

Tata AIA Group Sampoorna Raksha Supreme (UIN: 110N173V032)
Non-linked, Non-participating, Group Protection – Oriented Life Insurance Plan

Certificate of Insurance

Tata AIA Group Sampoorna Raksha Supreme (UIN:110N173V032)
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This is to certify that, in consideration of the application for enrolment and the premium paid, the person named hereunder (herein called the Insured Member) is insured under and subject to the terms and conditions of Tata AIA Group Sampoorna Raksha Supreme, Policy No. <<Policy No>> issued to <<Name of Master Policyholder>> (herein called the Policyholder which means the Master Policyholder) by Tata AIA Life Insurance Company Limited (herein called the Company).

Details of Master Policyholder						
Name of the Policyholder						
Policy Term						
Branch Name						
Details of the Member						
Proposer Name						
Address						
Certificate No.						
Membership No.						
Premium Mode						
Premium Payment Term						
Name of Insured Member	Primary Borrower/ Applicant	Co-Applicant/ Co-Borrowers				
Date of Birth						
Age (years)						
Gender	<< Male/ Female/ Transgender>>					
Joint Cover Percentage Share						
Joint Cover Sum Assured Share						

Nominee details (under section 39 of the Insurance Act 1938)					
Applicant Type	Name of the Nominee (s)	Relationship with Insured Member	Age	Date of Birth	Nomination %
Primary					
Co-Applicant 1					

Appointee Details (Applicable in case the Nominee is a minor)				
Name of the Nominee (s)	Name of the Appointee (s)	Relationship with Nominee	Age	Date of Birth

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Coverage Details												
Plan Option	Basic Sum Assured (Rs.)	Coverage Effective Date	Coverage Expiry Date	Coverage Term (Years / Months)	Type of Cover (Level/Reducing)	Moratorium Period, if any (Years / Months)	Premium Amount (Excluding Applicable Taxes, Cesses and Levies) (Rs.)	Applicable Taxes, Cesses and Levies (Rs.)	Total Premium (Rs.)	Premium Due Date	Due Date of Last Premium	Maturity Benefit
<< >>	<< >>	<< >>	<< >>	<< >>	<< >>	<< >>		<< >>	<<>>	<<>>	<<>>	<<>>

This should appear only if Hospital cash benefit is selected

Number of hours for continuous Hospitalization	<<24 hours/72 hours>>
Number of days Selected	<<15/30/45/60 days>>
Per day Benefit	<< >>
Recuperation Benefit	Yes/No

Add-on Benefits

Benefit name	Indexation Benefit	Ambulance Cover	Diagnostic Test Benefit	Restoration Benefit	Overseas Booster	Survival Days
Hospital Cash Benefit	NA	Yes/No	Yes/No	Yes/No	NA	NA
<<>>	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	<<0/7/14/30>> days
<<>>	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	<<0/7/14/30>> days
<<>>	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	<<0/7/14/30>> days
<<>>	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	<<0/7/14/30>> days
<<>>	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	Yes/No/NA	<<0/7/14/30>> days

Acceptance of premium does not constitute risk commencement. Risk commencement starts after realization of premium and acceptance of risk by the Company.

This Certificate of Insurance has been issued based on the information provided by Insured Member named herein, through the Policyholder during Insured Member's enrolment under the Policy mentioned herein.

Validity of this Certificate of Insurance is subject to remittance / payment of the premium payable for the coverage by you/Policyholder as and when they become due.

Free Look Option:

Date of Filing: ~~30th September 2024~~
Date of Modification: ~~30th September 2024~~
Final Policy Document Date: ~~30th September 2024~~

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MPH Insured Member have a free look period of 30 days whether received electronically or otherwise where the policy term is greater than equal to 1 year and 15 days where the policy term is less than 1 year, the date of receipt of the policy document , to review the terms and conditions of the Policy and if You disagree to any of those terms or conditions, You have the option to return the Policy to the Us for cancellation, stating the reasons for Your objection, and be entitled to a refund of the Premiums paid without interest after deduction of proportionate risk premium, stamp duty and medical examination cost along with applicable taxes, cesses and levies.

Note: This is a system-generated document and no signature is required.

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TERMS AND CONDITIONS APPLICABLE TO THE CERTIFICATE OF INSURANCE:

IMPORTANT DEFINITIONS:

“Annualised Premium” - shall be the premium payable in a year chosen by the policyholder, excluding the taxes, rider premiums, underwriting extra premiums and loadings for modal premiums, if any. The applicable taxes, cesses, and levies, if any, shall be collected separately over and above the premiums.

“Assignee” is the person to whom the rights and benefits under the Policy are transferred by way of an Assignment.

“Assignment” is the process of transferring the rights and benefits under the Policy to an Assignee in accordance with the provisions of Section 38 of Insurance Act, 1938 as amended from time to time;

“Appointee” means the person appointed by You and named in the Policy Schedule, to receive the benefits payable under the Policy until Your nominee attains the age of majority. This is applicable only where the nominee is a minor.

“Certificate of Insurance” means the certificate issued by the Company to an Insured Member to confirm his coverage under the Policy. Coverage in respect of an Insured Member shall commence from the Effective Date of Coverage mentioned therein.

“Beneficiary/Claimant” means the Insured Member or the Nominee or the Legal heir of the Insured Member as the case may be.

“Coverage Effective Date” shall mean the commencement date of the insurance Coverage in respect of each Insured Member as specified in his Certificate of Insurance.

“Coverage Term” shall be the period during which the insurance cover of the Insured Member shall continue till the expiry of the term as specified in the Certificate of Insurance

“Critical Illness/ CI” shall mean any Illness, medical event or Surgical Procedure as specifically defined below in the Definition section as per Annexure B whose signs or symptoms first commence post the specified waiting period after the Inception of Policy Period”

“Eligible Members” shall mean those members who satisfy and continue to satisfy the eligibility criteria and are eligible for coverage in the insurance plan under the Policy.

“Grace period” means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

“Hospital” means any institution established for in-patient care and day care treatment of illness and/ or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of section 56(1) of the said Act or complies with all minimum criteria as under:

- (i) Has qualified nursing staff under its employment round the clock
- (ii) Has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places

(iii) Has qualified medical practitioner (s) in charge round the clock

(iv) Has fully equipped operation theatre of its own where surgical procedures are carried out.

(v) Maintains daily records of patient and will make these accessible to the Insurance Company’s authorized personnel

“Insured Member/Member” shall mean those members who are and continue to be Eligible Members and who, in accordance with the provisions of this Certificate of Insurance, are covered in the insurance plan under this Certificate of Insurance.

“IRDAI/ Authority/ IRDA of India” means the Insurance Regulatory and Development Authority of India.

“Joint Insured Members” shall mean Eligible Members whom, in accordance with the provisions of Section 1 (B) of Part B are covered for Joint Life Insurance under a Single loan, provided there shall be insurable interest between the lives.

“Master Policyholder/Policyholder/ MPH” means an institution or organization or entity to whom this Policy is issued by Us, as specified in the Schedule. Where the policy is availed under Lender-Borrower Group Schemes, the Master Policyholder/ Policyholder shall be the Scheduled Commercial Bank (including co-operative banks), NBFC, Small Finance Bank regulated by Reserve Bank of India, Housing Finance Company regulated by National Housing Bank, National Minorities Development Finance Corporation and its stake channelizing agency, mutually aided Co-operative Society formed and registered under applicable State Act, Micro Finance Company registered u/s. 8 of the Companies Act, 2013 or any other category as approved by the IRDAI.

“Moratorium Period” – shall mean the benefit period available with the Reducing coverage option only wherein the member may take mortgage or retail loan where the Sum assured during the moratorium period will be equal to initial Sum assured. Insured member may choose a moratorium period of minimum 1 month to maximum 84 months. If the Sum Assured is linked to a loan, the moratorium period shall match that of the actual loan taken by the member.”

“Nominee” shall mean the person(s) nominated by the Insured Member to receive the insurance benefits payable in the event of the death of the Insured member.

“Policy” shall mean this agreement, any supplementary contracts or endorsements therein, whenever executed, any amendments thereto signed by the Company, the application attached hereto of the Policyholder, the Schedule.

“Premium” means the amount specified in the Schedule, payable by you, by the due dates to secure the benefits under the Certificate of Insurance, excluding applicable taxes, cesses or levies, if any.

“Regulated Entity” shall mean an entity administering Lender-Borrower Group Scheme and shall be the Reserve Bank of India (RBI) Regulated Scheduled Commercial Banks (including Co-operative Banks), NBFCs having Certificate of Registration from RBI, National Housing Bank (NHB) Regulated Housing Finance Companies, National Minority Development Finance Corporation (NMDFC) and its State Channelizing Agencies, Small Finance Banks regulated by RBI, Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies, Microfinance companies registered under section 8 of the Companies Act, 2013 or any other category as approved by the Authority.

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“Revival Period” means the period of five consecutive complete years from the date of first unpaid premium.

“**Sum Assured**” shall mean the amount of benefit payable on the occurrence of an insured event as mentioned in the Schedule. Under Reducing Coverage option, if the Sum Assured is linked to a loan, it shall reduce as per the interest rate considered at the time of risk commencement for the Insured Member.

“**Surrender**” means complete withdrawal or termination of the entire Policy contract.

“**Terminal Illness**” means an advanced or rapidly progressing incurable & un-correctable medical condition, which in the opinion of the treating physician is highly likely to lead to death within the next six months. A Specialized Medical Practitioner also needs to opine that the life expectancy of the Insured Member is less than six months. The Waiting Period for Terminal Illness benefit is 180 days. Terminal Illness is an accelerated benefit. The benefit can be equal to or less than base Sum Assured. On the payment of this benefit, the Sum Assured on death shall reduce by the same amount. In case, the terminal illness benefit is equal to the base Sum Assured, the cover shall terminate post the payment of the Terminal Illness benefit.”

“Total premiums paid” means total of all the premiums paid under the base product, excluding any extra premium and taxes, if collected explicitly.

“**Specific waiting period**” means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy/ Certificate of Insurance has been continuously renewed without any break.

“**Underwriting Policy**” means our then prevailing Underwriting Policy as approved by Our board of directors;

“**We**”, “**Us**”, “**Our**” or “**Company**” refers to Tata AIA Life Insurance Company Limited.

“**You**” or “**Your**” or “**Policyholder**” means the holder of this Policy as shown in the Policy Schedule.

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Tata AIA Group Sampoorna Raksha Supreme is a comprehensive group insurance plan that provides protection in the event of Death, Illness or Disability. This plan can be offered to both Employer - Employee and Non-Employer - Employee groups. Upon the death of an insured member, benefit equal to member's Sum Assured, applicable at time of death, will be payable provided the coverage is in force.

The plan covers various insured events based on the options chosen by You, such as death, Terminal Illness, Accidental Death, Cancer, Major/Comprehensive Critical Illness, any type of disability/dismemberment. The plan also offers Hospital cash, Surgical Cash, Waiver of Equated Monthly Instalment ("EMI") on Hospitalization, Waiver of Premium on Major Critical Illness, Waiver of Premium on Major Surgery, Waiver of Premium on Accidental Total and Permanent Disability and other options as specified in this Policy.

I. Death Benefit

The benefits shall depend on the plan option chosen by Master Policyholder /Insured Member at the inception of the Policy/Certificate of Insurance, which cannot be changed once chosen.

- Upon death of an Insured Member during the Coverage Term provided the coverage is in force, the Sum Assured shall be payable. The Sum Assured payable on Death will be as per the Coverage Option chosen by MPH/ Insured Member. MPH/Insured Member have 2 Coverage options which cannot be changed thereafter:
- Level Coverage: The Sum Assured chosen at inception will remain unchanged throughout the Insured Member's Coverage Term.
- Reducing Coverage: The Sum Assured chosen at inception will reduce as per the interest rate considered at the time of risk commencement for the member. The loan interest should lie in the range of 0% to 36%.

A) In case of Single Life:

If the Sum Assured is linked to a loan -

- The Coverage Term at inception shall not be more than the loan tenure.
- Sum Assured shall be consistent with the original loan amount sanctioned for level cover or with the loan schedule at inception for reducing cover.
- The Death/Optional benefit payable to the Life Insured shall be as follows where Master Policyholder is a regulated entity under the lender borrower schemes:
 - Outstanding loan amount as per the loan schedule in favour of Master Policyholder/ Nominee of the policy.
 - Balance claim amount, if any, after deduction of the outstanding loan amount will be paid to the Nominee or Beneficiary of the deceased Insured Member.
- The Death/Optional benefit payable to the Life Insured shall be as follows in case of other than lender borrower schemes:
 - Outstanding loan amount as per the loan schedule in favor of Nominee/Beneficiary.

B) In Case of Joint Life

Joint Life option shall mean a person, who is also insured along with the primary Insured Member, where the Sum Assured is jointly held in the names of the lives.

It will be ensured that there shall be insurable interest between the lives. If the cover is linked to loan, maximum of 5 co-borrowers shall be allowed.

Following options are available under Joint life basis:

1) Each member can be insured for entire Sum Assured (the benefit is paid only in case of first claim & coverage ceases for the Joint life): Each Insured Member will be insured for 100% of the Sum Assured. In case claim is paid for one member, cover ceases for the surviving member. If the insured event is triggered on multiple joint Insured Members at the same time, only one benefit equals to Sum Assured shall be payable in respect of the first Insured Member as stated on the Certificate of Insurance.

2) Each member is insured up to his/her respective share of the Sum Assured: If the claim is paid on occurrence of insured event of a member, then the cover shall cease only for that Insured Member. However, the cover shall continue for the other surviving member to the extent of his/her share of the Sum Assured. Any due proportionate premiums shall continue to be collected in case the cover continues for the surviving Insured Member(s).

If the insured event is triggered on multiple joint Insured Member(s) at the same time, Sum Assured shall be payable once to each, as per member's share of the Sum Assured stated on the Certificate of Insurance.

Spouse and Dependent Option Cover: Cover on the life of spouse/ dependents of a member can be opted by the Master policyholder. This will be ensuring insurable interest and will be underwritten as per the Underwriting policy of the company. The cover in respect of the spouse will cease immediately on the exit of the member from the scheme either due to death, resignation, and termination or in the case of divorce/annulment of marriage of spouse. In such cases, proportionate premium for the unexpired period of risk will be paid.

II. Other Optional Benefits

A. Optional Benefit is Payable on occurrence(s) of the insured event(s) Under each of the below cover type, Master Policyholder/Insured Member can opt for one of more of the following sixteen (16) benefit options.:

1. Cancer Protect (Additional/Accelerated)
2. Cancer Care (Additional/Accelerated)
3. Major Critical Illness (Additional/Accelerated)
4. Comprehensive Critical Illness (Additional/Accelerated)
5. Accidental Death Benefit (Additional)
6. Accidental Total and Permanent Disability (Additional/Accelerated)
7. All cause Total and Permanent Disability (Additional/Accelerated)

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8. Accidental Partial and Permanent Disability (Additional)
9. Accidental Dismemberment Benefit (Additional)
10. Hospital Cash Benefit (Additional)
11. Surgical Cash Benefit (Additional)
12. Waiver of EMI on Hospitalization (Additional)
13. Terminal Illness (Accelerated)
14. Waiver of Premium on Major Critical Illness
15. Waiver of Premium on Major Surgery
16. Waiver of Premium on Accidental Total and Permanent Disability

For details on the coverage, Specified Waiting Period, survival period etc, kindly refer **Annexure A**.

In the event of occurrence of any of the scenarios mentioned above, during the applicable waiting period,

- No benefit shall be payable.
- No waiting period shall be applicable for the event occurring solely due to accident.
- No waiting period shall be applicable for renewals of Yearly Renewable Term contracts.
- In case of Hospital Cash Benefit and Surgical Cash Benefit, the policy will continue with future premium payment and benefits shall be payable in case claim occurred after the waiting period.

For all other Optional Benefit(s) where waiting period is applicable, 100% of the premium will be refunded for the respective Optional benefit(s) and the Optional benefit(s) will terminate thereafter.

B. Conditions for Optional Benefits:

Master Policyholder or Insured Member can choose either one of the following –

- Major/Comprehensive Critical Illness (Additional) or Major/Comprehensive Critical Illness (Accelerated) or Cancer Protect/Cancer Care /(Cancer Protect/Cancer Care (Accelerated)).
- All cause Total and Permanent Disability or Accidental Total and Permanent Disability.
- Accidental Partial and Permanent Disability or Accidental Dismemberment benefit.

The Sum Assured at inception under Optional Benefit (as opted by MPH/Insured Member) may be less than or equal to the Sum Assured applicable for the Base product.

C. Return of Premium Option - These Base Benefit and Other Optional Benefits (if any) can be chosen to be taken by MPH/ Insured Member either:

- Without return of premium option: Available for Base and All Optional Benefits
- With return of balance premium option: Available for Base and the following Optional Benefit - Accidental Death Benefit, Accidental Total and Permanent Disability, Accidental Partial and Permanent Disability and Accidental Dismemberment Benefit.

The above option has to be chosen at inception by Master Policyholder/Insured Member and cannot be changed later.

D. Accelerated Benefit Clauses

For accelerated benefits, if the pay-out is triggered on occurrence of any event permissible under the chosen Optional Benefit(s), the policy will continue till the end of the original Policy Term with the Death Benefit reduced by the extent of any accelerated benefit already paid. The benefit payable is fixed irrespective of the actual expenses incurred by the MPH/Insured Member. The premium payment on account of respective Optional Benefit(s) will cease after the pay-out of the respective accelerated Optional Benefit(s) and the future premiums payable under the policy for coverage of Death Benefit will be reduced proportionately. In case no Optional Benefit(s) is triggered within the Optional Benefit term, the Optional Benefit(s) coverage will terminate and premiums corresponding to it will not be payable. However, the Insured Member would be required to continue to pay premiums for Death Benefit as well as for any other active Optional Benefit(s) (if any) to keep the policy in force.

In case the benefit of any accelerated Optional Benefit(s) is equal to the Death Benefit, the policy/ member coverage will terminate on the payment of the Optional Benefit.

