Prospectus

1. Suitability:

    a. This policy covers persons in the age group 91 days onwards (Dependent children between 91 days and 5 years can be insured only when both parents are getting insured). The maximum entry age is 65 years.
    b. There is no maximum cover ceasing age under this policy.
    c. The policy will be issued for a period 1/2/3 years.
    d. The policy offers coverage only on family floater basis.
    e. The family includes spouse and economically dependent children and parents/parents-in-law. Relationships covered: Self, spouse and up to 3 dependent children, up to 2 parents and up to 2 parent-in-laws. In case of family floater, where the dependent child(ren) attains 26 years of age at renewal, the child(ren) can be covered under a separate policy with eligible continuity benefit.

2. Sum Insured options (*in* ₹) :

    - 5 Lacs
    - 7.5 Lacs
    - 10 Lacs
    - 15 Lacs
    - 20 Lacs

3. Plans

    There are two plans available under the product:

    - **Value Plan**: Available for customers from Zone A, Zone B, Zone C
    - **Geo Plan**: Available for customers from Zone B, Zone C only.

4. Zone(s)

    For the purpose of premium calculation and payment under Geo Plan, India has been categorized in three different zones and premium payable under the policy will be calculated based on the residential location/address as provided by the proposer/insured person in the proposal form

    - **Zone A**: Mumbai (including Mumbai Metropolitan Region), Delhi (including National Capital Region, Faridabad, Ghaziabad), Ahmedabad, Surat & Baroda
    - **Zone B**: Hyderabad (including Secunderabad), Bengaluru, Kolkata, Indore, Chennai, Chandigarh (including Mohali, Punchkula, Zirakpur), Pune (including Pimpri Chinchwad) and Rajkot
    - **Zone C**: Rest of India

5. Key Benefits

i. **Range of benefits:** Indemnity based health insurance cover with range of benefits and optional covers.

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

iii. **Lifelong renewal:** We offer you a lifelong renewal for your policy provided premium is paid without any break. Your premiums will be basis the age, sum insured plan, zone (for Geo Plan), optional cover(s) and optional cost sharing selected. Your renewal premium will be basis your age on renewal and there will be no extra loadings based on your individual claim.

iv. **Restore Benefit:** If the balance Sum Insured and accrued 5X Supercharge Bonus is insufficient to pay an admissible claim under In-Patient Treatment, Pre-Hospitalization Expenses, Post-Hospitalization Expenses, Day Care Treatment, Domiciliary Treatment or Organ Donor cover, We will automatically reinstate 100% of the Sum Insured once during the policy year. In case of Any One Illness, this benefit for related Illness/ Injury would be available to the Insured Person(s), who have claimed earlier, only for Hospitalization/ Domiciliary Hospitalization where date of admission is beyond 45 days from the date of discharge of the immediately preceding Hospitalization/ date of end of Domiciliary Hospitalization, for which claim has been paid. This unutilized Restored Sum Insured cannot be carried forward to the next Policy Year.

v. **5X Supercharge Bonus:** Bonus in the form of 50% of the base Sum Insured of the expiring Policy, on each Renewal of the Policy, irrespective of claims in preceding Policy Years. The total accrued Bonus shall not exceed 500% of the base Sum Insured in any Policy Year.

vi. **Wellness Services:** We / our Empanelled Service Provider will provide below mentioned wellness services:

- Teleconsultation - General
- Teleconsultation – Specialty
- Ambulance Booking facility
- Emergency Help me feature
- Redeemable voucher/Discount on services
- Health Condition Management

vii. **Wellness Program:** We / our empanelled service provider will provide a wellness program designed to promote wellness and fitness amongst the insured persons through:

i. Health risk assessment

ii. Wellness Rewards: Wellness Reward accumulated through fitness activities can be converted into monetary value and can be utilized towards the payment of services/items under below categories, available through our Network/ empanelled service provider:

- OPD consultation/ treatment
- Pharmaceuticals
- Health-check-ups/ diagnostics
- Health Supplements
- Coverage of cost of treatment of any admissible claim in respect of non-payable items that are specified under the terms and conditions of the base policy

