Prospectus

1. Suitability:

a. This Product has 3 base benefit Sections and 1 Optional benefit as:

- Section A: Critical Illness,
- Section B:Cancer 360 Degree Indemnity Cover
- Section C:HospitalCash and
- Section D:Wellsurance Benefit(Optional).

Minimum one Section from the base benefit sections has to be chosen by the policyholder.

Note:This Product offers No Claim Benefit i:e,Section E: Personal Accident (only applicable for Section A: Critical Illness)

b. Entry age for all sections is as below:

Section	Section Name	Minimum entry age	Maximum entry age
A	Critical Illness	18 Years	65 years
B	Cancer 360 Degree - Indemnity	91 days	65 years
C	Hospital Cash	91 days	65 years
D	Wellsurance Benefit	18 years	65 years

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

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

e. This policy can be issued to an individual/multi-individual

f. For a multi-individual the relationships covered includes self, spouse , dependent children, parents, parents-in-law, grand children, brother, sister, brother-in-law/Sister-in-law, nephew/niece.

2. Key Benefits:

a. **Range of benefits:** Option of Covering Critical Illness(s) on a fixed benfit basis (50 or 100 Critical illness Plan available) through Section A,Cancer on an Indemnity basis through Section B,Hospital Cash through Section C under the same product

b. **Network of hospitals:** We are equipped to offer you health care with our network of 6000+ hospitals across India.

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

d. **Tax Benefit:** The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

3. Discounts on premium:

a. 10% long term discount on premium in case insured opts policy term of 3 years

b. 5% long term discount on premium in case insured opts policy term of 2 years

c. Multi-individual discount:

- 7.5% where > 2 individuals covered in a single policy

d. Tata GroupEmployee discount

- 5% in case business is sourced as direct (no intermediary involved)

e. E-Policy discount 2.5%

f. Multi cover discount – 2.5% in case more than 1 sections are opted under the policy

g. TATA AIG customer discount of 2.5% in case customer holders any other TATA AIG policy (active)

4. Benefits:

A. Critical Illness

A1. Critical Illness

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If the Insured Person is diagnosed to be suffering from a Critical Illness specified in the opted plan during the Policy Period, then, We shall pay the Sum Insured as a lump sum amount set out for that Critical Illness in the Policy Schedule provided that:

Conditions

1. The diagnosed critical illness is the first incidence
2. The Critical Illness is diagnosed after 90 days from the first risk commencement date.
3. The Insured Person survives the critical Illness, for a period as specified in the Policy Schedule.
4. Pre-existing diseases or its related conditions shall be covered after a waiting periodof 36 months. The said conditions must be declared, if known, to the insured person at the time of application and must not have been explicitly excluded in the policy as permanent exclusion.
5. Multi-Pay Feature: Under multi-pay feature, if more than one claim of critical illness (es) is/are lodged during the lifetime of the Policy , We shall pay for second as well as third claim of critical illness as listed in Critical illness categories (Category A/B/C as mentioned below) provided that we shall not pay more than one claim under the same Critical illness category. In case of multiple claims under Multi-pay Feature, waiting period of 60 days from the date of diagnosis of earlier admissible Critical Illness Claim shall apply.
6. Based on the number of claim Payment made under (Multi- Pay Feature), the Coverage under this section will cease to exist upon payment of 3 claims, during the lifetime of the Policy for that particular insured person.

Illustration for Multi-Pay Feature:

For example, an Individual has opted for Smart Century Premier Plan under Section A: Critical Illness with Sum insured of Rs 10 Lacs and Policy Inception date is on 1st May 2021 with Policy tenure of 1 Year

Critical Illness Claim	Sum Insured available (Rs.)	Claim Amount (Rs.)	Conditions applicable
1st admissible Claims date on 1st September 2021 under Category A	• 10 Lacs for Category A • 10 Lacs for Category B • 10 Lacs for Category C	10 Lacs under Category A	In future, no further claims will be payable under Category A in the Policy lifetime , however claims can be paid under Category B/C(one claim each)
2nd admissible Claims date on 5th December 2021 under Category B	• 10 Lacs for Category B • 10 Lacs for Category C	10 Lacs under Category B	In future, no further claims will be payable under Category A and Category B in the Policy lifetime, however claims can be paid under Category C (one claim). In case of multiple claims under Multi-pay Feature, waiting period of 60 days from the date of diagnosis of earlier admissible Critical Illness Claim shall apply.
3rd admissible Claim on 10th March 2022 under Category C	• 10 Lacs for Category C	10 Lacs under Category C	The Coverage under Critical Illness (Section A) will cease to exist upon payment of 3 claims, during the lifetime of the Policy. In case of multiple claims under Multi-pay Feature, waiting period of 60 days from the date of diagnosis of earlier admissible Critical Illness Claim shall apply.

7. Covered Critical Illness: A Covered Critical Illness shall mean any one of the following critical illnesses with specific meaning as defined in the policy.

(i) Smart Century Premier Plan

Sr. No	Category A
1	Cancer of Specified Severity
2	Kidney Failure requiring regular dialysis

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3	Major organ/Bone Marrow Transplant
4	Open Heart Replacement/Repair of Heart Valves
5	Open Chest Coronary Artery Bypass Graft
6	Myocardial Infarction (First Heart Attack of specific severity)
7	Refractory heart failure
8	Cardiomyopathy
9	Stroke resulting in permanent symptoms
10	Permanent Paralysis of Limbs
11	Parkinson's disease
12	Primary (Idiopathic) Pulmonary Hypertension
13	End Stage Lung Failure
14	Rabies
15	End Stage Liver Failure
16	Angioplasty
17	Chronic Aplastic Anemia
18	Cerebral Aneurysm with Specified Surgery
19	Hemiplegia
20	Chronic Relapsing Pancreatitis
21	Infective Endocarditis
22	Pericardectomy
23	Percutaneous Heart Valve Replacement
24	Pneumonectomy
25	Bariatric Surgery
26	Percutaneous Transluminal Angioplasty of Renal Artery
27	Severe Progressive Supranuclear Palsy
28	Surgical Removal of One Kidney
29	Total Glossectomy
30	Budd–Chiari syndrome
31	Carotid Angioplasty
32	Polycystic Kidney Disease
33	Primary Biliary Cirhosis
34	Cardiac Rupture
35	Total Laryngectomy
36	Cerebral Artery Bypass Surgery
37	Pulmonary Thromboembolism
38	Carotid endarterectomy Surgery
39	Spinal Surgery in case of Trauma

