TATA AIG MediCare Select
Policy Wordings

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

Section 1 – Definitions

The terms defined below and at other junctures in the Policy Wording have the meanings ascribed to them wherever they appear in this Policy and where appropriate, references to the singular include references to the plural; references to the male includes other genders and references to any statutory enactment includes subsequent changes to the same.

i. **Standard Definitions**

1. Accident

An **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. Any one Illness

Any one Illness means continuous period of **Illness** and includes relapse within 45 days from the date of last consultation with the **Hospital**/Nursing Home where treatment was taken.

3. AYUSH Day Care Centre

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

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

4. AYUSH Hospital

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

a. Central or State Government AYUSH **Hospital** or
b. Teaching **Hospital** attached to AYUSH college recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy, or
c. AYUSH **Hospital**, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the

supervision of a qualified registered AYUSH **Medical Practitioner** and must comply with all the following criterion:

i. Having atleast 5 in-patient beds;
ii. Having qualified AYUSH **Medical Practitioner** in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where **Surgical Procedure**s are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

5. AYUSH Treatment

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

6. Break in Policy

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

7. Cashless facility

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

8. Condition Precedent

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

9. Congenital Anomaly

Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a. **Internal Congenital Anomaly**
   Congenital Anomaly which is not in the visible and accessible parts of the body.
b. **External Congenital Anomaly**
   Congenital Anomaly which is in the visible and accessible parts of the body.

10. Cumulative Bonus

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

11. Day Care Centre

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

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

12. Day Care Treatment

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

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

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

13. Dental Treatment

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

14. Domiciliary hospitalization

Domiciliary hospitalization means medical treatment for an **Illness**/disease/**Injury** which in the normal course would require care and treatment at a **Hospital** but is actually taken while confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a **Hospital**, or
ii. the patient takes treatment at home on account of non-availability of room in a **Hospital**.

15. Emergency Care

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

16. Grace Period

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

17. Hospital

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

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified **Medical Practitioner**(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where **Surgical Procedure**s are carried out;
v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

18. Hospitalization

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

19. Illness

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

a. **Acute condition**

Acute condition is a disease, **Illness** or **Injury** that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ **Illness**/ **Injury** which leads to full recovery

b. **Chronic condition**

A chronic condition is defined as a disease, **Illness**, or **Injury** that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

20. Injury

Injury means accidental physical bodily harm excluding **Illness** or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a **Medical Practitioner**.

21. Inpatient Care

Inpatient Care means treatment for which the **Insured Person** has to stay in a **Hospital** for more than 24 hours for a covered event.

22. Intensive Care Unit:

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

23. ICU Charges:

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

24. Maternity Expenses:

Maternity Expenses means;

a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during **Hospitalization**);
b. expenses towards lawful medical termination of pregnancy during the **Policy Period**.

25. Medical Advice

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

26. Medical Expenses:

Medical Expenses means those expenses that an **Insured Person** has necessarily and actually incurred for medical treatment on account of **Illness** or **Accident** on the advice of a **Medical Practitioner**, as long as these are no more than would have been payable if the **Insured Person** had not been insured and no more than other **Hospital**s or doctors in the same locality would have charged for the same medical treatment.

27. Medical Practitioner

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

28. Medically Necessary Treatment

Medically Necessary Treatment means any treatment, tests, medication, or stay in **Hospital** or part of a stay in **Hospital** which:

i. is required for the medical management of the **Illness** or **Injury** suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a **Medical Practitioner**;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

29. Migration

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

30. Network Provider

Network Provider means **Hospital**s or health care providers enlisted by an **Insurer**, TPA or jointly by an **Insurer** and TPA to provide medical services to an insured by a **Cashless facility**.

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

31. New Born Baby

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

32. Non-Network Provider

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

33. Notification of Claim

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

34. OPD treatment

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

35. Pre-Existing Disease

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

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

36. Pre-hospitalization Medical Expenses

Pre-hospitalization Medical Expenses means **Medical Expenses** incurred during predefined number of days preceding the **Hospitalization** of the **Insured Person**, provided that:

i. Such **Medical Expenses** are incurred for the same condition for which the **Insured Person**'s **Hospitalization** was required, and
ii. The In-patient **Hospitalization** claim for such **Hospitalization** is admissible by the Insurance Company.

37. Portability

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

38. Post-hospitalization Medical Expenses

Post-hospitalization Medical Expenses means **Medical Expenses** incurred during predefined number of days immediately after the **Insured Person** is discharged from the **Hospital** provided that:

i. Such **Medical Expenses** are for the same condition for which the **Insured Person**'s **Hospitalization** was required, and
ii. The inpatient **Hospitalization** claim for such **Hospitalization** is admissible by the insurance company.

39. Qualified Nurse

Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

40. Reasonable and Customary charges

Reasonable and Customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the **Illness** / **Injury** involved.

41. Renewal

Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of **Grace Period** for treating the **Renewal** continuous for the purpose of gaining credit for **Pre-Existing Diseases**, time-bound exclusions and for all waiting periods.