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

6. Salient Features

i. **In-patient Treatment:** Covers 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. Medical Expenses directly related to the Hospitalization would be payable.

ii. **Pre-Hospitalization Expenses:** Covers Medical Expenses incurred upto 90 days prior to the date of admission to the Hospital

iii. **Post-Hospitalization Expenses:** Covers Medical Expenses incurred in upto 90 days immediately after the Insured Person was discharged post Hospitalisation.

iv. **Day Care Treatment:** Covers expenses for Day Care Treatment due to disease/illness/Injury taken in a Hospital or a Day Care Centre, during the Policy Period.

v. **Domiciliary Treatment:** Covers Medical 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.

vi. **Organ Donor**: Covers Medical Expenses incurred by or in respect of the organ donor, for an organ transplant Surgery, solely towards the harvesting of the organ donated. The insured person must be the recipient of the organ so donated by the organ donor.

vii. **AYUSH Benefit**: Covers medical Expenses incurred for In-patient/Day care treatment taken in an AYUSH hospital/AYUSH day care centre, including pre and post hospitalization expenses.

viii. **Road Ambulance Cover**: Covers expenses incurred on transportation of Insured Person in a registered ambulance to a Hospital for admission in case of an Emergency.

ix. **Restore Benefit**: Automatically reinstate 100% of the Sum Insured, if the balance Sum Insured and accrued 5X Supercharge Bonus is insufficient to pay an admissible claim under In-Patient Treatment, Pre-Hospitalization Expenses, Post-Hospitalization Expenses, Day Care Treatment, Domiciliary Treatment or Organ Donor cover, during the policy year.

x. **Compassionate Travel**: In the event the Insured Person is Hospitalized in India for more than Five consecutive days in a place where no adult member of his immediate family is present, We will cover expenses related to round trip economy class domestic air ticket, or first-class railway ticket, to allow the Immediate Family Member be at his bedside for the duration of his stay in the Hospital, subject to the maximum limit during a Policy Year, as mentioned in the 'Benefit Table'.

xi. **Prolonged hospitalization benefit**: We will pay the fixed amount per Policy Year in the event of Hospitalization of the Insured Person for an Illness/disease/Injury for a continuous period exceeding 10 days, subject to Hospitalization at Our Network Provider.

xii. **Medical Devices Cover**: Covers expenses incurred by the Insured Person towards renting or purchase of Crutches, Wheel chair, Walker, Walking stick and Lumbo-sacral belt, during the Policy year, if the same is prescribed by the treating Medical Practitioner post Hospitalization for the same condition for which the hospitalization claim was admissible.

xiii. **Vaccination cover**: Covers the cost of the following vaccines,

d) Anti-rabies vaccine following an animal bite

e) Typhoid vaccination

xiv. **Second Opinion:** Provides the Insured Person second medical opinion from Our empanelled service provider in India, if an Insured Person is diagnosed with the listed Illnesses during the Policy Period.

xv. **Wellness Services**: We / our Empanelled Service Provider will provide wellness services designed to assist insured persons in maintaining and improving good health and fitness.

xvi. **Wellness Program**: We / our empanelled service provider will provide a wellness program designed to promote wellness and fitness amongst the insured persons through:

a. Health risk assessment and

b. Wellness Rewards

7. Optional Covers

The availability of optional cover(s) shall be as per the grid below and are available on payment of additional premium. Once opted they will have to be mandatorily covered at each renewal.

Benefits	**Can be availed by the policyholder/Insured Person**
Restore Infinity	Only at Inception of first policy/coverage
Emergency Air Ambulance Cover	At Inception of first policy/coverage OR Renewal
Consumables benefit	Only at Inception of first policy/coverage
Preventive Annual Health Check-Up	Only at Inception of first policy/coverage
Advanced Cover	Only at Inception of first policy/coverage
Accidental Death Benefit	At Inception of first policy/coverage OR Renewal

i. **Restore Infinity:** Provides reinstatement of sum insured unlimited number of times during a Policy Year post exhaustion of the Restore Benefit.

ii. **Emergency Air Ambulance Cover:** Covers cost of air ambulance for transportation of the Insured Person in an airplane or helicopter, on reimbursement basis, subject to the maximum limit per Policy Year, as mentioned in the 'Benefit Table', for Emergency Care of life-threatening health conditions which require immediate and rapid ambulance transportation to a Hospital for further medical management.

