NAVI HEALTH GROUP SEASONAL BYTE

POLICY WORDINGS

This is Your Navi Health Group Seasonal Byte Policy which has been issued by *Us* relying on the Information disclosed by You in Your Proposal for this Policy or its preceding Policy/Policies of which this is a Renewal. It contains details of what is covered, what is not covered, the conditions and the basis on which all claims will be settled. The proposal, Policy Schedule, Policy document and endorsements are part of the Policy. Your Policy is evidence of the contract of insurance.

1. GENERAL DEFINITIONS

In the document, following words are assigned specific meaning. Wherever the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute. Where *We* explain what a word means that word will appear highlighted in bold print and have the same meaning wherever it is used in the Policy.

	Term	Definition
1.	**Age or Aged**	means completed Age in years as at the Commencement Date.
2.	**Any one Illness**	means continuous Period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3.	**Authority**	means the Insurance Regulatory and Development Authority of India established under the provisions of section 3 of the Insurance Regulatory and development Authority Act, 1999 (41 of 1999).
4.	**AYUSH**	means the forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy in the Indian context.
5.	**AYUSH Hospital**	means a healthcare facility wherein medical / surgical/ para – surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner(s)* comprising of any of the following – a. Central or State Government AYUSH Hospital; or b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or c. AYUSH hospital, standalone or co – located with in-patient healthcare facility of any recognised system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion : i. Having atleast 5 in-patient beds; ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock; iii. Having dedicated AYUSH therapy sections as required and / or has equipped operation theatre where surgical procedures are to be carried out;

		iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorised representative.
6.	**Cashless Facility**	means a facility extended by the Insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization is approved.
7.	**Cancellation (of policy)**	means the terms on which the policy contract can be terminated either by the insurer or the insured by giving sufficient notice to other which is not lower than a period of fifteen days. The terms of cancellation may differ from insurer to insurer.
8.	**Certificate of Insurance**	means the certificate issued to the ***Insured Person*** confirming the Policy details & coverages opted under the Policy. The ***Certificate of Insurance*** forms part of the policy.
9.	**Complaint or Grievance**	means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a Complainant with insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities.
10.	**Complainant**	means a Policyholder or prospect or any beneficiary of an insurance Policy who has filed a Complaint or Grievance against an Insurer or a distribution channel.
11.	**Commencement Date**	means the start date of this Policy as specified in the Policy Schedule.
12.	**Comorbid condition**	means an illness or injury happening at the same time but not related to Specified Illness.
13.	**Condition precedent**	means a Policy term or condition upon which the insurer's liability under the Policy is conditional upon.
14.	**Congenital Anomaly**	means a condition which is present since birth, and which is abnormal with reference to form, structure or position. a. Internal Congenital Anomaly - congenital anomaly which is not in the visible and accessible parts of the body. b. External Congenital Anomaly - congenital anomaly which is in the visible and accessible parts of the body.
15.	**Day**	means a period of 24 consecutive hours during a period of confinement. The first Day of confinement shall commence at the time of admission to the ***Hospital*** and each subsequent Day shall commence 24 hours after the commencement of the previous Day. In the event of the time of discharge of the ***Insured Person*** from the ***Hospital*** being more than 12 hours, but less than 24 hours from the end of the previous Day, then the day of discharge shall also be regarded as a Day.

16.	**Daily Benefit Amount**	means the amount payable for each Day spent in the Hospital.
17.	**Deductible**	means a cost sharing requirement under a health insurance Policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of ***Hospital*** cash policies which will apply before any benefits are payable by the Insurer. A Deductible does not reduce the sum insured.
18.	**Dependents / Family**	means the persons named in the Policy Schedule who are the Insured Person's - i. Spouse – The Insured's legally married spouse as long as she continues to be married to the Primary Insured. ii. Children – The Insured's children as long as they are financially dependent on him/her with no source of independent income and have not established their own independent households. iii. Parents – The Insured's natural parents or parents that have legally adopted him iv. Parents in Law – The Insured's Parents in Law.
19.	**Diagnosis**	means conclusion drawn by a registered Medical Practitioner, supported by acceptable clinical, radiological, histological, histo-pathological, and laboratory evidence wherever applicable.
20.	**Date of Diagnosis**	means the day when the diagnosis of ***Specified Illness*** is established by a Specialist / ***Medical Practitioner*** through the use of the clinical and/or laboratory findings as supported by the Insured medical records.
21.	**Emergency**	means severe ***Specified Illness*** resulting in symptoms which occur suddenly and unexpectedly and requires immediate care by a ***Medical Practitioner*** to prevent death or serious long-term impairment of the Insured Person's health.
22.	**Family Floater**	means a Policy described as such in the Policy Schedule where You and Your Family named in the Policy Schedule are covered under this Policy as at the Commencement Date. The Sum Insured for a Family Floater is the amount shown in the Policy Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Family during each Policy Year.
23.	**Franchise**	means an arrangement under a health insurance Policy that provides that the Insurer will not be liable upto the specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of ***Hospital*** cash policies but will pay for the entire amount of loss and days/hours when exceeds the agreed amount/days/hours.

24.	**Grace Period**	means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing diseases. Coverage is not available for the period for which no premium is received.
25.	**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 Clinical Establishment (Registration and Regulation) Act,2010 or under enactments specified under the Schedule of Section 56 (1) of the said Act Or complies with all minimum criteria as under: i. has qualified nursing staff under its employment round the clock; ii. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 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 makes these accessible to the insurance company's authorized personnel.
26.	**Hospitalisation or Hospitalised**	means admission in a ***Hospital*** for a minimum Period of 24 consecutive "In-patient Care" hours except for specified procedures / treatments, where such admission could be for a Period of less than 24 consecutive hours.
27.	**Illness**	means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment. **a) Acute Condition** is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/Illness/Injury which leads to full recovery. **b) Chronic Condition** is defined as a disease, Illness, or Injury that has one or more of the following characteristics: - i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests; ii. it needs ongoing or long-term control or relief of symptoms; iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it; iv. it continues indefinitely;