III. Maturity Benefit

- I) Cancer Care/ Cancer Protect/ Major Critical Illness/ Comprehensive Critical Illness/ Hospital Cash Benefit/ Surgical Cash Benefit/ All Cause Total and Permanent Disability/ Waiver of EMI on Hospitalisation/ Waiver of Premium on CI/ Waiver of Premium on Major Surgery/ Waiver of Premium on ATD:

Not Applicable

- II) Base Death Benefit/ Accidental Death Benefit/ Accidental Total and Permanent Disability/ Accidental Partial and Permanent Disability/ Accidental Dismemberment Benefit/ Terminal Illness:

The benefit is payable at Maturity only where Return of Balance Premium Option is chosen.

Maturity benefit shall be a X * Total Premiums Paid towards the respective Base/ Optional Benefit(s) less claim amount already paid out for the respective Optional Benefit(s).

Where X shall be within the range of 10% to 100% chosen by the You at the inception of the policy and cannot be altered thereafter.

IV. Moratorium Period

The Moratorium Period benefit is available with the Reducing Coverage option only wherein the Insured Member may take mortgage or retail loan where the Sum Assured during the moratorium period will be equal to initial Sum Assured. Insured Member may choose a moratorium period of 1 month to 84 months. If the Sum Assured is linked to a loan, the moratorium period shall match that of the actual loan taken by the Insured Member.

Moratorium cover options:

- **With payment of interest during the Moratorium Period:**
Where interest is paid by the borrower during the moratorium

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period, the Death/Optional benefit during the Moratorium Period is level coverage equal to the Sum Assured.

- **With no payment of interest during the Moratorium Period:** Where no interest is paid by the borrower during the moratorium period, the Death/Optional benefit during the moratorium period is equal to Sum Assured plus the accrued interest till that time.

The Death/Optional benefit after the moratorium period will be Level Sum Assured for Level coverage Option and reducing Sum Assured (as per the chosen loan interest rate) for reducing coverage option.

V. Survival Benefit

There is no Survival Benefit payable in this plan.

VI. Benefit Payout Option

The MPH/Insured Member at the inception of the policy would have the option to opt for one or more Benefit Pay-Out option (as defined). Once chosen, parameters in the Pay-Out option shall remain the same throughout the Coverage Term:

- a. Amount of lump sum benefit, (if any) or
- b. Income – The Insured Member can choose one of the following-
 1. Income period – the period for which income is expected (minimum income term of 1 month and up to a maximum of 600 months). The income period shall commence immediately on death/any other insured event(s) and continue for the chosen income period. In the event of a claim, the applicable monthly income would continue throughout the income term even if the Policy Term/ member Coverage Term has ended.
 2. Amount of Annual Income during the income period. This income will be payable monthly in arrears, in 12 equal instalments.
 3. A simple rate of increase of the annual income, if any. These increases will apply to the annual income from the 2nd year of the income period.

The monthly income shall be payable monthly in arrears and commence from the 1st day of the month subsequent to the month of the Insured Member's death/Any other insured event(s).

The Sum Assured for the income option shall be derived by discounting the income payments at 4% p.a.

At the time of claim intimation, all future income payments can be commuted for a lump sum. This lump sum shall be the discounted value of the future income payments at 7.45% per annum. This discounting rate is not guaranteed and is subject to change based on prevailing bond yields (aligned to 10-year G-sec). However, any change in the methodology/formula shall be subject to IRDAI approval.

- c. **Income till survival of chosen dependent partner(s) –** On incidence of death, a regular income is paid to the dependent partner/s covered under the payout option. This payout option is referred to as **Partner Care**.

A maximum of two partners between ages 45 years and 90 years (both last birthday) can be chosen at the time of purchase to receive the regular income. It shall be ensured that there is insurable interest between the life insured of the benefit option and the chosen partner/s.

The income frequency can be Annual / Half Yearly / Quarterly / Monthly. The regular income shall be paid in arrears as per the chosen payment frequency from the date of occurrence of insured event. The payment frequency can't be changed once the regular income commences. Any accrued income, due before intimation, will be paid along with first payout under this option.

The regular income instalments for frequencies other than annual shall be as specified below, where the Yearly Income below refers to the regular income payable in respect of annual frequency:

Frequency	Income Instalment (per frequency)
Half-yearly	98% of Yearly Income x 1/2
Quarterly	97% of Yearly Income x 1/4
Monthly	96% of Yearly Income x 1/12

If one dependent partner is chosen to receive income:

- the income streams are payable as per the premium frequency chosen and shall continue till the partner dies or reaches age 100 (last birthday), whichever happens first.
- the Sum Assured shall be the expected present value of the contingent yearly income streams payable on occurrence of death based on the Yearly income chosen.

If two dependent partners are chosen to receive income:

- the income streams are payable as per the premium frequency chosen and shall continue till the last surviving partner dies or reaches age 100 (last birthday), whichever happens first;
- the Sum Assured shall be the expected present value of the contingent yearly income streams payable on occurrence of death based on the Yearly income chosen.

The MPH/Insured Member would have the option to select either or combination(s) of benefit payout option mentioned above. However, the income option and the Partner Care option is only available wherein the entire Sum Assured for the specific Base/Optional benefit is payable. The Optional Benefit(s); where part of the Sum Assured is payable, only lumpsum benefit option can be chosen.

VII. Other benefits and features

A) Add on benefits (To be opted at inception)

- **Ambulance Cost:** A lump sum amount as mentioned below is payable if an ambulance cost was incurred to transfer the Insured Member to a hospital. This benefit is payable only if a claim is admissible under Hospital Cash Benefit, Surgical Cash Benefit, Major Critical Illness, Comprehensive Critical Illness, Cancer Care and Cancer Protect.

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- ➔ Ambulance Cost is HCB: 2 times of daily hospital cash benefit
- ➔ SCB/ Critical Illness/ Cancer: 1% of respective Benefit Option Sum Assured

The Ambulance Cost shall be subject to maximum payment of INR 5000 per annum and shall be payable only once per policy year.

In case where more than one benefit option is chosen and the claim is triggered for more than one benefit option at the same time, the ambulance cost payable in a policy year shall be respective benefit option's ambulance benefit. The ambulance cover shall continue for the other base benefits (excluding the one for which the payment has been made) for the remainder of the policy year. In case more than one benefit option chosen and the claim is triggered for one benefit option, the respective benefit option's ambulance cost shall be payable in a policy year subject to the maximum limit of INR 5000.

- **Indexation of Sum Assured:** The MPH/ Insured Member can opt to increase the Surgical Cash Benefit, Major Critical Illness, Comprehensive Critical Illness, Cancer Care and Cancer Protect by 5% at each policy anniversary during the policy term from second policy year onwards by paying an additional premium for every increase. The maximum Indexation of Sum Assured will be 100% of respective Optional benefit(s) original Sum Assured.

Indexation of Sum Assured is only available with Level Cover Option

- **Diagnostic Test Benefit:** An amount equal to 5% of the claim amount or INR 25,000, whichever is lower shall be payable, if a claim is admissible under Hospital Cash Benefit, Surgical Cash Benefit, Major Critical Illness, Comprehensive Critical Illness, Cancer Care and Cancer Protect.

In case more than one benefit option chosen and the claim is triggered for more than one benefit option at the same time, the diagnostic test cost payable in a policy year shall be the respective benefit option's diagnostic benefit.

- **Restoration Benefit:** The MPH/Insured Member shall have option to restore an additional per policy year limit of under Hospital Cash Benefit and/or 100% of Sum Assured under Surgical Cash Benefit following the exhaustion of the annual limit. However, the lifetime limit on maximum number of days benefit under Hospital Cash Benefit and maximum Sum Assured under Surgical Cash Benefit shall not be restored. Any claims made under the Hospital Cash Benefit or Surgical Cash Benefit from the restored annual days limits or restored annual Sum Assured will lead to a reduction in the lifetime limit on number of days under the Hospital Cash Benefit or on maximum Sum Assured limit under Surgical Cash Benefit.

The restored limits (as specified above) can only be utilized for next Hospitalization or Surgery and not for the same

Hospitalization or Surgery which resulted in the exhaustion of the original annual/per policy year limits.

The Restoration benefit is applicable only once in a policy year for Hospital Cash Benefit and Surgical Cash Benefit.

- **Recuperating Benefit:** A recuperating benefit in the form of lump sum benefit equivalent to 5% of the annual hospital cash benefit will be payable in case of continuous hospitalization (in non-ICU and / or ICU) in one or more hospitals for 7 or more days (excluding the time taken for transit between hospitals) for the same injury or disease, subject to the daily cash benefit being payable at the time of hospitalization. This recuperating benefit is payable only once per policy year.

Recuperation benefit is not payable if the Insured Member dies during hospitalization.

The Recuperating benefit is applicable only in Hospital Cash Benefit

- **Overseas Treatment Cover –** An additional amount equal to 10% of the Critical Illness Sum Assured/ Cancer Sum Assured subject to maximum of 10 Lac is payable on diagnosis of pre-defined Major Critical Illness/ Major Cancer. The cover under this benefit terminates on the first occurrence and pay-out of any of the covered Major CI/ Major Cancer. The list of CI and Cancer conditions along with definition and exclusions is provided in Annexure B. The Overseas treatment cover is only applicable:
 - the treatment for this major Critical Illness condition is availed in a foreign country from the list of standard countries within 30 days of diagnosis.
 - The sum assured chosen under the Major Critical Illness/ Major Cancer option is greater than or equal to INR 1000000 and the benefit is payable only in cases where a proof of availing treatment in a foreign country is made available.

The Overseas treatment cover is applicable only in Major Critical Illness, Comprehensive Critical Illness, Cancer Protect and Cancer Care.

B) Value Added Services

i) Health Status:

The Premium, under the One-year Renewable Term policy and Non-Single Pay policies, shall be derived above shall be adjusted basis the Health Status of the Life Insured, wherever available. The Health Status shall be measured through a Health Score driven by the objective criteria dependent on a range of parameters comprising of outcomes of a health & lifestyle assessments, level of physical activity and outcome of clinical health check-up etc., as per the Company's Board approved Policy.

The Health Status shall be classified into categories such as Platinum, Gold, Silver & Bronze basis the Health Score of the Life Insured to arrive at the applicable Premium.

Health Status	Adjustment Factor
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Bronze	100%
Silver	98%
Gold	90%
Platinum	80%

Any change in the scoring structure as per the Company's Board approved policy shall be communicated to the Policyholder/ Life Insured with a notice of minimum thirty (30) days in advance.

The measurement / assessment / classification of health status may be undertaken by the Company or through any other service provider(s).

The Health Score at a Member level shall be determined as per the Board Approved Policy. The current applicable grid / criteria is as below:

Tata AIA Health Score Grid and Criteria:

The health status level of the Life Insured (Member) shall be monitored over the duration of each Policy Year and a health status shall be earned throughout the year. The health status shall be used to determine the Premium.

The health Status shall not be at the discretion of the Company and shall be driven by an objective criterion in line with the Board approved underwriting policy. The health Status attributed to the Life Insured (Member) shall be based on a score-based structure and shall be either Bronze, Silver, Gold or Platinum. The health scores are allocated through a range of parameters comprising of online assessments, physical activity & health check-up.

➤ Health Status – Score

The Health Status is driven by accumulation of health score. The scores are allocated through a range of parameters comprising of online assessments, physical activity & health check-up.

The table below gives point distribution structure for determining Health status:

Health Status	Accumulated Health Score
Bronze	0 – 9,999
Silver	10,000 – 19,999
Gold	20,000 – 24,999
Platinum	25,000 and above

➤ Health Score Accumulation Structure

The Life Insured (Member) can earn health score through a range of parameters as provided below:

Details	Limits
Online Assessment	3,900
Health Screening	12,000
Physical activity	15,000

➤ Online Assessment – Annual

Points/ Activity	Activity	Max Health Score (limit p.a.)	Remarks
Assessments	Health Review	1,000	Assessment is available for all Life Insured (Member) irrespective of Health Status. Health Score are allocated to all Life Insured (Member) who have completed the assessment.
	Nutrition Assessment	1,000	
	Mental Wellbeing	900	
	Declaration: Smoker / Non-Smoker	1,000	

➤ Health Screening – Annual [to be undertaken by the Life Insured (Member)]

Details	Score for doing the health screening	Additional Score if the results are within the clinically accepted range	Remarks
BMI	1,500	1,500	Health scores are allocated to Life Insured (Member) basis health screenings conducted and if the results of the test being in line with WHO recommended clinical range
Blood Pressure	1,500	1,500	
Cholesterol	1,500	1,500	
Glucose	1,500	1,500	

➤ Physical Activity – Daily*

Steps / Heart Rate	Health Score per day
Steps: 7,500-9,999 Or, Heart rate: At least 30 mins of physical activity in one exercise session a day at an average heart rate of 60% or more of your age-related maximum heart rate	50

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Steps: $\geq 10,000$ Or, Heart rate: At least 30 mins of physical activity in one exercise session a day at an average heart rate of 70% or more of your age-related maximum heart rate Or, Heart rate: At least 60 mins of physical activity in one exercise session a day at an average heart rate of 60% or more of your age-related maximum heart rate	100
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**A maximum of one exercise event is allowed per day to earn health scores for physical activity. If more than one event is recorded in a single day, the event with the highest number of scores will be awarded.*

Each of these parameters have capping limits to ensure that the Life Insured (Member) engages in all the parameters defined above as this shall lead to overall improvement of Life Insured (Member) health.

ii) Health Management Services:

The Insured Member(s) of TATA AIA Group Sampoorna Raksha Supreme who are eligible for Health Management Services may avail Second Opinion / Personal Medical Case Management / Medical Consultation services from service provider(s) affiliated to/registered with the Tata AIA Life Insurance Co. Ltd. The services are expected to assist the life insured(s) to ascertain correct diagnosis of a medical condition and obtain due care for the life insured(s) in case of illness.

These services are subject to:

- the availability of suitable service provider(s);
- primary diagnosis has been done by a registered medical practitioner as may be authorized by a competent statutory authority;
- Health Management Service is available to be utilized throughout the policy/coverage term, subject to prevailing eligibility conditions.
- the eligibility of the life insured(s) as may of be determined by the Underwriting Policy which will be reviewed periodically and updated on Our website. The changes shall apply without any discrimination to all existing and new customers of the product.
- Policyholders can check their eligibility by visiting our website or contacting the Call Centre.
- Whenever the eligibility criteria changes or the service is withdrawn, the same shall be communicated to all the policyholders. Prior to effecting any changes, We shall inform the same to IRDAI

Note:

- These services are aimed at improving engagement with MPH/Insured Member.
- The cost of these services is expected to be offset by either lower costs of claims or better economies of scale or higher revenue due to better persistency.
- These value added services are completely optional for the eligible customer to avail
- For customers availing such services, they are offered at no additional cost to the Life Insured.
- Premiums charged to the Policyholder shall not depend on whether such a service(s) is availed by the Policyholder.
- The Life Insured- may exercise his/her own discretion to avail the services.
- These services shall be directly provided by the service provider(s).
- The services can be availed only where the policy / rider is in-force.
- All the supporting medical records should be available to avail the service.
- We reserve the right to discontinue the service or change the service provider(s) at any time.
- The services are being provided by third party service provider(s) and We will not be liable for any liability.

3.6. LOYALTY PROGRAM REWARD

If You are a member of the loyalty program administered by a service provider empaneled by the Company, You shall be entitled to the Loyalty Program Reward upon the purchase of the Policy and upon meeting the eligibility criteria. The loyalty programs foster long-term customer relationship and offer redemption benefits through the service provider's eco-systems based on applicable terms and conditions. Such reward shall accrue as percentage of the Annualized Premium or Single Premium (*as applicable*) and shall be made available by the service provider to You in the form of benefits (*points, coins, etc.*) in the first policy year by loyalty program service provider. The quantum of reward shall be determined by the

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Company's extant Policy and shall be disclosed in the Company's website from time to time.

The loyalty program rewards benefit shall be subject to the below:

- iii) The availability of "Loyalty Program Reward" shall be subject to the availability of suitable service provider(s).
- iv) The Loyalty Program reward shall be directly provided by the service provider(s). The rights and liabilities of the Policyholder/ Life Insured with respect to the Loyalty Program, shall be governed by the terms and conditions applicable to loyalty program.
- v) The Loyalty Program service is being provided by third party service provider(s) and the Company shall not be liable for such services.
- vi) The liability of the Company is limited to the transfer of the value of the reward to the service provider, so empaneled.
- vii) The Company reserves the right to discontinue the service or change the service provider(s) at any time and such changes shall be updated on the Company's website (www.tataaia.com).
- viii) The eligibility conditions including the quantum of reward shall be determined as per the Company's extant Policy and subject to change. Please refer our website (www.tataaia.com) for updated list of eligibility conditions, list of empaneled service providers, loyalty programs and the quantum of rewards. Any changes shall be applicable prospectively.
- ix) The Loyalty Program reward shall be applicable post completion of the free-look period, given the policy is still in-force at the time of extending such reward.

VII. Other details:

A. Premium Payment:

- i. A Single/ Limited/ Regular premium is payable in respect of each Insured Member at the time his enrolment, to the Company at either the issuing office or at its Head Office, based on the premium rates as determined by the Company and specified in the Schedule. The Company reserves the right to impose additional premium in respect of Insured Members that represent a substandard risk, as determined by the Company based on its underwriting guidelines and practices.
- ii. In the case of Joint Life Insurance Coverage, Premiums will be calculated separately for each Joint Insured Members as per their respective entry age with applicable Joint Life Insurance Coverage Discount specified in the Schedule attached hereto.
- iii. Collection of advance Premium shall be allowed within the same Financial Year for the premium due in that Financial Year. However, where the premium due in one financial year is being collected in advance in earlier financial year, the Company may collect the same for a maximum period

- of three months in advance of the due date of the Premium.
- iv. The Premium so collected in advance shall only be adjusted on the due date of the premium.
- v. The Company shall have the right to review and revise the Premium, at any time during the Policy Term, if:
 - 1. There is change in the number of lives/age to be covered Members changes materially affecting the risk assumed by the Company.
 - 2. The benefit structure of the group of the Master Policy is altered.
 - 3. The records, furnished by the Master Policyholder, in respect of the claims data and the information provided at the inception or renewal of the Policy are inconsistent.
 - 4. There is a material change in the Sum Assured, average Sum Assured weighted age and/or Occupation Class Profile under the Policy.
 - 5. The structure of the Master Policyholder entity changes, such as merger / demerger, amalgamation or otherwise of the Master Policyholder entity, addition of any sub-office or subsidiary to the Master Policyholder group entities covered under the Policy.

