Navi Health

POLICY WORDINGS

This is *Your* **Navi Health** 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*. The terms set out in this *Policy* and its Schedule will be the basis for any claim or benefit under this *Policy*.

1. DEFINITIONS

The words defined in this document are assigned specified meanings and they are appearing in italics. 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.

1.1 **Accident** or **Accidental -** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

1.2 **Admissible claim amount** - means the amount that is admissible as per policy terms and conditions before applying *deductible/co-payment*. Any *deductible/co-payment* will be applied on the admissible claim amount. The amount so arrived after application of *deductible/co-payment*, will be payable under the policy but not exceeding the *Sum Insured*.

1.3 **Adventure Sports** – Adventure sports (also called action sports, aggro sports, and extreme sports) are a popular term for certain activities perceived as having a high level of inherent danger. These sports / activities often involves speed, height, a high level of physical exertion and highly specialised gear such as racing on wheels or horseback, power boat racing, ski racing, hunting or equestrian activities, big game hunting, rock climbing/trekking/mountaineering, winter sports, Skydiving, Parachuting, paragliding/parapenting, Scuba Diving, ski doo riding, cavin/pot holing, bungee jumping, hell skiing, ski acrobatics, ski jumping, water ski jumping, ice hockey, ice speedway, ballooning, hand gliding, river rafting, black water rafting, yachting or boating outside coastal waters, canoeing involving rapid waters, micro-lighting, riding or driving in races or rallyies, piloting aircraft, power lifting, quad biking, river boarding, river bugging, rodeo, roller hockey.

1.4 **Age** or **Aged** – means completed age in years as at the Policy Commencement Date.

1.5 **Any one Illness -** means continuous period of *Illness* and it includes relapse within 45 days from the date of last consultation with the *Hospital*/Nursing Home where treatment was taken.

1.6 **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).

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1.7 **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.

1.8 **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under supervision of registered AYUSH Medical Practitioner(s) on day care basis without inpatient services and must comply with all the following criterion :

i. Having qualifies registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorised representative.

1.9 **Base Sum Insured** means the amount stated in the Policy Schedule.

1.10 **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.

1.11 **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.

1.12 **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.

1.13 **Condition Precedent** - means a *Policy* term or condition upon which the *Insurer*`s liability under the *Policy* is conditional upon.

1.14 **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.

1.15 **Cumulative Bonus** – means any increase or addition in the *Sum Insured* granted by the *Insurer* without an associated increase in premium.

1.16 **Co-Payment -** means a cost-sharing requirement under a health insurance *Policy* that provides that the *Policyholder/Insured* will bear a specified percentage of the admissible claim amount. A Co-Payment does not reduce the *Sum Insured*.

1.17 **Day Care Centre -** means any institution established for *Day Care Treatment* of *Illness* and / or *Injuries* or a medical setup with a *Hospital* and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified *Medical Practitioner* AND must comply with all minimum criterion as under:

i. has qualified nursing staff under its employment;
ii. has qualified *Medical Practitioner (s)* in charge;
iii. has a fully equipped operation theatre of its own where *Surgical Procedures* are carried out;
iv. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

1.18 **Day Care treatment -** 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 24 hrs because of technological advancement, and
ii. which would have otherwise required *Hospitalisation* of more than 24 hours.

Note - Treatment normally taken on an Out-patient basis is not included in the scope of this definition.

1.19 **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*.

1.20 **Dental Treatment -** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and *Surgery*.

1.21 **Dependent Child** – means biologically or legally adopted son or daughter of the Policyholder whose completed age is less than or equal to 30 years and who is financially dependent on the Policyholder with no source of income and have not established his/her own independent households.

1.22 **Diagnosis -** means conclusion drawn by a registered *Medical Practitioner*, supported by acceptable clinical, radiological, histological, histo-pathological, and laboratory evidence wherever applicable.