Sr.No	**Category B**
40	Multiple Sclerosis with Persisting Symptoms
41	Motor Neuron Disease with Permanent Symptoms
42	Alzheimer's disease
43	Benign brain tumor

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44	Major Head Trauma
45	Apallic syndrome
46	Deafness
47	Loss of speech
48	Loss of limbs
49	Loss of independent existence
50	Blindness
51	Third Degree Burns
52	Coma of specified severity
53	Chronic Rheumatoid Arthritis
54	Pheochromocytoma
55	Eisenmenger's Syndrome
56	Chronic Adrenal Insufficiency
57	Cardiac Pacemaker insertion
58	Surgical removal of an eyeball
59	Wilson's disease
60	Guillain Barre Syndrome (GBS)
61	Age Related Macular Degeneration
62	Surgery for removal of Acoustic Neuroma
63	Major Brain Surgery
64	Complete Splenectomy
65	Whipple procedure
66	Loss of sight of one eye and loss of one limb
67	Embolization of Acquired AV fistula
68	Myoxomas
69	Diabetes Insipidus
70	Full dental reconstruction due to accident
71	Keyhole Craniotomy
72	Terminal Illness

Sr.No	**Category C**
73	Creutzfeldt-Jakob disease
74	Progressive Scleroderma
75	Medullary Cystic Disease
76	Muscular dystrophy
77	Poliomyelitis
78	Systemic lupus erythematosus with renal involvement
79	Myasthenia gravis
80	Good pastures syndrome with lung or renal involvement
81	Aorta Graft surgery
82	Bacterial Meningitis
83	Encephalitis
84	Fulminant Viral Hepatitis

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85	Crohn's Disease
86	Ulcerative Colitis
87	Autoimmune Hepatitis
88	Total Pancreatectomy
89	Tuberculosis Meningitis
90	Dissecting Aortic aneurysm
91	Elephantiasis
92	Myelofibrosis
93	Cystic Fibrosis
94	Total proctocolectomy
95	Toxic epidermal necrolysis (TEN)
96	Chronic PAN (Polyarteritis Nodosa)
97	Adult Polymyositis
98	Giant Cell Arteritis
99	Multiple System Atrophy
100	HIV due to blood transfusion and occupationally acquired HIV

(ii) Smart Half Century Plan

Sr. No	Category A
1	Cancer of Specified Severity
2	Kidney Failure requiring regular dialysis
3	Major organ/Bone Marrow Transplant
4	Open Heart Replacement/Repair of Heart Valves
5	Open Chest Coronary Artery Bypass Graft
6	Myocardial Infarction (First Heart Attack of specific severity)
7	Cardiomyopathy
8	Stroke resulting in permanent symptoms
9	Permanent Paralysis of Limbs
10	Parkinson's disease
11	Primary (Idiopathic) Pulmonary Hypertension
12	End Stage Lung Failure
13	Rabies
14	End Stage Liver Failure
15	Angioplasty
16	Chronic Relapsing Pancreatitis
17	Infective Endocarditis
18	Severe Progressive Supranuclear Palsy

Sr.No	Category B
19	Multiple Sclerosis with Persisting Symptoms
20	Motor Neuron Disease with Permanent Symptoms
21	Alzheimer's disease
22	Benign brain tumor

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23	Major Head Trauma
24	Apallic syndrome
25	Deafness
26	Loss of speech
27	Blindness
28	Third Degree Burns
29	Coma of specified severity
30	Chronic Rheumatoid Arthritis
31	Pheochromocytoma
32	Eisenmenger's Syndrome
33	Chronic Adrenal Insufficiency
34	Major Brain Surgery
35	Terminal Illness

Sr.No	Category C
36	Creutzfeldt-Jakob disease
37	Progressive Scleroderma
38	Medullary Cystic Disease
39	Systemic lupus erythematosus with renal involvement
40	Aorta Graft surgery
41	Bacterial Meningitis
42	Encephalitis
43	Fulminant Viral Hepatitis
44	Crohn's Disease
45	Ulcerative Colitis
46	Dissecting Aortic aneurysm
47	Elephantiasis
48	Myelofibrosis
49	Multiple System Atrophy
50	HIV due to blood transfusion and occupationally acquired HIV

A2. Waiver of Premium (Applicable for Smart Century Premier Plan)

We will waive 70% of payable renewal Premium for next 3 Policy Years of the Insured Person where the first Claim has been admitted by Us under Smart Century Premier Plan under Section A of this Policy

Premium will be waived for Renewal of that particular Insured Person to the extent applicable to coverages, terms and conditions of the expiring Policy.

A3. Health Check up

We will cover expenses for Preventive Health Check-up upto 1% of previous policy year Sum Insured maximum up to Rs 10,000 provided this coverage exists in the previous Policy year and no claim has been reported in the previous three consecutive Policy years with Us . This limit is maximum per insured person. This Benefit is payable over and above the Sum Insured.

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

A4. Second Medical Opinion

We will organize second Medical opinion upon specific request of Insured person from Network Provider or Medical

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Practitioner, if an Insured Person is diagnosed with covered Critical Illness during the Policy Period. The expert opinion would be directly sent to the Insured Person and would be subject to the following conditions.

a) This Benefit can be availed by the Insured Person only once in the Policy Period

b) The Second Medical Opinion shall be arranged only on the basis of information and documentation provided to Us.

c) Under this Benefit, We are only providing the Insured Person with access to a Second Medical Opinion and it shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

d) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

e) Any Second Medical Opinion provided under this benefit shall not be valid for any medico-legal purposes.

A5. Smart Cancer Care

If the Insured Person is diagnosed to be suffering from Cancer of the nature as specified below during the Policy Period and survives the duration as specified on the Policy Schedule, then, We shall pay the below specified percentage of Sum Insured mentioned in the Policy Schedule against this benefit provided that the Critical Illness is diagnosed during the Policy Period as a first incidence subject to:

Conditions

a) Maximum liability during the lifetime of the Insured Person: 100% of the Sum Insured applicable to this benefit

b) Cover Termination: Once a claim for Advanced stage of Cancer becomes admissible, coverage for this benefit shall terminate.

c) Maximum number of claims: One under Early Stage Cancer and/or Major and/or Advanced Stage.

d) For any of the specified Early Stage Cancer Condition or Carcinoma-in-situ (CIS) 20% of the Sum Insured as specified in the Policy Schedule shall be payable only once and only for the first event of early stage/CIS cancer.

e) For specified Major Stage Cancer, 30% of the Sum Insured as specified in the Policy Schedule shall be payable.

f) For specified Advanced Stage Cancer, 50% of the Sum Insured as specified in the Policy Schedule shall be payable.

g) If more than one stage is diagnosed within a period of 7 days, only one claim, with the highest Benefit pay-out shall be admissible.

h) Cancer is diagnosed after 90 days from the first risk commencement date.

i) The Insured Person survives the diagnosed Cancer for a period as specified in the Policy Schedule.

j) Pre-existing diseases or its related conditions shall be covered after a waiting period of 36 months. The said conditions must be declared, if known, to the insured person at the time of application and must not have been explicitly excluded in the policy as permanent exclusion.

k) This benefit has a separate sum insured and is over and above the Critical Illness benefit sum insured.