If the Master Policyholder disagrees to continue the Policy as per the revised Premium communicated by the Company in writing, the Policy shall terminate, and the excess Premium (if any) shall be refunded after deducting the proportionate risk premium for the period of cover, charges of stamp duty paid and the expenses incurred on medical examination of the Insured Member(s), if any.

B. Payment of benefits:

If the Sum Assured is linked to a loan,

- a. Where Policyholder is a Regulated Entity under the Lender-Borrower Group Schemes - The payment of benefits shall be made to the Master Policyholder to offset the outstanding on Insured Member's loan account with the Master Policyholder, provided the authorization for such payment is obtained from the Insured Member. Any balance Sum Assured remaining subsequent to this payment, shall be paid via the Policyholder or directly to the Insured Member's nominee, legal representative, executor or administrator in case of death.
- b. Other than Lender-Borrower Group Schemes – The payment of benefits shall be made in the name of the Claimant.

If the Sum Assured is not linked to a loan, the payment of benefits shall be payable to the Claimant. Payment to the Policyholder and / or to the Insured Member's nominee, legal representative, executor or administrator, as provided by this Section, shall release the Company from all liabilities under this Policy with respect to the Policyholder and the Insured Member for whom the claim has been settled.

C. Change of frequency of premium payment/ Coverage

You may change the frequency of Premium payments by written request. Subject to our minimum Premium requirements, Premiums may be paid on Single Pay, Annual,

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Half- yearly, Quarterly or Monthly mode at the premium rates applicable on the Coverage Effective Date.

Modal loading on premiums is as mentioned below:

Annual Premium Rate: Multiply Annual Premium Rate by 1 (i.e., No loading).

Half-Yearly Premium Rate: Multiply Annual Premium Rate by 0.51(i.e., Loading of 2%)

Quarterly Premium Rate: Multiply Annual Premium Rate by 0.2575(i.e., Loading of 3%)

Monthly Premium Rate: Multiply Annual Premium Rate by 0.0883(i.e., Loading of 6%).

Changes in coverage amount is not allowed during the Coverage Term.

D. Grace Period

A Grace Period of fifteen (15) days for monthly mode and thirty (30) days for all other modes, from the due date will be allowed for payment of each subsequent premium except in case of Single Pay Policy and yearly renewal policies. The coverage will remain in force during this period. In case premium in respect of Insured Member is collected by Master Policyholder within grace period but is not remitted to the Company for some reason, then on expiry of grace period risk cover will continue in respect of those Insured Members. If any premium remains unpaid at the end of its Grace Period, the policies shall lapse from the due date of the first unpaid premium except as may be provided under Non-Forfeiture Provisions. If any claim occurs during the grace period, any premium (without interest) due for the coverage year of the Certificate of Insurance, shall be deducted from the claim pay out. Grace Period is not applicable for single premium option.

E. Deduction of Premium at Claim

If a claim is payable under this Certificate of Insurance, any balance of the premiums due for the full coverage year in which death occurs shall be deducted from the proceeds payable under the Certificate of Insurance.

F. Terms and Conditions where the cover is availed under Employee's Deposit Linked Scheme, 1976

The Master Policyholder can opt for the Employees Deposit Linked Insurance (EDLI) under this product. To the extent permitted under the Employees Deposit Linked Insurance Scheme, 1976 (as amended from time to time), the applicable terms and conditions including eligibility of this product shall be superseded by those mentioned under EDLI Scheme.

Below terms and conditions shall apply:

1. Under no circumstances, any premium shall be borne by the Insured Member.
2. At no point of time during the coverage term, the quantum of the death benefit shall be less favorable than the benefit available under the EDLI Scheme, 1976, as amended from time to time.

3. The death benefit shall be payable in accordance with the provisions of EDLI Scheme, 1976.
4. In the event the Master Policyholder fails to make the payment of premium for the enhancement of benefits or renewal of the Policy in line with the EDLI Scheme, 1976, Tata AIA Life Insurance Company limited shall report the same immediately to the concerned Regional Provident Fund Commissioner.
5. The members of the Employees Provident Fund Scheme, 1952 ("Scheme") employed with the Master Policyholder shall be eligible to be Insured Members, after inception of the Policy. The employee of the Master Policyholder shall be eligible for coverage under the Policy as soon as he or she becomes the member of the Scheme. The exit shall be as per the Scheme.
6. The coverage of the Insured Member shall cease upon payment of death benefit as specified in the terms and conditions of the Policy.
7. No amendment to the terms and conditions of the Policy shall adversely affect the interests of Insured Member
8. Upon the death of the Insured Member, the claim shall be ascertained expeditiously in line with the extant laws and regulations.
9. Upon death of the eligible Insured Member, the benefit shall be payable irrespective of nature/ cause of death and the provisions specified at 'Suicide Exclusion' shall not apply.
10. In case of claim, the beneficiaries shall be required to submit Death Certificate of the member, attested copy of the Member's Nomination Form and Cancelled cheque of the bank account in which payment is to be received is required.

IX. Free Look Period

You have a period of 30 (thirty) days whether received electronically or otherwise where the policy term is greater than equal to 1 year and 15 days where the policy term is less than 1 year, from the date of receipt of the Certificate of Insurance to review the terms and conditions of the Certificate of Insurance. If You disagree to any of the terms or conditions of the Certificate of Insurance, You have an option to return the original Certificate of Insurance to Us by stating the reasons for objection for such disagreement in writing. Certificate of Insurance shall terminate forthwith and all rights, benefits and interests shall cease immediately. We will only refund the premiums received by Us, after deducting the proportionate risk premium for the period of cover, charges of stamp duty paid and the expenses incurred on medical examination of the Insured Member (if any), along with applicable taxes, cesses or levies, if any.

Distance Marketing includes every activity of solicitation (including lead generation) and sale of insurance products through voice mode, SMS electronic mode, physical mode (like postal mail) or any other means of communication other than in person.

XI. REVIVAL

At any time during the Coverage Term, if the Premiums are not paid within the Grace Period, the coverage of the Insured Member shall lapse, except in case of the Single Premium Policy and Regular Premium/ Limited Pay policies for which Premiums have been paid for less than 2 Policy Years under Without Return of Premium option

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and 1 year for With Return of Balance Premium. Such coverage of the Insured Member may be revived within the Revival Period. However, if the coverage of the Insured Member is not revived, no further benefit will be payable and the coverage of the Insured Member will terminate.

The Policy may be revived within the Revival Period and the coverage shall be restored from the date of revival and the Premium will be collected accordingly. We shall not cover the claims occurring during the period for which the coverage shall be in a lapsed condition. In certain circumstances as specified in Policy Document/Certificate of Insurance or scheme rules, We may also change certain terms of the Policy.

For Yearly Renewable Term (“YRT”)

I) Revival within 150 days for YRT:

If a scheme is renewed within 150 days from the end of the Yearly Renewable Term, the revival would be subject to the following:

i. No change in YRT:

If the Master Policyholder opts to retain the original Yearly Renewable Term of the Policy on revival, the Premium payable shall be as per the revised quotation issued by Us based on the latest membership data and mortality statistics provided by the Master Policyholder.

Outstanding Premium(s) along with interest, if any, shall be applicable for the lapse period. Additionally, proportionate Premium from the date of revival to the next due date of Premium or YRT, as applicable, shall be paid. The interest on outstanding premium would be based on rates declared by Us from time to time.

Such revival shall be subject to the Master Policyholder's undertaking in writing to Us that no claims occurred during the lapsed period shall be filed with the Company.

ii. Revision in YRT:

An option can be given to the Master Policyholder to revise the YRT subject to receiving a request in writing. The date of revival shall be deemed to be the revised YRT. The Premium payable shall be as per the revised quotation issued by Us based on the latest membership data and mortality statistics provided by the Master Policyholder.

II) Revival after 150 days from Yearly Renewable Term:

If a lapsed Policy is revived after 150 days from the Yearly Renewable Term, the Policy can be revived subject to change of the YRT and a letter from the Master Policyholder accepting the change. The date of revival shall be deemed to be the revised YRT. The Premium payable shall be as per the revised quotation issued by Us, based on the latest membership data and the mortality statistics provided by the Master Policyholder.

For Single Pay

Not Applicable.

For Limited / Regular Pay

If a premium is in default beyond the Grace Period and subject to the Certificate of Insurance not having been surrendered, it may be revived, in accordance with prevailing Underwriting Guidelines duly approved by the Board within Revival Period and before the end of the Coverage Term subject to:

- (i) Insurance cover has not been surrendered;
- (ii) A written application for revival is received by the Company from the Insured Member, together with revival fee (including applicable interest), evidence of insurability of the Insured Member; and
- (iii) Payment of all overdue premiums with applicable interest charged by the Company to revive the coverage.

The cost incurred by the Company for the medical examination of the Insured Member in order to revive the Insurance cover shall also be borne and paid by the Insured Member to the Company.

Interest on premiums shall be charged at a simple annual rate as determined by the Company, using the State Bank of India (SBI) [or any other public sector undertaking bank] domestic term deposit rate for tenure ‘1 year to less than 2 years’, plus 2%. Any alteration in the formula will be subject to prior approval of IRDAI. The interest rate on revival is verified & updated on our company's systems every six months (on 1st April & 1st Oct every year) as per the given formula. The current interest rate on revival from 1st April, 2025 is 8.98% simple p.a. (i.e. SBI interest rate of 6.98% + 2%) Any evidence of insurability requested at the time of revival will be based on the prevailing Underwriting Guidelines duly approved by the Board.

The cover which is not revived by the end of the revival period shall be terminated. There is no revival option for Single Premium.

Upon revival of the Policy/ Certificate of Insurance, all the benefits shall be restored with effect from the date of revival.

LOAN:

Loan facility is not allowed under this Plan.

NON-FORFEITURE BENEFIT

i. Reduced Paid up

The status of Policy/ Certificate of Insurance will be converted into Reduced Paid-up by default, provided premiums for at least full 1 year is paid for Limited Pay / Regular Pay Option both with Return of Balance Premium Option, and subsequent premiums remain unpaid. Reduced Paid-up is a default non-forfeiture benefit. Such Reduced Paid-up coverage can be revived within Revival Period by payment of all due premiums together with interest as mentioned in COI. Once coverage of the Insured Member becomes Reduced Paid-up and is not revived till the end of the Revival Period, it will continue to be in Reduced Paid-up status, provided it has acquired Surrender Value and subsequent premiums remain unpaid.

Reduced Paid up Benefit is applicable only when the base Benefit and Optional Benefits (if any) are chosen with ‘Return of Balance Premium’.

The benefits to be paid in case of Reduced Paid up coverage are as follows:

For the purpose of the benefit descriptions below, the "Reduced Paid-up (RPU) Factor" at any point during the term of the policy shall be defined as:

$$\text{RPU Factor} = (\text{No of Premiums paid}) \text{ divided by } (\text{No of Premiums Payable during the entire premium payment term})$$

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ii. Benefits under a Reduced Paid-up Policy:

- Reduced Paid-up Death/ Accidental Death / All Cause Total Permanent Disability Benefit / Accidental Partial Permanent Disability Benefit / Accidental Dismemberment Benefit / Critical Illness/ Cancer Benefit/ Terminal Illness as the case may be

Benefit payable as per the option chosen by You (Under Coverage Option) x RPU Factor

- Reduced Paid up Maturity Benefit = (X * Total Premiums Paid towards the Base Benefit/respective Optional Benefit) less claim already paid out under the Base/respective Optional Benefit

Where X shall be within the range of 10% to 100% chosen by the You at the inception of the contract and cannot be altered thereafter.

Maturity benefit is payable only if Return of Balance Premium Option is chosen.

iii. Surrender Benefit/ Unexpired Risk Premium Value

The surrender value is payable immediately on surrender. Surrender Value/Unexpired Risk Value shall be acquired during the Coverage Term basis the Premium Payment Term (PPT) as below:

PPT Option	Without Return of Premium Option	With Return of Balance Premium Option
Single Pay	Unexpired Risk Value shall be payable at any point during the member coverage period.	Surrender Value shall be payable at any point during the member coverage period.
Limited Pay	Unexpired Risk Value will be available if at least two full years' premiums are paid.	Surrender Value will be available if at least one full year premiums are paid.
Regular Pay	Not Applicable	Surrender Value will be available if at least one full year premium is paid.

Unexpired Risk Value (without Return of Balance Premium benefit):

Premium Payment Term	Surrender Value/ Unexpired Risk Value
Single Pay	$Unexpired Risk Value = (70\% \text{ of the Total Premiums Paid}) \times (unexpired Coverage Term / total Coverage Term) \times (Coverage at the time of surrender / Sum Assured at inception)^*$
Yearly Renewable	No Surrender Value payable
Regular Pay	No Surrender Value payable
Limited Pay	$Unexpired Risk value = (70\% \text{ of Total Premiums Paid}) \times (unexpired Coverage Term / total$

Premium Payment Term	Surrender Value/ Unexpired Risk Value
	$Coverage Term) \times (Coverage at the time of surrender / Sum Assured at inception)^*$

*The Coverage Term shall be calculated independently for Base Death Benefit and Optional Benefit respectively.

Surrender Value (with Return of Balance Premium benefit):

Surrender Value shall be higher of

- Guaranteed Surrender Value (GSV) or
- Special Surrender Value (SSV).

Where the GSV and SSV shall be calculated as follows –

o $GSV = GSV Factor \times Total Premiums Paid \times X^*$

SSV shall be as follows:

Benefit option	Surrender Value
Base Death Benefit	Factor 1 x RPU Death Benefit plus Factor 2 x RPU Maturity Benefit
Optional Benefit	Factor 3 x RPU for the respective Optional Benefit plus Factor 4 x RPU Maturity Benefit towards the respective Optional Benefit

Where,

Factor 1: Expected present value for the base death benefit as at the date of surrender payable during the coverage term discounted at prevailing 10-year G-sec yield + 0.5%.

Factor 2: Expected present value of the base maturity benefit as at the date of surrender payable at the end of coverage term discounted at prevailing 10-year G-sec yield + 0.5%.

Factor 3: Expected present value of respective optional benefit as at the date of surrender payable during the coverage term discounted at prevailing 10-year G-sec yield + 0.5%.

Factor 4: Expected present value of maturity benefit towards respective optional benefit as at the date of surrender payable at the end of coverage term discounted at prevailing 10-year G-sec yield + 0.5%.

*X shall be within the range of 10% to 100% chosen by the MPH/ Insured Member at the inception of the contract and cannot be altered thereafter.

For applicable GSV and SSV factors, kindly refer Our website at www.tataaia.com, visit Our nearest branch or write to Us as per section POLICYHOLDER'S SERVICING.

Effect of Surrender by Master Policyholder –

The Policy can be surrendered by the Master Policyholder by giving a written intimation to the Company. In such cases, new enrolments shall cease after the surrender of the Policy and the existing Insured Members shall continue to be covered under the Policy as an individual cover on same terms and condition as those of the group Policy or avail surrender benefit and terminate the insurance cover.

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The exits would be alike in the product whereby the coverage ends in case of a claim, cancellations, coverage ending on attaining the maximum coverage age or expiry of term.

TERMINATION OF THE COVER:

The insurance coverage hereunder of any Insured Member shall automatically cease on the earliest of the following dates:

1. The date of the expiration of the Coverage Term.
2. The date on which the Insured Member attains the Maximum Age for coverage as defined in the Policy Schedule attached hereto.
3. Date of death of the Insured Member.
4. The date on which the Insured Member receives the payment for refund of Premium pursuant to free look cancellation request.
5. The date on which the Insured Member surrenders the Certificate of Insurance for availing the surrender benefit.
6. In case of joint life –
 - a. if more than one member is covered for 100% Sum Assured respectively, then on date of first death of the Insured Members.
 - b. if more than one member is covered for Sum Assured proportionately to the loan share, then on date of death of the last Insured Member.

RENEWAL OF POLICY

The Certificate of Insurance may be renewed at the end of the term of coverage. We reserve the right to review all the terms and conditions of the Certificate of Insurance at the time of renewal. We may not accept the renewal of the Certificate of Insurance for any reasons whatsoever, including below:

- If there is any a material change in the number of lives/age to be covered under the Certificate of Insurance,
- There is a change in the benefit structure of the scheme/ group, or
- There is a variation in the information of any previous claim details provided to Us.

FRAUD, MISREPRESENTATION AND FORFEITURE

Fraud, Misrepresentation and forfeiture would be dealt with in accordance with provisions of Section 45 of the Insurance Act 1938, as amended from time to time.

AUTO VESTING

For minor Insured Members, until the Insured Member attains the age of majority, the Holder of Certificate of Insurance (parents/ other legal guardians who has insurable interest with minor lives) shall have the right, to exercise every option, benefit, or privilege under this Policy on behalf of the Insured Member. The Certificate of Insurance shall automatically vest in the Insured Member on his/her attaining age of majority. In case of a Joint Life cover, the Policy shall vest on their lives once both Life Insureds attain the age of majority.

EXCLUSIONS

1) SUICIDE EXCLUSION

For all schemes other than those covering Employer-Employee

groups on a compulsory basis, if the Insured Member commits suicide, whether sane or insane, within 12 months from the Coverage Effective Date or from the date of revival of the Insured Member's coverage, as applicable, the nominee or beneficiary of the Insured Member shall be entitled to the following:

(i) Single Life Cover:

At least 80% of the Total Premiums Paid till the date of death or the surrender value available, without interest, as on the date of death whichever is higher, would be refunded, provided the coverage is in force.

(ii) Joint Life Cover:

- In case of Joint Life where each member is insured for entire 100% of Sum Assured, at least 80% of Total Premiums Paid till the date of death or Surrender Value whichever is higher for those Joint Life Insured Member(s) during the current policy year would be refunded without interest provided the policy is in force and the cover shall cease for other joint life Insured Member(s).
- In case of Joint Life where each member is insured up to his/her respective share of Sum Assured, at least 80% of Total Premiums Paid till the date of death or Surrender Value whichever is higher for that respective deceased life(s) during the current policy year would be refunded without interest provided the policy is in force. Further, the policy shall remain in-force for the surviving Life(s) to the extent of Sum Assured applicable for that life(s).