iii. **Consumables Benefit:** Covers 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.

iv. **Preventive Annual Health Check-Up:** We/ Our empanelled service provider will arrange for listed medical tests every Policy Year for all Insured Persons covered under the Policy irrespective of claim. The health check-ups shall be arranged by Us only on cashless basis either at Our empanelled service providers or at insured person's residence, as per availability.

v. **Advanced Cover:** In lieu of the policyholder opting for this Advanced Cover and paying additional premium for the specific Insured Person(s), the word "36 months" should be read as "30 days" under 'Pre-existing Diseases Waiting Period (Code- Excl 01)', only for the following named pre-existing diseases:
   a. Diabetes Mellitus (Type 2),
   b. Hypertension,
   c. Hyperlipidemia &
   d. Asthma

vi. **Accidental Death Benefit** - If an Insured Person suffers an accident during the policy period and this is the sole and direct cause of his death within 365 days from the date of accident, then we will pay the Sum Insured as mentioned in the 'Benefit Table'. This benefit is not applicable for insured children or Insured person less than 18 years of age as on Policy commencement date.

8. Cost Sharing

i. **Inbuilt in Policy**

i. Age linked Co-Payment (Applicable to Geo Plan & Value Plan)

If the entry Age of the Insured Person is 61 years or above at the time of first coverage under this Policy, then such Insured Person shall bear 20% of each admissible claim.

ii. Higher Zone Co-Payment (Applicable to Geo Plan)

Wherever, Geo Plan has been opted and the insured person(s) undergoes medical treatment at a Hospital/ Day Care Centre/ AYUSH Hospital/ AYUSH Day Care Centre in Zone A, then an additional Co-Payment of 20% will be applicable on each such claim except for emergency Hospitalization due to Injury arising from an Accident or for benefits which are over and above the sum insured.

Note: For the purpose of application of Higher Zone Co-payment, Zone A means Mumbai (including Mumbai Metropolitan Region), Delhi (including National Capital Region, Faridabad, Ghaziabad), Ahmedabad, Surat & Baroda

iii. **Co-Payment for treatment availed out of Our Network of Valued Provider – Pan India (Applicable to Value Plan)**

Wherever, Value Plan has been opted and the Insured Person avails treatment outside Our network of "Valued Provider-Pan India", then a Co-Payment of 30% will be applicable for each such claim resulting from admission of the insured person in a Hospital/ Day Care Centre/ AYUSH Hospital/ AYUSH Day Care Centre except for Hospitalization for an Injury arising from an Accident.

Note: 'Valued Provider - Pan India' is a specific network of Hospitals, designated as such. It consists of a defined list of Hospitals or health care providers enlisted by Us, and/or TPA to provide medical services to an insured person by a Cashless Facility.

Where the Policyholder has selected Value Plan, You shall be eligible only for 'Valued Provider -Pan India'. The updated list of Valued Provider – Pan India is available on Our website (www.tataaig.com).

iv. Mandatory Sub-Limits

Our liability for any and all claims related to Hospitalization/ Day Care Treatment (including their associated Pre & Post Hospitalization expenses) arising out of following ailments/surgical procedures shall be restricted to the following Sub-limits.

Table I : Mandatory Sub-limits applicable for Ailment/Surgical Procedure for **Geo Plan**
(in INR)

(Ailment/Surgical Procedure)	Sub limit, as applicable to each Insured Person based on the Sum Insured				
	5 Lacs	**7.5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**
Cataract Surgery (per eye)	40,000	56,000	80,000	120,000	160,000
Balloon Sinuplasty/ FESS	25,000	35,000	50,000	75,000	100,000
Oral chemotherapy	75,000	105,000	150,000	225,000	300,000
Immunotherapy- Monoclonal Antibody all forms	125,000	175,000	250,000	375,000	500,000
Robotic surgeries	125,000	175,000	250,000	375,000	500,000
Stem cell therapy for Hematopoietic stem cells for bone marrow transplant for hematological conditions	125,000	175,000	250,000	375,000	500,000