		v. it recurs or is likely to recur.
28.	**Injury**	means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a ***Medical Practitioner.***
29.	**Inpatient / Inpatient Care**	means treatment for which the ***Insured Person*** has to stay in a ***Hospital*** for more than 24 hours for a covered event.
30.	**Insured Person (Insured)**	means a person whose name specifically appears in the Policy Schedule and with respect to whom the premium has been received by Us.
31.	**Intensive Care Unit (ICU)**	means an identified section, ward or wing of a ***Hospital*** which is under the constant supervision of a dedicated ***Medical Practitioner*** (s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
32.	**ICU (Intensive Care Unit) Charges**	means the amount charged by a ***Hospital*** towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
33.	**IRDAI**	means Insurance Regulatory and Development Authority of India.
34.	**Material Fact**	means all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.
35.	**Medical Advice**	means any consultation or advice from a ***Medical Practitioner*** including the issuance of any prescription or follow-up prescription.
36.	**Medical Expenses**	means those expenses that an ***Insured Person*** has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the ***Insured Person*** had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
37.	**Medical Practitioner**	means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. ***Medical Practitioner*** should not be the ***Insured Person*** or his/her immediate Family member or anyone who is living in the same household as the Insured Person.
38.	**Medically necessary Treatment**	means any treatment, tests, medication, or stay in ***Hospital*** or part of a stay in ***Hospital*** which – i. is required for the medical management of the Illness or Injury suffered by the insured;

		ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity; iii. must have been prescribed by a Medical Practitioner; iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
39.	**Migration**	means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
40.	**Network Provider**	means the ***Hospital*** enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
41.	**Non-Network Provider**	means any hospital, day care centre or other provider that is not part of the network.
42.	**Nominee / Assignee**	means the person named in the Policy Schedule who is nominated by the Policyholder/Insured Person, to receive the benefits under this Policy in accordance with the terms of the Policy, if the Policyholder/Insured Person is deceased.
43.	**Notification of Claim**	means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
44.	**Outpatient (OPD) Treatment**	means the one in which the Insured visits a clinic/ ***Hospital*** or associated facility like a consultation room for Diagnosis and treatment based on the advice of a ***Medical Practitioner.*** The Insured is not admitted as a Day Care or In-Patient.
45.	**Policy**	means this Policy document read together with the attached Policy Schedule, Your Proposal Form including any attachment like endorsement, rider, condition, warranty, declaration etc.
46.	**Policyholder**	means the person named in the Policy Schedule as the Policyholder.
47.	**Policy Period**	means the period commencing from Policy start date and time as specified in the Policy Schedule and terminating at midnight on the Policy end date as specified in the Policy Schedule of this Policy.
48.	**Policy Schedule**	means schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the Policy Period and the limits and conditions, to which the benefits under the Policy are subject to, including any annexures and/or endorsements.
49.	**Policy Year**	means a period of 12 consecutive months commencing from the Policy Period Start Date and such 12 consecutive months thereafter but not beyond the Policy Period.

50.	**Portability**	means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions from one insurer to another or from one plan to another plan of the same insurer.
51.	**Pre-existing Disease**	means any condition, ailment, injury or disease - a) That is/are diagnosed by a physician within 48 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 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
52.	**Pre-Hospitalisation Medical Expenses**	means Medical Expenses incurred during pre-defined number of days preceding the Hospitalisation of the Insured Person, provided that: i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
53.	**Post Hospitalisation Medical Expenses**	means Medical Expenses incurred during pre-defined number of days immediately after the ***Insured Person*** is discharged from the ***Hospital*** provided that: i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and ii. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.
54.	**Primary Insured**	means the person who has been first enrolled by group Policy holder as a member under this Policy and who in turn has included his/her Family members.
55.	**Proposal Form**	means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the Insurer in respect of a risk, in order to enable the Insurer to take informed decision in the context of underwriting the risk, and in the Event of acceptance of the risk, to determine the rates, benefits, terms and conditions of the cover to be granted.
56.	**Qualified Nurse**	means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
57.	**Reasonable and Customary charges**	means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/Injury involved.

58.	**Relaxation Period**	means the specified period of time immediately following the premium instalment due date during which a payment can be made to continue a Policy in force without loss of continuity of waiting periods and coverage of Pre-existing diseases.
59.	**Renewal**	means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound exclusions and for all waiting periods.
60.	**Road Ambulance**	means a motor vehicle operated by a licenced/authorised service provider and equipped for taking sick or injured people requiring medical attention to and from ***Hospital*** in emergencies.
61.	**Specialist**	means a person who holds a master's degree in the field of medicine or Surgery and valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.
62.	**Specified Illness**	means Diagnosis of below listed illness(es) confirmed by the ***Medical Practitioner*** on the basis of defined laboratory investigations or any other laboratory diagnosis as per the guidelines laid by Ministry of Health & Family Welfare, Govt of India.

	Illness	Defined Laboratory Investigation
1	Dengue Fever	Non-Structural Protein-1 Antigen Positive/ IgM Antibody Capture ELISA (MAC- ELISA)
2	Zika Fever	Viral Nucleic Acid detection/Real Time-Polymerase Chain Reaction
3	Chikungunya	IgM Antibody Capture ELISA (MAC- ELISA)/Real Time-Polymerase Chain Reaction
4	Malaria	Microscopic laboratory testing or by a rapid diagnostic test
5	Leptospirosis	Microscopic agglutination test (MAT) or IgM-ELISA/ Polymerase Chain Reaction
6	Swine Flu	Real-time reverse transcriptase-polymerase chain reaction (rRT-PCR)
7	Vector Borne Encephalitis	Antibody Detection/Antigen Detection/Isolation/ IgM-Enzyme Linked Immuno-Sorbent Assay/RT-PCR

63.	**Sum Insured**	means the specified amount mentioned in the Policy Schedule which represents Our maximum liability for each ***Insured Person*** or Family in case of Family Floater for any and all benefits claimed for during the Policy Year.
64.	**Surgery or Surgical Procedure**	means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a ***Hospital*** or day care centre by a ***Medical Practitioner.***

65.	**TPA**	means any person who is registered under the IRDAI (Third Party Administrators - Health Services) Regulations, 2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.
66.	**Unproven/Experimental treatment**	means the treatment, including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
67.	**Waiting Period**	means the period during which ***We*** shall not be liable to make payment for any claim within specified number of days from the commencement date of the policy.
68.	**We/Our/Us/Insurer**	means Navi General Insurance Limited
69.	**You/Your**	means the Policyholder or Primary Insured named in the Policy Schedule.