1.23 **Domiciliary Hospitalisation -** means medical treatment for an *Illness*/disease/*Injury* which in the normal course would require care and treatment at a *Hospital* but is actually taken while confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a *Hospital*, or
ii. the patient takes treatment at home on account of non-availability of room in a *Hospital*.

1.24 **Emergency -** means a severe *Illness* or *Injury* which results 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.

1.25 **Emergency Care -** means management for an *Illness* or *Injury* which results 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.

1.26 **Family** - means the persons named in the *Policy Schedule* who are the *Policyholder*'s legal spouse, dependent children, parents/ parents-in-Law.

1.27 **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*.

1.28 **Non-Floater** – means a *Policy* where *You* and *Your Family* members named in the *Policy Schedule* are covered under this *Policy* as at the commencement date. The *Sum Insured* for Non-Floater is the amount shown in the *Policy Schedule* against each individual *Insured* Person which also represents *Our* maximum liability for that *Insured Person*.

1.29 **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**.**

1.30 **Harvesting** – means a *Surgical Procedure* to remove organs or tissues from a donor (Cadaveric or live), for the purpose of organ transplantation.

1.31 **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.

1.32 **Hospitalisation -** means admission in a *Hospital* for a minimum 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.

1.33 **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.

1.34 **Infertility** – means a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.

1.35 **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*.

1.36 **In-patient Care -** means treatment for which the *Insured Person* has to stay in a *Hospital* for more than 24 hours for a covered event.

1.37 **Insured Person (Insured)** – means persons named in the *Policy Schedule*.

1.38 **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.

1.39 **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.

1.40 **IRDAI** – means the Insurance Regulatory and Development Authority of India.

1.41 **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.

1.42 **Maternity Expenses -** means:

i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during *Hospitalisation*);
ii. expenses towards lawful medical termination of pregnancy during the *Policy Period*.

1.43 **Medical Advice -** means any consultation or advice from a *Medical Practitioner* including the issuance of any prescription or follow-up prescription.

1.44 **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.

1.45 **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.

1.46 **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.

1.47 **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.

1.48 **Network Provider -** means *hospital* enlisted by an *Insurer*, *TPA* or jointly by an *Insurer* and *TPA* to provide medical services to an *Insured* by a *Cashless Facility*.

1.49 **Non-Network Provider -** means any *Hospital*, *Day Care Centre* or other provider that is not part of the network.

1.50 **Non-Allopathic Treatment -** means forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy in the Indian context.

1.51 **New Born Baby -** means baby born during the *Policy Period* and is aged up to 90 days.

1.52 **Nominee -** 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.

1.53 **Notification of Claim -** means the process of intimating a claim to the *Insurer* or *TPA* through any of the recognized modes of communication.

1.54 **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**.**

1.55 **Policy -** means *Your* Proposal Form, the *Policy Schedule*, annexures, insuring clauses that are appearing in each applicable coverage, definitions, exclusions, conditions and other terms contained herein and any endorsement attaching to or forming part hereof, either at inception or during the *Policy Period*.

1.56 **Policyholder** - means the person named in the *Policy Schedule* as the *Policyholder*.

1.57 **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*.

1.58 **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, conditions to which the benefits under the *Policy* are subject to, including any annexures and/or endorsements.

1.59 **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*.

1.60 **Portability** – means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

1.61 **Pre-existing Disease -** means any condition, ailment or *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.

1.62 **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.

1.63 **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.

1.64 **Pre-Natal Period** – means the period between conception and birth.

1.65 **Post-Natal Period** – means the period beginning immediately after the birth of a child and extending for 60 days.

1.66 **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.

1.67 **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.

1.68 **Reasonable & Customary charges -** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of *Illness/ Injury* involved.

1.69 **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.

1.70 **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***.

1.71 **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.

1.72 **Room Rent -** means the amount charged by a *Hospital* towards Room and Boarding expenses and shall include the associated *Medical Expenses*.

1.73 **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* plan for any and all benefits claimed for during the *Policy Year*.