42. Room Rent

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

43. Surgery or Surgical Procedure

Surgery or **Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an **Illness** or **Injury**, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a **Hospital** or **Day Care Centre** by a **Medical Practitioner**.

44. Unproven/Experimental treatment

Unproven/Experimental treatment means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

ii. **Specific Definitions (Definitions other than as mentioned under Section 1 (i) above)**

1. Age

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

2. Aggregate Deductible

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

3. Associated Medical Expenses (AME)

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

4. Multi-Sharing Accommodation

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

5. Modern Treatment Methods and Advancement in Technologies

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

A. Uterine Artery Embolization and HIFU

B. Balloon Sinuplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy-Monoclonal Antibody to be given as injection

F. Intra vitreal injections

G. Robotic surgeries

H. Stereotactic radiosurgeries

I. Bronchical Thermoplasty

J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

K. IONM - (Intra Operative Neuro Monitoring)

L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

6. Policy

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

7. Policy Period

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

8. Policy Schedule

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

9. Policy Year

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

10. Single Private Room

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

11. Sum Insured

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

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

12. Twin Sharing Accommodation

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

13. We, Us, Our, Insurer

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

14. You, Your, Insured Person

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

15. Zone(s)

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

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

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

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

Section 2 – Benefits

If during the **Policy Period** one or more **Insured Person**(s) is required to be hospitalized for treatment (including **Modern Treatment Methods and Advancement in Technologies**) of an **Illness** or **Injury** at a **Hospital** / **Day Care Centre**, following **Medical Advice** of a duly qualified **Medical Practitioner**, the Company shall indemnify Medically Necessary expenses towards the coverage mentioned in the **Policy Schedule** for the amount of such **Reasonable and Customary charges** or compensate to the extent agreed, upto the limits mentioned, subject to terms and conditions of the **Policy** . Provided further that, any amount payable under the **Policy** shall be subject to the terms of coverage (including **Aggregate Deductible**, if opted), exclusions, conditions and definition contained herein. Maximum liability of the Company under all such Claims during each **Policy Year** shall be the **Sum Insured** opted and **Cumulative Bonus** (if accrued), as specified in the **Policy Schedule** (except in case of a claim under Infinite Advantage (if opted) or Early Access (if opted)).

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

B1. **In-Patient Treatment**

We will cover **Medical Expenses** for **Medically Necessary Treatment** in a **Hospital**, due to disease/**Illness/Injury**, that requires an **Insured Person**'s admission in a **Hospital** for an **Inpatient Care**, during the **Policy Period**.

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

i. **Room Rent**, Boarding, Nursing Expenses as provided by the **Hospital** / Nursing Home, up to the room category specified in the **Policy Schedule**.
ii. **Intensive Care Unit** (ICU) / Intensive Cardiac Care Unit (ICCU) expenses
iii. Surgeon, Anesthetist, **Medical Practitioner**, Consultants, Specialist Fees
iv. Anesthesia, **Qualified Nurse** charges, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

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

- Proportionate deductions are not applicable for **ICU Charges**.

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

B2. **Pre-Hospitalization expenses**

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

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

B3. **Post-Hospitalization expenses**

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

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

B4. **Day Care Procedures**

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

B5. **Organ Donor**

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

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

What is not covered

i. **Pre-hospitalization Medical Expenses** or **Post hospitalization Medical Expenses** of the organ donor

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

B6. **Domiciliary Treatment**

We will cover expenses related to **Domiciliary hospitalization** of the **Insured Person** if the treatment exceeds beyond three consecutive days and is availed during the **Policy Period**. The treatment must be for management of an **Illness** and not for enteral feedings or end of life care.

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

B7. **AYUSH Benefit**

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

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

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

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

B8. **Ambulance Cover**

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

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

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

B9. **Restore Infinity Plus**

We will provide reinstatement of the base **Sum Insured**, if the **Sum Insured** and **Cumulative Bonus** (if accrued) is insufficient to pay an admissible **Hospitalization** claim in the **Policy**. The reinstatement will be available for unlimited number of times during a **Policy Year**, subject to below conditions:

i. This benefit shall not be available for the first admissible **Hospitalization**/ Domiciliary Treatment claim in each **Policy Year**. The **Sum Insured** will be restored for the subsequent claim in the **Policy Year**.
ii. In case of Family Floater **Policy**, reinstatement of **Sum Insured** will be available for all **Insured Person**s in the **Policy** on floater basis.
iii. The unutilized restored **Sum Insured** cannot be carried forward to the next **Policy Year**.
iv. This benefit shall also be applicable annually for policies with tenure of more than 1 year.
v. Any restored **Sum Insured** can only be utilized for an admissible claim under following indemnity covers of the **Policy**, as applicable:
    a. In-Patient Treatment,
    b. Pre/Post **Hospitalization** expenses,
    c. Day Care Procedures,
    d. Organ donor,
    e. Domiciliary Treatment,
    f. AYUSH Benefit,
    g. Ambulance Cover,
    h. Consumable benefit (If opted)
vi. Any restored **Sum Insured** under this benefit cannot be utilized for an admissible claim under:
    a. Any cover other than the ones mentioned in the above section or
    b. Any cover which has **Sum Insured** over and above the base **Sum Insured**.
vii. **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.