2. SCOPE OF COVER

Your opted plan/ coverage(s) are mentioned in the Policy Schedule / Certificate of Insurance. ***We*** will provide the coverage as detailed below for an event that occurs during the Policy Year. Each coverage is subject to the terms, conditions and exclusions of this Policy. ***We*** will pay as specified under each of the coverage in the Policy Schedule / Certificate of Insurance, provided that –

a. The ***Insured Person*** is diagnosed with the "Dengue Fever" as defined in the ***Specified Illness*** of this Policy; and

b. Such ***Specified Illness*** is diagnosed after 15 days from the date of commencement of first Policy and being renewed thereafter within the Grace Period.

A. INDEMNITY PLAN

INPATIENT TREATMENT - We will cover Reasonable and Customary charges for Medically Necessary Treatment taken by the ***Insured Person*** during the Policy Year for the Specified Illness(es) as mentioned in the Policy Schedule / Certificate of Insurance.

I. INPATIENT HOSPITALISATION

We will cover the following Medical Expenses incurred as In-Patient in a ***Hospital*** for more than 24 consecutive hours:

Expenses shall include -

a. Room Rent and Nursing charges;
b. Intensive Care Unit (ICU) charges;
c. Operation Theatre charges;
d. Fees of Medical Practitioner/Specialists;
e. Investigation & Diagnostic procedures;
f. Medicines, Drugs and Consumables;
g. Anaesthesia, Blood, Oxygen

II. PRE - HOSPITALISATION

We will cover the Pre-hospitalisation Medical Expenses incurred upto 15 days before the date of admission to the Hospital.

Note –
The date of admission to the ***Hospital*** for this coverage shall be the date of the Insured Person's first admission to the ***Hospital*** in relation to Any One Illness.

III. POST- HOSPITALISATION

We will cover the Post-Hospitalisation Medical Expenses incurred upto 15 days after the Insured Person's date of discharge from the Hospital.

However, In case of Any one illness where ***Insured Person*** undergoes more than one Hospitalisation within 45 days, the cover for post hospitalisation expenses cumulatively shall not exceed 15 days.

IV. AYUSH

We will cover the Medical Expenses incurred on In-patient Hospitalisation up to the Sum Insured for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy treatment undergone in:

a. A government ***Hospital*** or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.

b. Teaching Hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homoeopathy (CCH).

c. AYUSH Hospitals

NOTE – AYUSH Hospitals and AYUSH Day Care Centres should have either pre entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

V. EMERGENCY ROAD AMBULANCE / REPATRIATION OF MORTAL REMAINS (RMR) / FUNERAL EXPENSES

We will cover the expenses up to the sub-limit stated in the Policy Schedule incurred towards transportation of an ***Insured Person*** by a registered healthcare or ambulance service provider in case of an Emergency provided that ***We*** have accepted the claim under In-patient Hospitalisation – 2) A) I)

Expenses shall include:

a. Transportation Costs towards transferring the ***Insured Person*** to ***Hospital*** or from one ***Hospital*** to another ***Hospital*** or to a Diagnostic Centre for advanced diagnostic treatment where such facility is not available at the existing ***Hospital*** and advised by the treating ***Medical Practitioner.***

b. When the ***Insured Person*** requires to be moved to a better ***Hospital*** facility due to lack of super speciality treatment in the existing Hospital.
When the ***Insured Person*** requires to be moved to home after discharge from the Hospital. The medical condition of ***Insured Person*** is such that it requires services of Ambulance and is certified by treating ***Medical Practitioner.***

c. We will also cover the following expenses if the ***Insured Person*** dies in the ***Hospital*** during the course of Hospitalisation.

i. Transportation of Mortal remains from ***Hospital*** to home and/or to cremation ground for funeral purpose;
ii. Cremation Expenses;
iii. Coffin Charges.

B. BENEFIT PLAN

FIXED CASH BENEFIT - If the ***Insured Person*** is admitted in a ***Hospital*** during the policy year for the treatment of ***Specified Illness*** and such hospitalisation is medically necessary & recommended by the ***Medical Practitioner***, then ***We*** will pay lumpsum amount as stated in the Policy Schedule / Certificate of Insurance.

Conditions -

1. The Lumpsum benefit shall become payable only when ***Insured*** Person is Inpatient in a hospital for more than 24 consecutive hours.
2. Once the lumpsum amount is paid, coverage shall be considered as exhausted for the remaining policy year.
3. In case, ***Insured Person*** is diagnosed with ***Specified Illness*** but is not required to undergo hospitalization, then ***We*** will pay a lumpsum amount equal to the sum insured or Rs 10,000/- whichever is lower only once during the Policy Year.
    a. If the Sum insured is exhausted by such payment, cover shall be considered as exhausted for the remaining policy year.
    b. If the sum insured is available after such payment, cover shall continue during the Policy Year till the exhaustion of balanced Sum Insured.
4. Refer the illustration in Annexure – III.

C. DAILY BENEFIT PLAN

HOSPICASH BENEFIT - If an ***Insured Person*** is admitted in a ***Hospital*** during the policy year for the treatment of ***Specified Illness*** and such hospitalisation is medically necessary & recommended by the Medical Practitioner, then ***We*** will pay Daily Benefit amount for each day in Hospital, during the Policy Year for treatment of such specified illness.

Conditions –

1. A Deductible / Franchise as specified in the ***Policy Schedule / Certificate of Insurance*** shall apply.
2. The benefits shall become payable only after Hospitalisation of ***Insured Person*** exceeds the specified number of hours/days.
3. This Benefit shall be payable for a maximum limit of days as specified in the ***Policy Schedule/*** Certificate of Insurance.

3. WAITING PERIODS

All waiting Periods shall apply individually for each ***Insured Person*** and claims shall be assessed accordingly.

3.1. **Initial waiting Period for 15 days** - ***We*** will not be liable for any claim for ***Specified Illness*** within 15 days from the commencement date of the Policy.

3.2. **Waiting Period for Pre-Existing *Specified Illness*** – The initial waiting period of 15 days will be increased to 90 days, if the ***Insured Person*** is suffering from any of the listed ***Specified Illness*** as shown in the ***Policy Schedule/Certificate of Insurance*** at the time of taking the policy. We will not be liable for any claim during the Policy Period for any Specified Illness which has been diagnosed prior to Policy inception. We will cover any new event post 90 days of waiting period.

4. GENERAL EXCLUSIONS

We will not make payment for a claim resulting directly or indirectly from or attributable to any of the following:

EXCLUSIONS SPECIFIC TO THE POLICY WHICH CANNOT BE WAIVED

1. **Covered Illnesses:**
   a. Any Illness(es) which is not specified under ***Specified Illness*** and not mentioned in the ***Policy Schedule / Certificate of Insurance.***
   b. Any ***Specified Illness*** that is not diagnosed by the ***Medical Practitioner.***

2. **Comorbid Conditions**
   Any medical expenses or non-medical expenses related to Comorbid Conditions.