B. Cancer 360 Degree-Indemnity Cover

The following benefits are payable for Treatment of Cancer (including In-situ Cancer or any pre-cancerous lesions) subject to applicable waiting period, otherTerms and Conditions of the policy:

B1. In-Patient Treatment

We will cover Medical Expenses up to the Sum Insured as specified in the Policy Schedule for Treatment of Cancer during the policy period which requires an Insured Person's admission in a hospital as an In -Patient .

Reasonable and Customary Charges for Medically Necessary treatment directly related to the hospitalization would be payable prescribed in writing, by a treating Medical Practitioner.

B2. Pre- Hospitalization expenses

We will cover Reasonable and Customary Pre-Hospitalization Medical expenses up to the Sum Insured and which is incurred up to 60 days before the date of admission to the hospital.

The benefit is payable if We have admitted a claim under In-Patient Treatment (SectionB1) or Day Care Treatment (Section B4) or Home Care (Section B6) of this policy.

B3. Post-Hospitalization expenses

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We will cover Reasonable and Customary Post-Hospitalization Medical expenses up to the Sum Insured and which is incurred upto 90 days after the date of discharge from the hospital.

The benefit is payable if We have admitted a claim under In-Patient Treatment (Section B1) or Day Care Treatment (Section B4) or Home Care (Section B6) of this policy.

B4. Day Care Treatment

We will cover Reasonable and customary Medical expenses for Day Care Treatments up to the Sum Insured which an Insured Person undergoes due to Cancer (including In-situ Cancer or any pre-cancerous lesions) during the policy period.

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

B5. Organ Donor Expenses

We will cover Reasonable and Customary Medical and surgical Expenses of the organ donor for harvesting the organ up to the Sum Insured where an Insured Person is the recipient provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs (Amendment) Bill, 1994 and its subsequent amendments and the organ donated is for the use of the Insured Person, and

ii. The Insured Person has been medically advised to undergo an organ transplant necessitated as a part of cancer treatment and We have accepted an inpatient Hospitalization claim for the Insured Person under In Patient Treatment for Cancer (under B1).

B6. Home Care (Cancer)

We will cover Reasonable and customary Medical expenses for Home Care Treatment for cancer up to the Sum insured for the Insured Person's Medically necessary Treatment at his/her home provided that:

I. Duration of the each Home Care Treatment does not exceed 15 days

II. OPD Treatment is not covered under this section

III. The same treatment is eligible for coverage under In Patient Treatment (under B1)

IV. The amount, frequency and time period of the home treatment services should be reasonable and advised by the treating Medical Practitioner

V. Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the home treatment plan, in accordance with the condition of the Insured Person.

VI. Home Treatment services are provided through Network Service Provider / Empanelled Service Provider in select cities for select treatment procedures only. Please contact Us or visitour website (www.tataaig.com) for updated list of treatment procedures and cities where Home Treatment service is provided.

VII. We do not assume any liability towards, and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner and/or Network Service Provider / Empanelled Service Provider or in any service under this Benefit or for any consequences of actions taken or not taken in reliance thereon.

B7. Chemotherapy and Radiotherapy Cover

We will cover Reasonable and Customary Medical Expenses up to the Sum Insured as specified in the Policy Schedule for availing Chemotherapy (including Oral Chemotherapy) and Radiotherapy treatment, provided that the Medical Expenses are related to Cancer.

B8. OPD Cover (Outpatient)

We will cover Reasonable and Customary Medical expenses related to consultations, diagnostics and pharmacy up to 1% of Sum Insured subject to maximum of Rs. 10,000/- per policy year .

B9. Advanced Treatments for Cancer

We will cover Reasonable and Customary Medical Expenses incurred for availing Advanced Treatments for Cancer up to the Sum Insured as mentioned in the Policy Schedule as listed below

- Proton Treatment
- Immunotherapy including immunology agents

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- Personalized and Targeted Therapy
- Hormonal Therapy or Endocrine manipulation
- Vaporisation of the prostate
- Stem cell transplantation
- Robotic/ Stereotactic radio Surgeries
- Any other Advanced and established Medical Practice(that has significant Medical documentation to support their effectiveness)

B10. Hotel accommodation

We will pay 1% of Sum Insured subject to maximum Rs 5000 per day up to 5 days per policy year for hotel accommodation for the Insured Person/accompanying person/attendant if the Insured Person is travelling a distance > 200 kms from his place of residence for treatment of Cancer.

For a Claim to be payable we must have accepted a Claim under In-Patient Treatment(Section B1) or Day Care Procedures (Section B2) or OPD Cover(Section B8).

B11. Transportation Expenses

We will arrange for your travel to Hospital/Day Care Centre also travel back to your residence/starting point of the said trip within the city in which you normally reside to avail Cancer Treatment through our empanelled service provider. Where ever this facility cannot be provided ,We will Pay a fixed amount of Rs 500 Per day.

Conditions:

- The Insured Person can avail this Benefit maximum up to 10 days in a Policy Year.
- The maximum number of trips in a day is limited to 2 trips a day whenever this facility is availed through our empanelled service provider.
- Services that are provided through our empanelled service provider, We would not be liable for any consequential loss, additional costs or the services incurred which are beyond the scope of this policy.
- The decision to utilize this service is solely at Your discretion.
- We do not assume any liability towards quality of service rendered, any loss or damage arising out of or in relation to these services rendered by the empanelled service provider.
- This facility may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule

B12. Ambulance Cover

We will cover expenses incurred on transportation of Insured Person in a registered ambulance to a Hospital for admission in case of an Emergency or from one hospital to another hospital for better medical facilities and treatment, subject to Rs. 5000 per Hospitalization.

For this claim to be paid, the claim must be admissible under In-Patient Treatment (Section B1) or Day Care Treatment (Section B4) of this policy.

The Insured Person can Claim either of Transportation Expenses (Section B11) or Ambulance Cover (Section B 12).