Payout under this benefit is only available if the room category eligibility applicable under this **Policy** is '**Single Private Room**' or room category higher than the **Single Private Room**.

This benefit has a separate limit (over and above base **Sum Insured**) and does not affect No Claim Bonus.

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.

Payout under this benefit is only available if the room category eligibility applicable under this **Policy** is '**Single Private Room**' or room category higher than the **Single Private Room**.

This benefit has a separate limit (over and above base **Sum Insured**) and does not affect No Claim Bonus.

B12. **No Claim Bonus**

Under this section, 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

i. 50% **Cumulative Bonus** will be applied on the **Sum Insured** of the expiring **Policy,** on each **Renewal** after every claim free **Policy Year**, provided that the **Policy** is renewed with **Us** and without a break. The maximum **Cumulative Bonus** shall not exceed 100% of the **Sum Insured** in any **Policy Year**.
ii. If a **Cumulative Bonus** has been applied and a claim is made, then in the subsequent **Policy Year** **We** will automatically decrease the **Cumulative Bonus** by 50% of the **Sum Insured** in that following **Policy Year**. There will be no impact on the base **Sum Insured**, only the accrued **Cumulative Bonus** will be decreased.
iii. In policies with a tenure of more than one year, the above guidelines of **Cumulative Bonus** shall be applicable post completion of each **Policy Year**

iv. In relation to a Family Floater, the **Cumulative Bonus** so applied will only be available in respect of those **Insured Person**(s) who were **Insured Person**(s) in the claim free **Policy Year** and continue to be **Insured Person**(s) in the subsequent **Policy Year**.

v. For the purpose of computation of **Cumulative Bonus**, the percentage (%) of **Cumulative Bonus** will
be applied on the base **Sum Insured** of the expiring **Policy** only. The Restore Infinity Plus amount will not be taken into consideration for such computation.

vi. Reduction of **Sum Insured**: In case the **Sum Insured** under the **Policy** is reduced at the time of **Renewal** then the accrued **Cumulative Bonus** under this benefit shall be reduced in proportion to the reduced **Sum Insured**.

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

2) Discount in Renewal Premium (No Claim Bonus)

Optional Covers

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

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

C1. Consumables Benefit

In consideration of additional premium paid and notwithstanding the exclusion mentioned under Section 3.ii (Specific Exclusions).A.(xii), if this optional cover has been opted, **We** will cover expenses incurred for specified consumables, subject to balance **Sum Insured**, which are mentioned in Annexure I – List I of optional items (Consumables Benefit) available on **Our** website (www.tataaig.com) which are consumed during the period of **Hospitalization** directly related to the **Insured Person**'s medical or surgical treatment of **Illness**/disease/**Injury**.

Conditions applicable for claim to be admissible under this cover:

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

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

C2. Maternity Care

In consideration of additional premium paid and if this optional cover has been opted, **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**.

This benefit has a separate limit (over and above base **Sum Insured**) and does not affect No Claim Bonus.

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**.

i. **Maternity Expenses:**

Notwithstanding the exclusion mentioned under Section 3.i (Standard Exclusions).B.(xii) Maternity (Code – Excl 18), **We** will cover **Maternity Expenses** related to childbirth and lawful medical termination of pregnancy during the **Policy Period**.

We will not cover ectopic pregnancy under this benefit; however, it shall be covered under section B1.

The following shall be excluded from the scope of this coverage:

- Expenses incurred for pre/post natal care
- Pre/Post **Hospitalization** Expenses (Section B2 and B3 of this **Policy**)

Also, no coverage is available for voluntary termination of pregnancy during the **Policy Period** under this **Policy**.

ii. Delivery Complications of New Born Baby:

For complications related to delivery, **We** will cover **Medically Necessary Treatment** of the **New Born Baby** incurred during the **Hospitalization**, if claim related to childbirth is admissible under the '**Maternity Expenses**' cover (C2. i) of this **Policy**.

iii. First year Vaccinations:

We will cover vaccination expenses for the child up to their first birthday, if claim related to childbirth is admissible under the '**Maternity Expenses**' cover (C2. i) of this **Policy** and subject to continuity of the **Policy** with **Us**.

The limit available under this benefit is a lifetime limit for each child.

C3. Reduction of Maternity Care Waiting Period

In consideration of additional premium paid, the waiting period specified under Section C2 of this **Policy** shall be reduced to 1 year of continuous coverage.