1.74 **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 or prolongation of life, performed in a *Hospital* or *Day Care Centre* by a *Medical Practitioner*.

1.75 **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.

1.76 **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.

1.77 **We/Our/Us / Insurer -** means the Navi General Insurance Limited.

1.78 **You/Your -** means the *Policyholder* named in the *Policy Schedule*.

2. SCOPE OF COVER

Your coverage(s) are mentioned in the Policy Schedule. We will cover *Reasonable and Customary charges* for *Medically Necessary Treatment* taken by the *Insured Person* during the *Policy Year*. Each coverage is subject to the terms, conditions and exclusions of this *Policy* up to the *Sum Insured* specified in the *Policy* or *Policy Schedule*.

2.1 In-patient Hospitalisation

We will cover the *Medical Expenses* incurred for *Medically Necessary Treatment* when the *Insured Person* is admitted 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*/ *Surgeon* / Anaesthetist / Specialists;
e) Physiotherapy, Investigation & Diagnostic procedures;
f) Medicines, Drugs and Consumables;
g) Blood, Oxygen, Surgical appliances;
h) The cost of prosthetic and other devices or equipment recommended by the attending *Medical Practitioner* and if implanted internally during a *Surgical Procedure*.

If *You* are admitted in a room where the *Room Rent* is higher than the limit opted as specified in the Policy Schedule then, we will proportionately deduct "associate medical expenses".

Associate Medical Expenses include medical expenses related to Nursing Charges, Operation Theatre Charges, Fees of Medical practitioner/ surgeon/ anaesthetist/ specialist and Physiotherapy charges.

Modern Treatment Methods

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy - Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchical Thermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Mental Illness:
We will cover Mental Illness as per the provisions of Mental Healthcare Act, 2017. However, in case of following mental illnesses the Inpatient Hospitalization benefit will be restricted to Policy Sum Insured or 3 lacs, whichever is Lower;

1. Schizophrenia (ICD - F20 ; F21;F25)
2. Bipolar Affective Disorders (ICD - F31; F34)
3. Depression (ICD - F32; F33)
4. Obsessive Compulsive Disorders (ICD - F42 ; F60.5)
5. Psychosis (ICD - F 22 ; F23 ; F28 ; F29)

HIV & AIDS
We will cover upto the Sum Insured in case Inpatient hospitalization (including Day Care Treatment) for the treatment arising out of HIV or any condition caused by or associated with Acquired Immuno-Deficiency Syndrome (AIDS).

Extra Care Cover:
In case *Hospitalisation* is for following *Illnesses*, the *Sum Insured* will not be reduced if the admissible claim amount is up to ₹ 20,000 during the *Policy Year*.

1. Dengue
2. Chikungunya
3. Malaria
4. Leptospirosis
5. Japanese Encephalitis
6. Swine Flu

If admissible claim amount exceeds ₹ 20,000 then the amount in excess of ₹ 20,000 will be reduced from the *Sum Insured* during *Policy Year*.

We will not pay for any *Hospitalisation* for treatment arising out of the above specified *Illnesses* during the first 15 days from the inception date of the first *Policy* with Us.

2.2 Day Care Treatment
We will cover all the *Day Care Treatments* undertaken in *Hospital / Day Care Centre*.

2.3 Pre-hospitalisation
We will cover the *Pre-hospitalisation Medical Expenses* incurred immediately before the *Insured Person's Hospitalisation* (including *Day Care Treatment*) for the number of days specified in the *Policy Schedule*.

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.

2.4 Post-hospitalisation

We will cover the *Post-Hospitalisation Medical Expenses* incurred immediately after the *Insured Person's* discharge from the *Hospital* (including *Day Care Treatment*) for the number of days specified in the *Policy Schedule*.

Note –

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 60 days.

2.5 Domiciliary Hospitalisation

We will cover *Domiciliary Hospitalisation* if medical treatment is continuously required for at least three (3) days, in which case the cost of medical treatment for the entire period shall be payable.