In addition to the above, if the Insured Member has opted for increase in Sum Assured, the following additional provisions shall be applicable for schemes on Voluntary basis (Both Employer Employee and Other than Employer Employee, wherever applicable):

From the date of increase of Sum Assured, the nominee or beneficiary of the Insured Member shall be entitled to 80% of the Total Premiums Paid (excluding any extra premium, any rider premium and taxes) for the increased tranche(s). The original death benefit (based on the Sum Assured chosen at the time of purchase) and any increased death benefit purchased by exercising the increasing Sum Assured option subsequently but prior to 12 months from the date of death (due to suicide) of Insured Member shall remain payable in full.

2) TERMINAL ILLNESS EXCLUSION:

The Insured Member shall not be entitled to any Terminal Illness Benefit if the Terminal Illness is caused directly or indirectly due to or occasioned, accelerated or aggravated by intentional self-inflicted injury or attempted suicide, whether medically sane or insane.

The above exclusion may be waived by the Company based on Claims Underwriting.

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MISSTATEMENT OF AGE AND GENDER

Subject to Section 45 of the Insurance Act, 1938 as amended from time to time.

The Certificate of Insurance is issued at the age and gender shown on the Certificate of Insurance which is the Insured's declared age at last birthday and declared gender in the proposal. If the age and/or gender is misstated and on the basis of actual age and/or gender the Certificate of Insurance would have been issued but with a higher premium, the benefit payable under this Certificate of Insurance shall be paid after deduction of such difference of premium along with interest thereon. In such cases, the coverage shall be subject to re-underwriting and the Sum Assured shall be subject to eligibility of the member as per Our Board Approved Underwriting Guidelines and if the Certificate of Insurance would have been issued, the premium to be deducted shall be calculated proportionately on such Sum Assured payable. Similarly, if the Insured's age/gender is misstated and on the basis of actual age and/or gender the Certificate of Insurance would have been issued but with a lower premium, the Company will refund any excess premiums paid without interest. If at the correct age/gender it is found that the Insured Member was not eligible to be covered under this Certificate of Insurance pursuant to our Underwriting rules, the Certificate of Insurance shall be terminate and the Company will refund the all the Premiums paid without interest after deducting all applicable charges like medical, Stamp duty, Proportionate Risk Premium along with applicable taxes, cesses or levies, if any incurred by the Company under the Certificate of Insurance.

NOMINATION

Nomination allowed as per provisions of Section 39 of the Insurance Act 1938 as amended from time to time.

ASSIGNMENT

Assignment shall be treated in accordance with the provisions of Section 38 of the Insurance Act, 1938 as amended from time to time.

CURRENCY AND PLACE OF PAYMENT

All amounts payable either to or by Us will be paid in the Indian currency. Such amounts will be paid by a negotiable bank draft or cheque drawn on a bank or NEFT (National Electronic Funds Transfer) or electronic clearing systems. All amounts due from Us will be payable from Our office.

FREEDOM FROM RESTRICTIONS

Unless otherwise specified, this Certificate of Insurance is free from any restrictions upon the Insured Member as to travel, residence or occupation.

APPLICABLE LAW:

DEATH CLAIMS REQUIREMENTS (Other than EDLI)

Type of Claim	Requirement
Death (all causes of death other than the Accidental Death)	a) Claim Forms Application Form for Death Claim (Claimant's Statement) along with NEFT form <ul style="list-style-type: none">Part II: Physician's Statement - to be filled by last attending physician

This Certificate of Insurance, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and shall be enforced in accordance with the laws of India.

TAXES

All Premiums and interest payable under the Certificate of Insurance are exclusive of applicable taxes, duties, surcharge, cesses or levies which will be entirely borne/ paid by the Insured Member, in addition to the payment of such Premium or interest. Tata AIA Life shall have the right to claim, deduct, adjust and recover the amount of any applicable tax or imposition, levied by any statutory or administrative body, from the benefits payable under the Certificate of Insurance.

NOTICE OF CLAIM AND FILING OF PROOF OF LOSS

In case of lender-borrower groups i.e. scheduled banks (including co-operative banks) regulated by Reserve Bank of India, Non Banking Financial Companies registered with Reserve Bank of India, National Housing Bank regulated Housing Finance Companies, National Minority Development Finance Corporation, it's State Channelizing Agencies' and Small Finance Banks regulated by Reserve Bank of India, the following conditions shall apply to claims payments under the Certificate of Insurance:

- Subject to the authorization from the Insured Member, We shall pay outstanding loan amount as per loan repayment schedule to the Master Policyholder. The Insured Members may provide the said authorization either on the date of enrolment or at a later date. The surplus claim proceeds, if any, will be paid to the Claimant by Us. The amount payable to Master Policyholder shall under no circumstances be more than the outstanding loan amount as per loan repayment schedule.

All cases of claim must be notified to us in writing In case of any delay on the part of the Company to process the claim within extant regulatory timeline, We shall pay interest as may be prescribed by the IRDAI from time to time.

Please note that all claims will be payable to the rightful Claimant.

Filing Proof of Claim – Unless otherwise specified, duly filled in requisite forms along with proof of loss shall be furnished to us, at the claimant's expenses, A list of documents required in general, is attached to the Policy. However, submission of such documents, forms or other proof shall not be construed as an admission of liabilities by the Company and we reserve right to request additional proof and/or documents in support.

For processing the claim request under this policy, we will require the following documents:

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	b) Death Certificate
	c) Indoor case papers from the hospital or Discharge/Death Summary
	d) Copy of pathological test Reports
	e) Out patient consultation notes
	f) Original Policy document
	g) Claimant's Photo ID (Pan card and latest Photo of the beneficiary) with age proof & relationship with the Insured Member along with Address proof of the claimant
	h) Cancelled cheque with name and account number printed or with copy of Bank Passbook / Bank Statement
	*If no nomination - Proof of legal title to the claim proceeds (e.g. legal succession/Guardianship paper)
	i) Outstanding Loan Statement as per loan repayment schedule as on the date of event (applicable for Lender – Borrower policy)
	j) Credit Account Statement from Master Policyholder (applicable for Lender – Borrower policy)
In case of an unnatural death (to be submitted in addition to the above)	Copy of the First Information Report (FIR) or Panchanama/Police complaint/Inquest# Copy of Post-Mortem report (PMR)/Autopsy and Viscera report# Copy of the Final Police Investigation report (FPIR)/Charge sheet# Copy of Newspaper article if available

Medical records shall be required if Life Insured was in hospital at the time of death or any time prior to the date of death. Original Seen Verified (OSV) by Branch Personnel will be accepted.

Death claims requirements (EDLI schemes Policies)

Type of Claim	Requirement
Death (all causes of death other than the Accidental Death)	a) Application Form for Death Claim (Claimant's Statement) along with NEFT form
	b) Death Certificate issued by Municipal Authority
	c) Claimant's Photo ID (Pan card and latest Photo of the beneficiary) with age proof & relationship with the Insured Member along with Address proof of the claimant
	d) Cancelled cheque with name and account number printed or cancelled cheque with copy of Bank Passbook / Bank Statement
	*If no nomination - Proof of legal title to the claim proceeds (e.g. legal succession/Guardianship paper)

Critical Illness claims requirements

Type of Claim	Requirements for Critical Illness Claim
Critical Illness	A. Claim Forms
	e) Part I: Application Form for Critical Illness Claim (Claimant's Statement) along with NEFT form
	f) Part II: Confidential Medical Report –to be filled by Attending Physician
	B. Hospital Bills for the confinement.
	C. Attested True Copy of Indoor Case Papers of the Hospital
	D. Discharge Summary of Present and Past Hospitalizations
	E. Photo Identity of Insured Member with age and address proof
	F. Bank Details of the claimant – Cancelled cheque (with printed name and account number)/bank passbook and NEFT Form
	G. Certificate of Diagnosis
	H. Medical Examination Certificate (First Consultation Notes).
I. All related clinical Reports pertaining to the claim event –	
	<ul style="list-style-type: none"> • Laboratory test reports, X-Ray / CT Scan / MRI Reports & Plates, Ultrasonography Report • Histopathology Report • Clinical / Hospital Reports • Angiography Reports & Plates

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	<ul style="list-style-type: none"> Others (please specify)
	J. All follow-up Consultation Notes in relation to the hospitalized condition.
	K. Outstanding Loan Statement as per loan repayment schedule as on the date of event (applicable for Lender – Borrower policy)
	L. Credit Account Statement from Master Policyholder (applicable for Lender – Borrower policy)
If Claims is due to accidental causes (submit in addition to the above)	M. All police reports - First Information Report, Final Investigation Report

TOTAL PERMANENT DISABILITY CLAIMS REQUIREMENTS

Type of Claim	Requirement
Disability Claim (all causes of disability)	a) Claim Forms <ul style="list-style-type: none"> Part I: Application Form for Disability Claim (Claimant's Statement) along with NEFT form Part II: Confidential Medical Report -to be filled by attending physician
	b) Attested True Copy of Indoor Case Papers of the Hospital
	c) Discharge Summary of Present and Past Hospitalizations
	d) Photo Identity of insured with age and address proof
	e) Bank Details of the claimant – Cancelled cheque (with printed name and account number)/bank passbook and NEFT Form
	f) Disability Certificate by attending Physician / Institute for disabled
	g) Rehabilitation Certificate - if applicable
	h) Employer's written confirmation / statement - for Disability claim
	i) All related Medical Examination Reports, e.g. - Laboratory test reports X-Ray / CT Scan / MRI Reports & Plates Ultrasonography Report Clinical / Hospital Reports
	j) Clinical Photographs showing the injured areas - if available
	k) Outstanding Loan Statement as per loan repayment schedule as on the date of event (applicable for Lender – Borrower policy)
If Disability due to Accident (to be submitted in addition to the above)	l) Credit Account Statement from Master Policyholder applicable for Lender-Borrower policy)
	m) All police reports- First Information Report Final Investigation Report

Medical Examination – We reserve the right to request medical examination of the Insured Member. In the event of the Company requesting for a medical examination, the cost of such medical examination shall be borne by Us.

NOTE:

- In case the claim warrants any additional requirement, the Company reserves the right to call for the same.
- Notification of claim & submission of the claim requirements does not mean admission of the claim liability by the Company.

Proof of Occurrence of an Insured Event - Proof of occurrence of any insured event covered by this Certificate of Insurance must be supported by:

- Appropriate Specialist Medical Practitioners registered in India (or other country approved by Tata AIA Life Insurance Company Limited), not being the Policy owner, Insured Member or the respective partner or spouse or relatives.
- Confirmatory investigations including, but not Limited to, clinical, radiological, histological and laboratory evidence, and,
- If the Insured event requires a surgical procedure to be performed, the procedure must be the usual treatment for the condition and be medically necessary.

Claims Intimation Process:

A claim can be made through any of the following avenues:

- Email - groupsupport@tataaia.com ([for employer-employee groupclaims@tataaia.com](mailto:groupclaims@tataaia.com))
- Call our helpline number 1-860-266-9966 (Call charges apply)
- Walk into any of the Company branch office
- Write directly to us on following address:

Claims Department:
Tata AIA Life Insurance Company Limited
9th Floor, B - Wing, I-Think Techno Campus (Lodha)
Behind TCS, Pokhran Road No.2,
Thane (West), Mumbai - 400 607

POLICY SERVICING AND GRIEVANCE HANDLING MECHANISM

POLICYHOLDER'S SERVICING

With regards to any query or issue related to the Policy, the Policyholder can contact the Company through the following service avenues:

- Contact your Tata AIA Life Agent / Distributor

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- Call our helpline number 1-860-266-9966 (Call charges apply)
- E-mail us at groupsupport@tataaia.com
- Visit the nearest the Tata AIA Life branch or CAMS Service Center
- Log on to Online Customer Portal by visiting www.tataaia.com
- Write to Us at:
Tata AIA Life Insurance Company Limited
9th Floor, B - Wing, I-Think Techno Campus,
Behind TCS (Lodha), Pokhran Road No.2,
Thane (West), Mumbai – 400 607

GRIEVANCE REDRESSAL PROCEDURE

1) Resolution of Grievances

Customers can register their grievances through Multiple Service Avenues:

- Call our helpline number 1-860-266-9966 (Call charges apply)
- Email us at life.complaints@tataaia.com
- Login to online Policy account on www.tataaia.com
- Visit any of the nearest Tata AIA Life branches or CAMS Service Centers
- Contact your Tata AIA Life Agent / Distributor
- Write to us on the following address:
Customer Service Department
Tata AIA Life Insurance Company Ltd.,
9th Floor, B - Wing, I-Think Techno Campus,
Behind TCS (Lodha), Pokhran Road No.2,
Thane (West), Mumbai – 400 607
- We shall acknowledge a customer's grievance immediately through SMS/ email wherever available, along with the information on the turn-around-time to resolve the complaint.
- We shall provide the customer with an equitable resolution within 14 (fourteen) days of receipt of the grievance.
- In case customers wishes to contact us during the course of the assessment, they can contact us at any of the above-mentioned touch points.
- All Tata AIA Life branches have a Grievance Redressal Officer who can be contacted for any support during the grievance redressal process.
- A complaint/grievance shall be considered as resolved where the Policyholder has not responded to the Company within 8 (eight) weeks of the Company's written response.

2) Escalation Mechanism

In case customers are not satisfied with the resolution provided by the Company, or has not received any response within the stipulated timelines, they may contact the following officials for resolution:

- Level of Escalation: Grievance Redressal Officer (GRO)- A senior member at corporate office of the Company shall be designated as the GRO.

For escalations, customers can email to GRO@tataaia.com or write to –

Tata AIA Life Insurance Company Limited,
Grievance Redressal Officer (GRO)
Tata AIA Life Insurance Company Limited,

9th Floor, B - Wing, I-Think Techno Campus,
Behind TCS (Lodha),
Thane (West), Mumbai – 400 607

We request our customers to follow the escalation mechanism in case of non-receipt of response or unsatisfactory response from the concerned persons mentioned above.

If You are not satisfied with the response or do not receive a response from us within 15 (fifteen) days, You may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

- IRDAI Grievance Call Centre (IGCC) TOLL FREE NO: 155255 or 18004254732 (Toll free).
- Email ID: complaints@irdai.gov.in
- You can also register your complaint online at Bima Bharosa System - <https://bimabharosa.irdai.gov.in/>
- Address for communication for complaints by paper:

Consumer Affairs Department - Grievance Redressal Cell.
Insurance Regulatory and Development Authority of India
Sy.No.115/1, Financial District, Nanakramguda,
Gachibowli, Hyderabad – 500 032.

3) Insurance Ombudsman:

Where the redressal provided by the Company is not satisfactory despite the escalation above, the customer may represent the case to the Ombudsman for Redressal of the grievance, if it pertains to the following:

- delay in settlement of claims;
- any partial or total repudiation of a claim by Us;
- disputes over premium paid or payable in terms of insurance cover;
- misrepresentation of terms and conditions at any time in the Certificate of Insurance;
- legal construction of the Certificate of Insurance in so far as such dispute relates to claim;
- servicing related grievances against insurers and their agents and intermediaries;
- issuance of life insurance cover, general insurance policy including health insurance policy which is not in conformity with the proposal form submitted by the proposer;
- non-issuance of any insurance document after receipt of the Premium
- any other matter resulting from the violation of provisions of the Insurance Act, 1938 or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the Certificate of Insurance, in so far as they relate to issues mentioned hereinabove.

The complaint should be made in writing duly signed by the complainant or through his legal heirs, nominee or assignee, and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman. As per provision 14(3) of the Insurance Ombudsman Rules, 2017; the complaint to the Ombudsman can be made:

- Only if the grievance has been rejected by the Grievance Redressal Machinery of the Insurer; or

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- The complainant may approach the Insurance Ombudsman if their complaint is not resolved within 30 (thirty) days or if the decision of the Company is not acceptable to them if it is not simultaneously under any litigation
- Please refer to our website www.tataaia.com for further details in this regard.
- The list of Ombudsman address is attached as Annexure I

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Annexure I - List of Insurance Ombudsman

Annexure 1

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Office of the Ombudsman	Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL	Office of the Insurance Ombudsman, 1s floor, “Jeevan Shikha” 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462011 Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chattisgarh.
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH	Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17A Chandigarh - 160017Tel.: 0172 - 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh) , Himachal Pradesh, Union Territories of Jammu &

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Office of the Ombudsman	Details	Jurisdiction of Office (Union Territory, District)
		Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204/2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Puducherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI	Office of the Insurance Ombudsman,	Kerala, Lakshadweep, Mahe-a part

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NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Office of the Ombudsman	Details	Jurisdiction of Office (Union Territory, District)
	10 th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G. Road, Kochi – 682011 Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	of Puducherry.
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082/3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar,

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Office of the Ombudsman	Details	Jurisdiction of Office (Union Territory, District)
		Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 – 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P-201301. Tel.: 0120- 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha Nagar, Ghaziabad, Hardoi,

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NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Office of the Ombudsman	Details	Jurisdiction of Office (Union Territory, District)
		Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

For further information or latest updated list of Ombudsman Office addresses, kindly visit the IRDA of India website <http://www.policyholder.gov.in> - Ombudsman / List of Insurance Ombudsmen OR our website www.tataaia.com

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Annexure A

The Optional Benefits are as listed below:

1. Cancer Protect

An amount equal to 100% of applicable Sum Assured (As per the Coverage Option) is payable on diagnosis of pre-defined Cancer events. The cover under this benefit terminates on the first occurrence and payout of the covered Cancer events.

Specified Waiting Period - 90 days for Major Cancer conditions and 180 days for minor Cancer conditions shall be applicable from the policy commencement date.

Survival Period – 0/7/14/30 days survival period is applicable as chosen by the MPH/Insured Member at inception. This refers to the period from the diagnosis and fulfilment of the definition of the conditions covered which the Life insured must survive before the benefit will be paid.

Rate Guarantee (Not applicable for yearly renewable policies)
– Up to 5 years

This optional benefit can be chosen either on level cover or reducing cover basis.