C4. Infinite Advantage

In consideration of additional premium paid, **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**, subject to the following conditions:

i. The cover can be selected only at the inception of the **Policy**. Once opted, the cover has to be opted continuously under the **Policy**, until a claim is made under this cover.
ii. All the conditions applicable for the admissibility of In-Patient Treatment/Daycare Procedures cover shall be applicable to this cover
iii. This cover is applicable only for one claim in the lifetime of the **Policy**.
iv. Once a claim has been made under this Cover, the cover will cease to exist and cannot be opted again upon subsequent **Renewal**s.
v. The available amount shall be utilized as per following sequence in event of a claim under this Optional Cover:
    a. Base **Sum Insured**/ Early Access (if opted)
    b. **Cumulative Bonus**
    c. Infinite Advantage (only when the total amount available for claim is exhausted)
vi. After utilization of all the above-mentioned benefits, the total available amount shall be reduced to zero for that **Policy Year**/tenure (If Early Access has been opted) following the payment of claim under Infinite Advantage.
vii. Room category applicable under this cover shall be as per the room category opted and mentioned in the **Policy Schedule**
viii. 'Aggregate Deductible' or any other cost sharing covers, if opted, shall be applicable under this cover.

C5. Early Access

In consideration of additional premium paid, for single premium multi-year policies, the **Sum Insured** of the **Policy Period** shall be available anytime during the **Policy Period**, for utilization towards an admissible claim under Section B1, B2, B3, B4, B5, B6, B7 or B8.

With Early Access: **Your** annual Base **Sum Insured** is combined for the entire tenure opted by **You**. This combined Base **Sum Insured** will be available for the entire **Policy** tenure which means that unutilized **Sum Insured**, if any, shall be carried forward to the next **Policy Year** of the same **Policy Period**.

Illustration

Base **Sum Insured** (per **Policy Year**): Rs. 20 Lakhs

Policy Tenure: 3 Years

Year	**Without Early Access**	**With Early Access**
	Sum Insured (Rs.)	
Year 1	20 Lakhs	
Year 2	20 Lakhs	
Year 3	20 Lakhs	60 Lakhs
Year 4	20 Lakhs	
Year 5	20 Lakhs	
Year 6	20 Lakhs	60 Lakhs

Explanation:

Without Early Access: If **You** purchase a **Policy** of tenure of more than 1 year, **Your Policy Sum Insured** operates on annual basis. Which means if **You** have a **Policy** of Base **Sum Insured** Rs. 20 Lakhs, **You** can use Rs. 20 Lakhs in each **Policy Year** towards admissible claims.

C6. Room Category Select

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

However, if the **Insured Person** is admitted in a room whose category is higher than the one that is specified in the **Policy Schedule**, then the **Insured Person** shall bear a rateable proportion of the **Room**

Rent and the total **Associated Medical Expenses**, including surcharge or taxes thereon in the proportion of the 'difference between the **Room Rent** actually incurred & the **Room Rent** of the entitled room category' to 'the **Room Rent** actually incurred'.

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

C7. Aggregate Deductible

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

i. Aggregate Deductible, shall be applicable on aggregate of final assessed amount of all admissible claims in a **Policy Year** and **Our** liability shall be restricted to the balance amount, subject to availability of **Sum Insured**

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

iii. **Aggregate Deductible** shall be applicable for all indemnity claims under following covers of this **Policy**, as applicable:
   a. In-Patient Treatment,
   b. Pre/Post **Hospitalization** expenses,
   c. Day Care Procedures,
   d. Organ donor,
   e. Domiciliary Treatment,
   f. AYUSH Benefit,
   g. Ambulance Cover
   h. Consumable benefit (if opted)
   i. Infinite Advantage (if opted)
   j. Early Access (if opted)

Section 3 – Exclusions

We will neither be liable nor make any payment for any claim in respect of any **Insured Person** which is caused by, arising from or in any way attributable to any of the following exclusions. All the waiting periods shall be applicable individually for each **Insured Person**.

i. **Standard Exclusions**

A. **Exclusions with waiting periods**

i. ***Pre-Existing Diseases Waiting Period (Code- Excl 01):***

a. Expenses related to the treatment of a **Pre-Existing Disease** (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first **Policy** with **Us**.

b. In case of enhancement of **Sum Insured** the exclusion shall apply afresh to the extent of **Sum Insured** increase.

c. If the **Insured Person** is continuously covered without any break as defined under the **Portability** norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the **Policy** after the expiry of 36 months for any **Pre-Existing Disease** is subject to the same being declared at the time of application and accepted by **Us**.