3. **Geography**
   Any diagnosis and treatment related to Specified Illness outside India.

4. 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**

5. **Medically Necessary Expenses**
   Any treatment or part of a treatment that is not reasonable and medically necessary and drugs or treatments which are not supported by a prescription.

6. **Preventive Vaccinations**
   Expenses towards any treatment related to preventive care, vaccination, inoculation and immunizations (except in case of post-bite vaccination treatment) unless certified and recommended by the attending ***Medical Practitioner*** as part of in-patient treatment as a direct consequence of an otherwise covered claim.

7. **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.

8. **Congenital anomalies**

Screening, counselling and treatment related to External congenital anomalies.

9. **Unrecognized Physician**
   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.

10. **Maternity Expenses - 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.

11. **Unproven Treatments – Code – Excl16 -** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

5. GENERAL TERMS & CONDITIONS

5.1 CONDITION PRECEDENT TO THE CONTRACT

1. **AGE**
   A person shall be eligible to become an ***Insured Person*** under this policy from birth (as a dependent child). However, there is no maximum age limit.

2. **CONDITION PRECEDENT TO ADMISSION OF LIABILITY**
   The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. **DISCLOSURE OF INFORMATION**
   The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any *material fact* by the policyholder.

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

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4. **ELECTRONIC TRANSACTIONS**
   The Policy holder / ***Insured Person*** agrees to adhere to and comply with all terms and conditions as may be imposed for electronic transactions from time to time. The Policyholder hereby agrees and confirms that all transactions effected by or through facilities including the Internet, , call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of automated machines network or through other means of telecommunication, established by or on behalf of Us, for and in respect of the Policy or its terms, shall constitute legally binding and valid when done in adherence to and in compliance with the terms and conditions for such facilities and as may be prescribed from time to time and shall be within the terms and conditions of this contract. However, these terms and condition shall not override provisions of any law(s) or statutory regulations as amended from time to time.

5. NO CONSTRUCTIVE NOTICE

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ ***Insured Person*** which is in Our possession and not specifically informed by the Policyholder/ ***Insured Person*** shall not be held to bind or prejudicially affect ***Us*** notwithstanding subsequent acceptance of any premium.

5.2 CONDITIONS APPLICABLE DURING CONTRACT

1. ALTERATIONS TO THE POLICY

The Proposal Form, declaration, Certificate, and Policy constitutes the complete contract of insurance. For any change(s) / alteration/ modification in contract You are requested to give ***Us*** in writing. Any change that ***We*** make will be communicated to You by a written endorsement signed and stamped by Us. This Policy cannot be changed by any one (including an insurance agent or broker) except Us.

2. CANCELLATION

a. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Months	1 year	2 years	3 years	4 years	5 years
1	59%	77%	83%	86%	88%
2	40%	67%	76%	81%	84%
3	21%	57%	70%	76%	80%
4	2%	47%	63%	71%	76%
5	0%	37%	56%	66%	72%
6	0%	27%	50%	61%	68%
7	0%	18%	43%	56%	64%
8	0%	8%	36%	51%	60%
9	0%	0%	30%	46%	56%
10	0%	0%	23%	41%	52%
11	0%	0%	16%	36%	48%
12	0%	0%	10%	31%	44%
13		0%	3%	26%	39%
14		0%	0%	21%	35%
15		0%	0%	16%	31%
16		0%	0%	11%	27%
17		0%	0%	6%	23%
18		0%	0%	1%	19%
19		0%	0%	0%	15%
20		0%	0%	0%	11%
21		0%	0%	0%	7%
22		0%	0%	0%	3%
23		0%	0%	0%	0%
24		0%	0%	0%	0%
25			0%	0%	0%

26			0%	0%	0%
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60					0%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

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

3. COMMUNICATIONS & NOTICES

a. Any notice, direction or instruction under this Policy shall be in writing and if it is:

- To any Insured Person, then it shall be sent to You at Your last updated address as shown in Our records and You shall act for all Insured Persons for these purposes.

- To Us, it shall be delivered to Our address specified in the Schedule.

b. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless ***We*** have expressly stated to the contrary in writing.

c. Notice and instructions will be deemed served ten (10) days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

d. You must immediately bring to Our notice any change in the address or contact details. If You fail to inform Us, ***We*** shall send notice to the last known address and it would be considered that the notice has been sent to You.

e. You must include Your Policy number for any communication with Us.

4. GEOGRAPHY

This Policy applies to events or occurrences taking place only in Republic of India. All payments under this Policy will only be made in Indian Rupees.

5. GROUP ADMINISTRATOR

The Group Administrator i.e. Policyholder shall take all reasonable steps to cover their members or employees of the company and ensure timely payment of premium in respect of the persons covered. The Group administrator will collect premium from members wherever applicable as mentioned in the Group/Master policy issued to the Group administrator. The Group administrator will neither charge more premium nor alter the scope of coverage offered under the Group/Master policy.

Group/Master policy will be issued to the group administrator and all members wherever required will be provided with the ***Certificate of Insurance*** by Us. Wherever mutually agreed group administrator will issue the ***Certificate of Insurance*** to its member as per agreed terms and conditions and in the format prescribed by ***Us*** and shall keep the record of such issuance. ***We*** reserve the right to inspect the record at any time to ensure that terms and conditions of group policy and provisions of IRDAI group guidelines contained in circular ref: 015/IRDA/Life/Circular/GI Guidelines/2005 dated 14th July 2005 and any amendments thereto are being adhered. ***We*** may also require submission of certificate of compliance from Your Group Administrator auditors.

The Group administrator will provide all possible help to its member and facilitate any service required under the Policy including claims. Notwithstanding this a member of the group covered under the Policy shall be free to contact ***Us*** directly for filing the claim or any assistance required under the Policy.