B13. High End Diagnostics

We will cover Reasonable and Customary charges incurred for the following diagnostic tests only on OPD basis if required as part of a medically necessary treatment subject to maximum Rs. 25,000 per policy year:

i. Computed Tomography (CT) guided Biopsy
ii. Liver Biopsy
iii. Magnetic Resonance Cholangiography Scan
iv. Positron Emission Tomography– Computed Tomography (PET-CT)
v. Positron emission tomography–Magnetic Resonance Imaging (PET-MRI)

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B14. Palliative Care for Cancer

We will cover Palliative or Supportive Care up to 10% of sum insured ; maximum upto Rs.5 Lacs in a policy year for taking care of the overall side effects of treatment on the Insured Person after diagnosis of Cancer subject to

I. Palliative Care is medically prescribed by the Medical Practitioner for improving the quality of life of the Insured Person.

II. The benefit is payable if We have admitted a claim under In-Patient Treatment (Section B1) or Day Care Treatment (Section B4) or Home Care(Section B6) .

Please note : Medical Exclusion (Code-Excl05) is superseded to the extent covered under this Benefit

B15. Psychiatric Counseling

We will cover expenses incurred for a consultation with a psychologist up to an amount of Rs 2000 per session if the same is availed by the insured Person for dealing with emotional/mental trauma after being diagnosed with Cancer.

The maximum number of session that can be availed under this Benefit is up to 8 sessions per Policy year .

B16. Health Check up

We will cover expenses for Preventive Health Check-up upto 1% of previous Policy sum insured maximum up to Rs 10,000 provided this coverage exists in the previous Policy and no claim has been reported in the previous three consecutive Policy years with Us . This limit is maximum per insured person. This Benefit is payable over and above the Sum Insured.

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

B17. Second Medical Opinion

We will organise second medical opinion upon specific request of Insured person from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with Cancer during the Policy Period. The expert opinion would be directly sent to the Insured Person and would be subject to the following conditions.

a) This Benefit can be availed by the Insured Person only once in the Policy Period

b) The Second Medical Opinion shall be arranged only on the basis of information and documentation provided to Us.

c) Under this Benefit, We are only providing the Insured Person with access to a Second Medical Opinion and it shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

d) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

e) Any Second Medical Opinion provided under this benefit shall not be valid for any medico-legal purposes.

B18. Global Cover

We will cover Reasonable and Customary Medical Expenses of the Insured Person incurred outside India, up to the sum insured, for Medically necessary Treatment of Cancer provided that the diagnosis was made in India and the insured person travels abroad for treatment.

The Medical Expenses payable shall be limited to Inpatient and daycare Hospitalization only on reimbursement basis

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

We shall require the following additional documents supporting the claim under this benefit:

- Proof of diagnosis in India
- Insured's Passport and Visa

B19. Consumable Benefit

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

However, the following items shall be excluded from scope of this coverage:

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- Items of personal comfort, toiletries, cosmetics and convenience shall be excluded from scope of this coverage.
- External durable devices like Bilevel Positive Airway Pressure (BIPAP) machine, Continuous Positive Airway Pressure (CPAP) machine, Peritoneal Dialysis (PD) equipment and supplies, Nimbus/water/air bed, dialyzer and other medical equipments.
- Any item which is neither medical consumable nor medically necessary nor prescribed by doctor

For this claim to be paid, the main claim must be admissible under section B1 or B4 or B6 of this policy.

C: Hospital Cash

The following benefits shall be payable subject to applicable waiting period and other terms/conditions of the policy:

C1. In –Patient Hospital Cash

We will pay a Fixed Daily Cash Benefit as specified in the Policy Schedule for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person due to an illness during the Policy Year, provided that:

i. All Benefits will be available up to the maximum number of coverage days specified in the policy schedule.

ii. On the day of discharge, when insured person is discharged before completion of consecutive 24 hours of hospitalization, we shall pay 50% of daily cash benefit.

C2. Prolonged Hospital Cash Benefit

We will pay a fixed amount of Rs 10,000 in the event of insured person hospitalisation for an illness/injury exceeds continuous period 10 days.

This Benefit is over and above the In –Patient Hospital Cash (Section C1) and can be availed only once per Policy year provided that the In-patient Hospital Cash claim is admissible under benefit C1 of this policy.

C3. ICU Cash Benefit

In case Insured Person's Hospitalization is in Intensive Care Unit (ICU), We will pay twice the In –Patient Hospital Cash Benefit(Section C1) for the duration of stay in Intensive Care Unit(ICU) for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person due to an illness during the Policy Year.

Note: During the hospitalization period if the insured person is transferred from hospital ward/room to ICU or vice versa the benefit would be payable only under one heading as specified above, as per the hospital bill for the respective day.

C4. Accidental Hospitalization Cash Benefit

In case Insured Person's Hospitalization is due to an accidental injury, We will pay twice the In-Patient Hospital Cash Benefit (Section C1). for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person due to an injury during the Policy Year.

In the event, claim is admissible under this benefit, We will not pay for inpatient hospital cash benefit (Section C1) for that particular claim.

C5. Accidental Hospitalization ICU Cash Benefit

In case Insured Person's Hospitalization is in Intensive Care Unit (ICU) due to an accidental injury, We will pay twice the ICU Cash Benefit (Section C3) for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person due to an injury during the Policy Year.

In the event, claim is admissible under this benefit, We will not pay for ICU cash benefit (Section C3) for that particular claim.

D: Optional Benefits

The following Optional Benefit shall apply only if the premium in respect of the Optional Benefit has been received and the same is mentioned in the Policy Schedule. Benefits under this Section are subject to the applicable waiting period, terms, conditions and exclusions of this Policy.

D1. Wellsurance Benefit:

a. **Minor Surgical Benefit:**

We will pay lump sum as specified in the Policy schedule irrespective of the actual Medical expenses for hospitalization, subject to the waiting period of 90 days in the event of an Insured Person undergoing any Medically necessary **Covered Minor Surgery** which is not due to any Pre-existing Condition.