Table II: Mandatory Sub-limits applicable for Ailment/Surgical Procedure for **Value Plan**
(in INR)

(Ailment/ Surgical Procedure)	Sub limit, as applicable to each Insured Person based on the Sum Insured				
	5 Lacs	**7.5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**
Cataract Surgery (per eye)	45,000	60,000	90,000	130,000	175,000
Balloon Sinuplasty/ FESS	30,000	40,000	55,000	85,000	110,000
Oral chemotherapy	85,000	115,000	165,000	250,000	330,000
Immunotherapy- Monoclonal Antibody all forms	140,000	195,000	275,000	415,000	550,000
Robotic surgeries	140,000	195,000	275,000	415,000	550,000
Stem cell therapy for Hematopoietic stem cells for bone marrow transplant for hematological conditions	140,000	195,000	275,000	415,000	550,000
Total Knee Replacement (per knee)	165,000	175,000	180,000	215,000	230,000
Any type of Hernia surgery	70,000	75,000	75,000	95,000	100,000
Any type of Hysterectomy	70,000	75,000	75,000	95,000	100,000
Benign Prostate Hypertrophy	70,000	75,000	75,000	95,000	100,000
Stones of Renal System	70,000	75,000	75,000	95,000	100,000

ii. Optional (Selection available at inception of first policy/coverage OR at Renewal)

v. **Voluntary Sub-Limits**

In lieu of premium discount opted by the policyholder/ insured person, the following sub-limits shall be applicable in addition to the Mandatory Sub-limits. Our liability for any and all claims related to Hospitalization/ Day Care Treatment (including their associated Pre & Post Hospitalization expenses) arising out of following ailments/surgical procedures shall be restricted to the following Sub-limits subject to availability of Sum Insured and other terms and conditions of the policy.

Table A : Voluntary Sub-limits applicable for Ailment/Surgical Procedure for **Geo Plan** *(in INR)*

(Ailment/ Surgical Procedure)	Sub limit, as applicable to each Insured Person based on the Sum Insured				
	5 Lacs	**7.5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**
Total Knee Replacement (per knee)	150,000	157,500	165,000	195,000	210,000
Any type of Hernia surgery	65,000	68,000	70,000	85,000	90,000
Any type of Hysterectomy	65,000	68,000	70,000	85,000	90,000
Benign Prostate Hypertrophy	65,000	68,000	70,000	85,000	90,000
Stones of Renal System	65,000	68,000	70,000	85,000	90,000
Cerebrovascular & Cardiovascular	250,000	275,000	300,000	325,000	350,000
Cancer	250,000	275,000	300,000	325,000	350,000
Renal Complications & Disorders (excluding Stones of Renal System)	250,000	275,000	300,000	325,000	350,000
Breakage of Bones requiring surgery under general anesthesia	250,000	275,000	300,000	325,000	350,000

Table B: Voluntary Sub-limits applicable for Ailment/Surgical Procedure for **Value Plan** *(in INR)*

(Ailment/ Surgical Procedure)	Sub limit, as applicable to each Insured Person based on the Sum Insured				
	5 Lacs	**7.5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**
Cerebrovascular & Cardiovascular	275,000	300,000	330,000	360,000	385,000
Cancer	275,000	300,000	330,000	360,000	385,000
Renal Complications & Disorders (excluding Stones of Renal System)	275,000	300,000	330,000	360,000	385,000
Breakage of Bones requiring surgery under general anesthesia	275,000	300,000	330,000	360,000	385,000

vi. **Aggregate Deductible(in ₹)**

In lieu of premium discount opted by the policyholder/ insured person, Our liability under this Policy shall be subject to application of Aggregate Deductible as opted by the the policyholder/ insured person.

Sum Insured (in ₹)	Deductible Options (in ₹)
5 Lacs	25,000/ 50,000
7.5 Lacs	37,500/ 75,000
10 Lacs	50,000/ 100,000
15 Lacs	75,000/ 150,000
20 Lacs	100,000/ 200,000

vii. Shared Accommodation (Applicable in case of Geo Plan)
A discount on premium is offered in case insured opts for shared room category.