The list of definitions and exclusions for this Optional Benefit are listed in Annexure B

2. Cancer Care

An amount defined as a percentage of applicable Sum Assured (As per the Coverage Option) is payable on diagnosis of pre-defined Cancer event(s). The benefit payout is as follows –

a) Minor Cancer

3. Level Sum Assured – Lower of 25% of applicable Sum Assured or INR 10,00,000 is payable on diagnosis of pre-defined minor Cancer conditions.
4. Reducing Sum Assured – Lower of 25% of applicable Sum Assured (as per the outstanding loan amount) or 6 EMIs or INR 10,00,000 is payable on pre-defined minor Cancer conditions.

The cover under minor cancer shall terminate on the first occurrence of any of the covered minor Cancer. However the cover shall continue for the accelerated major cancer benefit

b) Major Cancer

100% of the balance of applicable Sum Assured (As per the Coverage Option) is payable on diagnosis of pre-defined Major Cancer condition. The cover under this benefit terminates on the first occurrence and pay-out of any of the covered Cancer.

The list of Minor and Major Cancer condition along with the definition and exclusion is provided in **Annexure B**.

Specified Waiting Period - 90 days for Major Cancer conditions and 180 days for minor Cancer conditions, shall be applicable from the policy commencement date.

Survival Period – 0/7/14/30 days survival period is applicable as chosen by the MPH/Insured Member at inception. This refers to the period from the diagnosis and fulfilment of the definition of the conditions covered which the Life Insured must survive before the benefit will be paid.

Rate Guarantee (Not applicable for yearly renewable policies)–Up to 5 years .

This optional benefit can be chosen either on level cover or reducing cover basis

3. Major Critical Illness (Major 8/20/42 CI's as chosen by You)

An amount equal to 100% of applicable Sum Assured (As per the Coverage Option) is payable on diagnosis of pre-defined CI condition. The cover under this benefit terminates on the first occurrence and pay-out of any of the covered CI. The MPH/ Insured member has an option to choose from the listed 8, 20 or 42 Major Critical Illness conditions at inception of the contract and once chosen, cannot be altered thereafter. The list of CI condition along with the definition and exclusion is provided in Annexure B.

Specified Waiting Period - 90 days applies from the policy commencement date.

Survival Period – 0/7/14/30 days survival period is applicable as chosen by the MPH/Insured Member at inception. This refers to the period from the diagnosis and fulfilment of the definition of the conditions covered which the Life Insured must survive before the benefit will be paid.

Rate Guarantee (Not applicable for yearly renewable policies)
– up to 15 years

This optional benefit can be chosen either on level cover or reducing cover basis.

The list and definitions of Major Critical Illness for this Optional Benefit are provided in detail in **Annexure B**

4. Comprehensive Critical Illness (Major 8/20/42 CI's + 15 Minor CI's as chosen by You) –

The following benefit is payable on diagnosis of pre-defined CI condition.

a) Minor CI

- Level Sum Assured – Lower of 25% of applicable Sum Assured or INR 10,00,000 is payable on diagnosis of pre-defined minor CI conditions.
- Reducing Sum Assured – Lower of 25% of applicable Sum Assured (as per the outstanding loan amount) or 6 EMIs or INR 10,00,000 is payable on pre-defined minor CI conditions.

The cover under minor CI shall terminate on the first occurrence of any of the covered minor CI.

However, the cover shall continue for the accelerated major CI benefit.

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- b) Major CI
100% of the balance of applicable Sum Assured (As per the Coverage Option) is payable on diagnosis of pre-defined Major CI condition. The cover under this benefit terminates on the first occurrence and pay-out of any of the covered CI. The MPH/ Insured member has an option to choose from the listed 8, 20 or 42 Major Critical Illness conditions at inception of the contract and once chosen, cannot be altered thereafter.

The list of Minor and Major CI condition along with the definition and exclusion is provided in Annexure B.

Specified Waiting Period - 90 days for Major CI conditions and 180 days for minor CI conditions, shall be applicable from the policy commencement date.

Survival Period – 0/7/14/30 days survival period is applicable as chosen by the MPH/Insured Member at inception. This refers to the period from the diagnosis and fulfilment of the definition of the conditions covered which the Life Insured must survive before the benefit will be paid.

Rate Guarantee For Minor CI – up to 5 years; For Major CI - up to 15 years.

This optional benefit can be chosen either on level cover or reducing cover basis.

The list and definitions of Major Critical Illness and Minor Critical Illness for this Optional Benefit are provided in detail in **Annexure B**

5. **Accidental Death Benefit (ADB)** - In the event of the death of the Insured Member due to an accident provided the death occurs within 180 days from the accident, an additional amount equal to ADB Sum Assured shall be payable in addition to Base Death Benefit.

The ADB Sum Assured, at inception, can be up to Base Sum Assured, as chosen by the MPH/Insured Member at inception.

ADB benefit option can be chosen either on level cover or reducing cover basis.

Enhanced Death Benefit - The benefit payable will be equal to 200% of ADB Sum Assured if the death due to accident occurs under any of the following circumstances:

- While the Insured is riding as a fare paying passenger on commercially licensed public land transportation over an established route such as a bus, tram or train. A taxi or any form of transport chartered for private travel is excluded.
- While the Insured is in an elevator car (elevators in mines, rigs and on construction sites excluded) duly certified to carry passengers; or
- As a direct result of the burning of the following public buildings only: theatre, cinema, public auditorium, hotel, school and hospital.

- When the Insured is on a commercial passenger airline on a regular scheduled passenger trip over its established passenger route.

This benefit shall be applicable for yearly renewable policies only.

Specified Waiting/Survival Period – Not Applicable

Rate Guarantee – Throughout the term/ coverage term...

The list and definitions and exclusions for Accidental Death Benefit are listed in **Annexure C**

6. **Accidental Total and Permanent Disability** – An amount equal to 100% of the applicable Sum Assured (As per the Coverage Option) is payable in the event of pre-defined total and permanent disability conditions provided the disability occurs within 180 days from the occurrence of the event. The disability should occur as a result of bodily injury caused by an accident and should result in at least one of the following:

- Loss of sight in both eyes
- Loss of both arms or both hands;
- Loss of one arm and one leg;
- Loss of one arm and one foot;
- Loss of one hand and one foot;
- Loss of one hand and one leg;
- Loss of both legs;
- Loss of both feet;
- Removal of the entire lower jaw
- Loss of one hand and loss of sight in one eye
- Loss of one foot and loss of sight in one eye

Specified Waiting/Survival Period – Not Applicable

Rate Guarantee – Throughout the coverage term of the policy.

This optional benefit can be chosen either on level cover or reducing cover basis.

The list and definitions and exclusions for Accidental Total and Permanent Disability are provided in detail in **Annexure C**

7. **All Cause Total and Permanent Disability Benefit (ACTPD)** - An amount equal to 100% of the applicable sum assured (As per the Coverage Option) will be payable, in case of Total and Permanent Disability (TPD) caused by either an accident, sickness, or disease, provided that the disability occurs within 180 days from either of these causes.

Specified Waiting Period – 90 days applies from the policy commencement date.

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Survival Period – 0/7/14/30 days (as chosen by the MPH/Insured Member) for disability due to sickness or disease. Not applicable for Accidental based conditions.

Rate Guarantee (Not applicable for yearly renewable policies) – up to 15 years..

All Cause Total and Permanent Disability Benefit can also be opted in acceleration to 42 CI under Major Critical Illness or Comprehensive Critical illness wherein only one claim will be payable either on diagnosis of one of the covered CI conditions or happening of TPD due to sickness/accident and the policyholder may not be eligible for any further claims with respect to the above-mentioned benefit.

This optional benefit can be chosen either on level cover or reducing cover basis.

The list and definitions and exclusions for **All Cause Total and Permanent Disability Benefit (ACTPD)** are listed in **Annexure B**.

8. Accidental Partial and Permanent Disability (APPD) – A percentage of applicable Sum Assured shall be payable in case of Partial Permanent Disability caused by an accident, provided that the disability occurs within 180 days from that accident. The percentage of Sum Assured pay-out is as follows

Nature of Losses	Amount of Benefit (% of applicable Sum Assured)
Loss of All Toes	20%
Great Toe	5%
Other than great toe, if more than one toe lost, each	1%
Loss of hearing – both ears	50%
Loss of hearing – one ear	25%
Loss of four fingers and thumb of one hand	40%
Loss of four fingers	25%
Loss of thumb	15%
Loss of index finger	10%
Loss of middle finger	6%
Loss of ring finger	5%
Loss of Little Finger	4%
Any other permanent partial disablement	Percentage as assessed by Independent Medical Practitioner

This sum assured under this optional benefit can be chosen only on level cover basis.

Specified Survival//Waiting Period – Not Applicable

Rate Guarantee (Not applicable for yearly renewable policies) - Throughout the Policy Term

The list and definitions and exclusions for **Accidental Partial and Permanent Disability (APPD)** are provided in detail in **Annexure C**

9. Accidental Dismemberment Benefits –

A percentage of applicable Sum Assured is (As per the Coverage Option) in the event of dismemberment of the Insured Member due to an accident within the benefit option term, is paid as per the below table based on the Nature of Losses, provided it occurs within 180 days from that accident:

Nature of Losses	Amount of Benefit (% of applicable Sum Assured)
Loss of Sight of one eye	50%
Loss of Sight of both eyes	100%
Loss of or Loss of Use of one Limb	50%
Loss of or Loss of Use of two Limbs	100%
Loss of Speech and Loss of Hearing	100%
Loss of Hearing – Both Ears	75%
Loss of Hearing – one ear	25%
Loss of Speech	50%
Loss of or Loss of Use of four Fingers and Thumb of Right Hand	40%
Loss of or Loss of Use of four Fingers and Thumb of Left Hand	30%
Loss of or Loss of Use of one Thumb	
Loss of or Loss of Use of one Thumb - both right joints	30%
Loss of or Loss of Use of one Thumb - one right joint	15%
Loss of or Loss of Use of one Thumb - both left joints	20%
Loss of or Loss of Use of one Thumb - one left joint	10%
Loss of or Loss of Use of Fingers – Three right joints	10%
Loss of or Loss of Use of Fingers – Two right joints	7.5%
Loss of or Loss of Use of Fingers – One right joint	5%
Loss of or Loss of Use of Fingers – Three Left joints	7.5%
Loss of or Loss of Use of Fingers – Two Left joints	5%
Loss of or Loss of Use of Fingers – One Left joint	2%
Loss of or Loss of use of toes – All-one foot	15%
Loss of or Loss of use of toes – great both joints	5%
Loss of or Loss of Use of Toes - great-one joint	3%
Shortening of leg by at least 5cms	7.5%

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Survival/Specified Waiting Period – Not Applicable

Rate Guarantee (Not applicable for yearly renewable policies) - Throughout the Coverage Term

This Sum assured under this optional benefit can be chosen only on level cover basis.

The list and definitions and exclusions for **Accidental Dismemberment Benefits** are provided in **Annexure C**

10. Hospital Cash Benefit (HCB) – A daily benefit amount as chosen by the MPH/Insured Member is payable for non-ICU hospitalization. This amount of daily benefit needs to be chosen at inception and cannot be changed later. The following clauses shall be applicable

- a. In case of ICU admission, an additional daily benefit of 1 time of non-ICU daily benefit is payable for hospitalization.
- b. This benefit is payable as per the number of days (per policy year) opted by Master Policyholder / Insured Member at inception.
- c. The maximum of 900 days of hospitalization over the lifetime of the policy is allowed for Group linked to loan.
- d. The specified number of days per policy year is inclusive of hospital days in ICU. For this benefit to be payable a minimum of 24 hours/72 hours of hospitalisation is required (as chosen at inception). Hospitalization has to be to treat an injury due to an accident or Sickness and should have been advised in writing by a medical professional.

Specified Waiting Period – 30 days applies from the policy commencement date, or policy revival date

Survival Period – Not applicable.

Rate Guarantee (Not applicable for yearly renewable policies) – 5 Years.

This sum assured under this optional benefit can be chosen only on level cover basis.

The list of definition and exclusions for Hospital Cash Benefit are provided in detail in **Annexure E**

11. Surgical Cash Benefit (SCB) - A lumpsum amount as percentage of applicable Sum Assured is payable on hospitalisation for undergoing medically necessary surgery in India. The benefit amount shall be based on the surgery resulting in the highest claim amount in case of more than one surgery is performed on the life insured during the same hospitalization. The pay-out shall be as follows –

Surgery	Description	Payout (% applicable of Annual Sum Assured)
Listed Day Care Procedures	Day Care Surgeries as per Annexure F	Minimum (10% of Sum Assured, 50,000)
Listed Surgeries	Listed Surgeries by Organ type as per Annexure F	25% to 100%
Non-Listed Surgery	All non-listed surgeries meeting the surgery definition and requiring minimum 24 hours of Hospitalization	10%

The Insured Member could claim multiple times under this benefit while it is in effect and irrespective of any previous claims paid subject to the following limits:

- 100% of surgical benefit Sum Assured in any one policy year
- Maximum of 3 claims under Day Care procedures in a policy year
- Same surgery for the same site or organ cannot be covered more than once in the same policy year
- Maximum of 30 day-care claims over the benefit term for Group linked to loan.

Specified Waiting Period - 30 days (subject to Underwriting Policy) is applicable for surgical benefit from policy commencement date, or policy revival date. Specific waiting period shall be applicable from policy issue date or revival date for specific conditions/ procedures.

Survival/Cooling Off Period – Not applicable.

Rate Guarantee (Not applicable for yearly renewable policies) – 5 Years.

This sum assured under this optional benefit can be chosen only on level cover basis.

The list of definition and exclusions for Surgical Cash Benefit is provided in detail in **Annexure F**.

12. Terminal Illness – An amount equal to 100% of applicable (As per the Coverage Option) Sum Assured is payable on diagnosis of terminal illness. The terminal illness is defined as an advance or rapidly progressing incurable and un-correctable medical condition, which in the opinion of the treating physician is highly likely to lead to death within six months. This is an accelerated benefit; hence, any payout of terminal illness benefit shall reduce the base death benefit. If the terminal illness benefit is equal to the base death benefit, entire Sum Assured shall be paid on the occurrence of terminal illness and the base death benefit along with the terminal illness cover shall be terminated thereafter.

Specified Waiting Period – 180 days =

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Survival Period – Not applicable.

This sum assured under this optional benefit can be chosen for level or reducing cover basis.

The list of definition and exclusions is provided in detail in Annexure B.

13. Waiver of EMI (WOEMI) on Hospitalization – An amount equal to the number of EMIs to the loan as selected by the member, subject to maximum of 6 EMI's p.a. or INR 5,00,000 whichever is lower shall be paid out as benefit in the event of continuous hospitalisation of at least 7/10/15 days as opted by the Insured Member at inception. This benefit does not reduce any other benefit.

This sum assured under this optional benefit can be chosen for level or reducing cover basis and for non-yearly renewable policies.

Specified Waiting Period – 90 days applies from the policy commencement date, or policy revival date.

Survival Period – Not applicable.

Rate Guarantee (Not applicable for other than yearly renewable contracts) – 5 Years.

The definition of hospital and corresponding condition and exclusions is defined in Annexure D

14. Waiver of Premium on Major Surgery: All the future premiums (including base plan and other optional/ rider benefit premiums) shall be waived on occurrence of pre-defined major surgical events. The policy shall continue to remain in-force for the applicable base/ remaining optional benefit.

Specified Waiting Period – 30 days is applicable for surgical benefit from policy commencement date, or policy revival date. Specific waiting period of 2 years or 4 years apply from policy issue date or revival date for specific conditions/ procedures. Please refer to Annexure F for details.

Survival/Cooling Off Period – Not applicable.

Rate Guarantee (Not applicable for yearly renewable policies) – 5 Years.

This optional benefit can be chosen either on level cover or reducing cover basis.

15. Waiver of Premium on Major Critical Illness: All the future premiums (including base plan and other optional/ rider benefit premiums) shall be waived in the event of diagnosis of pre-defined Critical illness. The policy shall continue to remain force for the applicable base/ remaining optional benefit.

Specified Waiting Period - 90 days applies from the policy commencement date.

Survival Period – 0/7/14/30 days survival period is applicable as chosen by the MPH/Insured Member at inception. This refers to the period from the diagnosis and fulfilment of the definition of the conditions covered which the Life Insured must survive before the benefit will be paid.

Rate Guarantee (Not applicable for Other than yearly renewable policies) – Up to 15 years.

This optional benefit can be chosen either on level cover or reducing cover basis.

16. Waiver of Premium on Accident Total and Permanent Disability: All the future premiums (including base plan and other rider premiums) shall be waived in the event of pre-defined total and permanent disability conditions provided the disability occurs within 180 days from the occurrence of the event. The policy shall continue to remain force for the applicable base/ remaining optional benefit.

Specified Waiting Period – Not applicable

Survival Period – Not applicable

Rate Guarantee – Throughout the policy term

This optional benefit can be chosen either on level cover or reducing cover basis.

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Annexure B: Definitions and Exclusions – Terminal Illness/ Critical Illness/Cancer/ACTPD Benefits

The definitions and exclusions given in this Annexure are applicable to Terminal Illness/ Major and Minor Critical Illness, Cancer and ACTPD benefits.

Terminal Illness

Terminal Illness is an advanced or rapidly progressing incurable & un-correctable medical condition, which in the opinion of the treating physician is highly likely to lead to death within the next six months. A Specialized Medical Practitioner also needs to opine that the life expectancy of the Insured Member is less than six months. The Specified Waiting Period for Terminal Illness benefit is 180 days.

Terminal Illness is an accelerated benefit. The benefit can be equal to or less than base Sum Assured. On the payment of this benefit, the Sum Assured on death shall reduce by the same amount. In case, the terminal illness benefit is equal to the base Sum Assured, the cover shall terminate post the payment of the Terminal Illness benefit.

Critical Illness shall mean any Illness, medical event or Surgical Procedure as specifically defined below whose signs or symptoms first commence post the specified waiting period after the Inception of Policy Period.