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Covered Minor Surgeries

i. **Appendectomy/Cholecystectomy:** Surgical removal of the appendix due to acute appendicitis, rupture of appendix. Surgical removal of gall bladder due to acute or chronic Cholecystitis or Symptomatic gall stones.

ii. **Removal of Gall stones/kidney stones:** Laser/surgical removal of gall stones and kidney stones.

iii. **Hernia repair:** Hernia repair surgery is done by using mesh to repair the weakness on the abdominal wall from where the bulging appeared.

iv. **Hemorrhoids:** Piles/Hemorrhoids removal in case of Symptomatic bleeding anal varices.

v. **Removal of Skin lesion:** Removal of Skin lesion like Symptomatic cyst, melanoma ganglion.

vi. **Biopsy of Growth:** Surgical removal of a portion of growth for histopathological study.

b. **Major Surgical Benefit**

We will pay lump sum as specified in the Policy schedule irrespective of the actual Medical expenses for hospitalization, subject to the waiting period of 90 days in the event of an Insured Person undergoing any Medically necessary C**overed Major Surgery** which is not due to any Pre-existing Condition.

Covered Major Surgeries

i. **Post traumatic surgery:** Surgery due to trauma induced surgeries of skull fracture, pelvis fracture, and compound / comminuted fractures requiring ORIF (Open Reduction and Internal Fixation) in other parts of body.

ii. **Knee replacement:** This procedure is performed by using artificial prosthesis in case of traumatic arthritis, severe knee injuries.

iii. **Knee ligament surgery:** Surgery conducted to repair ligaments of knee joint damaged due to trauma

iv. **Hip replacement:** Procedure is performed by using artificial prosthesis in case of severe injuries, trauma.

v. **Cosmetic Reconstructive Surgery**

Surgery conducted as a reconstructive procedure on structures of the body for the purpose of restoring / improving bodily function or correcting significant deformity resulting from accidental injury as covered under the Hazard, subject to the maximum shown in the Policy Schedule.

c. **Post Operative Expenses (Physiotherapy)**

We will pay lump sum amount for Physiotherapy for any covered Major or Minor Surgery as defined above post discharge from Hospital. The Benefit shall be paid lump sum as specified in the Policy schedule irrespective of the actual expenses incurred. We will pay once during the lifetime of the Insured person.

d. **Ambulance Service**

We will pay lump sum amount towards road Ambulance while admitting and/or while discharging from the Hospital as specified in the policy.

E:– Personal Accident (only applicable for Section A: Critical Illness)

If no claim is reported under benefit section A1 or A5 in the expiring policy year in a Long term policy or Policy period in an Annual policy, We will pay Rs. 3 Lac of Sum Insured, if the Insured person suffers an injury due to an accident during the current Policy year/Policy period which is the sole and direct cause of death of insured person within twelve (12) months from the date of Accident.

This cover shall be available only to those insured persons who are covered under the policy in the expiring policy year. This cover shall not be applicable to dependent children covered in the policy.

5. Sum Insured and Plans options: (in Rs.)

1. Section A: Critical Illness(Rs): 5 Lacs -2 Cr (in multiples of 5 Lacs) in each category(Category A/B/C). Plans options available are Smart Century Premier (100 Critical Illnesses) and Smart Half Century (50 Critical Illnesses)
2. Section B:Cancer 360 Degree(Indemnity Cover): 5 Lacs to 2 Cr in multiples of 5 Lacs
3. Section C:Hospital Cash :Rs 500 per day to Rs. 20,000 per day(in multiple of 500's); Maximum Payable days in a Policy Year: 30 days/60 days/180 day
4. Wellsurance Benefit

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Benefits/Plan	Classic	Supreme	Elite
i. Minor Surgeries			
a. Appendectomy/Removal of Kidney stones/ Haemorrhoids	Rs 10,000	Rs 10,000	Rs 15,000
b. Cholecysectomy/ Removal of Gall bladder Stones/ Hernia/Biopsy or growth	Rs 15,000	Rs 20,000	Rs 20,000
ii. Major Surgeries			
a. Post Traumatic Surgery	Rs 50,000	Rs 75.000	Rs 100,000
b. Knee replacement/knee ligament surgery	Rs 75,000	Rs 1,25,000	Rs 150,000
c. Hip replacement	Rs 75,000	Rs 100,000	Rs 150,000
d. Cosmetic Reconstructive Surgery (in case of Accidents)	Rs 50,000	Rs 100,000	Rs 200,000
iii. Post Operative Expenses (Physiotherapy)	Rs 3500	Rs 5000	Rs 7000
iv. Ambulance Service	Rs 2000	Rs 2000	Rs 2000

6. Renewal Incentives:

a. **Health Check-up** - Expenses for a Preventive Health Check-up upto 1% of previous year policy sum insured subject to a maximum of Rs. 10,000/- per policy in the event of every two continuous claim free policy years with us. Applicable only if Section A or Section B is opted.

7. Portability:

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

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

i. 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.

9. Waiting Period:

We shall not be liable to make any payment under the policy in connection with or in respect of following **expenses** till the expiry of waiting period mentioned below:

i. Initial Waiting Period

a. Expenses related to the treatment of any illness within 90 days (applicable for Section A: Critical Illness and Section B: Cancer 360 Degree Indemnity Cover) and 30 days(applicable for Section C:Hospital Cash) from the first policy

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commencement date depending on plan chosen by the Insured Person and as specified in the Policy Schedule shall be excluded except claims arising due to an accident, provided the same are covered.

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

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii. Pre-existing Diseases Waiting Period

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, for 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. Coverage under the policy after the expiry of specified months as per the Policy Schedule for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

iii. Specified Disease/Procedure Waiting Period (Applicable only for Hospital Cash section):

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 diseases, 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.

List of Specific Diseases/procedures:

a. Tumors, Cysts, polyps including breast lumps (benign)
b. Polycystic ovarian disease
c. Fibromyoma
d. Adenomyosis
e. Endometriosis
f. Prolapsed Uterus
g. Non-infective arthritis
h. Gout and Rheumatism
i. Osteoporosis
j. Ligament, Tendon or Meniscal tear
k. Prolapsed Inter Vertebral Disc
l. Cholelithiasis
m. Pancreatitis
n. Fissure/fistula in anus, haemorrhoids, pilonidal sinus
o. Ulcer & erosion of stomach & duodenum
p. Gastro Esophageal Reflux Disorder (GERD)
q. Liver Cirrhosis
r. Perineal Abscesses
s. Perianal / Anal Abscesses
t. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.