We will also cover the pre and post Hospitalisation medical expenses.

2.6 Organ Donor Expenses

We will reimburse the *Surgical* Expenses incurred towards donor in case of major organ transplant for *Harvesting* of the organ provided that:

a) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 and amendments thereof and other applicable laws & rules.
b) The organ donated is for the use of the *Insured Person*.
c) The *Insured Person* (recipient) has been medically advised to undergo an organ transplant.
d) *We* will cover the expenses incurred for transportation including preservation during transportation of the Organ subject to a maximum of Rs. 20,000/- per such event.
e) *We* have accepted claim under In-patient *Hospitalisation* - 2.1.

We will not pay for –

i) Any expense other than specified above.
ii) Cost towards donor screening.
iii) *Pre / post hospitalisation Medical Expenses* of the organ donor.
iv) Cost directly or indirectly associated with acquisition of the organ.
v) Any other medical treatment for the donor consequent to the *Harvesting*.
vi) Expenses related to only organ preservation.
vii) Transplant of any organ/tissue where the transplant is experimental or investigational.
viii) Expenses incurred by an insured person while donating organ.

2.7 Emergency Road Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses

i. We will cover the expenses up to the limits stated in the *Policy Schedule* for each *Policy Year*, incurred towards transportation of an *Insured Person* by a registered healthcare or ambulance service provider for treatment of a disease / *Illness* / *Injury* in case of an *Emergency*.

Expenses shall include:

(i) Transportation Costs towards transferring the *Insured Person* from the place of incident 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*.

(ii) When the *Insured Person* requires to be moved to a better *Hospital* facility due to lack of super speciality treatment in the existing *Hospital*.

(iii) 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*.

ii. 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.

Coverage shall be applicable only if We have accepted claim under In-patient *Hospitalisation* - 2.1 or under *Day Care Treatment* 2.2.

2.8 Emergency Air Ambulance

We will cover the expenses up to the limits stated in the *Policy Schedule* for each *Policy Year*, incurred towards necessary transportation of an *Insured Person* by an Air Ambulance offered by a *Hospital* or by an Ambulance Service Provider in India for treatment of a disease / *Illness* / *Injury* in case of an *Emergency*, provided that:

a) The severity of *Illness* of *Insured Person* is such that it requires services of an Air Ambulance and is certified by treating *Medical Practitioner*.

b) The transportation Costs is towards transferring the *Insured Person* from place of occurrence of Medical *Emergency* to the nearest *Hospital* or from one *Hospital* to another *Hospital* for providing better and adequate medical treatment, following a Medical *Emergency* where such facility is not available at the existing *Hospital*.

c) The Service Provider is able to provide the Air Ambulance service at the location of occurrence of Medical Emergency.

d) Ambulance Bill and payment receipt is submitted to us.

e) The Ambulance provider is registered in India.

f) Coverage shall be applicable only if We have accepted claim under In-patient *Hospitalisation* - 2.1.

g) The *Sum Insured* available under this benefit is in addition to the *Sum Insured* under the *Policy*.

We will not pay for -

i) Return transportation to *Insured Person's* home by air ambulance.

2.9 Hospital Daily Cash

If *We* have accepted a claim under Inpatient *Hospitalisation* - 2.1, then *We* will pay a fixed amount stated in the *Policy Schedule*, for each day of *Hospitalisation*, during the *Policy Year* for treatment of an *Illness* /disease/ *Injury* provided that:

a) The *Insured Person* has been hospitalised for a minimum continuous period of 24 hours.
b) *We* will pay twice the daily cash amount for each day that the *Insured Person* spends in an *Intensive Care Unit*.
c) Our maximum liability is for 30 consecutive days of *Hospitalisation* during a *Policy Year*.
d) The *Sum Insured* available under this benefit will be in addition to the *Sum Insured* under the *Policy*.
e) In case, insured person spends a day partly in ICU and partly in Non-ICU then we will pay twice the daily cash amount for such day.
f) This coverage will not be applicable If the hospitalisation is under section 2.1 – Inpatient Hospitalization for Mental Illness

2.10 AYUSH

We will cover the *Medical Expenses* incurred on In-patient *Hospitalisation* (2.1) 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 –

(1) Clause 3.2.20 will not be applicable to the extent of cover provided under this section.