A. List of CI conditions under 8/ 20/ 42 CI as chosen by You

Sr no	Name of CI/ Surgery	8 CI	20 CI	42 CI
1	Cancer of Specified Severity	✓	✓	✓
2	Myocardial Infraction (First Heart Attack of Specific Severity)	✓	✓	✓
3	Open Chest CABG	✓	✓	✓
4	Permanent Paralysis of Limbs	✓	✓	✓
5	Stroke resulting into permanent symptoms	✓	✓	✓
6	Coma of Specified Severity	✓	✓	✓
7	Kidney Failure requiring Regular Dialysis	✓	✓	✓
8	Major Organ /Bone Marrow Transplant	✓	✓	✓
9	Open Heart Replacement or Repair of Heart Valves		✓	✓
10	Multiple Sclerosis with Persisting Symptoms		✓	✓
11	Primary (Idiopathic) Pulmonary Hypertension		✓	✓
12	Benign Brain Tumor		✓	✓
13	Blindness		✓	✓
14	End Stage Lung Failure		✓	✓
15	End Stage Liver Failure		✓	✓

16	Third Degree Burns		✓	✓
17	Major Head Trauma		✓	✓
18	Loss of limbs		✓	✓
19	Deafness		✓	✓
20	Loss of Speech		✓	✓
21	Aorta Graft Surgery			✓
22	Cardiomyopathy (of specified severity)			✓
23	Apallic Syndrome			✓
24	Severe Rheumatoid Arthritis			✓
25	Encephalitis			✓
26	Alzheimer's Disease			✓
27	Aplastic Anaemia			✓
28	Medullary Cystic Kidney Disease			✓
29	Muscular Dystrophy			✓
30	Apallic Syndrome			✓
31	Parkinson's Disease			✓
32	Systemic Lupus Erythematosus with Renal Involvement			✓
33	Bacterial Meningitis			✓
34	Chronic Recurrent Pancreatitis			✓
35	Poliomyelitis			✓
36	Progressive Scleroderma			✓
37	Chronic Adrenal Insufficiency (Addison's Disease)			✓
38	Creutzfeldt-Jacob disease (CJD)			✓
39	Myelofibrosis			✓
40	Eisenmenger's Syndrome			✓
41	Loss of Independent Existence (Cover up to Age 74)			✓
42	End Stage Cancer			✓

Definitions of CI conditions under 8/ 20/ 42 CI as chosen by You

1. Cancer of Specified Severity

A malignant tumor characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and

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sarcoma.

The following are excluded –

- i. All tumors which are histologically described as carcinoma in situ, benign, premalignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
- ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- iii. Malignant melanoma that has not caused invasion beyond the epidermis;
- iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- vi. Chronic lymphocytic leukaemia less than RAI stage 3
- vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs

2. Carcinoma In-Situ (CiS)

Carcinoma-in-situ shall mean first ever histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma in any of the following covered organ groups, and subject to any classification stated:

- i. Breast, where the tumor is classified as Tis according to the TNM Staging method
- ii. Corpus uteri, vagina, vulva or fallopian tubes where the tumor is classified as Tis according to the TNM Staging method or FIGO (staging method of the Federation International Federation of Gynecology and Obstetrics) Stage 0
- iii. Cervix uteri, classified as cervical intraepithelial neoplasia grade III (CIN III) or as Tis according to the TNM Staging method or FIGO Stage 0
- iv. Ovary –include borderline ovarian tumors with intact capsule, no tumor on the ovarian surface, classified as T1aN0M0, T1bN0M0 (TNM Staging) or FIGO 1A, FIGO 1B
- v. Colon and rectum; Penis; Testis; Lung; Liver; Stomach, Nasopharynx and oesophagus
- vi. Urinary tract, for the purpose of in-situ cancers of the bladder, stage Ta of papillary Carcinoma is included.

3. Specified Early-Stage Cancers

Specified Early Cancers shall mean first ever presence of one of the following malignant conditions:

- i. Prostate Cancer that is histologically described using the TNM Classification as T1N0M0 or Prostate cancers described using another equivalent classification.

- ii. Thyroid Cancer that is histologically described using the TNM Classification as T1N0M0.
- iii. Tumors of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification).
- iv. Chronic Lymphocytic Leukaemia (CLL) RAI Stage 1 or 2. CLL RAI Stage 0 or lower is excluded.
- vi. Malignant melanoma that has not caused invasion beyond the epidermis.
- vii. Hodgkin's lymphoma Stage I by the Cotswold's classification staging system.
- viii. The diagnosis must be based on histopathological features and confirmed by a Pathologist.

Pre - malignant lesions and conditions, unless listed above, are excluded.

2. Myocardial Infarction (First Heart Attack of Specific Severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

- i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
- ii. New characteristic electrocardiogram changes
- iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- i. Other acute Coronary Syndromes
- ii. Any type of angina pectoris
- iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure

3. Open Chest CABG

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist

The following are excluded:

- i. Angioplasty and/or any other intra-arterial procedures

4. Open Heart Replacement or Repair of Heart Valves

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The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. Coma of specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- i. No response to external stimuli continuously for at least 96 hours;
- ii. Life support measures are necessary to sustain life; and
- iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting from alcohol or drug abuse is excluded.

6. Kidney Failure Requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

- i. Transient ischemic attacks (TIA)
- ii. Traumatic injury of the brain
- iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Major Organ /Bone Marrow Transplant

The actual undergoing of a transplant of:

- i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- ii. Human bone marrow using haematopoietic stem cells. The undergoing of atransplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

- i. Other stem-cell transplants
- ii. Where only Islets of Langerhans are transplanted

9. Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a Specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. Multiple Sclerosis with Persisting Symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

- i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Neurological damage due to SLE is excluded.

12. Benign Brain Tumor

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist:

- i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

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- ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded:

- a. Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

13. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:

- i. corrected visual acuity being 3/60 or less in both eyes or;
- ii. the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

14. Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means “the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing” in both ears.

15. End Stage Lung Failure

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

- i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- iii. Arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO₂ < 55 mmHg); and
- iv. Dyspnea at rest.

16. End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

- i. permanent jaundice; and
- ii. ascites; and
- iii. hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

17. Loss of speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

18. Loss of Limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

19. Major Head Trauma

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

Activities of daily living:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;
- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice-versa;
- iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- v. Feeding: the ability to feed oneself once food has been prepared and made available;
- vi. Mobility: The ability to move indoors from room to room on level surfaces.

The following is excluded:

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- i. Spinal cord injury.

20. Primary (Idiopathic) Pulmonary Hypertension

An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

- i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

22. Alzheimer's Disease

Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner.

The disease must result in a permanent inability to perform three or more Activities of daily living with "Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days.

The following conditions are however not covered:

- a. neurosis or neuropsychiatric symptoms without imaging evidence of Alzheimer's Disease;
- b. alcohol related brain damage; and
- c. any other type of irreversible organic disorder/dementia not associated with Alzheimer's Disease.

Activities of daily living:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;
- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice-versa;
- iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- v. Feeding: the ability to feed oneself once food has been prepared and made available;
- vi. Mobility: The ability to move indoors from room to room on level surfaces.

23. Parkinson's disease

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to us.

The diagnosis must be supported by all of the following conditions:

- a. the disease cannot be controlled with medication;
- b. signs of progressive impairment; and
- c. inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;
- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice-versa;
- iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- v. Feeding: the ability to feed oneself once food has been prepared and made available;
- vi. Mobility: The ability to move indoors from room to room on level surfaces.

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Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

24. Aorta Graft Surgery

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen.

For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

The insured person understand and agrees that we will not cover:

- a. Surgery performed using only minimally invasive or intra arterial techniques.
- b. Angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures.

Aorta graft surgery benefit covers Surgery to the aorta wherein part of it is removed and replaced with a graft.

25. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

- the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
- clinical manifestations of anemia, polyuria, and progressive deterioration in kidney function; and
- the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this benefit.

26. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities of daily Living.

This diagnosis must be confirmed by:

- a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
- b. A consultant neurologist.

Activities of daily living:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;
- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice-versa;
- iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- v. Feeding: the ability to feed oneself once food has been prepared and made available;
- vi. Mobility: The ability to move indoors from room to room on level surfaces.

27. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- a. Blood product transfusion;
- b. Marrow stimulating agents;
- c. Immunosuppressive agents; or
- d. Bone marrow transplantation.

The diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:

- a. Absolute neutrophil count of less than 500/mm³ or less
- b. Platelets count less than 20,000/mm³ or less
- c. Reticulocyte count of less than 20,000/mm³ or less

Temporary or reversible Aplastic Anaemia is excluded.

28. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Doctor who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class III or Class IV, or its equivalent, for at least six (6) months based on the following classification criteria:

Class III - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure.

Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced and Echocardiography findings confirming presence of cardiomyopathy and Left Ventricular Ejection Fraction (LVEF %) of 40% or less.

Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

29. Encephalitis

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Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Doctor who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks. The permanent deficit should result in permanent inability to perform three or more Activities for Daily Living (listed below).

Activities of daily living:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;
- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice- versa;
- iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- v. Feeding: the ability to feed oneself once food has been prepared and made available;
- vi. Mobility: The ability to move indoors from room to room on level surfaces.

30. Apallic Syndrome

Apallic Syndrome or Persistent vegetative state (PVS) or unresponsive wakefulness syndrome (UWS) is a Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist acceptable to us and the patient should be documented to be in a vegetative state for a minimum of at least one month in order to be classified as UWS, PVS, Apallic Syndrome.

31. Severe Rheumatoid Arthritis

Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:

- Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
- Permanent inability to perform at least two (2) “Activities of Daily Living”;
- Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and
- The foregoing conditions have been present for at least six (6) months.

Activities of daily living:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;
- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice- versa;
- iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- v. Feeding: the ability to feed oneself once food has been prepared and made available;
- vi. Mobility: The ability to move indoors from room to room on level surfaces.

32. Chronic Relapsing Pancreatitis

An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Registered Doctor who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterised by irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence.

Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

33. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a Registered Doctor who is a consultant neurologist. The condition must result in the inability of the Life Insured to perform (whether aided or unaided) at least 3 of the 6 “Activities of Daily Living” for a continuous period of at least 6 months.

Activities of daily living:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;
- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice- versa;
- iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- v. Feeding: the ability to feed oneself once food has been prepared and made available;
- vi. Mobility: The ability to move indoors from room to room on level surfaces.

34. Systemic Lupus Erythematosus with Lupus Nephritis

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A multi-system autoimmune disorder characterised by the development of autoantibodies directed against various self-antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a Registered Doctor specialising in Rheumatology and Immunology.

The WHO Classification of Lupus Nephritis:

- Class I Minimal Change Lupus Glomerulonephritis
- Class II Mesangial Lupus Glomerulonephritis
- Class III Focal Segmental Proliferative Lupus Glomerulonephritis
- Class IV Diffuse Proliferative Lupus Glomerulonephritis
- Class V Membranous Lupus Glomerulonephritis

35. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:

1. Poliovirus is identified as the cause,
2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

36. Progressive Scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic.

Proportions to involve the heart, lungs or kidneys.

The systemic involvement should be evidenced by any two of the following findings -

- Lung fibrosis with a diffusing capacity (DCO) of less than 70% of predicted.
- Pulmonary hypertension with a mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterization.
- Chronic kidney disease with a GFR of less than 60 ml/min (MDRD-formula)
- Echocardiographic findings suggestive of Grade III and above left ventricular diastolic dysfunction.

The diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologist.

The following conditions are excluded:

- Localised scleroderma (linear scleroderma or morphea);
- Eosinophilic fasciitis; and
- CREST syndrome

37. Chronic Adrenal Insufficiency (Addison's Disease)

An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for lifelong glucocorticoid and mineral corticoid replacement therapy. The

disorder must be confirmed by a Registered Doctor who is a specialist in endocrinology through one of the following:

- ACTH simulation tests
- Insulin-induced hypoglycemia test
- Plasma ACTH level measurement
- Plasma Renin Activity (PRA) level measurement.

Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiencies are excluded.

38. Creutzfeldt-Jacob Disease (CJD)

Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A Registered Doctor who is a neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.

39. Myelofibrosis

A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent, and the severity is such that the Life Insured requires a blood transfusion at least monthly. The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a Registered Doctor who is a specialist.

40. Eisenmenger's Syndrome

Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a Registered Doctor who is a specialist with echocardiography and cardiac catheterisation and supported by the following criteria:

- Mean pulmonary artery pressure > 40 mm Hg
- Pulmonary vascular resistance > 3mm/L/min (Wood units); and
- Normal pulmonary wedge pressure < 15 mm Hg.

41. Loss of Independent Existence (cover up to Insurance Age 74)

The insured personal is physically incapable of performing at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months, signifying a permanent and irreversible inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor who is a specialist.

Only Life Insured with Insurance Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this illness.

Activities of daily living:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means:

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- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances
- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa
- iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene
- v. Feeding: the ability to feed oneself once food has been prepared and made available
- vi. Mobility: The ability to move indoors from room to room on level surfaces

42. End Stage Cancer

All Stage IV malignant tumor with the presence of distant metastasis. A spread to lymph nodes only is not covered under this definition. The diagnosis of malignancy must be confirmed by histological evidence. Metastatic cancer is a cancer that has spread from the part of the body where it started (the primary site) to other parts of the body. When cancer cells break away from a tumour, they can travel to other areas of the body through the bloodstream, the lymph system (which contains a collection of vessels that carry fluid and immune system cells) or through the peritoneum.

Following are excluded:

- a. Locally advanced cancers (these will be considered as Early Stage/ Stage II Major for the purpose of this policy)
- b. Any leukaemia and lymphoma (these will be considered as Stage II Major for the purpose of this policy)

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B. List of Minor CI conditions under 15 Minor CI

Sr no	Name of Minor CI/ Surgery
1	Cardiac Arrest requiring permanent Cardiac Pacemaker or ICD insertion
2	Angioplasty
3	Fulminant Viral Hepatitis
4	Severe Osteoporosis
5	Small Bowel Transplant
6	Intestinal Gangrene requiring surgery
7	Surgical removal of one kidney
8	Percutaneous Transluminal Balloon Valvuloplasty or Valvotomy
9	Severe Ulcerative Colitis
10	Specified Early-stage Cancer
11	Carcinoma-in-Situ
12	Necrotizing Fasciitis
13	Pneumonectomy
14	Amputation of Feet Due to Complications from Diabetes
15	Cirrhosis of Liver

1. Cardiac Arrest requiring permanent Cardiac Pacemaker or ICD insertion

Insertion of a Permanent Cardiac Pacemaker, Implantable Cardioverter-defibrillatory (ICD) or Cardiac resynchronisation therapy with defibrillator (CRT-D) that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of such device must be certified as absolutely necessary by a consultant cardiologist and evidence of surgery to be provided.

Cardiac arrest secondary to illegal drug abuse is excluded.

2. Angioplasty

- i. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).
- ii. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.
- iii. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

3. Fulminant Viral Hepatitis

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

- a. Rapid decreasing of liver size;
- b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
- c. Rapid deterioration of liver function tests;
- d. Deepening jaundice; and
- e. Hepatic encephalopathy.

Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

4. Severe Osteoporosis

The occurrence of Osteoporosis with Fractures must be confirmed by a Specialist in the relevant medical field and all of the following conditions are met:

- a. at least a fracture of the neck of femur or two (2) vertebral body fractures, due to or in the presence of osteoporosis; and
- b. bone mineral density measured in at least two (2) sites by dual-energy x-ray densitometry (DEXA) or quantitative CT scanning is consistent with severe osteoporosis (T-score of less than -2.5).

Actual undergoing of internal fixation or replacement of the fractured bone is required.

Coverage for osteoporosis with Fracture will automatically cease after the Insured attains seventy (70) years of age.

5. Small Bowel Transplant

The receipt of a transplant of small bowel with its own blood supply via a laparotomy resulting from intestinal failure.

6. Intestinal Gangrene requiring surgery

The diagnosis of intestinal gangrene confirmed by specialist.

This must be confirmed by all of the following.

- a. Evidence of bowel resection surgery
- b. Imaging and histopathological evidences

Abdominal exploration alone without resection of bowel is specifically excluded.

7. Surgical Removal of One Kidney

The complete surgical removal of one kidney necessitated by any disease or accident of the Life Insured. The need for the surgical removal of the kidney must be certified to be absolutely necessary by a specialist in the relevant field.

Removal of kidney as a donor and removal of congenital kidney condition including renal agenesis and non-functioning kidney are excluded.

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8. Percutaneous Transluminal Balloon Valvuloplasty or Valvotomy

The actual undergoing of Valvotomy or Valvuloplasty where the treatment is performed totally via intravascular procedure necessitated by damage of the heart valve as confirmed by a specialist in the relevant field and established by a cardiac echocardiogram or any other appropriate diagnostic test that is available. For purpose of this Benefit, procedures done for treatment of Congenital Heart Disease are excluded.

9. Severe Ulcerative Colitis

Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.

All of the following criteria must be met:

- the entire colon is affected, with severe bloody diarrhoea; and
- the necessary treatment is total colectomy and ileostomy; and
- the diagnosis must be based on histopathological features and confirmed by a Registered Doctor who is a specialist in gastroenterology.

10. Carcinoma In-Situ (CiS)

Carcinoma-in-situ shall mean first ever histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma in any of the following covered organ groups, and subject to any classification stated:

- i. Breast, where the tumor is classified as Tis according to the TNM Staging method
- ii. Corpus uteri, vagina, vulva or fallopian tubes where the tumor is classified as Tis according to the TNM Staging method or FIGO (staging method of the Federation Internationale de Gynecologie et d'Obstetrique) Stage 0
- iii. Cervix uteri, classified as cervical intraepithelial neoplasia grade III (CIN III) or as Tis according to the TNM Staging method or FIGO Stage 0
- iv. Ovary –include borderline ovarian tumors with intact capsule, no tumor on the ovarian surface, classified as T1aN0M0, T1bN0M0 (TNM Staging) or FIGO 1A, FIGO 1B
- v. Colon and rectum; Penis; Testis; Lung; Liver; Stomach, Nasopharynx and oesophagus
- vi. Urinary tract, for the purpose of in-situ cancers of the bladder, stage Ta of papillary Carcinoma is included.

