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

S. No.	Title	Description	Policy Clause No.
1.	Name of the Insurance Policy	TATA AIG Medicare Protect	
2.	Policy Number	<< Policy Number >>	
3.	Type of Insurance Policy	<<Indemnity- Where insured losses are covered up to the Sum Insured under the policy >> <<Both Indemnity and Benefit – Policy has elements of both, Indemnity (which cover insured loses) and Benefit (which pays a fix amount under the policy on the occurrence of a covered event)>>	
4.	Sum Insured (Basis) (Along with amount)	<<Sum Insured Amount>> As per Sum Insured mentioned in Policy Schedule Sum Insured represents Our maximum, total and cumulative liability under the Policy, for all the Insured Person(s) covered in aggregate, for the respective Policy Year	
5.	Policy Coverage (What the policy covers?)	B1. **In-Patient Treatment** – Covers hospitalization expenses for period more than 24 hrs. B2. **Pre-Hospitalization expenses-** Medical Expenses incurred in 30 days before the date of admission to the hospital B3. **Post-Hospitalization expenses** - Medical Expenses incurred in 60 days after the date of discharge from the hospital B4. **Day Care Procedures** – Medical expenses for listed Day Care Treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre. B5. **Organ Donor** - Medical Expenses on harvesting the organ from the donor for organ transplantation. B6. **Domiciliary Treatment** - Medical Expenses incurred for availing medical treatment at home which would otherwise have required hospitalization. We will also cover pre and post hospitalization expenses in case of domiciliary hospitalization	Section (2)

		B7. **Restore benefits** - Automatically restore the Basic Sum Insured upon exhaustion of the Sum Insured and accrued Cumulative Bonus, during the policy period. B8. **AYUSH Benefit** - We will cover Medical Expenses incurred for treatment as In-Patient or Day Care Treatment in an AYUSH Hospital/ AYUSH day care centre. This benefit shall also cover Pre-Hospitalization medical expenses for a period of upto 30 days before the date of admission to the AYUSH hospital/ AYUSH day care centre and Post-Hospitalization Medical Expenses for a period upto 60 days, subject to AYUSH In-Patient hospitalization or AYUSH day care treatment claim being admissible under this benefit. Claims under this section shall be assessed as per the insurance guidelines related to AYUSH and benchmark rates as available on Ministry of AYUSH website (https://ayushnext.ayush.gov.in/site/insurance-guidelines-related-to-ayush). B9. **Ambulance cover** – For utilizing ambulance service for transporting insured person to hospital in case of an emergency. B10. **Health Checkup** - Expenses for a Preventive Health Check-up upto 1% of previous year policy sum insured per policy once in block of every three continuous claim free policy years with us. B11. **Compassionate travel** - In the event the Insured Person is Hospitalized for more than Five consecutive days in a place where no adult member of his immediate family is present, we will cover expenses related to a round trip economy class air ticket, or first-class railway ticket, to allow the Immediate Family Member be at his bedside for the duration of his stay in the hospital. The expenses must be incurred within India and shall not exceed Rs. 20,000 during a policy year. B12. **Consumables Benefit** - We will pay for expenses incurred, for specified consumables which are listed in 'annexure 1 – List 1 as optional items' under 'Guidelines on Standardization in Health Insurance, 2016' & its amendments,which are consumed during the period of hospitalization directly related to the	

		insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I-Optional items are available on our website (www.tataaig.com). B14. **Cumulative Bonus**- 10% Cumulative Bonus will be applied on the Sum Insured for next policy year under the Policy after every claim free Policy Year, provided that the Policy is renewed with Us and without a break. The maximum cumulative bonus shall not exceed 100% of the Sum Insured in any Policy Year. Optional Cover **(For applicability of this optional cover, please refer your Policy Schedule):** B13. Accidental Death Benefit - If an Insured Person suffers an accident during the policy period and this is the sole and direct cause of his death within 365 days from the date of accident, then we will pay a fixed amount of 100% of the base Sum Insured.	
6.	Exclusions	**Standard Exclusions** 1. Medical Exclusions I. Investigation and evaluation (Code- Excl 04) II. Rest cure, rehabilitation and respite care (Code- Excl 05) III. Obesity/ Weight Control (Code- Excl 06) IV. Change-of-Gender treatments (Code-Excl07) V. Cosmetic or Plastic Surgery (Code- Excl 08) VI. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code- Excl 12). VII. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code- Excl13) VIII. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. (Code-Excl14)	Section (3)

