website (www.tataaig.com)

5. Optional covers/Riders:

You can choose optional covers listed below by paying an additional premium.

- **Accidental Death Benefit:** If an Insured Person suffers an accident during the policy period and this is the sole and direct cause of his death within 365 days from the date of accident, then we will pay a fixed amount of 100% of the base Sum Insured.

6. Sum Insured options (₹):

- 3 Lacs
- 4 Lacs
- 5 Lacs
- 7.5 Lacs
- 10 Lacs
- 15 Lacs
- 20 Lacs

7. Renewal Incentives:

i. **Cumulative Bonus:** We will offer Cumulative Bonus of 50% of the Sum Insured for every claim free year accumulating up to 100% of sum insured. In the event of a claim, the cumulative bonus shall be reduced by 50% at the time of renewal**.** Cumulative Bonus shall be provided only if No Claim Discount has not been availed for the claim free previous Policy Year**.**

ii. **Health Check-up-** Expenses for a Preventive Health Check-up upto 1% of previous year policy sum insured subject to a maximum of Rs. 10,000/- per policy after block of every two continuous claim free policy years with us.

8. Portability:

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

9. Free Look Period:

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

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

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to a refund of the premium paid subject to deduction of proportionate risk premium for the period of cover and the expenses, if any, incurred by Us on medical examination of the proposer and stamp duty charges.

10. Waiting Period:

i. **30 days Waiting Period** (Code- Excl 03)::

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii. Specified Disease/Procedure Waiting Period (Code- Excl 02):

i. 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.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. 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.
vi. List of Specific Diseases/procedures as furnished below:

I. Tumors, Cysts, polyps including breast lumps (benign)
II. Polycystic ovarian disease
III. Fibromyoma
IV. Adenomyosis
V. Endometriosis
VI. Prolapsed Uterus
VII. Non-infective arthritis
VIII. Gout and Rheumatism
IX. Osteoporosis
X. Ligament, Tendon or Meniscal tear

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

The following treatments are covered after a waiting period of two years irrespective of the illness for which it is done:

XXVII. Adenoidectomy
XXVIII. Mastoidectomy
XXIX. Tonsillectomy
XXX. Tympanoplasty
XXXI. Surgery for nasal septum deviation
XXXII. Nasal concha resection
XXXIII. Surgery for Turbinate hypertrophy
XXXIV. Hysterectomy
XXXV. Joint replacement surgeries EX: Knee replacement, Hip replacement
XXXVI. Cholecystectomy
XXXVII. Hernioplasty or Herniorraphy
XXXVIII. Surgery/procedure for Benign prostate enlargement
XXXIX. Surgery for Hydrocele/ Rectocele
XL. Surgery of varicose veins and varicose ulcers

iii. Pre-existing Diseases Waiting Period(Code- Excl 01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

11. General Exclusions:

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

Medical Exclusions:

i. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code- Excl 12).
ii. Alcoholic pancreatitis
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. Congenital External Diseases, defects or anomalies;;
v. Stem cell therapy; however hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under benefit B1 or B4 of this policy
vi. Growth Hormone Therapy
vii. Sleep-apnoea
viii. Admission primarily for administration of Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid
ix. 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.
x. Venereal disease, sexually transmitted disease or illness;

xi. Sterility and Infertility (Code- Excl 17):
Expenses related to Sterility and infertility. This includes:
   i. Any type of contraception, sterilization
   ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   iii. Gestational Surrogacy
   iv. Reversal of sterilization

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

xiii. Change-of-Gendertreatments:Code- Excl07:
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

xiv. 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.

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

xvi. All preventive care, vaccination including inoculation and immunisations (except in case of post- bite treatment and other vaccines explicitly covered);

xvii. 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.

xviii. Dental treatment or surgery of any kind except specified in 'Inpatient Treatment – Dental'

xix. Maternity (Code - Excl 18) :
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
   b. Expenes towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

xx. 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)

xxi. 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)

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

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

III. 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.

IV. 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.

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

VI. Items of personal comfort and convenience like television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service

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

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

IX. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy unless explicitly stated and covered in the policy,

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

XI. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.

XII. Crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively and explicitly stated and covered in the policy).

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.