6. PREMIUM PAYMENT IN INSTALMENTS

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

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

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

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

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

IMPORTANT POINTS TO BE NOTED WHILE OPTING FOR INSTALMENT PREMIUM PAYMENT VIA ELECTRONIC CLEARING SERVICE (ECS)

1. Completely filled & signed Electronic Clearing Service Mandate Form is mandatory.
2. Ensure that the Premium amount which would be auto debited & frequency of instalment is duly filled in the ECS Mandate form.
3. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Daily Benefit Amount / Sum Insured / coverages/revision in premium.
4. You need to inform ***Us*** atleast 15 days prior to the due date of instalment premium if you wish to discontinue with the ECS facility.
5. Non-payment of premium on due date as opted by You in the mandate form subject to an additional 15 days of relaxation period will lead to termination of the policy.

7. POLICY DISPUTES

Any and all disputes or differences concerning the interpretation of the coverage, terms, conditions, limitations and/ or exclusions under this Policy shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

8. PROTECTION OF POLICY HOLDERS INTEREST

This Policy is subject to IRDAI (Protection of Policyholders' Interest) Regulation, 2017 or any amendment thereof from time to time.

9. RECORDS TO BE MAINTAINED

You or the Insured Person, as the case may be shall keep an accurate record containing all medical records pertaining to the treatment taken for any liability under the Policy and shall allow ***Us*** or Our representative(s) to inspect such records. You or the ***Insured Person*** as the case may be, shall furnish such information as may be required by ***Us*** under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

10. POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUM RATES

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

11. **MORATORIUM PERIOD**

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

12. TERMINATION OF POLICY

This Policy terminates on earliest of the following events-

- **a.** Cancellation of Policy as per the cancellation provision.
- **b.** On the Policy expiry date.
- **c.** On death of the Insured Person.

13. WITHDRAWAL OF THE POLICY

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

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

5.3 CONDITIONS FOR RENEWAL OF CONTRACT

1. CONTINUITY

Insured Person would have an option to migrate to Our individual health insurance plans if the group Policy is discontinued or if ***Insured Person*** is leaving the group on account of resignation, retirement, termination of employment or otherwise, subject to Our underwriting guidelines. Dependent children likewise when exiting on account of reaching upper age limit will have an option to migrate to Our individual health insurance plans subject to Our underwriting guidelines. ***Insured Person*** will be entitled for accrued continuity benefits as per prevailing migration guidelines issued by the Authority.

2. MIGRATION

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration. For Detailed Guidelines on migration, kindly refer the link – www.naviinsurance.com

3. RENEWAL OF POLICY

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of thirty (30) days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

5.4 CONDITIONS WHEN A CLAIM ARISES

1. ARBITRATION

If ***We*** admit liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration. The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996 or any amendment thereto. No reference to Arbitration shall be made unless ***We*** have admitted Our liability for a claim in writing.

2. COMPLETE DISCHARGE

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

3. NOMINATION

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

4. DISCLAIMER OF CLAIM

If ***We*** shall disclaim liability to the Insured for any claim and if the Insured shall not, within twelve (12) calendar months from the date or receipt of the notice of such disclaimer notify ***Us*** in writing that he does not accept such disclaimer and intends to recover his claim from Us, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under the Policy.

5. PHYSICAL EXAMINATION

Any ***Medical Practitioner*** authorized by ***Us*** shall be allowed to examine the ***Insured Person*** in case of any alleged Specified Illness. Non-co-operation by the ***Insured Person*** will result into rejection of his/her claim. ***We*** will bear the cost towards performing such medical examination (at the specified location) of the Insured Person.

6. CLAIM PROCESS & MANAGEMENT

In the event of any claim under the Policy, completed claim form and required documents must be furnished to ***Us*** within the stipulated time. Failure to furnish this documentation

within the stipulated time shall not invalidate nor reduce any claim if You can satisfy ***Us*** that it was not reasonably possible for You to submit / give proof within such time.

a. POLICYHOLDER'S / INSURED PERSON'S DUTIES AT THE TIME OF CLAIM

On occurrence of an event which will eventually lead to a Claim under this Policy, the Policyholder / ***Insured Person*** shall:

a. Forthwith intimate the Claim in accordance with claim intimation section # 5.4)5)II) of this Policy.

b. Claim processing is through Our service partner TPA, details of the same will be available on the ***Policy Schedule / Certificate of Insurance*** / Health Card issued by ***Us*** .

c. You can log on to Our /TPA website for Network Providers list. TPA will facilitate cashless claims processing (inpatient only) in case of Indemnity Plan.

d. If so requested by Us, the ***Insured Person*** will have to submit himself / herself for a medical examination including any Pathological / Radiological examination by Independent ***Medical Practitioner*** as often as it is considered reasonable and necessary. The cost of such examination will be borne by Us.

e. Allow the ***Medical Practitioner*** or any of Our representatives to inspect the medical and Hospitalization records, investigate the facts.

f. Assist and not hinder or prevent Our representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

b. CLAIM INTIMATION

If You suffer from any of the ***Specified Illness*** that may result in a claim, then as a Condition Precedent to Our liability, You must comply with the following claims procedures:

You must notify Your claim to ***Us*** / Our TPA in writing or at call centre.

Plan	Type of Event	Notify *Us* or Our TPA
▪ Indemnity Plan	Planned Hospitalisation for Specified Illness	Immediately and in any event at least 48 hours prior to **Your** admission.
▪ Daily Benefit Plan	Emergency Hospitalisation for Specified Illness	Within 24 hours of **Your** admission to ***Hospital*** or before discharge whichever is earlier
▪ Benefit Plan	Diagnosis of Specified Illness	Immediately and in any event at least 48 hours from the date of diagnosis.

The following details are to be provided to ***Us*** at the time of intimation of Claim:

a. Policy Number
b. Name of the Policyholder
c. Health card id number
d. Name of the ***Insured Person*** in whose relation the Claim is being lodged
e. Name of Specified Illness
f. Name and Address of the attending ***Medical Practitioner*** and ***Hospital*** (if admission has taken place)
g. Date of Diagnosis of Specified Illness
h. Date of Admission
i. Any other information, documentation as requested by Us

c. CASHLESS FACILITY (APPLICABLE ONLY FOR INDEMNITY PLAN)

Cashless Facility is available for Hospitalisation only at Our Network Provider. The ***Insured Person*** can avail Cashless Facility at Network Provider, by presenting the health card as provided by ***Us*** with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / Aadhar Card, any other identity proof as approved by Us.