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u. Benign Hyperplasia of prostate
v. Varicocele
w. Cataract
x. Retinal detachment
y. Glaucoma
z. Congenital Internal Diseases
aa. Adenoidectomy
bb. Mastoidectomy
cc. Tonsillectomy
dd. Tympanoplasty
ee. Surgery for nasal septum deviation
ff. Nasal concha resection
gg. Surgery for Turbinate hypertrophy
hh. Hysterectomy
ii. Joint replacement surgeries Eg: Knee replacement, Hip replacement
jj. Cholecystectomy
kk. Hernioplasty or Herniorraphy
ll. Surgery/procedure for Benign prostate enlargement
mm. Surgery for Hydrocele/ Rectocele
nn. Surgery of varicose veins and varicose ulcers

10. General Exclusions

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

1. Standard GeneralExclusions

1) Medical Exclusions

i. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof .(Code-Excl12)
ii. Obesity and weight control: (Code- Excl06)
    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
iii. Investigation and evaluation (Code-Excl04):
    a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

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

iv. Sterility and Infertility (Code- Excl17):

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

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

vi. Cosmetic or Plastic Surgery (Code – Excl08) : Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

vii. Rest cure, rehabilitation and respite care (Code-Excl05):

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,

viii. Unproven treatments (Code-Excl16) : 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.

ix. Maternity (Code- Excl18):

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

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

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

2) Non-Medical Exclusions

i. Hazardous or Adventure Sports (Code Excl09) : 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 Excl10): 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-Excl11): 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.

2. Specific General Exclusions

1) Medical Exclusions

Specific to Section 2 A: Critical Illness:

i. Any Critical Illness other than as defined under Section A1

Specific to Section 2 B: Cancer 360 Degree -Indemnity Cover

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ii. Any Illness or Injury other than Cancer

Other Exclusions:

Exclusion	Applicable Section(s)
iii. Alcoholic pancreatitis	Applicable to Hospital cash(Section C)
iv. Congenital External Diseases, defects or anomalies;	Applicable to Hospital Cash(Section C) and Wellsurance Benefit (Section D)
v. Growth hormone therapy;	Applicable to Hospital Cash(Section C)
vi. Sleep-apnoea	Applicable to Hospital Cash(Section C)
vii. Admission primarily for administration of Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid	Applicable to Hospital Cash (Section C)
viii. Venereal disease, sexually transmitted disease or illness;	Applicable to Hospital Cash (Section C)and Wellsurance Benefit (Section D)
ix. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization	Applicable to Hospital Cash (Section C)and Wellsurance Benefit (Section D)
x. Any existing disease specifically mentioned as Permanent exclusion in the Policy Schedule	Applicable to all Sections

2) Non-Medical Exclusions

i. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.

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

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

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

v. 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.

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

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

viii. 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

11. Claim Procedure:

This section explains about the procedures involved in filing a claim by the insured member and processes related to managing the claim by Us. 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.

1. Notification of Claim

	Treatment, Consultation or Procedure:	We must be informed:
1	If any treatment for which a claim may be made and that treatment requires planned Hospitalisation:	At least 48 hours prior to the Insured Person's admission.
2	If any treatment for which a claim may be made and that treatment requires emergency Hospitalisation	Within 24 hours of the Insured Person's admission to Hospital.

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2. Cashless Service (Applicable for Cancer 360 Degree)

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:
	If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	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 treatment or Hospitalisation
	If any treatment, consultation or procedure for which a claim may be made, requiring emergency hospitalisation	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation

3. Procedure for Cashless Service

i. Cashless Service is only available at Network Hospitals. Please refer our website (www.tataaig.com) for list of network hospitals.

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

a. Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, You must notify Us and request pre-authorization.

b. For any emergency Hospitalisation, We must be informed no later than 24 hours of the start of Your hospitalization/ treatment.

c. For any planned hospitalization, We must be informed atleast 48 hours prior to the start of your hospitalization/ treatment.

d. 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 Us to the Network Hospital.

e. In case of deficiency in the documents sent to Us for cashless authorization, the same shall be communicated to the hospital by Us.

f. In case the ailment /treatment is not covered under the policy or cashless is rejected due to insufficient documents submitted, a rejection letter would be sent to the hospital by Us.

g. 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.

h. If the cashless is approved, the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

i. 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.

4. Supporting Documentation & Examination

i. We 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

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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 www.tataaig.com

b) **For Section A: Critical Illness / Section C:Hospital Cash / Optional Benefit Section D: Wellsurance Benefit**

1. Medical Certificate and investigation report confirming the diagnosis of Critical Illness/Surgery
2. Copy of complete medical records such as Hospital Discharge card/Summary, Indoor case papers along with the diagnostic Laboratory & radiological investigation reports including CT Scan, MRI & USG report with plates, wherever applicable and done
3. A precise diagnosis of the treatment for which a claim is made
4. Previous and subsequent consultation letter(including first consultation letter), medical records and prescriptions related to illness/surgery
5. 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.
6. Death certificate/Death summary, if applicable
7. Post Mortem report (wherever applicable & conducted)
8. Legal heir/succession certificate, if applicable & available
9. 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

In the event insured person suffers from one of the following critical illness and where death occurs within 3 months of such diagnosis, but after confirmed diagnosis of the illness, then the modified condition as mentioned below shall be applicable to the respective Critical Illness. However, this is subject to fulfilment of other conditions as laid down under definitions of respective critical illness and for the period for which the Insured survived the diagnosis of Critical Illness

Critical Illness (Section A1)	Name of Critical Illness	Modified Condition applicable
9	Stroke resulting in permanent symptoms	Evidence of permanent neurological deficit lasting for the period for which the Insured person survived
10	Permanent Paralysis of Limbs	Evidence of existence of paralysis for the period for which the Insured person survived
11	Parkinson's disease	Medical documentation of conditions (i-vi) of activities of daily living for the period the Insured Person survived
13	End Stage Lung Failure	Condition (I) wherein FEV1 test results for the period the Insured Person survived

c) For Section B: Cancer 360 Degree

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

b. All medical reports, case histories, investigation reports, indoor case papers/ treatment papers (in reimbursement cases, if available), discharge summaries.

c. A precise diagnosis of the treatment for which a claim is made.

d. 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.

e. 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.

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f. 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.

g. Treating doctor's certificate regarding missing information in case histories

h. Copy of settlement letter from other insurance company

i. 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

j. Legal heir/succession certificate , if required

k. PM report (wherever applicable)

l. Transportation and Hotel accommodation bills (wherever applicable)

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 persons 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.

12. Renewal of Policy:

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

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

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

iii. 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. Coverage is not available during the grace period.

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

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. Migration:

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits 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.

15. Withdrawal of the policy:

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the 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. as per IRDAI guidelines, provided the policy has been maintained without a break.

16. 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

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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.

17. 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/Policy Certificate/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.