XIV. 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.

12. Claim Procedure:

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

a. Intimation & Assistance:

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

b. Claim Related Information:

For any claim related query, intimation of claim and submission of claim related documents, You can contact us through:

Claims Servicing Details	
Name	TAGIC Health Claims
Claims Administrator Address	TATA AIG General Insurance Company Limited, 5th and 6th Floor, Imperial Towers, H.No 7-1-6-617/A, GHMC No - 615,616, Ameerpet, Hyderabad – 500016, Telangana, Phone: 040-66864900
Email ID	healthclaimsupport@tataaig.com
Toll-Free No.:	1800 266 7780 or 1800 229 966 (For Senior Citizens)
Website	www.tataaig.com

c. Procedure for reimbursement claims:

- Our TPA/We must be informed within 7 days of completion of such treatment, consultation or procedure using the Claim Intimation Form.
- Please send the duly signed claim form and all the information/documents mentioned therein to our TPA/Us within 15 days of the occurrence of the Incident.
- Please refer to claim form for complete documentation.
- If there is any deficiency in the documents/information submitted by you, our TPA/We will send the deficiency letter within 7 working days of receipt of the claim documents.
- On receipt of the complete set of claim documents, We will send the payment for the admissible amount, along with a settlement statement within 30 days.
- The payment will be sent in the name of the proposer/ Nominee in case of death of Proposer

d. Procedure for availing cashless facility:

- For any emergency Hospitalisation, our TPA/We must be informed within 24 hours after hospitalization.
- For any planned hospitalization, kindly seek cashless authorization from our TPA/Us atleast 48 hours prior to the hospitalization.
- TPA/We will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital by TPA/Us.
- In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider by TPA/Us.

Note:

- Insured person is entitled for cashless coverage only in our empanelled hospitals.
- Please refer to our website (www.tataaig.com) or call us on our toll free number at 1800-266-7780/ 1800 22 9966 (For Senior Citizens) for empaneled hospital list.
- Rejection of cashless facility in no way indicates rejection of the claim.

e. Claim settlement (provision for Penal Interest):

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.

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

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

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

f. Claim Procedure and management of Wellness Services:

Services are only available at Network. To avail the same, following procedure must be followed:

Teleconsultation – General Physician:

Insured Person can gain access to tele/video/digital consultation with a general physician, using Our digital Customer application.

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.

Ambulance Booking facility:

Insured person can use Our digital Customer application to book an ambulance. This service will be offered on best effort basis and does not have a legal binding on us.

g. Co-payment :

If the insured person is admitted in a hospital room where the room category opted is higher than the eligible category as specified in the policy schedule, then the policy holder/insured person shall bear 10% of the admissible claim amount.

13. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of established fraud, non-disclosure or misrepresentation by the insured person.

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

ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iii. Single premium payment mode Policy can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period after the end of the policy period. If not renewed under the Grace Period, the Policy shall terminate at the end of the Grace period.

iv. The grace period for payment of the premium during the Policy Period, for instalment premium shall be fifteen days where premium payment mode is monthly and thirty days in all other cases (Annually/Half-Yearly/Quarterly/ Limited Premium Paying Term).

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

vi. 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.

vii. No loading shall apply on renewals based on individual claims experience

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

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

15. Sum Insured Enhancement

- Sum Insured can be enhanced only at the time of renewal subject to underwriting guidelines of the company.
- In case of increase in the Sum Insured waiting period and exclusions will apply afresh in relation to the amount by which the Sum Insured has been enhanced. However, the acceptance of Sum Insured enhancement request & quantum of increase shall be as per Our underwriting guidelines. For claims arising in respect of accident, injury or illness contracted or suffered during a preceding Policy period, liability of the Company shall be only to the extent of the Sum Insured under the Policy in force at the time when it was contracted or suffered.

16. 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. 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

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

17. Withdrawal of the 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.

18. Moratorium Period

After completion of five continuous years of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This continuous period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of five continuous years would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

19. Nomination

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

20. Requirement:

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

21. Pre-policy medical check-up:

Pre-Policy Check-up at our network may be required based upon the age and/or Sum Insured. 100% of the expenses incurred per insured person will be payable by Tata AIG only on the acceptance of the proposal. The medical reports are valid for a period of 90 days from the date of Pre-Policy Checkup.