		IX. Refractive error (Code- Excl 15) X. Unproven treatments (Code- Excl 16) XI. Sterility and Infertility (Code- Excl 17) XII. Maternity (Code - Excl 18) 2. Non-Medical Exclusions I. Hazardous or Adventure Sports (Code- Excl 09) II. Breach of law (Code- Excl 10) III. Excluded Providers: (Code-Excl 11) **Specific Exclusions (Exclusions other than as those mentioned above)** **1. Medical Exclusions** I. Alcoholic pancreatitis II. Congenital External Diseases, defects or anomalies; III. Stem cell therapy; IV. Growth Hormone Therapy; V. Sleep-apnoea VI. Admission primarily for administration of Intra-articular or intra-lesional injections or Int ravenous immunoglobulin infusion or supplementary medications VII. Venereal disease, sexually transmitted disease or Illness; VIII. All preventive care IX. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization X. Any existing disease specifically mentioned as Permanent exclusion in the Policy Schedule. **2. Non-Medical Exclusions** I. War or any act of war, invasion, act of foreign enemy, war like operations. 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. Items of personal comfort and convenience. V. Treatment rendered by a Medical Practitioner which is outside his discipline. VI. 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. VII. Provision or fitting of hearing aids, spectacles or contact lenses etc. VIII. Any treatment and associated expenses for alopecia, baldness, wigs or toupees, medical supplies. IX. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; X. Crutches or any other external appliance and/or device used for diagnosis or treatment. XI. Any Illness diagnosed or Injury sustained or where there is change in health status of the member after date of proposal and before commencement of Policy and the same is not communicated and accepted by Us. This is summary of exclusions. For detailed exclusions, please refer Policy wordings (Section 3)	
7.	Waiting period	I. Initial waiting period of 30 days for all illnesses (not applicable for accidents or on renewals) II. Specified Waiting periods (Not applicable for claims arising due to an accident) of 24 months for 40 listed Diseases/procedure III. Pre-existing disease covered after 48 months	Section (3)
8.	Financial limits of coverage i. Sub-limit (it is a pre-defined limit and the insurance company will not pay any amount in excess of this limit)	The policy will pay only up to the limits specified hereunder for the following diseases/procedures **Sub-limit:** <u>Benefit Specific Sub-limit:</u> • Ambulance Cover Upto ₹1,000 per hospitalization **Co-payment:** 10% copayment shall be applicable in case you are admitted in a hospital room where the room category	Section (2) & Section (4)

	ii. Co-payment (it is a specified amount/percentage of the admissible claim amount to be paid by policy holder/insured) iii. Deductible (it is a specified amount: - Up to which an insurance company will not pay any claim, and - Which will be deducted from total claim amount (if claim amount is more than the specified amount) Any other limit (as applicable)	opted is higher than shared accommodation. **Any Other limit:** • In-Patient Treatment- Upto Sum Insured • Pre-Hospitalization expenses- Upto 30 days, Upto Sum Insured • Post-Hospitalization expenses- Upto 60 days, Upto Sum Insured • Day Care Procedures- Upto Sum Insured • Organ Donor- Upto Sum Insured • Domiciliary Treatment- Upto Sum Insured • AYUSH Benefit- Upto Sum Insured • Health Checkup- Upto 1% of previous Sum Insured, once after every block of three continuous claim free policy years (over and above base sum insured) • Compassionate Travel- Upto ₹20,000 per policy year (over and above base sum insured) • Consumables benefit- Upto Sum Insured Optional Cover: • Accidental Death Benefit: 100% of the base Sum insured. **For cover applicable to you, please refer your Policy Schedule.**	
9.	Claims/ Claims Procedure	**Claim procedure:** • For Cashless Service: 1. If any planned treatment for which a claim may be made then the insured must notify us at least 48 hours before the planned Hospitalization. 2. If any treatment for which a claim may be made, requiring emergency Hospitalization, then the insured must notify us within 24 hours after the treatment or Hospitalization and prior to discharge 3. You have to provide the ID card issued to You along with any other information or documentation that is requested by the TPA/Us to the Network Hospital. • For Reimbursement of Claim: 1. Please intimate our TPA/Us within 7 days of	Section (5)

		completion of treatment, consultation or procedure. 2. Please submit claim documents to our TPA/Us within 15 days of occurrence of incident. 3. Kindly send the claim documents to: 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 **Turn Around Time (TAT) for claims settlement:** i. TAT for preauthorization of cashless facility: 2 hours ii. TAT for cashless final bill authorization: 4 hours **Assistance:** 1. Please refer to our website www.tataaig.com or call us on our toll free number at 1800-266-7780 to get details on our empanelled hospitals and list of Excluded providers/ Blacklisted Hospitals. 2. Helpline number: Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders) 3. Please refer our website www.tataaig.com to download claim form	
10.	Policy Servicing	Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders)	Section (4)
11.	Grievances/ Complaints	**Redressal of Grievance** In case of any grievance the insured person may contact the company through: Website: www.tataaig.com Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders) Email: customersupport@tataaig.com Courier: Customer Support, TATA AIG General Insurance Company Limited, 7th and 8th Floor, Romell Tech Park, Cama Industrial Estate, Western Express Highway, Goregaon(E), Mumbai, Maharashtra 400063 Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.	Section (4)

		Escalation level 1: If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at manager.customersupport@tataaig.com **Escalation level 2:** If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region (details as mentioned in the Annexure A of this policy) for redressal of grievance as per Insurance Ombudsman Rules 2017. Grievance may also be lodged at IRDAI Integrated Grievance Management System (https://igms.irda.gov.in/)	
12.	Things to remember	**Free Look Period** The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document 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 less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period; **Policy renewal** The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person. i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.	Section (4)

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

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

iv. 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.

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

Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration.

For Detailed Guidelines on Migration, kindly refer Guidelines issued by IRDAI(Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof.

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 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability.

For Detailed Guidelines on Portability, kindly refer Guidelines issued IRDAI(Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020and subsequent amendments thereof.

Change in Sum Insured

Sum Insured can be enhanced only at the time of renewal subject to underwriting guidelines of the company.

Moratorium Period

After completion of eight continuous years under the

		policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.	
13.	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid and termination of Your policy.	