

TATA AIG MediCare Select

Customer Information Sheet/Know Your Policy

This document provides key information about your policy. You are also advised to go through your policy document.

S No	Title	Description	Policy Clause No.
1.	Name of the Insurance Product/Policy	TATA AIG MediCare Select	-
2.	Policy Number	Policy Number	-
3.	Type of Insurance Policy	Both Indemnity and Benefit – Policy has elements of both, Indemnity (which cover insured loses) and Benefit (which pays a fix amount under the policy on the occurrence of a covered event).	-
4.	Sum Insured (Basis) (Along with amount)	<<Sum Insured Amount>>As per Sum Insured mentioned in Policy Schedule Sum Insured represents Our maximum, total and cumulative liability under the Policy, for all the Insured Person(s) covered in aggregate, for the respective Policy Year	-
5.	Policy Coverage (What the policy covers?)	B1. In-Patient Treatment - Covers medical expenses for hospitalization for period more than 24 hrs. B2. Pre-Hospitalization expenses - Medical Expenses incurred upto 90 days prior to the date of admission to the hospital. B3. Post-Hospitalization expenses – Medical Expenses incurred upto 90 days after the date of discharge from the hospital. B4. Day Care Procedures- - Medical expenses for Day Care Treatment due to disease/illness/Injury during the policy period taken at a Hospital or a Day Care Centre. B5. Organ Donor - Medical Expenses towards the harvesting the organ from the donor for organ transplantation. B6. Domiciliary Treatment – Medical Expenses incurred for availing medical treatment at home which would otherwise have required hospitalization. B7. AYUSH Benefit - We will cover Medical Expenses incurred for treatment as In-Patient or Day Care in an AYUSH Hospital/ AYUSH day care centre, for a room category, as specified in the Policy Schedule and applicability of Associated Medical Expenses.	Section (2)

TATA AIG General Insurance Company Limited

Registered office: Peninsula Business Park, Tower A, 15th Floor, G.K Marg, Lower Parel, Mumbai - 400013, Maharashtra, India 24*7 Toll free No.: 1800 266 7780/1800 22 9966 (For Senior Citizens) • Email: customersupport@tataaig.com • Website: www.tataaig.com IRDA of India Registration

No.: 108 • CIN: U85110MH2000PLC128425 • **TATA AIG MediCare Select UIN: TATHLIP25051V012425**