(2) 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).

2.11 Reinstatement of In-patient Hospitalisation Sum Insured

If Base *Sum Insured* and accrued Cumulative Bonus and / or medical Inflation ,if any, is exhausted due to claims paid and payable (payable here means the claim where liability under the policy is admitted and amount of claim is established) during the *Policy Year*, then *We* will automatically reinstate 100% of the Base *Sum Insured* for the particular *Policy Year*. The benefit is subject to the following –

a) The reinstated Base *Sum Insured* will only be applicable for the benefits described under 2.1 – In-Patient Hospitalisation.

b) Reinstated amount shall not be available for the claim which has exhausted the base sum insured including accrued cumulative bonus &/ or medical inflation, if any. It will also not applicable to the claims related to relapse of same illness / injury within 45 days. The reinstated sum insured can be availed by the Insured person for any subsequent hospitalization(s).
c) This reinstatement of the Base *Sum Insured* will be done only once during the *Policy Year*.
d) For claims related to Cancer and Chronic Kidney Disease requiring regular dialysis, this benefit will be applicable only once during the lifetime of the *Insured Person*.
e) The reinstatement of Base *Sum Insured* will not be considered while calculating the Cumulative Bonus.
f) For *Family Floater* Policies, the reinstated Base *Sum Insured* will be available on a floater basis for all the *Insured Persons* in the *Family*.
g) The unutilised reinstated Base *Sum Insured* cannot be carried forward to any subsequent *Policy Year*.
h) During a *Policy Year*, the aggregate of all claims payable under the *Policy*, shall not exceed the sum of:
    i) Base *Sum Insured*
    ii) Cumulative Bonus
    iii) Reinstated Sum Insured
    iv) Medical Inflation

2.12 Maternity and New Born Baby

I. Maternity Expenses

We will cover *Maternity Expenses* up to the limits stated in the *Policy Schedule* for the delivery of a child and/or lawful termination of pregnancy up to a maximum of 2 deliveries or terminations during the lifetime of an *Insured Person*. The benefit is subject to the following –

a) The female *Insured Person* along with spouse must have been covered for a continuous period of 24 months before availing this benefit.
b) This benefit is only applicable for the female *Insured Person* of 18 years of *Age* or above.
c) *Pre/Post Hospitalisation Medical Expenses* will not be applicable to this benefit.
d) The *Sum Insured* available under this benefit is in addition to the *Sum Insured* of the *Policy*.
e) *Medical Expenses* for ectopic pregnancy are not covered under this benefit. However, these expenses are covered under 2.1 – In-patient Hospitalisation.
f) Clause 3.2.22 shall not apply to the extent of cover provided under this section.
g) Coverage of *Pre-Natal* and *Post-Natal Medical Expenses* – It includes expenses incurred on antenatal check-ups, doctor's consultations for monitoring of the pregnancy and any complications arising therefrom. Coverage of Pre-& Post-natal *Medical Expenses* are valid for inpatient / *Outpatient Treatment*. *Medical Expenses* incurred towards pre/ post-natal treatment would be considered within the *Sum Insured* limit of this section.

II. New Born Baby

We will cover *Medical Expenses* towards treatment of a *New Born Baby* post birth up to 90 days from the date of delivery.

The benefit is subject to the following –

a) We have accepted claim under maternity expenses cover under 2.12 (I).
b) *Medical Expenses* will be within the limits of this Cover.
c) We will cover the expenses incurred for the vaccination of the *New Born Baby* as listed below, till the baby completes 1 year, within the *Sum Insured* limits of this Cover irrespective of expiry of the policy.
d) Clause 3.2.22 shall not apply to the extent of cover provided under this section.