Note: the maximum discount(s) in lieu of optional cost sharing (e, f, g) will be added and applied on the base premium. The total of above discount(s) shall not exceed 25% under any Policy.

9. Discounts on premium:
   i. Young Family Discount – 5%
      - This discount is applicable only if all the Insured Persons covered are of age of 40 years or below at the time of first inception of the policy.
      - This discount will be effective from the first year of the policy and will continue for the lifetime of the policy, irrespective of claims.
      - This discount will be discontinued if, at any point during the policy year, a new member is added whose entry age in policy is 40 years or above.
   ii. 10% long term discount on premium in case insured opts policy term of 3 years
   iii. 5% long term discount on premium in case insured opts policy term of 2 years
   iv. Family floater discount on premium:
      - 2 members - 20%
      - 3 members - 28%
      - 3+ members - 32%
   v. 10% discount to all TATA Group employees

Note: The above mentioned discounts are added and applied on the base premium. The total of above discount(s) shall not exceed 40% under any Policy.

Discounts in lieu of optional cost sharing and discount under this section are multiplicative and in total shall not exceed 55% under any Policy.

10. Renewal Incentives:

5X Supercharge Bonus: We will provide 5X Supercharge Bonus in the form of 50% of the base Sum Insured of the expiring Policy, on each Renewal of the Policy, irrespective of claims in preceding Policy Years, provided that the Policy is renewed with Us without a break. The

total accrued 5X Supercharge Bonus shall not exceed 500% of the base Sum Insured in any Policy Year.

11. 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.

12. 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.

13. Waiting Period:

i. 30 Days Waiting Period (Code-Excl03):
   a. Expenses related to the treatment of any Illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
   c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii. Specified Disease/Procedure Waiting Period (Code- Excl02):

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.
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)
II. Polycystic ovarian disease, Fibromyoma, Adenomyosis, Endometriosis
III. Prolapsed Uterus
IV. Rheumatism
V. Ligament, Tendon or Meniscal tear
VI. Prolapsed Inter-Vertebral Disc
VII. Cholelithiasis
VIII. Pancreatitis
IX. Fissure/fistula in anus, haemorrhoids, pilonidal sinus
X. Ulcer & erosion of stomach & duodenum
XI. Gastro Esophageal Reflux Disorder (GERD)
XII. Liver Cirrhosis
XIII. Perineal Abscesses
XIV. Perianal / Anal Abscesses
XV. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.
XVI. Benign Hyperplasia of prostate
XVII. Varicocele
XVIII. Cataract, Retinal detachment, Glaucoma
XIX. Congenital Internal Diseases

List of procedure/surgeries/treatments:

XX. Adenoidectomy
XXI. Mastoidectomy
XXII. Tonsillectomy
XXIII. Tympanoplasty
XXIV. Surgery for nasal septum deviation
XXV. Nasal concha resection

XXVI. Surgery for Turbinate hypertrophy
XXVII. Hysterectomy
XXVIII. Osteoarthritis, joint replacement, osteoporosis,
XXIX. Systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid, Gout
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

iii. Pre-existing Diseases Waiting Period (Code-Excl01)

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.

14. 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.

1. 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.

xiii. Alcoholic pancreatitis or Alcoholic liver disease;

xiv. Congenital External Diseases, defects or anomalies;

xv. Stem cell therapy; however, hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under this Policy, subject to applicable sub-limits;

xvi. Growth Hormone Therapy;

xvii. Sleep-apnoea and Sleeping disorder;

xviii. Admission primarily for administration (via any form or mode) of immunoglobulin infusion or supplementary medications like Zolendronic Acid, etc;

xix. Venereal disease, sexually transmitted disease or Illness;

xx. All preventive care including Health Check-ups, vaccination including inoculation and immunisations;

xxi. 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;

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

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

2. 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.

iv. 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.

v. 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.

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

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

viii. 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.

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

x. 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.

xi. Hearing aids, spectacles or contact lenses, etc. including optometric therapy.

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

xiii. Any treatment or part of a treatment that does not form part of 'Reasonable and Customary charges', nor is medically necessary.

xiv. 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.

xv. Any external appliance and/or device used for diagnosis or treatment except when used intra-operatively.

xvi. 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.