A. <u>For Planned Hospitalization</u>

i. The ***Insured Person*** should at least 48 hrs prior to admission to the ***Hospital*** approach the Network Provider for Hospitalisation for medical treatment.

ii. The Network Provider will issue the request for authorization letter for Hospitalisation in the pre-authorization form prescribed by the Authority.

iii. The Network Provider shall electronically send the pre-authorization form along with all the relevant details to the 24 (twenty-four) hour authorization/cashless department of the TPA along with contact details of the treating ***Medical Practitioner*** and the Insured Person.

iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider, the eligibility of cover under the Policy will be verified.

v. Wherever the information provided in the request is sufficient to ascertain the authorisation, the authorisation letter will be issued to the Network Provider. Wherever additional information or documents are required, the same will be called for from the Network Provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 3 hours from the receipt of last complete documents.

vi. The Authorisation letter will include details of sanctioned amount and any non- payable items if applicable.

vii. The authorisation letter shall be valid only for a period of 15 days from the date of issuance of authorization.

In the event that the cost of Hospitalisation exceeds the authorized limit as mentioned in the authorization letter:

a. The Network Provider shall request for an enhancement of authorisation limit. Eligibility will be verified, and the enhancement will be evaluated on the availability of further limits.

b. We shall accept or decline such additional expenses within 3 hours of receiving the request for enhancement.

At the time of discharge:

a. The Network Provider may forward a final request for authorization for any residual amount along with the discharge summary and the billing format in accordance with the process.

b. Upon receipt of the final authorisation letter, Insured may be discharged by the Network Provider.

c. Network provider to ensure that the final authorization letter is signed by Insured.

d. Insured must ensure to take photocopies of relevant medical records for future reference.

B. <u>In case of Emergency Hospitalization</u>

i. The ***Insured Person*** may approach the Network Provider for Hospitalisation.

ii. Insured Person will need to provide health Card / Health insurance Policy details at ***Hospital*** admission counter.

iii. The Network Provider shall forward the request for authorization within 24 hours of admission to the ***Hospital*** or before discharge whichever is earlier.

iv. In the interim, the Network Provider may either consider treating the ***Insured Person*** by taking a token deposit or treating as per their norms.

v. The Network Provider shall refund the deposit amount to you barring a token amount to take care of non-covered expenses once the authorization is issued.

vi. The Network Provider will send the claim documents to TPA within 15 days from the date of discharge from Hospital

vii. Any additional documents may be called as required based on the circumstances of the claim.

viii. There can be instances where Cashless Facility may be denied for Hospitalisation due to insufficient Sum Insured or insufficient information to determine admissibility in which case You/Insured Person may be required to pay for the treatment and submit the claim for reimbursement to TPA which will be considered subject to the Policy Terms &Conditions.

ix. We in Our sole discretion, reserves the right to modify, add or restrict any Network Provider for Cashless services under the Policy. Before availing the Cashless service, the Policyholder / ***Insured Person*** is required to check the applicable/latest list of Network Provider on TPA's website or by calling call centre

d. CLAIM REIMBURSEMENT PROCESS

Wherever You have opted for a reimbursement of expenses, You may submit the documents for reimbursement of the claim to Our / TPA office not later than 15 days from the date of discharge from the Hospital. You can obtain a Claim Form from any of Our / TPA Offices or download a copy from Our website at www.naviinsurance.com.

e. CLAIM DOCUMENTS

In case of any Claim for the covered Benefit, the list of necessary documents as mentioned below shall be provided by the Policyholder/Insured Person, immediately but not later than 15 days from the date of completion of treatment / discharge from the Hospital, to avail the Claim.

Completed claim forms and required documents must be furnished to ***Us*** within the stipulated timelines for all claims. ***We*** may consider the delay in extreme cases of hardship where it is proved to Our satisfaction that under the circumstances in which the ***Insured Person*** was placed, it was not possible for him or any other person to give notice or file claim within the prescribed time limit. However, no proof will be accepted if furnished later than one (1) year from the time the loss occurred. Requirement of all or any of the following documents will depend on the nature of claim.

a. Claim Form Duly Filled and Signed
b. Original signed pre-authorisation request, if applicable
c. Copy of authorisation approval letter (s)
d. Copy of Photo ID of Patient Verified by the Hospital
e. Original Discharge/Death Summary
f. Operation Theatre Notes (if any)
g. Original ***Hospital*** Main Bill along with break up Bill and original receipts
h. Original Investigation Reports, X Ray, MRI, CT Films, HPE
i. Doctors Reference Slips for Investigations/Pharmacy
j. Original Pharmacy Bills

k. Post Mortem Report (if applicable and conducted).
l. KYC documents (Photo ID proof, Pan Card, Aadhar Card)
n. Cancelled cheque for NEFT payment

f. SCRUTINY OF CLAIM DOCUMENTS

We shall scrutinize the Claim and accompanying documents. Any deficiency of documents shall be intimated to You and the Network Provider, as the case may be and subsequent reminders will follow.

a. During claim processing if the claims are found deficient in documents, TPA shall intimate the same to the Policyholder / ***Insured Person*** within five (5) working days of receiving claim documents.
b. First reminder for deficient documents will be sent within seven (7) days of first deficiency letter and Second reminder – within ten (10) days of first reminder deficiency letter. Final reminder letter will be sent from ten (10) days from second reminder.
c. We will send a maximum of three (3) reminders following which, ***We*** will send a rejection letter after fifteen (15) days from the final reminder if the deficient documents are not received.

g. CLAIM INVESTIGATION

We may investigate Claims at Our own discretion to determine the validity of Claim. Such investigation may be concluded within thirty (30) days from the date of receipt of last necessary document of the Claim. Verification carried out, if any, will be done by individuals or entities authorized by ***Us*** to carry out such verification/investigation(s) and the costs for such verification/ investigation shall be borne by Us.

h. PRE-& POST HOSPITALISATION CLAIMS (APPLICABLE ONLY FOR INDEMNITY PLAN)

Claim documents for Pre-& Post hospitalisation should be sent to TPA within 15 days of completion of treatment.

i. CLAIM SETTLEMENT (PROVISION OF PENAL INTEREST)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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

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

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

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

j. Multiple Policies

Indemnity Plan

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

Daily Benefit Plan / Benefit Plan - In case of multiple policies which provide fixed benefits, on the occurrence of the insured event, each *Insurer* shall make the claim payment independent of payments received under other similar polices in accordance with the terms and conditions of their respective policies.

i. In all such cases, the *Insurer* who has issued the chosen *Policy* shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen *Policy*.

ii. Claims under other *Policy/ies* may be made after exhaustion of *Sum Insured* in the earlier chosen *Policy / Policies*. The *Policyholder* shall also have the right to prefer claims from other *Policy /Policies* for the amounts disallowed under the earlier chosen *Policy /Polices*, even if the *Sum Insured* is not exhausted.

iii. If the amount to be claimed exceeds the *Sum Insured* under a single *Policy* after considering the *Deductible*(s) or *Co-Payment*, the *Policyholder* shall have the right to choose insurers from whom he/she wants to claim the balance amount.