Vaccines	Age (Completed weeks/months)	Frequency
BCG	At Birth	1
OPV	At Birth, 6 months, 9 months	3
Hepatitis B	At Birth, 6 weeks, 6 months	3
IPV	6, 10, 14 weeks	3
DPT	6, 10, 14 weeks	3
Hib	6, 10, 14 weeks	3
Rotavirus	6, 10, 14 weeks	3
PCV	6, 10, 14 weeks	3
MMR	9 months	1

2.13 Worldwide Emergency Hospitalisation

We will cover *Medical Expenses* for in-patient *Hospitalisation* (as described in 2.1 – In-patient Hospitalisation), incurred outside India, subject to the limit stated in the *Policy Schedule*, provided that:

a) The *Hospitalisation* is medically necessary, and the *Medical Practitioner* certifies that the *Insured* is suffering from a life-threatening *illness* which requires *Emergency Care* and such treatment cannot be postponed until the *Insured Person* returns to India.
b) The *Medical Expenses* payable shall be limited to In-patient Hospitalisation only.
c) This benefit will be extended through reimbursement facility only.
d) This cover can only be availed once in a *Policy Year*.
e) The claim documents as mentioned in clause 4.3.2.3 is submitted to us.
f) Clause 4.2.5 (Geography); Coverage 2.11 (Re-instatement of in-patient *Hospitalization Sum Insured*) and Coverage 2.1 – Inpatient Hospitalization (for Mental Illness) shall not apply to this section.

2.14 Cumulative Bonus

We will enhance the *Renewal Policy Sum Insured* by 10% of the Base *Sum Insured*, on cumulative basis for each claim free *Policy Year*.

The benefit is subject to the following:

a) The accumulated Cumulative Bonus shall not exceed 50% of the Base *Sum Insured* in any *Policy Year*.
b) The entire Cumulative Bonus will be lost if the *Policy* is not renewed on or before the end of the *Grace Period*.
c) If a claim is made in a policy year, then Cumulative Bonus will be reduced by 10% in the subsequent policy year but will not reduce the Base sum insured.
d) The Cumulative Bonus shall be applicable on annual basis subject to continuation of the *Policy*.
e) In a *Family Floater Policy*, the Cumulative Bonus shall be available on Floater basis. The Cumulative Bonus will only accumulate if no claim has been made in respect of any *Insured Person* during the expiring *Policy Year*.
f) The Cumulative Bonus which is accumulated during the claim free *Policy Year* will only be available to those *Insured Persons* who were insured in such claim free *Policy Year* and continue to be covered in the subsequent *Policy Year*.
g) This clause does not alter *Our* rights to decline *Renewal* or cancellation of the *Policy*.
h) If the Base *Sum Insured* under the *policy* is decreased at renewal, then the applicable *Cumulative Bonus* shall also be proportionally reduced to the *Sum Insured*.
i) If the Base *Sum Insured* under the *policy* is increased at renewal, then the *Cumulative Bonus* shall be applicable separately to the policy preceding Base Sum Insured and to the amount by which Sum Insured is enhanced.
j) In case the previous *policy* is a non-floater *policy*, then each insured member will have a separate cumulative bonus and when such *policy* is renewed on a floater basis, then the credit of cumulative bonus to the renewed *policy* will be the lowest cumulative bonus of all the individual insured members.
k) In case the previous policy is a floater *policy* and when such *policy* is renewed by splitting into 2 or more floater or non-floater *policies*, then the credit of cumulative bonus shall be apportioned to each of the renewed *policy* in the proportion of the Sum Insured.
l) The Cumulative Bonus shall be decreased by the same percentage (as was increased in the previous year subject to a minimum of '0') of the Base *Sum Insured* in the subsequent *Policy Year*, in case a claim is paid or payable under following sections in the previous *Policy Year*:
    (i) In Patient Hospitalisation
    (ii) Day Care Procedures
    (iii) Domiciliary Hospitalisation
    (iv) Organ Donor Expenses
    (v) AYUSH Cover
    (vi) Worldwide Emergency Hospitalisation

NOTE - A detailed illustration is available in Annexure II – Illustration 1.