The diagnosis of the Carcinoma in situ must always be supported by a histopathological report. Furthermore, the diagnosis of Carcinoma In-Situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard.

Pre-malignant lesion and carcinoma in situ of any organ, unless listed above, are excluded.

11. Specified Early-Stage Cancers

Specified Early Cancers shall mean first ever presence of one of the following malignant conditions:

- i. Prostate Cancer that is histologically described using the TNM Classification as T1N0M0 or Prostate cancers described using another equivalent classification.
- ii. Thyroid Cancer that is histologically described using the TNM Classification as T1N0M0.
- iii. Tumors of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification).
- iv. Chronic Lymphocytic Leukaemia (CLL) RAI Stage 1 or 2. CLL RAI Stage 0 or lower is excluded.
- v. Malignant melanoma that has not caused invasion beyond the epidermis.
- vi. Hodgkin's lymphoma Stage I by the Cotswold's classification staging system.
- vii. The Diagnosis must be based on histopathological features and confirmed by a Pathologist.

Pre - malignant lesions and conditions, unless listed above, are excluded.

12. Necrotising Fasciitis

Necrotizing fasciitis is a progressive, rapidly spreading, infection located in the deep fascia causing necrosis of the subcutaneous tissues. An unequivocal diagnosis of necrotizing fasciitis must be made by a Registered Doctor who is a specialist and the diagnosis must be supported with laboratory evidence of the presence of a bacteria that is a known cause of necrotising fasciitis. There must also be widespread destruction of muscle and other soft tissues that results in a total and permanent loss or function of the affected body part.

13. Pneumonectomy

The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the Life Insured

The following conditions are excluded:

- a. Removal of a lobe of lungs (lobectomy)
- b. Lung resection or incision

14. Amputation of Feet due to Complications from Diabetes

Diabetic neuropathy and vasculitis resulting in the amputation of both feet at or above ankle as advised by a Registered Doctor who is a

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specialist as the only means to maintain life. Amputation of toe or toes, or any other causes for amputation shall not be covered.

15. Cirrhosis of Liver

Chronic hepatitis due to hepatitis virus infection having progressed to liver cirrhosis. At time of claim all the below conditions must be fulfilled:

- Clinical evidence of chronic viral hepatitis in the form of serology and other laboratory tests.
- Unequivocal diagnosis of liver cirrhosis caused by viral hepatitis must be made based on liver tissue histopathology, clinical findings and medical history by registered gastroenterologist in a hospital recognized by the insurer.
- Histopathological report shows stage F4 by Metavir grading or a HAI-Knodell Score of 4.

Liver disease caused by alcohol or drug abuse is excluded.

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Definition for Cancer Benefit

1. Cancer of Specified Severity

A malignant tumor characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

- i. All tumors which are histologically described as carcinoma in situ, benign, premalignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
- ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- iii. Malignant melanoma that has not caused invasion beyond the epidermis;
- iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- vi. Chronic lymphocytic leukaemia less than RAI stage 3
- vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

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Definitions for All Cause Total and Permanent Disability

TPD shall mean the occurrence of any of the following conditions as a result of accidental bodily injury, sickness or disease:

1. Permanent Disability

Disability means inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

The Activities of Daily Living are:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means
- ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances
- iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice-versa
- iv. Mobility: the ability to move indoors from room to room on level surfaces
- v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene
- vi. Feeding: the ability to feed oneself once food has been prepared and made available.

2. Physical Impairment:

- i. Total and irrecoverable loss of sight of both eyes. The blindness must be confirmed by an Ophthalmologist, OR
- ii. Loss of use or loss by severance of two or more limbs at or above wrists or ankles; OR
- iii. The total and irrecoverable loss of sight of one eye and loss of use or loss by severance of one limb at or above wrist or ankle.

The above disability must have lasted, without interruption, for at least six consecutive months from the date of diagnosis or accident and must, in the opinion of a qualified medical practitioner appointed by the Company, be deemed permanent.

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

Accidental Injury means bodily injury of the insured caused solely, directly and independently of any other intervening causes from an accident (i.e., a traumatic event of violent, unexpected, external and visible nature).

The loss of use of a limb is considered as a loss of use when such loss of use involves total and permanent loss of function of the limb affected as determined by a registered medical practitioner nominated by the Company.

Permanent Exclusions for Critical Illness, Cancer and ACTPD Benefits

We shall not be liable to make any payment under this Policy towards a covered condition/illness/procedure, caused by, based on, arising out of or howsoever attributable to any of the following:

1. Any Illness, sickness or disease other than those specified as Critical Illnesses/Disability under this Policy;
2. Any Pre-existing Disease or any complication arising therefrom.

Pre-existing Disease means any condition, ailment, injury or disease / critical illness / disability:

- a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement; or
- b. For which medical advice or treatment was recommended by, or received from, a Physician within 36 months Prior to the effective date of the policy issued by the insurer or its reinstatement

In case of enhancement of sum Assured the exclusion shall apply afresh to the extent of Sum Assured increase.

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 Insurer.

3. Any Critical Illness or Disability caused due to treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

4. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner,

5. Any Critical Illness or Disability caused due to intentional self-injury, suicide or attempted suicide

6. Any Critical Illness or Disability caused by or arising from or attributable to a foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), civil war, public defense, rebellion, revolution, insurrection, military or usurped power;

7. Any Critical Illness or Disability caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

8. Congenital External Anomalies or any complications or conditions arising therefrom including any developmental conditions of the Insured;

9. Any Critical Illness or Disability caused by any treatment necessitated due to participation as a professional in hazardous or adventure sport, including but not limited to, para jumping, rock climbing, mountaineering, rafting, motor racing, horse

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racing or scuba diving, hand gliding, sky diving, deep sea diving

10. Participation by the Insured Person in any flying activity, except as a bona fide, farepaying passenger of a recognized airline on regular routes and on a scheduled timetable.

11. Any Critical Illness or Disability caused by Medical treatment traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy. Any Critical Illness caused due to miscarriages (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

12. Any Critical Illness or Disability caused by any unproven/ experimental treatment, service and supplies for or in connection with any treatment. Unproven/ experimental treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

13. Any Critical Illness or Disability based on certification/diagnosis/treatment from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he/ she is licensed for.

14. Any Critical Illness or Disability caused due to any treatment, including surgical management, to change characteristics of the body to those of opposite sex.

15. Any Critical Illness or Disability caused due to cosmetic or plastic surgery or any treatment to change the 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.

16. Any Critical Illness or Disability caused due to surgical treatment of obesity that does not fulfil all 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):
 - greater than or equal to 40 or
 - 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:
 - i. Obesity related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type 2 Diabetes

17. Any Critical Illness or Disability caused due to 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 reason.

18. Any Critical Illness or Disability caused by treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

19. In the event of the death of the Insured Person within the stipulated survival period as set out above.

20. Any Critical Illness or Disability caused by sterility and infertility. This includes:

- a. Any type of contraception, sterilization
- b. Assisted Reproductive services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- c. Gestational Surrogacy
- d. Reversal of sterilization

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Annexure C: Definitions and Exclusions – ADB, ATPD, APPD and Accidental Dismemberment Benefits

Definition

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

Accidental Injury means bodily injury of the insured caused solely, directly and independently of any other intervening causes from an accident (i.e., a traumatic event of violent, unexpected, external and visible nature).

Accidental Death means the death of the Insured which results directly, solely and independently of any other causes from Bodily Injury and occurs within 180 days of the date of Accident.

Accidental Dismemberment must be a result of a traumatic event caused solely by external, violent, unforeseeable and visible means, occurring independently of any other causes and within 180 days of such trauma, proved to the satisfaction of the insurer. The permanence of the disability will only be established 180 days following the date of the event causing the disability except in the case of complete severance of the hand at or above the wrist or foot at or above the ankle joint.”

Accidental Total and Permanent Disability means disability as a result of bodily injury caused by an accident and such injury shall within 180 days of its occurrence solely, directly and independently of any other cause, result in the Member's disability which must be total and permanent, and must result in at least one of the following:

- i. Loss of sight in both eyes
- ii. Loss of both arms or both hands;
- iii. Loss of one arm and one leg;
- iv. Loss of one arm and one foot;
- v. Loss of one hand and one foot;
- vi. Loss of one hand and one leg;
- vii. Loss of both legs;
- viii. Loss of both feet;
- ix. Removal of the entire lower jaw
- x. Loss of one hand and loss of sight in one eye
- xi. Loss of one foot and loss of sight in one eye

If the disability is due to amputation/dismemberment, the loss of hand will mean amputation/dismemberment above wrist, the loss of arm will mean amputation/ dismemberment above elbow, the loss of feet will mean amputation/dismemberment above ankle and the loss of leg will mean amputation/dismemberment above knee. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. If the disability is not due to amputation/dismemberment, the loss will mean loss of usage of both limbs and the limbs should have motor power grade 0/5, 1/5 or 2/5 only.

Loss of a limb resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded. The loss of use of the particular limb must be certified by a relevant Medical Practitioner and documented for an uninterrupted period of at least six months.

The total Loss of Sight in one eye means total, permanent and irreversible loss of all vision in an eye as a result of accident.

Loss of Sight in both eyes - Total, permanent and irreversible loss of all vision in both eyes as a result of accident, evidenced by:

- i. corrected visual acuity being 3/60 or less in both eyes or;
- ii. the field of vision being less than 10 degrees in both eyes

The diagnosis of Loss of Sight in both eyes must be certified by an Ophthalmologist to be permanent in nature and must not be correctable by aids or surgical procedure.

Permanent Exclusions for ADB, ATPD, APPD and Accidental Dismemberment Benefits

No benefit shall be payable for any claim under this Section in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. Suicide or attempted suicide or self-inflicted injury, whether the Life Insured is medically sane or insane.
2. Any Pre-existing Disease or any complication arising therefrom.

Pre-existing Disease means any condition, ailment, injury or disease / illness / disability:

- a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement; or
- b. For which medical advice or treatment was recommended by, or received from, a Physician within 36 months Prior to the effective date of the policy issued by the insurer or its reinstatement

In case of enhancement of Sum Assured the exclusion shall apply afresh to the extent of Sum Assured increase.

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 Insurer.

3. Failure to seek medical advice or treatment.
4. War, terrorism, invasion, act of foreign enemy, hostilities, civil war, martial law, rebellion,

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revolution, insurrection, military or usurper power, riot or civil commotion. War means any war whether declared or not.

5. Committing an assault, a criminal offence, an illegal activity or any breach of law with criminal intent only.

6. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to, diving or riding or any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee jumping

7. Alcohol or Solvent abuse or taking of Drugs, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner

8. Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable.

9. Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

10. Death or bodily injuries which result directly, solely and independently of any other causes from an Accident AND which occurs after 180 days of the Accident are excluded. In the event the Insured enters into a Coma (as per definition of health regulations) within 180 days after the date of Accident and the death of the Insured occurs 180 days after the date of Accident, such a claim shall be payable, provided that the claimant can prove using primary medical records that the death of the Insured resulted directly and solely from accident and independent of any other causes and claims investigations conducted by the company concur in their findings.

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Annexure D: Definitions and Exclusions – Waiver of EMI on Hospitalisation Benefits

Definition

Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

- i. has qualified nursing staff under its employment round the clock;
- ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
- iii. has qualified medical practitioner (s) in charge round the clock;
- iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
- v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

Hospitalisation means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

Any terms not defined in this proposal will follow the definitions from IRDAI's Master Circular on Standardisation of Health Insurance Products (Ref: IRDAI/HLT/REG/CIR/193/07/2020) dated 22 July 2020.

This Benefit shall be payable subject to the following:

- i. Liability to make any payment under this Benefit shall commence only after a continuous and completed 24 hours of Hospitalization of the Insured Person for each claim.
- ii. The Hospitalization is for Medically Necessary Treatment for an Illness/Accident and is commenced and continued on the written advice of the treating Medical Practitioner.
- iii. We shall not be liable to pay the daily amount for more than the maximum number of days as specified, during the Period of cover.
- iv. A waiting period of 30 days is applicable for hospital cash claims relating to sickness.

Such a waiting period is not applicable to claims arising due to accident provided the accident occurs after the inception of the policy.

Exclusions

No benefit shall be payable for any claim under this Section in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. Any Illness, or Accident causing the Injury leading to the Hospitalization, which has occurred prior to the Risk Inception Date.
2. Any Pre-existing Disease or any complication arising therefrom. Pre-existing Disease means any condition, ailment, injury or disease / illness / disability:
 - a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement; or
 - b. For which medical advice or treatment was recommended by, or received from, a Physician within 36 months Prior to the effective date of the policy issued by the insurer or its reinstatement

In case of enhancement of Sum Assured the exclusion shall apply afresh to the extent of sum insured increase.

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 Insurer.

3. Any Procedure/ treatment which is carried out as a Day Care Treatment, or which requires less than 24 continuous hours of Hospitalisation.
4. Any treatment arising from or traceable to pregnancy and its related complication, childbirth including caesarean section.
5. Any treatment performed solely due to cosmetic or aesthetic reasons, weight reduction, change of sex, and lasik Surgery.
6. Any admission for any dental treatment except any dental Surgery or facial reconstruction being performed under Emergency Care due to an Accident.
7. Hospitalization for the sole purpose of traction, physiotherapy or any ailment for which Hospitalization is not warranted due to advancement in medical technology.
8. Treatment by a family member and self-medication or any treatment that is not

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scientifically recognized.

9. Any Unproven/Experimental treatment

10. Any alternative treatments except treatment taken under Ayurveda, Unani, Sidha and Homoeopathy in a Government Hospital or any institute recognized by the Government and/or accredited by Quality Council of India / National Accreditation Board for Hospitals and Healthcare Providers.

11. Any treatment received outside India unless specifically covered and specified in the Policy Certificate.

12. Routine medical, dental, eye and ear examinations is not covered unless specifically covered and specified in the Policy Certificate.

13. Circumcision unless necessary for treatment.

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Annexure E: Definitions and Exclusions for Hospital Cash Benefit (HCB)

Definition

Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

- vi. has qualified nursing staff under its employment round the clock;
- vii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
- viii. has qualified medical practitioner (s) in charge round the clock;
- ix. has a fully equipped operation theatre of its own where surgical procedures are carried out
- x. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

Hospitalisation means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

Any terms not defined in this proposal will follow the definitions from IRDAI's Master Circular on Standardisation of Health Insurance Products (Ref: IRDAI/HLT/REG/CIR/193/07/2020) dated 22 July 2020.

This Benefit shall be payable subject to the following:

- v. Liability to make any payment under this Benefit shall commence only after a continuous and completed 24 hours of Hospitalization of the Insured Person for each claim.
- vi. The Hospitalization is for Medically Necessary Treatment for an Illness/Accident and is commenced and continued on the written advice of the treating Medical Practitioner.
- vii. We shall not be liable to pay the daily amount for more than the maximum number of days as specified, during the Period of Cover.
- viii. A waiting period of 30 days is applicable for hospital cash claims relating to sickness. Such a waiting period is not applicable to claims arising due to accident provided the accident occurs after the inception of the policy.

- ix. More than one claim can be considered in respect of the Insured Person under this benefit during the Period of Cover, subject to the maximum number of days specified, and provided that the Illness/Accident causing the Injury is distinct and unrelated for each such claim. On exhaustion of the maximum number of days allowed, the cover under this Benefit will terminate in relation to such Insured Person.
- x. Once claim is considered admissible as per the terms and condition under this benefit, the Insured Person is eligible for the daily amount from the first day of Hospitalisation, provided that the Insured Person is Hospitalized for a continuous period of 24 hours.
- xi. The amount payable under this Benefit will be calculated on the basis of the number of continuous and completed days of Hospitalization and will be given as a single lumpsum payment.

Exclusions

No benefit shall be payable for any claim under this Section in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. Any Illness, or Accident causing the Injury leading to the Hospitalization, which has occurred prior to the Risk Inception Date.
2. Any Pre-existing Disease or any complication arising therefrom. Pre-existing Disease means any condition, ailment, injury or disease / illness / disability:
 - a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement;
 - or
 - b. For which medical advice or treatment was recommended by, or received from, a Physician within 36 months Prior to the effective date of the policy issued by the insurer or its reinstatement.

In case of enhancement of Sum Assured sum the exclusion shall apply afresh to the extent of Sum Assured

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 Insurer.

3. Any Procedure/ treatment which is carried out as a Day Care Treatment, or which requires less than 24 continuous hours of Hospitalisation.
4. Any treatment arising from or traceable to pregnancy and its related complication, childbirth including caesarean section.
5. Any treatment performed solely due to cosmetic or aesthetic reasons, weight reduction, change of sex, and lasik Surgery.

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6. Any admission for any dental treatment except any dental Surgery or facial reconstruction being performed under Emergency Care due to an Accident.
 7. Hospitalization for the sole purpose of traction, physiotherapy or any ailment for which Hospitalization is not warranted due to advancement in medical technology.
 8. Treatment by a family member and self-medication or any treatment that is not scientifically recognized.
 9. Any Unproven/Experimental treatment.
 10. Any alternative treatments except treatment taken under Ayurveda, Unani, Sidha and Homoeopathy in a Government Hospital or any institute recognized by the Government and/or accredited by Quality Council of India / National Accreditation Board for Hospitals and Healthcare Providers.
 11. Any treatment received outside India unless specifically covered and specified in the Policy Certificate.
 12. Routine medical, dental, eye and ear examinations is not covered unless specifically covered and specified in the Policy Certificate.
 13. Circumcision unless necessary for treatment.
 14. Specified disease/procedure waiting period - Code- Excl02
 - a. In case of enhancement of Sum Assured the exclusion shall apply afresh to the extent of Sum Assured increase.
 - b. If any of the specified disease/procedure falls under the waiting period specified for preExisting diseases, then the longer of the two waiting periods shall apply.
 - c. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- 24 Months waiting period:
- o Benign ENT disorders
 - o Tonsillectomy
 - o Adenoidectomy
 - o Mastoidectomy
 - o Tympanoplasty
 - o Hysterectomy
 - o All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
 - o Benign prostate hypertrophy
 - o Cataract and age-related eye ailments
 - o Gastric/ Duodenal Ulcer
 - o Gout and Rheumatism
 - o Hernia of all types
 - o Hydrocele
 - o Non-Infective Arthritis
 - o Piles, Fissures and Fistula in anus
 - o Pilonidal sinus, Sinusitis and related disorders
 - o Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
 - o Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
 - o Varicose Veins and Varicose Ulcers
 - o Internal Congenital Anomalies
- 36 Months waiting period
- o Treatment for joint replacement unless arising from accident
 - o Age-related Osteoarthritis & Osteoporosis
15. Rest Cure, rehabilitation and respite care – Code - Excl05 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.
 16. Investigation & Evaluation - Code- Excl04
 - 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.
 17. 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.
 18. 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.
 19. 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.
 20. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code - Excl12
 21. Any Expenses related to intentional self-injury, suicide or attempted suicide
 22. Expenses arising out of or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), participation in any naval, military or air force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power
 23. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
 - a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
 - b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous

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chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

24. Congenital External Anomalies or any complications or conditions arising therefrom
25. Any expenses incurred on Domiciliary hospitalization and OPD treatment.
26. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes
27. 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

Annexure F: Definitions, Exclusions and List of Surgeries for Surgical Cash Benefit (SCB)

Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner

Any terms not defined in this proposal will follow the definitions from IRDAI's Master Circular on Standardisation of Health Insurance Products (Ref: IRDAI/HLT/REG/CIR/193/07/2020) dated 22 July 2020.