Pre-policy medical examination gird:

Age(Yrs)/Sum Insured	All Sum Insured Options
Upto age 45	No medicals/No Tele- Medical Examination Report
46 years and above	Tele- Medical Examination Report (TeleMER)

Note:In case of adverse medical declaration, we may call for TeleMER/additional medical tests at our diagnostic centre

22. Premium Rates & Payment Zones:

i. The premium will be charged on the completed age of the Insured Person.
ii. Premium rates are subject to change.
iii. The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.
iv. For family floater, premium is calculated by adding the premium of respective individual members and applying family floater discount.
v. Monthly instalment option would be allowed and following loadings shall be applicable:

Term of Policy	Loading%
1 year Policy	5%
2 year Policy	9%
3 year Policy	13%

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

I. Grace Period of 15 days would be given to pay the installment premium due for the policy, during the policy period.
II. During such grace period, coverage shall be available from the due date of installment premium till the date of receipt of premium by Company.

III. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
IV. No interest will be charged If the installment premium is not paid on due date
V. In case of installment premium due not received within the grace period, the policy will get cancelled.
VI. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
VII. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Premium Payment Zones:

For the purpose of premium computation, the country is divided into following three Zones and 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:

a. Zone A: Mumbai including MMR/ Thane, Delhi NCR/Faridabad/Ghaziabad, Ahmedabad, Surat, and Baroda
b. Zone B: Hyderabad, Bengaluru, Kolkata, Indore, Chennai, Chandigarh/ Mohali/ Punchkula/Zirakpur, Pune/Pimpri Chinchwad and Rajkot
c. Zone C: Rest of India

Note:

i. No co-payment shall apply due to change in zone and insured person can avail treatment in any of the zones
ii. In case of mid-term address change which also involves change in premium payment zone, the premium would be modified and computed on pro-rata basis

Zone A (Annual)Per Person Rates(Rs.) (Exclusive of taxes)

Zone A							
Age Band	**3 Lakhs**	**4 Lakhs**	**5 Lakhs**	**7.5 Lakhs**	**10 Lakhs**	**15 Lakhs**	**20 Lakhs**
0-17	4,812	5,664	5,869	6,337	6,559	7,372	7,662
18-35	7,529	8,836	9,136	9,785	10,126	11,433	11,914
36-45	9,356	10,978	11,423	12,233	12,674	14,288	14,881
46-50	13,644	15,917	16,546	17,717	18,275	20,573	21,413
51-55	17,039	19,714	20,224	21,708	22,355	25,150	26,170
56-60	20,573	23,767	24,543	26,374	26,945	30,194	31,366
61-65	27,351	31,753	32,837	35,287	36,134	40,577	42,188
66-70	42,605	49,737	51,503	55,309	56,756	63,912	66,522
71+	52,776	61,990	64,304	68,962	71,134	80,187	83,482

Zone B (Annual)Per Person Rates(Rs.) (Exclusive of taxes)

Zone B							
Age Band	**3 Lakhs**	**4 Lakhs**	**5 Lakhs**	**7.5 Lakhs**	**10 Lakhs**	**15 Lakhs**	**20 Lakhs**
0-17	4,522	5,315	5,502	5,943	6,155	6,913	7,182
18-35	7,066	7,704	7,957	8,518	9,482	10,702	11,150
36-45	8,784	9,574	9,965	10,666	11,890	13,394	13,946
46-50	12,833	14,933	15,526	16,616	17,139	19,275	20,054
51-55	16,088	18,538	18,973	20,365	20,966	23,560	24,505
56-60	19,450	22,376	23,081	24,808	25,301	28,297	29,374
61-65	25,780	29,830	30,823	33,129	33,880	37,988	39,474
66-70	40,004	46,597	48,223	51,795	53,100	59,737	62,152
71+	49,535	58,123	60,280	64,637	66,678	75,107	78,167

Zone C (Annual)Per Person Rates(Rs.) (Exclusive of taxes)