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

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first **Policy** with **Us**. This exclusion shall not be applicable for claims arising due to an **Accident**.

b. In case of enhancement of **Sum Insured**, the exclusion shall apply afresh to the extent of **Sum Insured** increase.

c. If any of the specified disease/procedure falls under the waiting period specified for **Pre-Existing Disease**s, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the **Policy** or declared and accepted without a specific exclusion.

e. If the **Insured Person** is continuously covered without any break as defined under the applicable norms on **Portability** stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

List of Specific disease/conditions/treatments:

I. Tumors, Cysts, polyps including breast lumps (benign) (*Arbud, Granthi, including arbud in Sthana*)

II. Polycystic ovarian disease (*garbhashaya granthi)*, Fibromyoma {*Aartav dushti (Sowmya arbudham)}*, Adenomyosis, Endometriosis *(Udavarthani yoni vyaazpt*)

III. Prolapsed Uterus (Yoni bhramsha)

IV. Gout and Rheumatism (*Vaathraktha and Aamvaat / Aadhya vata*), Rheumatoid arthritis, Non-infective arthritis (*Sandhi shool {Dhatukshay janya or Avrodhjanya, both, Sandhigata vata, Vata roga})*

V. Ligament, Tendon or Meniscal tear (*Sira, kandara, maamsgat vaat janya shool, sandhi shola)*

VI. Prolapsed Inter-Vertebral Disc (*Katishool, Greevashool, Grudhrasi vata)* and Spinal Diseases including spondylitis/spondylosis unless arising from **Accident**

VII. Cholelithiasis (*yakrut roga)*

VIII. Pancreatitis

IX. Fissure/fistula in anus, haemorrhoids, pilonidal sinus (*Arsha, Parikartika, bhagandar, gudagat vranshoth, nadi vrana)*

X. Ulcer & erosion of stomach & duodenum

XI. Gastro Esophageal Reflux Disorder (GERD) (*Parinamshool, annadravakhya shool, Amlapitta, Grahani)*

XII. Liver Cirrhosis

XIII. Perineal Abscesses (*bhagandhara)*

XIV. Perianal / Anal Abscesses

XV. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone (*Ashmari of all types)*

XVI. Benign Hyperplasia of prostate (*Aththila vruddhi*)

XVII. Varicocele (*Vruddhi, Vrushanshoth*)

XVIII. Cataract (*avrana Shukla)*, Retinal detachment, Glaucoma (*abhishyandha)*

XIX. Congenital Internal Diseases

XX. Osteoarthritis and osteoporosis (*Asthikshay/ asti gata vata)*

XXI. Systemic connective tissue disorders, inflammatory polyarthropathies

List of procedure/surgeries/treatments:

XXII. Adenoidectomy

XXIII. Mastoidectomy

XXIV. Tonsillectomy

XXV. Tympanoplasty

XXVI. **Surgery** for nasal septum deviation and Nasal concha resection

XXVII. **Surgery** for Turbinate hypertrophy

XXVIII. Hysterectomy

XXIX. Joint replacement (for example: Knee replacement, Hip replacement)

XXX. Cholecystectomy

XXXI. Hernioplasty or Herniorraphy

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

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

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

XXXV. Obesity / Weight control procedures including Gastric bypass surgeries

iii. ***30 Days Waiting Period (Code- Excl 03):***

a. Expenses related to the treatment of any **Illness** within 30 days from the first **Policy** commencement date shall be excluded except claims arising due to an **Accident**, provided the same are covered.

b. This exclusion shall not, however, apply if the **Insured Person** has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced **Sum Insured** in the event of granting higher **Sum Insured** subsequently.

B. **Medical Exclusions**

i. **Investigation and evaluation (Code- Excl 04):**

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

ii. **Rest cure, rehabilitation and respite care (Code- Excl 05):**

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. **Obesity/ Weight Control (Code- Excl 06):**

Expenses related to surgical treatment of obesity that does not fulfil the below conditions:

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

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

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

d. Body Mass Index (BMI);

i. greater than or equal to 40 or

ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

1. Obesity-related cardiomyopathy
2. Coronary heart disease

3. Severe Sleep Apnea
4. Uncontrolled Type2 Diabetes

iv. **Change-of-Gender treatments (Code- Excl07):**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

v. **Cosmetic or Plastic Surgery (Code- Excl 08):**
Expenses for cosmetic or plastic **Surgery** or any treatment to change appearance unless for reconstruction following an **Accident**, Burn(s) or Cancer or as part of **Medically Necessary Treatment** to remove a direct and immediate health risk to the **Insured Person**. For this to be considered a medical necessity, it must be certified by the attending **Medical Practitioner**.

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

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

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

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

x. **Unproven treatments (Code- Excl 16):**
Expenses related to any **Unproven Treatment**, services and supplies for or in connection with any treatment. **Unproven treatments** are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

xi. **Sterility and Infertility (Code- Excl 17):**
Expenses related to Sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

xii. **Maternity (Code - Excl 18):**

1. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during **Hospitalization**) except ectopic pregnancy;
2. Expenses towards miscarriage (unless due to an **Accident**) and lawful medical termination of pregnancy during the **Policy Period**.

C. **Non-Medical Exclusions**

i. **Hazardous or Adventure Sports (Code- Excl 09):**
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

ii. **Breach of law (Code- Excl 10):**
Expenses for treatment directly arising from or consequent upon any **Insured Person** committing or attempting to commit a breach of law with criminal intent.

iii. **Excluded Providers: (Code-Excl 11):**
Expenses incurred towards treatment in any **Hospital** or by any **Medical Practitioner** or any other provider specifically excluded by the **Insurer** and disclosed in its website / notified to the Policyholders are not admissible. However, in case of life-threatening situations or following an **Accident**, expenses up to the stage of stabilization are payable but not the complete claim.

ii. **Specific Exclusions (Exclusions other than as those mentioned under Section 3 (i) subsection A, B & C above)**
We will neither be liable nor make any payment for any claim in respect of any **Insured Person** which is caused by, arising from or in any way attributable to any of the following exclusions.