15. Claim Procedure:

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

a. Notification of claim & Assistance:

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

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

b. Claim Related Information:

For any claim related query, intimation of claim and submission of claim related documents, the Policyholder/Insured Person can contact us through:

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Claims Servicing Details	
Name	TAGIC Health Claims

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

c. Procedure for reimbursement claims:

- Please send the duly signed claim form and all the information/documents mentioned therein to our TPA/Us within 15 days of the occurrence of the Incident.
- Please refer to claim form for complete documentation.
- If there is any deficiency in the documents/information submitted by the Policyholder/Insured Person, our TPA/We will send the deficiency letter within 7 working days of receipt of the claim documents.
- On receipt of the complete set of claim documents, We will send the payment for the admissible amount, along with a settlement statement within 30 days.
- The payment will be sent in the name of the proposer/ Nominee in case of death of Proposer.

d. Procedure for availing cashless facility:

i. Cashless Service is only available at Our Network Provider (for Geo Plan)/ Valued Provider – Pan India (for Value Plan), as applicable.

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

a. Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, Policyholder/Insured Person 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.

c. In case of deficiency in the documents sent to TPA/Us for cashless authorization, the same shall be communicated to the Hospital by TPA/Us.

Note:

- Please refer to our website(www.tataaig.com) or call us on our toll free number at 1800-266-7780 or 1800 229 966(for Senior Citizens) for updated list of Network Provider and Valued Provider – Pan India.
- Rejection of cashless facility in no way indicates rejection of the claim.

e. Claim Settlement (provision for Penal Interest)

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

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

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

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

f. Claim procedure and management of Wellness Services, Wellness Program and Preventive Annual Health Check-Up

Service 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. Alternatively, details of our empanelled service provider are available on our website (www.tataaig.com).

g. **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.

16. Renewal of Policy:

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

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

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

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

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

v. Coverage during such grace period (in case of instalment premium):
   a. Within the policy period - coverage will be available from the due date of instalment premium till the date of receipt of premium by Company within the grace period.
   b. At the end of the policy period - the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of

benefits without break in policy. Coverage is not available during the grace period after the end of the policy period.

vi. The insured person will get the accrued continuity benefit to the extent of Sum Insured, No Claim Bonus, Specified Waiting Periods, waiting periods for pre-existing diseases, Moratorium period, as applicable, in the event of payment of premium within the stipulated grace Period.

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

17. 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.

18. 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 ubsequent amendments thereof.

19. Withdrawal of policy:

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.

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 5X Supercharge Bonus, waiver of waiting period as per IRDAI guidelines, provided the Policy has been maintained without a break.

20. Moratorium Period

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

sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, Co-Payments, Aggregate deductibles as per the Policy contract.

21. 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.

22. Requirement:

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

23. Pre-policy medical check-up:

Pre-Policy Check-up at our network is required. The medical reports are valid for a period of 90 days from the date of Pre-Policy Checkup.

Age(Yrs)/Sum Insured	All Sum Insured Options
Upto age 45	Tele MER (only if positive medical declaration)
46 - 55	Tele MER/Video MER/ PPC
56 - 65	MER, Urine Routine, CBC with ESR, LFT, RFT, Lipid Profile, Hba1c, ECG

MER – Medical Examination Report, CBC – Complete Blood Count, ESR – Erythrocyte Sedimentation Rate , LFT – Liver Function test, RFT – Renal Function Test, Hba1c - Hemoglobin A1C Test, ECG – Electro Cardiogram, PPC – Pre-Policy Check-up

- In case of adverse medical declaration, we may call for additional medical tests. We may conduct medical tests at diagnostic centre based on medical disclosure wherever applicable.
- 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 Tata AIG in case where proposal is accepted.

24. Premium Rates:

i. The premium will be charged on the completed age of the Insured Person and as per applicable Zone (for Geo Plan).
ii. For family floater, premium is calculated by adding the premium of respective individual members and applying family floater discount.

iii. Monthly/Quarterly/Half-Yearly instalment option would be allowed and following loadings shall be applicable as per the selected installment option and Policy Tenure:

Installments	Policy Tenure		
	1 Year	2 Year	3 Year
Monthly	5.00%	9.00%	13.00%
Quarterly	4.00%	8.00%	11.50%
Half-Yearly	3.00%	7.00%	10.50%

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

I. Grace Period of 15 days would be given to pay the installment premium due for the policy where premium payment mode is monthly and 30 days in all other cases (Half-Yearly/ Quarterly), during the policy period. During such grace period, coverage shall be available from the due date of installment premium till the date of receipt of premium by Company.

II. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

III. No interest will be charged If the installment premium is not paid on due date

IV. In case installment premium due is not received within the grace period, the policy will get cancelled.

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

VI. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Value Plan ***(Annual Per Person Rates in ₹)***

Age (in years)/ Sum Insured	5 Lacs	7.5 Lacs	10 Lacs	15 Lacs	20 Lacs
91 Days -17	5,136	5,385	5,422	6,145	6,636
18-35	8,067	8,463	8,523	9,676	10,458
36-40	9,537	10,005	10,075	11,440	12,367
41-45	10,156	10,656	10,730	12,187	13,176
46-50	13,973	14,657	14,753	16,761	18,126
51-55	18,483	19,388	19,514	22,174	23,982
56-60	22,621	23,729	23,884	27,145	29,362
61-65	31,739	33,223	33,394	37,910	40,993
66-70^	43,909	45,965	46,208	52,480	56,761
71+^	61,467	64,322	64,650	73,431	79,425

(Exclusive of taxes)

Geo Plan for Zone B) (Annual Per Person Rates in ₹, rates applicable

Age (in years)/ Sum Insured	5 Lacs	7.5 Lacs	10 Lacs	15 Lacs	20 Lacs
91 Days -17	4,457	4,769	4,871	5,543	6,117
18-35	6,752	7,234	7,391	8,426	9,309
36-40	8,206	8,793	8,984	10,247	11,325
41-45	8,370	8,970	9,589	10,938	12,091
46-50	11,355	12,171	12,436	14,194	15,696
51-55	15,667	16,796	17,160	19,594	21,673
56-60	20,904	22,414	22,901	26,157	28,939
61-65	28,226	30,218	30,837	35,185	38,914
66-70^	38,423	41,123	41,966	47,892	52,975
71+^	55,935	59,843	61,069	69,705	77,111

(Exclusive of taxes)

Geo Plan for Zone C) (Annual Per Person Rates in ₹, rates applicable

Age (in years)/ Sum Insured	5 Lacs	7.5 Lacs	10 Lacs	15 Lacs	20 Lacs
91 Days -17	3,814	4,080	4,166	4,736	5,222
18-35	5,763	6,171	6,305	7,182	7,931
36-40	6,998	7,496	7,658	8,729	9,643
41-45	7,466	7,998	8,171	9,315	10,293
46-50	9,670	10,362	10,585	12,077	13,351
51-55	13,335	14,291	14,599	16,663	18,426
56-60	17,783	19,063	19,474	22,236	24,595
61-65	24,011	25,701	26,223	29,911	33,074
66-70^	32,676	34,966	35,678	40,704	45,015
71+^	47,557	50,871	51,906	59,231	65,512

(Exclusive of taxes)

Accidental Death Benefit (Optional Cover)

Sum Insured	5 Lacs	7.5 Lacs	10 Lacs	15 Lacs	20 Lacs
Annual Per Person Rates in ₹	279	418	558	836	1,115

(Exclusive of taxes)

^ Premium rates for age above 65 is for renewal.

25. 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 or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).
    i. We will inform You about the applicable risk loading through a counter offer letter.
    ii. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter.
    iii. 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.
iv. Please note that We will issue Policy only after getting Your consent.

26. 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.