18. Requirement:

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

19. Pre-policy medical calling (Tele-MER):

Critical Illness **(Grid I)**	Sum Insured Upto 25 Lacs	Sum Insured > 25 Lacs
<=45 Yrs	NA	TeleMER
>46 Yrs	PPC	PPC

Cancer 360 Degree – Indemnity Cover (**Grid II)**	All Sum Insured Options
<=45 Yrs	NA
>46 Yrs	TeleMER

Hospital Cash **(Grid III)**	All Sum Insured options
upto 65 Yrs	NA

PPC tests includes:

Tests
MER
Urine Routine
CBC with ESR
LFT
RFT
Lipid Profile
TMT/ (2D Echo+ECG)
USG Abdomen & Pelvis
Hba1c
HBsAg
X ray chest
Sonomammography (female)
PSA (male)

- If Critical Illness is one of the sections opted then,Grid I as mentioned above will be applicable .
- Incase only Cancer 360 Degree-Indemnity cover and Hospital Cash are opted, Grid II is applicable
- In case of adverse medical declaration, we may call for TeleMER/additional medical tests

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- PPC means Pre-Policy Medical Check up and Tele-MER means Tele Medical Examination Reporting
- Incase of rejection of Proposal , we will bear only 50% of the Cost of PPC.
- 100% of TeleMER cost would be borne by the Company, in case of proposal acceptance.
- At least 50% of pre-policy medical checkup cost would be borne by the Company in case where proposal is accepted.

In case of adverse medical declaration, we may call for Tele-MER/additional medical tests.

20. Premium Rates*:

a. The premium will be charged on the completed age of the Insured Person.

b. Premium rates are subject to change.

c. The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.

*Annexure enclosed

21. Loadings:

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

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

iii. Insured has an option to choose Survival Period for 0/7/15 days(only applicable for Section A:Critical Illness cover) . Survival Period loading applicable for 7 days is 5% and for 0 days is 7.5%.

iv. Maximum overall Loading per person is capped at 150% for covers other than Critical Illness cover. For Critical Illness cover, the maximum over all loading is capped at 157.5%.

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

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

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

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

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

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

22. Cancellation:

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

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

23. 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 **022 6489 8282/1800 22 9966 (For Senior Citizens)** or **022-66939500** (toll charges apply), or email us at **customersupport@tataaig.com**. We will investigate and respond within the regulatory turnaround time (TAT).

Escalation Level 1

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

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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**.

24. 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.

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

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

Disclaimer:

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

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

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

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Annexure-1 : Premium Rates

Gross premium per member (Pre-Tax) table by age and sum insured

Section A: Critical Illness

Critical Illness Cover without Health Check-up (per mille rate) for survival period of 15 days:

Age Band	Smart Half Century	Smart Century Premier
18yrs	0.94	1.06
19-25yrs	1.28	1.43
26-30yrs	2.14	2.41
31-35yrs	3.51	3.95
36-40yrs	6.08	6.88
41-45yrs	10.29	11.66
46-50yrs	14.57	16.58
51-55yrs	23.45	26.74
56-60yrs	35.29	40.35
61-65yrs	50.65	58.02
66-70yrs	67.26	77.18
71+yrs	98.51	113.74

Health Check-up for Critical Illness (Smart Half-Century)

Age/ SI (in lakhs)	5	10	15 to 200
18yrs	134	269	385
19-25yrs	134	269	383
26-30yrs	134	268	383
31-35yrs	134	268	383
36-40yrs	266	532	762
41-45yrs	265	529	755
46-50yrs	263	525	751
51-55yrs	388	775	1,108
56-60yrs	380	760	1,086
61-65yrs	371	742	1,058
66-70yrs	360	722	1,029
71+yrs	342	683	977

Health Check-up for Critical Illness (Smart Century Premier)

Age/ SI (in lakhs)	5	10	15 to 200
18yrs	134	269	385
19-25yrs	134	269	383
26-30yrs	134	268	383
31-35yrs	134	268	382
36-40yrs	266	532	760
41-45yrs	265	528	754

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46-50yrs	262	523	748
51-55yrs	386	771	1,102
56-60yrs	377	754	1,075
61-65yrs	366	731	1,045
66-70yrs	354	708	1,012
71+yrs	332	666	951

Personal Accident Cover of Sum Insured Rs 300,000 (applicable for Section A)

Age Band	Smart Half Century	Smart Century Premier
18yrs	76.31	76.31
19-25yrs	76.29	76.29
26-30yrs	76.26	76.25
31-35yrs	76.2	76.18
36-40yrs	76.09	76.05
41-45yrs	75.92	75.85
46-50yrs	75.72	75.63
51-55yrs	75.34	75.18
56-60yrs	74.83	74.58
61-65yrs	74.18	73.86
66-70yrs	73.51	73.08
71+yrs	72.22	71.58

Section B: Cancer 360 Degree Indemnity Cover

Age/ SI (in lakhs)	5	10	15	20	25	30	35	40	45	50
91days - 18yrs	229	420	558	615	672	707	742	776	811	846
19-25yrs	306	543	702	803	908	971	1,034	1,096	1,159	1,222
26-30yrs	448	771	963	1,151	1,342	1,456	1,571	1,685	1,800	1,914
31-35yrs	642	1,083	1,323	1,628	1,938	2,124	2,310	2,496	2,682	2,868
36-40yrs	1,135	1,934	2,377	2,900	3,434	3,753	4,072	4,390	4,709	5,028
41-45yrs	1,763	2,955	3,555	4,462	5,388	5,941	6,494	7,046	7,599	8,152
46-50yrs	2,197	3,666	4,382	5,563	6,765	7,485	8,204	8,924	9,643	10,363
51-55yrs	3,766	6,242	7,462	9,523	11,620	12,876	14,131	15,387	16,642	17,898
56-60yrs	5,760	9,438	11,195	14,457	17,791	19,782	21,774	23,765	25,757	27,748
61-65yrs	8,806	14,329	16,920	22,040	27,275	30,401	33,527	36,654	39,780	42,906
66-70yrs	12,758	20,663	24,355	31,892	39,594	44,195	48,795	53,396	57,996	62,597
71+yrs	19,554	31,515	37,178	48,877	60,834	67,976	75,118	82,261	89,403	96,545