A. **Medical Exclusions**

i. Alcoholic pancreatitis or Alcoholic liver disease;

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

B. **Non-Medical Exclusions**

i. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not) or caused during service in the armed forces of any country, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.
ii. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

- Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any **Illness**, incapacitating disablement or death

- Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any **Illness**, incapacitating disablement or death.

- Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced

toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any **Illness**, incapacitating disablement or death.

iii. Any **Insured Person**'s participation or involvement in 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, except where the **Insured Person** is not directly responsible for the **Injury**/**Accident** though under influence of intoxication.
vi. Items of personal comfort and convenience like television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service.
vii. Treatment rendered by a **Medical Practitioner** which is outside his discipline.
viii. Doctor's fees charged by the **Medical Practitioner** sharing the same residence as an **Insured Person** or who is an immediate relative of an **Insured Person**'s family.
ix. Hearing aids, spectacles or contact lenses, etc. including optometric therapy.
x. Any treatment and associated expenses for alopecia, baldness, wigs or toupees, medical supplies including elastic stockings, diabetic test strips and similar products.
xi. Any treatment or part of a treatment that does not form part of '**Reasonable and Customary charges**', nor is medically necessary;
xii. Expenses which are either not supported by a prescription of a **Medical Practitioner** or are not related to **Illness** or disease for which claim is admissible under the **Policy**.
xiii. Any external appliance and/or device used for diagnosis or treatment except when used intra-operatively.
xiv. Any **Illness** diagnosed or **Injury** sustained or where there is change in health status of the member after date of proposal and before commencement of **Policy** and the same is not communicated and accepted by **Us**.

Section 4 – General Terms and Clauses

i. Standard General Terms & Clauses

1. Disclosure of Information

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

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

2. **Condition Precedent to Admission of Liability**

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

3. **Claim Settlement (provision for Penal Interest)**

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

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

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

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

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).

4. **Complete Discharge**

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

5. **Multiple Policies**

i. In case of multiple policies taken by an **Insured Person** during a period from one or more insurers to indemnify treatment costs, the **Insured Person** shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the **Insurer** chosen by the

Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen **Policy**.

ii. **Insured Person** having multiple policies shall also have the right to prefer claims under this **Policy** for the amounts disallowed under any other **Policy** / policies even if the **Sum Insured** is not exhausted. Then the **Insurer** shall independently settle the claim subject to the terms and conditions of this **Policy**.

iii. If the amount to be claimed exceeds the **Sum Insured** under a single **Policy**, the **Insured Person** shall have the right to choose **Insurer** from whom he/she wants to claim the balance amount and **We** will assist the **Insured Person** in facilitating the same.

iv. Where an **Insured Person** has policies from more than one **Insurer** to cover the same risk on indemnity basis, the **Insured Person** shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen **Policy**.

6. **Fraud**

If any claim made by the **Insured Person**, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the **Insured Person** or anyone acting on his/her behalf to obtain any benefit under this **Policy**, all benefits under this **Policy** and the premium paid shall be forfeited.

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

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

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

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

7. **Cancellation**

The policyholder may cancel this **Policy** by giving 7 days written notice and in such an event, the Company shall refund proportionate premium for unexpired **Policy Period**. No refunds of premium

shall be made in respect of Cancellation where any claim has been admitted or has been lodged or any benefit under this **Policy** has been availed by the **Insured Person**.

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

8. **Migration**

The **Insured Person** will have the option to migrate the **Policy** to other health insurance products/plans offered by the company by applying for **Migration** of the **Policy** at least 30 days before the **Policy Renewal** date per IRDAI guidelines. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the **Insured Person** will get the accrued continuity benefits to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy, as applicable.

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

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

9. **Portability**

The **Insured Person** will have the option to port the **Policy** to other insurers by applying to such **Insurer** to port the entire **Policy** along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the **Policy Renewal** date per IRDAI guidelines. If such person is presently covered and has been continuously covered without any lapses under any health insurance **Policy** with an Indian General/Health **Insurer**, the proposed **Insured Person** will get the accrued continuity benefits to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the existing Insurer to the acquiring Insurer in the previous policy, as applicable.

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

Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance

Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and their subsequent amendments thereof.

10. **Renewal of Policy**

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

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

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

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

iv. The **Grace Period** for payment of the premium during the **Policy Period**, for instalment premium shall be fifteen days where premium payment mode is monthly and thirty days in all other cases (Annual/ Half-Yearly/ Quarterly/Limited Premium paying term).

v. Coverage during such **Grace Period** (in case of instalment premium):

   a. Within the **Policy Period** - coverage will be available from the due date of instalment premium till the date of receipt of premium by Company within the **Grace Period**.