		This benefit shall also cover Pre-Hospitalization medical expenses for a period of upto 90 days before the date of admission to the AYUSH hospital/ AYUSH day care centre and Post-Hospitalization Medical Expenses for a period upto 90 days, subject to AYUSH In-Patient hospitalization or AYUSH day care treatment claim being admissible under this benefit. Claims under this section shall be assessed as per the applicable insurance guidelines related to AYUSH and benchmark rates as available on Ministry of AYUSH website (https://ayushnext.ayush.gov.in/site/insurance-guidelines-related-to-ayush). For reference, please refer the document "Annexure B for AYUSH Benefit" available on Our website (www.tataaig.com) B8. Ambulance Cover – Expenses incurred for the transportation of the Insured Person in a registered road ambulance for circumstances as mentioned in the policy wordings. B9. Restore Infinity Plus- We will provide reinstatement of base sum insured, unlimited number of times, if the Sum Insured and Cumulative Bonus (if accrued) is insufficient to pay an admissible Hospitalization claim in the Policy. Our maximum liability in aggregate of all claims arising out of a single Hospitalization shall not exceed the Sum Insured of the base Policy. B10. Daily Cash for choosing Twin Sharing Accommodation- We will pay a fixed amount per day as mentioned in the policy schedule if the Insured Person is Hospitalized in a Twin Sharing Accommodation for each continuous and completed period of 24 hours. B11. Daily Cash for choosing Multi-Sharing Accommodation- We will pay a fixed amount per day as mentioned in the policy schedule if the Insured Person is Hospitalized in a Multi-Sharing Accommodation for each continuous and completed period of 24 hours. B12. No Claim Bonus- The below mentioned 'No claim Bonus' options will be available and applicable as opted by You. Either of the two options is to be selected: 1) Cumulative Bonus: 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. 2) Discount in Renewal Premium (No Claim Bonus)- If you choose Discount in Renewal Premium, We will allow 1% discount on renewal premium for every claim free Policy Year, provided that the Policy is renewed with Us without break.	
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		Optional Covers (For covers applicable to you, please refer your Policy Schedule): C1. Consumables Benefit- We will pay for expenses incurred, for specified consumables, which are mentioned in Annexure I – List of Optional Items (Consumables Benefit) available on Our website (www.tataaig.com) which are consumed during the period of Hospitalization directly related to the Insured Person's medical or surgical treatment of Illness/disease/Injury. C2. Maternity Care - We will cover Maternity Expenses, delivery complication of a New Born Baby and First Year Vaccinations of the New Born Baby up to the limits specified in the Policy Schedule. The cover is available for the selected Insured Person(s) and is subject to a waiting period of 2 years of continuous coverage of the insured person(s) under this cover with Us. C3. Reduction of Maternity Care Waiting Period- The waiting period specified under Optional Cover 'Maternity Care' of this Policy shall be reduced to 1 year of continuous coverage. C4. Infinite Advantage- We will cover the Medical Expenses incurred for an admissible claim under In-Patient Treatment/Daycare Procedures for any one claim during the lifetime of the policy, without any limits on the available annual Sum Insured. C5. Early Access- For single premium multi-year policies, the Sum Insured of the policy period shall be available anytime during the Policy Period, for utilization for an admissible claim. C6. Room Category Select- The room category entitlement in the Policy shall be replaced to the room category as specified in the Policy Schedule. C7. Aggregate Deductible- Our liability under this Policy shall be subject to Aggregate Deductible as specified in the Policy Schedule.	
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6.	Exclusions	i. Standard Exclusions B. Medical Exclusions I. Investigation and evaluation (Code- Excl 04) II. Rest cure, rehabilitation and respite care (Code- Excl 05) III. Obesity/ Weight Control (Code- Excl 06) IV. Change-of-Gender treatments (Code- Excl07) V. Cosmetic or Plastic Surgery (Code- Excl 08) VI. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code- Excl 12). VII. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code- Excl13) VIII. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. (Code- Excl14) IX. Refractive error (Code- Excl 15) X. Unproven treatments (Code- Excl 16) XI. Sterility and Infertility (Code- Excl 17) XII. Maternity (Code - Excl 18) C. Non-Medical Exclusions I. Hazardous or Adventure Sports (Code- Excl 09) II. Breach of law (Code- Excl 10) III. Excluded Providers: (Code-Excl 11) ii. Specific Exclusions (Exclusions other than as those mentioned above) A. Medical Exclusions	Section (3)
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		i. Alcoholic pancreatitis or Alcoholic liver disease ii. Congenital External Diseases, defects or anomalies iii. Stem cell therapy iv. Growth Hormone Therapy v. Sleep-apnoea and Sleeping disorder vi. Admission primarily for administration (via any form or mode) of immunoglobulin infusion or supplementary medications. vii. Venereal disease, sexually transmitted disease or Illness. viii. All preventive care. ix. Cost of dentures, dental implants and braces. x. Any form of Non-Allopathic treatment (except AYUSH Benefit). xi. Any existing disease specifically mentioned as Permanent exclusion in the Policy Schedule. xii. Non payable items as mentioned in Annexure I – List I of Optional Items available on Our website (www.tataaig.com). B. Non-Medical Exclusions i. War or any act of war, invasion, act of foreign enemy, war like operations. ii. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event. iii. Any Insured Person's participation or involvement in naval, military or air force operation. iv. Intentional self-Injury or attempted suicide while sane or insane. v. If the Insured Person is under the influence of intoxicating liquor or drugs or other intoxicants vi. Items of personal comfort and convenience. vii. Treatment rendered by a Medical Practitioner which is outside his discipline. viii. Doctor's fees charged by the Medical Practitioner sharing the same residence as an Insured Person or who is an immediate relative of an Insured Person's family. ix. Hearing aids, spectacles or contact lenses, etc. x. Any treatment and associated expenses for alopecia, baldness, wigs or toupees, medical supplies.	
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		xi. Any treatment or part of a treatment that does not form part of 'Reasonable and Customary Charges', nor is medically necessary. xii. Expenses which are either not supported by a prescription of a Medical Practitioner or are not related to Illness or disease for which claim is admissible under the Policy. xiii. Any external appliance and/or device used for diagnosis or treatment except when used intra-operatively. xiv. Any Illness diagnosed or Injury sustained or where there is change in health status of the member after date of proposal and before commencement of Policy and the same is not communicated and accepted by Us. This is summary of exclusions. For detailed exclusions, please refer Policy wordings (Section 3)	
7.	Waiting period	I. Initial waiting period of 30 days for all illnesses (not applicable for accidents or on renewals) II. Specified Waiting periods (Not applicable for claims arising due to an accident) of 24 months for 35 listed Diseases/procedure III. Pre-existing disease covered after 36 months	Section (3)
8.	Financial limits of coverage i. Sub-limit (it is a pre-defined limit and the insurance company will not pay any amount in excess of this limit) ii. Co-payment (it is a specified amount/percentage of the admissible claim amount to be paid by policy)	The policy will pay only up to the limits specified hereunder for the following diseases/procedures Sub-limit <u>Benefit Specific Sub-limit:</u> - Room Category -Upto Single private room. For category applicable to you, please refer your Policy Schedule Optional Sub-limit: 1- Room Category Select- Twin Sharing accommodation 2- Aggregate Deductible: In lieu of premium discount opted by you, Our liability under this Policy shall be subject to application of Aggregate Deductible as mentioned in the Policy Schedule, if applicable. Any Other limit: - In-Patient Treatment- Upto Sum Insured - Pre-Hospitalization expenses- Upto 90 days, Upto Sum Insured - Post-Hospitalization expenses- Upto 90 days, Upto Sum Insured - Day Care Procedures- Upto Sum Insured	Section (2) & Section (5)