27. Redressal of Grievance:

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

Escalation Level 1

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

Escalation Level 2

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

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

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

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

Benefit Table:

Plan Name	Value Plan	Geo Plan
Availability	For customers from Zone A, Zone B and Zone C	For customers from Zone B and Zone C
Benefit Name	**Coverage Limit**	**Coverage Limit**
In-Patient Treatment	Upto Sum Insured	Upto Sum Insured
Pre-Hospitalisation expenses	Upto 90 Days	Upto 90 Days
Post-Hospitalisation Expenses	Upto 90 Days	Upto 90 Days
Day Care Treatment	Upto Sum Insured	Upto Sum Insured
Domiciliary Treatment	Upto Sum Insured	Upto Sum Insured
Organ Donor	Upto Sum Insured	Upto Sum Insured
AYUSH Benefit	Upto Sum Insured	Upto Sum Insured
Road Ambulance Cover	Upto ₹1,000 per hospitalization	Upto ₹1,000 per hospitalization
Restore Benefit	Available	Available
Compassionate Travel	Upto ₹10,000 per policy year, over and above base Sum Insured	Upto ₹10,000 per policy year, over and above base Sum Insured
Prolonged Hospitalisation Benefit	₹10,000 per policy year, over and above base Sum Insured	₹10,000 per policy year, over and above base Sum Insured
Medical Devices Cover	Upto ₹5,000 per policy year as per the list, over and above base Sum Insured	Upto ₹5,000 per policy year as per the list, over and above base Sum Insured
Vaccination Cover	Upto ₹10,000 per policy year as per the list, over and above base Sum Insured	Upto ₹10,000 per policy year as per the list, over and above base Sum Insured
Second Opinion	Available for listed medical conditions	Available for listed medical conditions
Wellness Services	i. Unlimited Teleconsultation - General ii Unlimited Teleconsultation – Specialist iii. Ambulance Booking facility iv. Emergency-Help me feature v. Redeemable voucher/Discount on services vi. Health Condition Management (a. Diet & Weight Management Program b. Stress Management Program)	i. Unlimited Teleconsultation - General ii Unlimited Teleconsultation – Specialist iii. Ambulance Booking facility iv. Emergency Help me feature v. Redeemable voucher/Discount on services vi. Health Condition Management (a. Diet & Weight Management Program b. Stress Management Program)
Wellness Program	Available	Available
5X Supercharge Bonus	50% of the base Sum Insured of the expiring Policy, on each	50% of the base Sum Insured of the expiring Policy, on each

	Renewal of the Policy, irrespective of claims in preceding Policy Years, maximum upto 500% of the base Sum Insured in any Policy Year	Renewal of the Policy, irrespective of claims in preceding Policy Years, maximum upto 500% of the base Sum Insured in any Policy Year
Room Eligibility**	Room Rent upto ₹5,000 per day	Single Private Room
Optional Covers		
Restore Infinity	Available	Available
Emergency Air Ambulance Cover	Upto ₹5,00,000 per policy year, over and above base Sum Insured	Upto ₹5,00,000 per policy year, over and above base Sum Insured
Consumables benefit	Upto Sum Insured	Upto Sum Insured
Preventive Annual Health Check-Up	Once every policy year for listed tests, only on Cashless basis	Once every policy year for listed tests, only on Cashless basis
Advanced Cover	Available	Available
Accidental Death Benefit	Available	Available
Cost Sharing		
Age Linked Co-Payment	Applicable	Applicable
Higher Zone Co-Payment	Not Applicable	Applicable
Co-payment for treatment availed out of Our Network of Valued Provider – Pan India	Applicable	Not Applicable
Mandatory Sub-Limits	Applicable as per Sub-Limits mentioned in Table II of Mandatory Sub-Limits	Applicable as per Sub-Limits mentioned in Table I of Mandatory Sub-Limits
Optional Cost Sharing		
Voluntary Sub-Limits	Applicable as per Sub-Limits mentioned in Table B of cost sharing as per policy wordings	Applicable as per Sub-Limits mentioned in Table A of cost sharing as per policy wordings
Aggregate Deductible	Available	Available
Shared Accommodation**	Not Available	Available

**Proportionate deduction of Associated Medical Expenses applicable in case insured person is admitted in a room whose category/room rent is higher than the eligible room category/rent.

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

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

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

Disclaimer:

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

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

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

Tata AIG General Insurance Company Limited
Registered Office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Off Senapati Bapat Road, Lower Parel, Mumbai- 400013.
24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For Senior Citizens) Fax: 022 6693 8170
Email:customersupport@tataaig.com Website: www.tataaig.com IRDA of India Registration No: 108 CIN: U85110MH2000PLC128425