2.15 Medical Second Opinion

If the *Insured Person* is diagnosed with any Critical Illness as specified in section 2.24 or has been advised by the treating *Medical Practitioner* to undergo a *Surgery* during the *Policy Year* and opts to obtain medical second opinion with regards to the *Diagnosis* of the Critical Illness or before planning for any *Surgical Procedure* / *Surgery* / Course of treatment, *We* will organize the same by *Our* service provider provided:

a) *We* have received a request from *You* to exercise this option.
b) That the Second opinion will be based only on the information and documentation provided by the *Insured Person* that will be shared with the *Medical Practitioner*.
c) For a *Family Floater Policy* - This benefit can be availed once by any *Insured Person* during a *Policy Year* for a specified Critical Illness/before undergoing any *Surgery*.
d) For a *Non-Floater Policy* - This benefit can be availed once by each *Insured Person* during a *Policy Year* for a specified Critical Illness/before undergoing any *Surgery*.
e) This benefit is only a value-added service provided by *Us* and does not deem to substitute the *Insured Person*'s visit or consultation to an independent *Medical Practitioner*.
f) The *Insured Person* is free to choose whether or not to obtain the Second opinion, and if obtained, then whether or not to act on it.
g) *We* shall not, in any event, be responsible for any actual or alleged errors or representations made by *Medical Practitioner* in any Medical Second opinion or for any consequence of actions taken or not taken in reliance thereon.
h) The Second opinion under this *Policy* shall not be valid for any medico legal purposes.
i) *We* do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the *Medical Practitioner*.

Service Provider - means any person, clinic, organization or institution that has been empanelled with Us to provide Second Opinion.

2.16 Counselling

We will cover cost incurred for counselling sessions, to help *you* deal with, anxiety, stress, depression, relational problems, substance related disorders, emotional and behavioural disorders during the policy year subject to the below conditions -

a) The requirement of such counselling session should be advised by the treating medical practitioner/psychiatrist. Such written referral/advise should be submitted to Us.
b) Counsellor Bill and payment receipt is submitted to *Us*.
c) A total of 5 sessions for each insured member (18 years of age and above) is allowed under the policy in a *Policy Year*.
d) *Our* liability is limited to ₹ 1500/- per session.

2.17 Health Care and Wellness

We will provide the following Healthcare and Wellness services during the *Policy Period*.

2.17.1 Health Check Up

Health check-up benefit will be available for each *Insured Person* (≥ 18 years of age) at the end of every claim free *Policy Year* as per the grid below.

Age / Sum Insured	Up to ₹ 10 lac	₹ 15-25 Lac	50-100 Lac
18 - 45 yrs.	Set-I	Set-II	Set-III
46-55 yrs.	Set-II	Set-III	Set-IV
Above 55 yrs.	Set-II	Set-III	Set-IV

Set	**List of Medical Tests**
Set-I	Complete Blood Count, ESR, Blood Group, Total Cholesterol, SGPT, Sr. Creatinine, FBSL, ECG, Urine Routine
Set-II	Complete Blood Count, ESR, Blood Group, Total Cholesterol, SGOT, SGPT, Bilirubin, Sr. Creatinine, FBSL, PPBSL, ECG, Urine Routine, Consultation on the reports
Set-III	Complete Blood Count, ESR, Blood Group, Lipid Profile, SGOT, SGPT, Bilirubin, Sr. Creatinine, BUN, HbA1c, ECG, Urine Routine, Consultation on the reports
Set-IV	Complete Blood Count, Blood Group, Lipid Profile, Bilirubin, Sr. Creatinine, HbA1c, 2D-Echo, Urine Routine, Consultation on the reports, PAP smear (Females)/PSA (Males)

A) <u>Locations where *Our Empanelled Service Providers* are available</u>

a) Health check Up benefit shall be available on cashless basis at *Our Empanelled Service Providers only*.

b) *We* will arrange for the *Insured Person's* Health Check-up at *Our Empanelled Service Providers* as per the above grid.

c) *We* will provide the Original Copies of all reports to *You*, while retaining a copy of the same with *Us*.