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	holder/insured) i. Deductible (it is a specified amount: - Up to which an insurance company will not pay any claim, and - Which will be deducted from total claim amount (if claim amount is more than the specified amount) Any other limit (as applicable)	• Organ Donor- Upto Sum Insured • Domiciliary Treatment- Upto Sum Insured • AYUSH Benefit- Upto Sum Insured • Ambulance Cover- Upto Sum Insured • Daily Cash for choosing Twin Sharing Accommodation- Rs.1200 per day (over and above base sum insured) • Daily Cash for choosing Multi-Sharing Accommodation- Rs.1500 per day (over and above base sum insured) Optional Covers (For covers applicable to you, please refer your Policy Schedule): • Consumables Benefit- Upto Sum Insured • Maternity Care- 10% of Sum Insured, maximum up to Rs.1,00,000 per policy year (over and above base sum insured) <table><tr><td>Basic Sum Insured (Over and above base sum insured)</td><td>Limit (per policy year)</td></tr><tr><td>Rs 5 Lacs</td><td>Rs. 50,000</td></tr><tr><td>Rs 7.5 Lacs</td><td>Rs. 75,000</td></tr><tr><td>Rs 10 Lacs & above</td><td>Rs. 100000</td></tr></table> For limits applicable to you, please refer your Policy Schedule Rider(s) for TATA AIG MediCare Select UIN << >> (For Rider cover(s) applicable to you please refer Policy Schedule. For applicability of the Rider(s), applicable cover(s), terms and conditions, please refer Policy Wordings): <<Name of package 1>> 1. <<Name of the Rider 1>> <<UIN 1>> I. <<Coverage Name 1>> <<Coverage Details and Sum Insured/Services Limit>> II. <<Coverage Name 2>> <<Coverage Details and Sum Insured/Services Limit>> 2. <<Name of the Rider 2>> <<UIN 2>> I. <<Coverage Name 1>> <<Coverage Details and Sum Insured/Services Limit>> II. <<Coverage Name 2>> <<Coverage Details and Sum Insured/Services Limit>>	Basic Sum Insured (Over and above base sum insured)	Limit (per policy year)	Rs 5 Lacs	Rs. 50,000	Rs 7.5 Lacs	Rs. 75,000	Rs 10 Lacs & above	Rs. 100000	
Basic Sum Insured (Over and above base sum insured)	Limit (per policy year)										
Rs 5 Lacs	Rs. 50,000										
Rs 7.5 Lacs	Rs. 75,000										
Rs 10 Lacs & above	Rs. 100000										
9.	Claims/Claims Procedure	Claim procedure: • For Cashless Service:	Section (5)								