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

k. FRAUD

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

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

l. **PAYOUT OPTIONS -** Policy with Benefit Plan (2B) shall terminate on the occurrence of the covered specified illness and shall be paid as per the pay-out option selected in the Proposal Form and specified in the Policy Schedule/ Certificate of Insurance.

i. Option 1 – 100% Sum Insured as Payout.

a. We will pay 100% Sum Insured as lumpsum on first Hospitalization due to diagnosis of Specified illness or,
b. In case, Insured Person is first diagnosed with Specified Illness and is not required to undergo hospitalisation, then We will pay a lumpsum amount equal to the sum insured or Rs 10,000/- whichever is lower only once in a Policy Year and the Balanced sum insured (if any) as Lump sum upon hospitalization due to diagnosis of Specified Illness for the second time during the policy year.

ii. Option 2 – 150 % Sum Insured as Payout .

a. We will pay 100% Sum Insured as lumpsum on first Hospitalization due to diagnosis of Specified illness or In case, Insured Person is first diagnosed with Specified Illness and is not required to undergo Hospitalization, then We will pay a lumpsum amount equal to the sum insured or Rs 10,000/- whichever is lower only once in a Policy Year and the Balanced sum insured (if any) as Lump sum upon first hospitalization due to diagnosis of Specified Illness during the policy year.
b. We will pay 50% of Sum Insured as lumpsum on Second Hospitalization, if any, due to diagnosis of Specified illness during the policy year provided the specified illness is diagnosed after 6 months of first claim

Refer the illustration in Annexure – III for better understanding.

m. TPA RELATED INFORMATION – (Applicable for Indemnity Plan)

For intimation of claim, submission of claim related documents and any claim related query, *You* can contact *TPA* assigned as per zone wise and /or as selected by You and which is appearing on your Policy Schedule and Health Card.

Region	TPA Address & Contact Details
WEST DADRA & NAGAR HAVELI | DAMAN & DIU | GOA | GUJARAT | MADHYA PRADESH | MAHARASHTRA	**PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED** Plot No. A-442, Road No. 28, MIDC Industrial Area, Wagle Estate, Ram Nagar, Near Vitthal Rukhmani Mandir, Thane (W), Maharashtra 400604 **Website** - www.paramounttpa.com **IRDAI Reg No:** 006 **Email** - navigi@paramounttpa.com **Toll Free** - 1800 2256 01
SOUTH ANDAMAN & NICOBAR ISLANDS | ANDHRA PRADESH | KARNATAKA | KERALA | LAKSHADWEEP | TAMIL NADU | TELANGANA | PUDUCHERRY	**FAMILY HEALTH PLAN INSURANCE TPA LIMITED** No:8-2-269/A/2-1 To 6, 2nd Floor, Srinilaya Cyber Spazio, Road No.2, Banjara Hills, Hyderabad, Telangana – 500034 **Website** - www.fhpl.net **IRDAI Reg No:** 013 **Email** - navigi@fhpl.net **Toll Free** - 1800 599 2488
EAST & NORTH ARUNACHAL PRADESH | ASSAM | BIHAR | CHHATTISGARH | JHARKHAND | MANIPUR | MEGHALAYA | MIZORAM | NAGALAND | ODISHA | SIKKIM | TRIPURA | WEST BENGAL | CHANDIGARH | DELHI | HARYANA | HIMACHAL PRADESH | JAMMU & KASHMIR | PUNJAB | RAJASTHAN | UTTAR PRADESH | UTTARAKHAND	**RAKSHA HEALTH INSURANCE TPA PRIVATE LIMITED** C/O Escorts Corporate Centre, 15/5, Mathura Road, Faridabad - 121003 Haryana **Website** - www.rakshatpa.com **IRDAI Reg No:** 015 **Email** - navigi@rakshatpa.com **Toll Free** - 1800 180 1555

6. REDRESSAL OF GRIEVANCE

In case of any grievance, the insured person may contact the company through

Website: www.naviinsurance.com
Toll free: 1800-123-0004
E-mail: insurance.help@navi.com
Courier: Navi General Insurance Limited
Salarpuria Business Centre,
4th B Cross Road, 5th Block,
Koramangala Industrial Layout,
Bengaluru, Karnataka – 560095

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at Manager.CustomeExperience@navi.com

For updated details of grievance officer, kindly refer the link - www.naviinsurance.com/service/

For Senior Citizens, we have a special cell and our Senior Citizen customers can email us at seniorcare@navi.com for priority resolution

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

OMBUDSMAN AND ADDRESSES: Refer the link http://ecoi.co.in/ombudsman.html

S. No.	CONTACT DETAILS	JURISDICTION OF OFFICE
1	**AHMEDABAD** Office of the Insurance Ombudsman. Jeevan Prakash Building, 6th Floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201 / 02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu
2	**BENGALURU** Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
3	**BHOPAL** Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	States of Madhya Pradesh and Chattisgarh.

4	**BHUBANESHWAR** Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	State of Orissa
5	**CHANDIGARH** Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.
6	**CHENNAI** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
7	**DELHI** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	State of Delhi
8	**GUWAHATI** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
9	**HYDERABAD** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of the Union Territory of Pondicherry

	Email: bimalokpal.hyderabad@ecoi.co.in	
10	**JAIPUR** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	State of Rajasthan
11	**ERNAKULAM** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry
12	**KOLKATA** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	States of West Bengal, Bihar, Sikkim and Union Territories of Andaman and Nicobar Islands
13	**LUCKNOW** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	District of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varansi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sulanpur, Maharajganj, Santkabirnagar, Azamgarh, Kaushinagar, Gorkhpur, Deoria, Mau, Chandauli, Ballia, Sidharathnagar.
14	**MUMBAI** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	States of Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.

15	**NOIDA** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in	States 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, Firozabad, Gautam Budh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
16	**PATNA** Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	States of Bihar and Jharkhand
17	**PUNE** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in	States of Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

7. ANNEXURES

I. OPTIONAL COVERS

A. **EXTRA ILLNESSES** – Coverage for ***Specified Illness*** as stated under Section 2 stands extended to the illness(es) mentioned in the ***Policy Schedule/ Certificate of Insurance*** for all Insured Persons covered under this Policy.