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

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 **Renewal**s based on individual claims experience.

11. **Withdrawal of Policy**

i. In the likelihood of this product being withdrawn in future, the Company will intimate the **Insured Person** about the same 90 days prior to expiry of the **Policy**.

ii. **Insured Person** will have the option to migrate to similar health insurance product available with the Company at the time of **Renewal** with all the accrued continuity benefits such as No Claim Bonus, waiver of waiting period as per IRDAI guidelines, provided the **Policy** has been maintained without a break.

12. **Moratorium Period**

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

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

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

14. **Free look period**

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

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

15. **Redressal of Grievance**

At TATA AIG, **We** strive to provide the best service to **Our** customers. If **You**'re not satisfied and wish to lodge a complaint, please call **Our** 24/7 toll-free number 1800-266-7780 /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).

Escalation Level 1

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

Escalation Level 2

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

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

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

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

16. **Nomination**

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

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

17. Insured Person

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

18. Loadings

i. **We** may apply a risk loading on the premium payable (based upon the declarations made in the proposal and the health status of the persons proposed for insurance).
ii. The loading shall be applied basis outcome of **Our** underwriting.

iii. These loadings are applied from Commencement Date of the **Policy** including subsequent **Renewal**(s) with **Us** and on the applicable **Sum Insured** for each **Policy Year** including increased **Sum Insured**, if any.
   a. **We** will inform **You** about the applicable risk loading through a counter offer letter.
   b. **You** need to revert to **Us** with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter.
   c. In case, **You** neither accept the counter offer nor revert to **Us** within 15 days, **We** shall cancel **Your** application and refund/ release the amount subject to deduction of the Pre-**Policy** Check up charges, as applicable.

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

19. Entire Contract

i. This **Policy**, its Schedule, endorsement(s), proposal constitutes the entire contract of insurance. No change in this **Policy** shall be valid unless approved by **Us** and such approval be endorsed hereon.

ii. This **Policy** and the Schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this **Policy** or of the Schedule shall bear such meaning wherever it may appear.

20. Notices

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

21. Premium Payment Zone

For the purpose of premium computation, the country is divided into three Zones {as mentioned in Section 1: ii. Specific Definitions. 15. **Zone**(s)} and the premium payable under this **Policy** will be computed based on the residential location/address as provided by the proposer/**Insured Person** in the proposal form.

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

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

The coverage for the **Insured Person**(s) shall automatically terminate in case of his/ her (**Insured Person**) demise. However, the cover shall continue for the remaining **Insured Person**s till the end of **Policy Period**.

Provided no claim has been made and deletion from **Policy** takes place on account of death of the **Insured Person** during the **Policy Period**, pro-rata refund of premium of the deceased **Insured Person** for the balance period of the **Policy** will be made. Refund will be made to the **Policy** holder or the nominee as the case may be in case of demise of the **Policy** holder. **We** would require death certificate of the Deceased **Insured Person** for processing of the refund amount.

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

Section 5 – Claims Procedure and Claims Payment

This section explains about the procedure involved to file a valid claim by the **Insured Person** and processes related to assessment, cost sharing and management of the claim. All the procedures and processes such as **Notification of Claim**, availing cashless service, supporting claim documents and related claim terms of payment are explained in this section.

a. Notification of Claim

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

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

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

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

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

b. **Cashless Service**

Treatment, Consultation or Procedure:	**Taken at:**	**Cashless Service is Available:**	**We must be given notice that the Insured Person wishes to avail cashless service accompanied by full particulars:**
If any planned treatment, consultation or procedure for which a claim may be made:	**Network Provider**	**We** will provide cashless service by making payment to the extent of **Our** liability directly to the Network **Hospital**.	At least 48 hours before the planned **Hospitalization**
If any treatment, consultation or procedure for which a claim may be made, requiring emergency **Hospitalization**	**Network Provider**	**We** will provide cashless service by making payment to the extent of **Our** liability directly to the Network **Hospital**.	Within 24 hours of the **Hospitalization** and prior to discharge

c. **Procedure for Cashless Service**

i. Cashless Service is only available at **Our Network Provider**.

ii. In order to avail cashless treatment, the following procedure must be followed by **You**:

a. Prior to taking treatment and/or incurring **Medical Expenses** at a **Network Provider**, **You** must notify **Our** designated TPA/**Us** and request pre-authorization.

b. **Our** designated TPA/**We** will check **Your** coverage as per the eligibility and send an authorization letter to the provider. **You** have to provide the ID card issued to **You** along with

any other information or documentation that is requested by the TPA/**Us** to the **Network Provider**.

c. In case of deficiency in the documents sent to TPA/**Us** for cashless authorization or the ailment /treatment is not covered under the **Policy**, the same shall be communicated to the **Hospital/You** by TPA/**Us.**
d. **We/TPA will respond** within turn around time as prescribed by the Regulator under the Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 and its subsequent amendments thereof.
e. Rejection of cashless in no way indicates rejection of the claim. **You** are required to submit the claim along with required documents for **Us** to decide on the admissibility of the claim.
f. If the cashless is approved, the original bills and evidence of treatment in respect of the same shall be left with the **Network Provider**.
g. Pre-authorization does not guarantee that all costs and expenses will be covered. **We** reserve the right to review each claim for **Medical Expenses** and accordingly coverage will be determined according to the terms and conditions of this **Policy**.