Day Care Procedures means medical treatment, and/or surgical procedure which is:

- I. undertaken under general or local anaesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement, and
- II. which would have otherwise required a hospitalisation of more than twenty-four hours.
Treatment taken on an out-patient basis is not included in the scope of this definition.

Exclusions for Surgical Benefit

1. Pre-Existing Diseases 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 insurer.
- b. In case of enhancement of Sum Assured the exclusion shall apply afresh to the extent of Sum Assured increase.
- c. 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 Insurer.

2. Specified disease/procedure waiting period - Code- Excl02

- a) In case of enhancement of Sum Assured the exclusion shall apply afresh to the extent of Sum Assured increase.
- b) 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.
- c) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
 - i. 24 Months waiting period:

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age-related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non-Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

- ii. 36 Months waiting period

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1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

3 Investigation & Evaluation - Code- Excl04

- 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.

4 Rest Cure, rehabilitation and respite care – Code - Excl05

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.

5 Obesity/ Weight Control -Code - Excl06

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

- 1) Surgery to be conducted is upon the advice of the Doctor
- 2) The surgery/Procedure conducted should be supported by clinical protocols
- 3) The member has to be 18 years of age or older and
- 4) Body Mass Index (BMI):
 - a) greater than or equal to 40 or
 - b) greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

6 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.

7 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.

8 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.

9 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.

10 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.

11 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code - Excl12

12 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

13 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

14 Refractive Error: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries. Code - Excl15

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15 Unproven Treatments: 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 Code - Excl16

16 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

17 Maternity Code - Excl18

- i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

18 Any Sexually Transmitted Diseases

19 Any Expenses related to intentional self-injury, suicide or attempted suicide

20 Participation by the Insured Person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable.

21 Expenses arising out of or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), participation in any naval, military or airforce operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power

22 Expenses arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from

any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

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

- Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) microorganisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

23 Treatment taken outside India.

24 Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

25 All expenses related to donor treatment, including screening, surgery to remove organs from the donor, in case of transplant surgery.

26 Congenital External Anomalies sor any complications or conditions arising therefrom including any developmental conditions of the Insured.

27 Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine.

28 Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence and any treatment in an establishment that is not a Hospital.

29 Deliberate exposure to exceptional danger (except in an attempt to save human life)

30 Out-patient treatment.

31 Domiciliary hospitalization or treatment.

32 Training for or participating in professional sport of any kind or any sport for which the insured receives a salary or monetary reimbursement, including grants or sponsorship.

33 All preventive care, Vaccination including Inoculation and Immunizations (except in case of post bite treatment) and tonics.

34 Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, remodeling clinic or similar institutions.

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35 Hormone Replacement Therapy.

36 Dental, Orthodontics, Periodontics, Endodontics or any preventative dentistry no matter who gives the treatment.

37 Ear or body piercing and tattooing or treatment needed as a result of any of these.

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List of Surgeries

A. Day Care Procedures

X Microsurgical operations on the middle ear	1 Stapedectomy
	2 Revision of a stapedectomy
	3 Other operations on the auditory ossicles
	4 Myringoplasty (Type -I Tympanoplasty)
	5 Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
	6 Revision of a tympanoplasty
	7 Other microsurgical operations on the middle ear
Other operations on the middle & internal ear	8 Myringotomy
	9 Removal of a tympanic drain
	10 Incision of the mastoid process and middle ear
	11 Mastoidectomy
	12 Reconstruction of the middle ear
	13 Other excisions of the middle and inner ear
	14 Fenestration of the inner ear
	15 Revision of a fenestration of the inner ear
	16 Incision (opening) and destruction (elimination) of the inner ear
	17 Other operations on the middle and inner ear
Operations on the nose & the nasal sinuses	18 Excision and destruction of diseased tissue of the nose
	19 Operations on the turbinates (nasal concha)
	20 Other operations on the nose
	21 Nasal sinus aspiration
Operations on the eyes	22 Incision of tear glands
	23 Other operations on the tear ducts
	24 Incision of diseased eyelids
	25 Excision and destruction of diseased tissue of the eyelid
	26 Incision of diseased eyelids
	27 Operations on the canthus and epicanthus
	28 Corrective surgery for entropion and ectropion
	29 Corrective surgery for blepharoptosis
	30 Removal of a foreign body from the conjunctiva

	31 Removal of a foreign body from the cornea
	32 Incision of the cornea
	33 Operations for pterygium
	34 Other operations on the cornea
	35 Removal of a foreign body from the lens of the eye
	36 Removal of a foreign body from the posterior chamber of the eye
	37 Removal of a foreign body from the orbit and eyeball
	38 Operation of cataract
Operations on the skin & subcutaneous tissues	39 Incision of a pilonidal sinus
	40 Other incisions of the skin and subcutaneous tissues
	41 Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
	42 Local excision of diseased tissue of the skin and subcutaneous tissues
	43 Other excisions of the skin and subcutaneous tissues
	44 Simple restoration of surface continuity of the skin and subcutaneous tissues
	45 Free skin transplantation, donor site
	46 Free skin transplantation, recipient site
	47 Revision of skin plasty
	48 Other restoration and reconstruction of the skin and subcutaneous tissues
49 Chemosurgery to the skin	
50 Destruction of diseased tissue in the skin and subcutaneous tissues	
Operations on the tongue	51 Incision, excision and destruction of diseased tissue of the tongue
	52 Partial glossectomy
	53 Glossectomy
	54 Reconstruction of the tongue
	55 Other operations on the tongue
Operations on the salivary	56 Incision and lancing of a salivary gland and a salivary duct

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glands & salivary ducts	57 Excision of diseased tissue of a salivary gland and a salivary duct
	58 Resection of a salivary gland
	59 Reconstruction of a salivary gland and a salivary duct
	60 Other operations on the salivary glands and salivary ducts
Other operations on the mouth & face	61 External incision and drainage in the region of the mouth, jaw and face
	62 Incision of the hard and soft palate
	63 Excision and destruction of diseased hard and soft palate
	64 Incision, excision and destruction in the mouth
	65 Plastic surgery to the floor of the mouth
	66 Other operations in the mouth
Operations on the tonsils & adenoids	67 Transoral incision and drainage of a pharyngeal abscess
	68 Tonsillectomy without adenoidectomy
	69 Tonsillectomy with adenoidectomy
	70 Excision and destruction of a lingual tonsil
	71 Other operations on the tonsils and adenoids
	72 Trauma surgery and orthopaedics
	73 Incision on bone, septic and aseptic
	74 Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
	75 Suture and other operations on tendons and tendon sheath
	76 Reduction of dislocation under GA
	77 Arthroscopic knee aspiration
Operations on the breast	78 Incision of the breast
	79 Operations on the nipple
Operations on the digestive tract	80 Incision and excision of tissue in the perianal region
	81 Surgical treatment of anal fistulas
	82 Surgical treatment of haemorrhoids
	83 Division of the anal sphincter (sphincterotomy)
	84 Other operations on the anus
	85 Ultrasound guided aspirations

	86 Sclerotherapy etc.
	87 Laparoscopic cholecystectomy
Operations on the female sexual organs	88 Incision of the ovary
	89 Insufflation of the Fallopian tubes
	90 Other operations on the Fallopian tube
	91 Dilatation of the cervical canal
	92 Conisation of the uterine cervix
	93 Other operations on the uterine cervix
	94 Incision of the uterus (hysterotomy)
	95 Therapeutic curettage
	96 Culdotomy
	97 Incision of the vagina
	98 Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
	99 Incision of the vulva
	100 Operations on Bartholin's glands (cyst)
Operations on the prostate & seminal vesicles	101 Incision of the prostate
	102 Transurethral excision and destruction of prostate tissue
	103 Transurethral and percutaneous destruction of prostate tissue
	104 Open surgical excision and destruction of prostate tissue
	105 Radical prostatovesicectomy
	106 Other excision and destruction of prostate tissue
	107 Operations on the seminal vesicles
	108 Incision and excision of periprostatic tissue
	109 Other operations on the prostate
Operations on the scrotum & tunica vaginalis testis	110 Incision of the scrotum and tunica vaginalis testis
	111 Operation on a testicular hydrocele
	112 Excision and destruction of diseased scrotal tissue
	113 Plastic reconstruction of the scrotum and tunica vaginalis testis
	114 Other operations on the scrotum and tunica vaginalis testis
	115 Incision of the testes

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Operations on the testes	116 Excision and destruction of diseased tissue of the testes
	117 Reconstruction of the testis
	118 Implantation, exchange and removal of a testicular prosthesis
	119 Other operations on the penis
Operations on the spermatic cord, epididymis and ductus deferens	120 Surgical treatment of a varicocele and a hydrocele of the spermatic cord
	121 Excision in the area of the epididymis
	122 Epididymectomy
	123 Reconstruction of the spermatic cord
	124 Reconstruction of the ductus deferens and epididymis
Operations on the penis	125 Other operations on the spermatic cord, epididymis and ductus deferens
	126 Operations on the foreskin
	127 Local excision and destruction of diseased tissue of the penis
	128 Amputation of the penis
	129 Plastic reconstruction of the penis
Operations on the urinary system	130 Other operations on the penis
	131 Cystoscopic removal of stones
Other Operations	132 Lithotripsy
	133 Coronary angiography
	134 Haemodialysis
	135 Radiotherapy for Cancer
	136 Cancer Chemotherapy

Day care procedures, which are not listed here but, falls under 'Day Care Procedure' definition of IRDA will be considered for pay out under this section.

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B. List of Surgeries by Organ System

Organ system	Surgery/Procedure	Pay-out %
Operations on Blood Vessels	1 Surgery of the Aorta	100
	2 Proximal Aortic Aneurysmal repair by coronary artery transplantation	100
	3 Repair of Cerebral or Spinal Arterio-Venous Malformations or aneurysms	100
	4 Surgery of Carotid Artery	50
	5 Major vein repair with or without grafting for traumatic & nontraumatic lesions	50
Operations on neck, pharynx, larynx and trachea	6 Partial Pharyngectomy	50
	7 Total Pharyngectomy	75
	8 Total Laryngectomy	75
	9 Wide excision and Major reconstruction of malignant Oro-pharyngeal tumors	75
	10 Tracheal reconstruction for various lesion	50
Operations on the bones, muscles and joints	11 Replantation of upper limb	75
	12 Replantation of lower limb	75
	13 Entrapment syndrome-decompression surgery	50
	14 Total hip replacement (With Cement)	50
	15 Total hip replacement (Without Cement)	50
	16 Total hip replacement- Others	50
	17 Total Knee replacement (With Cement)	50
	18 Total Knee replacement (With Cement)	50
	19 Total Knee replacement- Others	50
	20 Total prosthetic replacement of other joint using cement	50
	21 Total prosthetic replacement of other joint not using cement	50
	22 Other total prosthetic replacement of other joint	50
	23 Prosthetic replacement of head of femur using cement	50
	24 Prosthetic replacement of head of femur not using cement	50
	25 Other prosthetic replacement of head of femur	50

	26 Prosthetic replacement of head of humerus using cement	50
	27 Prosthetic replacement of head of humerus not using cement	50
	28 Other prosthetic replacement of head of humerus	50
	29 Prosthetic replacement/articulation/other bone using cement	50
	30 Prosthetic replacement/articulation/other bone not using cement	50
	31 Other prosthetic replacement of articulation of other bone	50
	32 Prosthetic interposition reconstruction of joint	50
	33 Other interposition reconstruction of joint	50
	34 Excision reconstruction of joint	50
	35 Other reconstruction of joint	50
	36 Implantation of prosthesis for limb	50
	37 Amputation of hand	25
	38 Amputation of foot	25
	39 Therapeutic knee Arthroscopy	25
	40 Replantation of finger following traumatic amputation	25
	41 Surgical Drainage and Curettage for osteomyelitis	25
Operations on the breast	42 Radical Mastectomy	75
	43 Simple Mastectomy	25
Operations on the ear	44 Total ear amputation with reconstruction	75
	45 Trans mastoid removal cholesteatoma with extended Mastoidectomy	75
	46 Labyrinthomy for various lesions	50
Operations on the eyes	47 Orbit Tumor Exenteration /Flap reconstruction	50
	48 Corneal or Retinal Repair for Traumatic eye injuries	25
	49 Penetrating injuries of the eye or repair of ruptured globe	25
Operations on the face	50 Major reconstructive oro-maxillafacial surgery due to trauma or burns and not for cosmetic purpose	75

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	51 Osteotomy including segmental resection with bone grafting for Mandibular and maxillary lesions	75
	52 Elevation, Exploration and Fixation of fractured Zygoma	50
Operations on the Gastrointestinal organs	53 Excision of esophagus and stomach	100
	54 Abdominal-Perineal Pull Through Resection of rectum with Colo-Anal Anastomosis	100
	55 Total Esophagectomy	75
	56 Total Gastrectomy	75
	57 Partial Resection of Liver	75
	58 Partial Pancreatectomy	75
	59 Resection and Anastomosis of any part of digestive tract	50
	60 Open Surgery for treatment of Peptic Ulcer	50
	61 Cholecystectomy /Choledochotomy for various Gall bladder lesions	25
	62 Artificial opening into stomach	25
	63 TIPS procedure for portal Hypertension	25
	64 Hysterectomy for malignant conditions	50
	65 Radical prostatesctomy	75
	66 Penile replantation for post traumatic amputation	75
	67 Penile Amputation repair	50
	68 Excision of vagina	50
	69 Unilateral or Bilateral excision of adnexa of uterus	50
	70 Unilateral or Bilateral excision of testes	25
	71 Other operations on Scrotum and tunica vaginalis testis	25
	72 Reconstruction of the testis	25
73 Open surgical excision and destruction of prostate tissue	25	
74 Extirpation of lesion of vulva	25	
75 Excision of vulva	25	
Operations on the heart	76 CABG (two or more coronary arteries) via open thoracotomy	100
	77 Prosthetic replacement of Heart Valve	100

	78 Coronary Angioplasty with Stent implantation	50
	79 Pericardiotomy / Pericardectomy	50
	80 Implantation of Cardioverter Defibrillator	50
	81 Permanent pacemaker Implantation in heart	50
	82 Mitral valve repair	75
	83 Aortic valve repair	75
	84 Tricuspid valve repair	75
	85 Pulmonary valve repair	75
Operations on the Kidney, ureter and bladder	86 Total nephrectomy(Not as transplant donor)	50
	87 Partial Nephrectomy	50
	88 Open extirpation of lesion of kidney	50
	89 Excision of ureter	50
	90 Total excision of bladder	50
	91 Kidney injury repair	50
	92 Pyloplasty / Ureterocalycostomy for pelvic ureteric junction obstruction	50
	93 Partial excision of bladder	25
	94 Therapeutic ureteroscopic operations on ureter	25
	95 Urinary diversion	25
96 Replantation of ureter	25	
operations on the lung and bronchus	97 Pneumonectomy	75
	98 Open Lobectomy of Lung	75
	99 Partial Extirpation of Bronchus	75
	100 Pleurectomy or Pleural decortication	50
	101 Major Nasal Reconstruction due to Traumatic lesions	75
	102 Total Glossectomy	50
	103 Operations on frontal sinus	50
	104 Oral Leukoplakia- Wide excision	25
	105 Operations on maxillary antrum using sublabial approach	25
operations on the skull, brain and meninges	106 Craniotomy for malignant Cerebral tumors	100
	107 Craniotomy for non malignant space occupying lesions	75
	108 Operations on Subarachnoid space of brain	75

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	109 Craniotomy- Surgery on meninges of Brain	75
	110 Other operations on the meninges of the Brain	75
	111 Micro vascular decompression of cranial nerves/nervectomy	75
	112 Craniotomy for Drainage of Extradural, subdural or intracerebral space	50
	113 Therapeutic Burr Hole on skull- Drainage of Extra-Dural, intra-Dural or intracerebral space	25
operations on the spine and nerves	114 Unilateral or Bilateral sympathectomy	50
	115 Peripheral nerve Graft	50
	116 Free Fascia Graft for Facial Nerve Paralysis	50
	117 Excision of deep-seated peripheral nerve tumor	50
	118 Multiple Microsurgical Repair of digital nerve	50
Operations on the Thoracic cavity	119 Fracture fixation- Spine	50
	120 Diaphragmatic/Hiatus Hernia Repair	75
	121 Thoracoplasty	75
Operations on the Thyroid, Parathyroid and other endocrine glands	122 Open excision of benign mediastinal lesions	75
	123 Excision of Diaphragmatic tumors	75
	124 Pineal Gland excision	100
	125 Pituitary Gland excision	100
	126 Complete excision of adrenal glands	75
	127 Total thyroidectomy	75
	128 Complete excision of Parathyroid gland	75
	129 Partial excision of adrenal glands	50
Other operations	130 Subtotal/Partial Thyroidectomy	50
	131 Partial excision of Parathyroid gland	50
Other operations	132 Major Excision and grafting of Lymphedema	75
	133 Splenectomy	75