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Age/ SI (in lakhs)	55	60	65	70	75	80	85	90	95	100
91days - 18yrs	880	914	949	983	1,017	1,106	1,195	1,284	1,373	1,462
19-25yrs	1,284	1,347	1,409	1,472	1,534	1,695	1,856	2,018	2,179	2,340
26-30yrs	2,028	2,142	2,257	2,371	2,485	2,780	3,075	3,370	3,665	3,960
31-35yrs	3,053	3,238	3,424	3,609	3,794	4,273	4,752	5,231	5,710	6,189
36-40yrs	5,346	5,664	5,981	6,299	6,617	7,439	8,261	9,082	9,904	10,726
41-45yrs	8,703	9,254	9,804	10,355	10,906	12,334	13,762	15,190	16,618	18,046
46-50yrs	11,078	11,794	12,509	13,225	13,940	15,804	17,668	19,532	21,396	23,260
51-55yrs	19,147	20,397	21,646	22,896	24,145	27,393	30,640	33,888	37,135	40,383
56-60yrs	29,732	31,715	33,699	35,682	37,666	42,800	47,934	53,067	58,201	63,335
61-65yrs	46,021	49,136	52,250	55,365	58,480	66,540	74,599	82,659	90,718	98,778
66-70yrs	67,180	71,763	76,346	80,929	85,512	97,373	1,09,233	1,21,094	1,32,954	1,44,815
71+yrs	1,03,660	1,10,774	1,17,889	1,25,003	1,32,118	1,50,530	1,68,942	1,87,353	2,05,765	2,24,177

Age/ SI (in lakhs)	105	110	115	120	125	130	135	140	145	150
91days - 18yrs	1,524	1,585	1,647	1,708	1,770	1,831	1,893	1,954	2,016	2,077
19-25yrs	2,452	2,564	2,675	2,787	2,899	3,011	3,123	3,234	3,346	3,458
26-30yrs	4,165	4,369	4,574	4,778	4,983	5,187	5,392	5,596	5,801	6,005
31-35yrs	6,521	6,852	7,184	7,516	7,848	8,179	8,511	8,843	9,174	9,506
36-40yrs	11,295	11,864	12,434	13,003	13,572	14,141	14,710	15,280	15,849	16,418
41-45yrs	19,034	20,021	21,009	21,996	22,984	23,972	24,959	25,947	26,934	27,922
46-50yrs	24,546	25,831	27,117	28,403	29,689	30,974	32,260	33,546	34,831	36,117
51-55yrs	42,626	44,869	47,111	49,354	51,597	53,840	56,083	58,325	60,568	62,811
56-60yrs	66,890	70,445	74,000	77,555	81,111	84,666	88,221	91,776	95,331	98,886
61-65yrs	1,04,360	1,09,941	1,15,523	1,21,104	1,26,686	1,32,268	1,37,849	1,43,431	1,49,012	1,54,594
66-70yrs	1,53,028	1,61,242	1,69,455	1,77,668	1,85,882	1,94,095	2,02,308	2,10,521	2,18,735	2,26,948
71+yrs	2,36,927	2,49,678	2,62,428	2,75,178	2,87,928	3,00,679	3,13,429	3,26,179	3,38,930	3,51,680

Age/ SI (in lakhs)	155	160	165	170	175	180	185	190	195	200
91days - 18yrs	2,115	2,152	2,190	2,228	2,266	2,303	2,341	2,379	2,416	2,454
19-25yrs	3,526	3,595	3,663	3,732	3,800	3,868	3,937	4,005	4,074	4,142
26-30yrs	6,130	6,254	6,379	6,504	6,629	6,753	6,878	7,003	7,127	7,252
31-35yrs	9,709	9,912	10,114	10,317	10,520	10,723	10,926	11,128	11,331	11,534
36-40yrs	16,766	17,114	17,462	17,810	18,158	18,505	18,853	19,201	19,549	19,897
41-45yrs	28,526	29,129	29,733	30,336	30,940	31,544	32,147	32,751	33,354	33,958

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46-50yrs	36,903	37,688	38,474	39,260	40,046	40,831	41,617	42,403	43,188	43,974
51-55yrs	64,182	65,552	66,923	68,294	69,665	71,035	72,406	73,777	75,147	76,518
56-60yrs	1,01,059	1,03,232	1,05,404	1,07,577	1,09,750	1,11,923	1,14,096	1,16,268	1,18,441	1,20,614
61-65yrs	1,58,005	1,61,416	1,64,827	1,68,238	1,71,650	1,75,061	1,78,472	1,81,883	1,85,294	1,88,705
66-70yrs	2,31,968	2,36,987	2,42,007	2,47,026	2,52,046	2,57,065	2,62,085	2,67,104	2,72,124	2,77,143
71+yrs	3,59,472	3,67,264	3,75,057	3,82,849	3,90,641	3,98,433	4,06,225	4,14,018	4,21,810	4,29,602

Section C: Hospital Cash Benefit (For 500 per day with out Prolonged Hospitalization)

Age Band	Max No. of Days		
	30	**60**	**180**
91days - 18yrs	189	223	254
19-25yrs	200	235	268
26-30yrs	210	247	283
31-35yrs	284	334	382
36-40yrs	358	421	481
41-45yrs	462	544	621
46-50yrs	566	666	760
51-55yrs	653	769	878
56-60yrs	719	846	966
61-65yrs	791	931	1,063
66-70yrs	949	1,117	1,275
71+yrs	1,138	1,340	1,530

Note: Gross Premium for other Sum Insured (in multiple of 500's) can be found by multiplying the above rates

Prolonged Hospitalization Cash Benefit:

Age Band	Gross Premium
91days - 18yrs	57.38
19-25yrs	60.57
26-30yrs	63.77
31-35yrs	86.17
36-40yrs	108.58
41-45yrs	140.11
46-50yrs	171.62
51-55yrs	198.22
56-60yrs	218.03
61-65yrs	239.83
66-70yrs	287.80
71+yrs	345.35

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Section D: Wellsurance Cover(Optional)

Age/Sum Insured	Classic	Supreme	Elite
18yrs	277	312	597
19-25yrs	315	355	680
26-30yrs	343	386	738
31-35yrs	363	411	783
36-40yrs	392	442	845
41-45yrs	406	458	875
46-50yrs	428	483	922
51-55yrs	440	495	946
56-60yrs	462	522	995
61-65yrs	472	532	1,017
66-70yrs	480	543	1,035
71+yrs	489	551	1,052

Discounts/Loading applicable

Discounts:

1. E-Policy discount – 2.5%
2. TATA AIG Customer discount-2.5%
3. Multi-cover discount-2.5%
4. TATA group Employee discount -5%
5. Multi-Individual discount: More than 2 persons – 7.5%
6. Long term discount:

   2 year policy – 5%

   3 year policy – 10%

Loadings:

1. Survival Period loading: (only applicable for Critical Illness cover)
   a) 7 days- 5%
   b) 0 days- 7.5%

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