d. **Supporting Documentation & Examination**

i. **We** or **Our** TPA may require documentation, medical records and information to establish the circumstances of the claim, its quantum or **Our** liability for the claim within 15 days or earlier of **Our** request or the **Insured Person**'s discharge from **Hospitalization** or completion of treatment.
ii. In case the delay is at **Your** end, failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if **You** can satisfy **Us** that it was not reasonably possible for **You** to give proof within such time.
iii. **We** may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the **Insured Person**.
iv. Such documentation will include the following:
    a. **Our** claim form, duly completed and signed for on behalf of the **Insured Person**. **We**, upon receipt of a notice of claim, will furnish **Your** representative with such forms as **We** may require for filing proofs of loss or **You** may download the claim form from **Our** Web site.
    b. Original Bills (pharmacy purchase bill, consultation bill, diagnostic bill, medical devices) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become **Our** property.
    c. All medical reports, case histories, investigation reports, indoor case papers/ treatment papers (in reimbursement cases, if available), discharge summaries.
    d. A precise diagnosis of the treatment for which a claim is made.
    e. A detailed list of the individual medical services and treatments provided and a unit price for each in case not available in the submitted **Hospital** bill.
    f. Prescriptions that name the **Insured Person** and in the case of drugs: the drugs prescribed, their price and a receipt for payment. In case of pre/post **Hospitalization** claim Prescriptions must be submitted with the corresponding Doctor/**Hospital** invoice.

g. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made, if and where applicable.
h. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of **Injury** and Alcohol or drug influence at the time of **Accident**, if available.
i. Copy of settlement letter from other insurance company or TPA.
j. Stickers and invoice of implants used during **Surgery**.
k. Copy of MLC (Medico legal case) records, if carried out and FIR (First information report), if registered, in case of claims arising out of an **Accident** and available with the claimant.
l. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements.
m. Legal heir/succession certificate, if required
n. PM report (wherever applicable)
o. The Company reserves the right to call for additional documents wherever required.

v. Note: In case **You** are claiming for the same event under an indemnity-based **Policy** with **Us** and with another **Insurer** and are required to submit the original documents related to **Your** treatment with that particular **Insurer**, then **We** will require the attested copies of such documents along with a declaration from the particular **Insurer** specifying the availability of the original copies of the specified treatment documents with it.
vi. **We** at **Our** own expense, shall have the right and opportunity to examine **Insured Person**s through **Our** Authorised **Medical Practitioner** whose details will be notified to **Insured Person** when and as often as **We** may reasonably require during the pendency of a claim hereunder.

e. **Claims Assessment and Payment**

i. **General**

a. **We** shall be under no obligation to make any payment under this **Policy** unless:
   - **We** have received all premium payments in full and in time and
   - **We** have been provided with the documentation and information which **We** or **Our** TPA has requested to establish the circumstances of the claim, its quantum or **Our** liability for it, and
   - unless **You** have complied with **Your** obligations under this **Policy**.

b. This **Policy** only covers claims incurred within India, and payments under this **Policy** shall only be made in Indian Rupees within India.
c. **Medical Expenses** incurred for **AYUSH Treatment** shall be assessed only under benefit B7 of this **Policy** and shall be admissible only if incurred within India.

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

Claim assessment for policies with instalment Premium Payment Mode:

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

ii. **Sequence of applicability & Utilization**

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

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

[#] Deduction may vary subject to selection of 'Consumables Benefit' optional cover.

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

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

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

1. Balance **Sum Insured**/Early Access (if opted),
2. Any accrued **Cumulative Bonus**,
3. Restore Infinity Plus amount/Infinite Advantage amount (If opted)

Supporting Documentation & Examination

Insured Person or someone booking services on **Your** behalf shall provide **Us** with identification documentation, medical records and information **We** may request to establish the circumstances of the claim.

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

Section 6 - Dispute Resolution

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

Annexure A

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES

Sr.No.	Centre	Address & Contact	Jurisdiction of Office Union Territory, District
1	AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
2	BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
3	BHOPAL	Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir,Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202/ 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh

4	BHUBHANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/ 2596429/ 2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
5	CHANDIGARH	Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
6	CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)
7	DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 – 46013992/ 23213504/ 23232481 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
8	GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Near Panbazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205/ 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura

9	HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 – 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
10	JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
11	KOCHI	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
12	KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
13	LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur,

			Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
14	MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
15	NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
16	PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand

17	PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
18	THANE	Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane - 400604 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."

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

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

Prohibition of Rebates - Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the **Policy**, nor shall any person taking out or renewing or continuing a **Policy** accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the **Insurer**.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

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