B. **DELETION / REDUCTION IN INITIAL WAITING PERIOD**

Deletion – 15 days Initial Waiting Period (3.1) under Section 3 stands deleted as specified in the ***Policy Schedule/ Certificate of Insurance*** for all Insured Persons covered under this Policy.

Extension – 15 days Initial Waiting Period (3.1) under Section 3 stands extended to the duration as specified in the Policy Schedule for all Insured Persons covered under this Policy.

C. **DELETION / REDUCTION IN PRE-EXISTING *Specified Illness* WAITING PERIOD**

Deletion – 90 days Waiting Period (3.2) under Section 3 stands deleted as specified in the ***Policy Schedule/ Certificate of Insurance*** for all Insured Persons covered under this Policy.

Reduction - 90 days Waiting Period (3.2) under Section 3 stands reduced to the duration as specified in the Policy Schedule for all Insured Persons covered under this Policy.

D. **OPD TREATMENT**

OPD CONSULTATIONS INCLUDING AYUSH - *We* will reimburse the Reasonable and Customary charges related to the medical expenses incurred towards the medically necessary treatment taken on Outpatient basis –

i. MEDICAL PRACTIONER EXPENSES
We will reimburse the Medical expenses incurred for the consultation service of ***Medical Practitioner*** for Outpatient Treatment.

ii. DIAGNOSTIC TESTS
We will reimburse the Medical expenses incurred for laboratory investigations and /or Diagnostic examinations , if recommended by the treating ***Medical Practitioner.***

iii. PHARMACY

We will reimburse the Medical expenses incurred for purchase of medicines from a pharmacy , if prescribed by the treating Medical Practitioner/ Specialist.

E. HOME CARE TREATMENT

TREATMENT AT HOME - ***We*** will reimburse the Reasonable and Customary charges related to the medical expenses incurred towards the medically necessary treatment taken at home if –

a. The severity of ***Specified Illness*** of ***Insured Person*** is such that it requires continuous care and observation and can be managed at home and the treating ***Medical Practitioner*** has recommended for such treatment at home; and
b. Such treatment is certified by treating ***Medical Practitioner*** as non-Emergency.
c. For this coverage, medically necessary treatment includes:

i. Fees of Medical Practitioner/ Specialists;
ii. Private Qualified Nurse charges
iii. Investigation & Diagnostic procedures;
iv. Medicines, Drugs and Consumables;
v. Blood, Oxygen;
vi. Non- Medical Expenses (Refer Annexure - 1 for complete list)

d. Such treatment shall be applicable for the period of 30 days from the date of diagnosis of specified illness.

e. Quick Steps to follow in case of a claim under this coverage -
1. Insured Person is diagnosed with Specified illness by Treating Medical Practitioner.
2. Treating medical practitioner certifies the condition as non-emergency and recommends for treatment at home which requires observation & care from time to time.
3. Insured Person incurs medical expenses as described in 7 E)c) above.
4. Once the treatment is completed, Insured person to take original documents from the respective healthcare provider(s) and submit the claim documents to Us / TPA as defined in Section 5)e).

F. CRITICAL ILLNESS - ***We*** will pay the lumpsum amount as specified in the ***Policy Schedule/ Certificate of Insurance*** against each Insured Person, provided that:

a) The ***Insured Person*** is diagnosed as suffering from irreversible end stage organ failure due to ***Specified Illness*** or complication arising from it during the Policy Year; and
b) The Specified Illness is diagnosed as a first incidence subject to the waiting period or
c) The Specified Illness is diagnosed as new incidence subject to the Pre-existing specified illness waiting period; and
d) The ***Insured Person*** survives at least fifteen (15) days as "survival period" following such Diagnosis.
e) This benefit is payable once during the Policy Year.

We will not make any payment if:

a) The ***Insured Person*** has already made a claim for the same Organ Failure.

II. NON-MEDICAL EXPENSES

SR NO	ITEMS
LIST 1 – Non Payable Items	
1	BABY FOOD
2	BABY UTILITES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVENYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES

35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG / SHORT / HINGED)
46	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
LIST II - ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER

4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET / WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES
LIST III – ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES	
1	HAIR REMOVAL CREAM
2	DISPOSABLE RAZOR CHARGES (FOR SITE PREPARATIONS)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER

6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT	
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP / CAPD EQUIPMENTS
7	INFUSION PUMP – COST
8	HYDROGEN PEROXIDE \ SPIRIT \ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

III. ILLUSTRATIONS

Scenario 1	**Description of Case**	Insured Person, 35-year-old, having a Benefit Plan with Sum Insured of ₹ 50,000 & Lumpsum payout of 100%. Let's understand how payout of Fixed Cash Benefit will happen in benefit plan.
	Policy Period	01-Jan-2019 to 31-Dec-2019
	Sum Insured	₹ 50,000
	Lumpsum Payout Option	100% = ₹ 50,000
	1st Claim	Diagnosed with Dengue on 01-Feb-2018 without hospitalisation
	Amount Paid by Us	₹ 10,000 (as a sublimit amount in case of diagnosis of Dengue without hospitalisation).
	2nd Claim	Hospitalisation due to Dengue on 01-Nov-2018
	Amount Paid by Us	₹ 40,000 (being the balance sum insured after payment of ₹ 10,000 in 1st claim)

Scenario 2	**Description of Case**	Insured Person, 35 yr old, having a Benefit Plan with Sum Insured of ₹ 50,000 & Lumpsum payout of 150%. Let's understand how payout of Fixed Cash Benefit will happen in benefit plan.
	Policy Period	01-Jan-2019 to 31-Dec-2019
	Sum Insured	₹ 50,000
	Lumpsum Payout Option	150% = ₹ 75,000 { i.e. 100 % SI payout on first illness + 50% SI payout on second illness (if diagnosed after 6 months of first claim within policy period)}
	1st Claim	Diagnosed with Dengue on 01-Feb-2018 without hospitalisation
	Amount Paid by Us	₹ 10,000 (sublimit amount in case of diagnosis of Dengue without hospitalisation).
	2nd Claim	Hospitalisation due to Dengue on 01-Oct-2018
	Amount Paid by Us	₹ 65,000 (₹ 40,000 : remaining SI during 1st claim) + (₹ 25,000 = 50% SI on 2nd illness)