		1. If any planned treatment, consultation or procedure for which a claim may be made then the insured must notify us at least 48 hours before the planned Hospitalization. 2. If any treatment, consultation or procedure for which a claim may be made, requiring emergency Hospitalization, then the insured must notify us within 24 hours after the treatment or Hospitalization 3. You have to provide the ID card issued to You along with any other information or documentation that is requested by the TPA/Us to the Network Hospital. • <u>For Reimbursement of Claim:</u> 1. Please submit claim documents to our TPA/Us within 15 days of occurrence of incident. 2. Kindly send the claim documents to: TATA AIG General Insurance Co. Ltd. 5th and 6th Floor, Imperial Towers, H.No 7-1-6-617/A, GHMC No-615, 616, Ameerpet, Hyderabad – 500016, Telangana, Phone-040-66864900 Turn Around Time (TAT) for claims settlement: TAT for preauthorization of cashless facility and for cashless final bill authorization shall be as prescribed by the Regulator under the Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 and its subsequent amendments thereof. Assistance: 1. Please refer to our website www.tataaig.com or call us on our toll free number at <1800-266-7780> to get details on our empanelled hospitals and list of Excluded providers/ Blacklisted Hospitals. 2. Helpline number: Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders) 3. Please refer our website www.tataaig.com to download claim form	
10.	Policy Servicing	Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders)	Section (4)
11.	Grievances/Complaints	<u>Redressal of Grievance</u> 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-	Section (4)

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		7780/1800 22 9966 (for Senior Citizen) or 022-66939500 (toll charges apply), or email us at customersupport@tataaig.com. We will investigate and respond within the regulatory turnaround time (TAT). <u>Escalation Level 1</u> If you do not receive a response or are not satisfied with the resolution, please contact us at manager.customersupport@tataaig.com. <u>Escalation Level 2</u> 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 in The name and address of the Insurance Ombudsman of competent jurisdiction is provided under Annexure A of the Policy wordings.	
12 .	Things to remember	Free Look Period The insured person shall be provided a free look period of thirty days beginning from the date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy, and to return the same if not acceptable. If the Insured Person has not made any claim during the Free Look Period, the Insured Person shall be entitled to a refund of the premium paid subject to deduction of proportionate risk premium for the period of cover and the expenses, if any, incurred by Us on medical examination of the proposer and stamp duty charges. Policy renewal 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.	Section (4)

		ii. Request for Renewal along with requisite premium shall be received by the Company before the end of the Policy Period. iii. Single premium payment mode Policy can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period after the end of the policy period. If not renewed under the Grace Period, the Policy shall terminate at the end of the Grace period. iv. The grace period for payment of the premium during the Policy Period, for instalment premium shall be fifteen days where premium payment mode is monthly and thirty days in all other cases (Annual/ Half-Yearly/ Quarterly/Limited Premium paying term). v. Coverage during such grace period (in case of instalment premium): - 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. vi. The insured person will get the accrued continuity benefit to the extent of Sum Insured, No Claim Bonus, Specified Waiting Periods, waiting periods for pre-existing diseases, Moratorium period, as applicable, in the event of payment of premium within the stipulated grace Period. vii. No loading shall apply on Renewals based on individual claims experience. Migration The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for Migration of the Policy at least 30 days before the Policy Renewal date as per IRDAI guidelines on Migration. 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-	
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		Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 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 related to 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. Moratorium Period After completion of five continuous years of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This continuous period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of five continuous years would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, Co-Payments, Aggregate Deductibles (If opted) as per the Policy contract.	
13	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid and termination of Your policy.	