Zone C							
Age Band	**3 Lakhs**	**4 Lakhs**	**5 Lakhs**	**7.5 Lakhs**	**10 Lakhs**	**15 Lakhs**	**20 Lakhs**
0-17	3,762	4,417	4,567	4,932	5,112	5,737	5,959
18-35	5,873	6,870	7,089	7,584	7,860	8,865	9,235
36-45	7,305	8,544	8,895	9,515	9,879	11,117	11,572
46-50	10,697	12,408	12,901	13,799	14,234	15,987	16,626
51-55	13,474	15,450	15,764	16,920	17,414	19,539	20,312
56-60	16,318	18,675	19,235	20,679	21,045	23,480	24,351
61-65	21,546	24,828	25,625	27,552	28,129	31,479	32,685
66-70	33,271	38,648	39,967	42,935	43,964	49,397	51,369
71+	41,174	48,253	50,031	53,641	55,339	62,275	64,786

(Annual) Per Person Rates for Accidental Death Benefit Rider (Rs.)(Exclusive of taxes) all Zones

Age\Sum Insured	3 Lakh	4 Lakh	5 Lakh	7.5 Lakh	10 Lakh	15 Lakh	20 Lakh
All Ages	167	223	279	418	558	836	1,115

23. Loadings:

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

ii. The maximum risk loading applicable for an individual shall not exceed 100% of premium per diagnosis / medical condition and an overall risk loading of over 150% of premium per person.

iii. The loading shall only be applied basis an outcome of Our medical underwriting.

iv. 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.

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

24. Cancellation:

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

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

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

The coverage for the Insured Person(s) shall automatically terminate in case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. 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. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

Refund will be made to the Policy holder or the nominee in case of demise of the Policy holder. We would require death certificate of the Deceased Insured Person for processing of the refund amount.

26. Redressal of Grievance:

At TATA AIG, we strive to provide the best service to our customers. If you're not satisfied and wish to lodge a complaint, please call our 24/7 toll-free number **1800-266-7780/1800 22 9966 (For Senior Citizens)** or **022-66939500** (toll charges apply), or email us at customersupport@tataaig.com. We will investigate and respond within the regulatory turnaround time (TAT).

Escalation Level 1

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

Escalation Level 2

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

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

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

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

27. Section 41 of Insurance Act 1938 (Prohibition of Rebates), 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 premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurer.
2. Any person making default in complying with the provision of this section shall be liable for penalty which may extend to ten lakh rupees.

IRDAI REGULATION: This policy is subject to Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024

Note: Policy Term and Conditions & Premium rates are subject to change.

Disclaimer:

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

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

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

Benefit Table

Cover	Coverage
In-patient Treatment	Upto Sum Insured
Pre-Hospitalization	Upto 60 days
Post-Hospitalization	Upto 90 days
Day-Care procedures	Upto Sum Insured
Organ Donor	Upto Sum Insured
Domiciliary Treatment	Upto Sum Insured
Restore benefit	Upto Sum Insured
AYUSH benefit	Upto Sum Insured
Ambulance cover	Upto Rs. 3000 per Hospitalization
Health Check-up	Upto 1% previous year Sum Insured; max. Rs.10,000 per policy
Compassionate travel	Upto Rs.20,000 per policy year
Consumables Benefit	Upto Sum Insured
Global Cover	Upto Sum Insured
Bariatric Surgery Cover	Upto Sum Insured
In-patient Dental Treatment	Upto Sum Insured
Vaccination cover	Upto Rs.5000 per policy
Hearing Aid	50% of actuals; maximum Rs.10,000 per policy
Daily cash for choosing shared accommodation	0.25% of base Sum Insured; maximum Rs. 2000 per day
Daily cash for accompanying an insured child	0.25% of base Sum Insured; maximum Rs. 2000 per day
Second Opinion	Covered
Cumulative Bonus	50% increase in cumulative bonus for every claim free year. In the case a claim is made during the policy year, the cumulative bonus would reduce by 50% in the following year. Cumulative Bonus shall be provided only if No Claim Discount has not been availed for the claim free previous Policy Year. Alternately, No Claim

	Discount in premium can be opted, in which case policy will not be entitled for Cumulative Bonus
Wellness Service	8 teleconsultations and Ambulance booking services
Accidental Death Benefit (if opted)	100% of the base Sum Insured

Tata AIG General Insurance Company Limited
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24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For Senior Citizens) Email:customersupport@tataaig.com Website: www.tataaig.com IRDA of India Registration No: 108 CIN: U85110MH2000PLC128425