B) <u>Locations where *Our Empanelled Service Providers* are not available</u>

a) The benefit will be available on reimbursement basis only if, there is no *Empanelled Service Provider* within the municipal limits of the *Insured's* City of residence.

b) The *Insured Person* can opt for Health Check-up as per the above grid at any of the Diagnostic Centre of his choice near to his residence.

c) *We* will pay the amount towards the cost of health check-up up to the limit defined in the below grid or at actuals, whichever is lesser.

Registered & Corporate Office: Navi General Insurance Limited
402, 403 & 404, A & B Wing, 4th Floor, Fulcrum, Sahar Road, Next to Hyatt Regency, Andheri (E), Mumbai - 400099
Toll-free number: 1800 123 0004 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: insurance.help@navi.com
CIN: U66000MH2016PLC283275 | IRDAI Registration Number: 155

Age / Sum Insured	Up to ₹ 10 lac	₹ 15-25 Lac	₹ 50-100 Lac
18 - 45 yrs.	₹ 750	₹ 1000	₹ 1500
46-55 yrs.	₹ 1000	₹ 1500	₹ 2500
Above 55 yrs.	₹ 1000	₹ 1500	₹ 2500

Note:

i) If this benefit is not claimed within a year from the date it becomes applicable, then this benefit cannot be carried forwarded further.

ii) This benefit will not be available, if the *Policy* is not renewed further.

2.17.2 Wellness

You have option to enrol and participate in *Our* below mentioned wellness programs so as to lead a healthier lifestyle. On achieving the various wellness goals, *You* will not only lead a healthier lifestyle but avail a discount in premium as well.

Wellness for the purpose of this *Policy* is an active process of becoming aware and making choices towards a healthy and fulfilling life in order to subdue stress, reduce the risk of *Illness* and ensure positive interactions.

I. Health Risk Assessment (HRA) –

It is a screening tool based on questionnaire to assess *Your* lifestyle habits and health history to determine how healthy *You* are and whether *You* are at risk for certain chronic diseases or *Illness*.

You can complete the online HRA at the time of buying the *policy* and avail an individual discount equivalent to 0.5% of the *policy* premium, for participation. In case of family floater, discount shall be applied on the individual who has completed the HRA.

In case *You* have not completed the HRA at the time of buying the *policy*, then *You* can enrol and complete the same online anytime during the *Policy Period*. In such a case, the discount will be applicable at subsequent renewal only.

Once *You* complete the HRA, *you* will receive a report which contains a health score based on the assessment of *your* current health.

If *Your* health score is optimal (≥ 70), *you* will earn an additional discount in premium equivalent to 2%, which would be applied on the *Policy* Premium of the respective Individual.

We will allow above discount once either at the time of obtaining first policy from us or at any subsequent renewal depending upon when you have completed HRA.
In case *Your* score indicates risk of developing any lifestyle related diseases, then *We* will provide necessary counselling and guidance on healthy diet, nutrition and Stress management.

II. **Self-Disease Management –**

Self-disease management for the purpose of this *policy* means adopting healthy lifestyle practices such as healthy diet, regular physical activity, quitting smoking and good compliance to medication for preventing or controlling the onset of debilitating and expensive complications of chronic diseases.

You can earn discounts as mentioned under this section for controlling/managing your chronic disease (Hypertension/Diabetes/Hyperlipidaemia) by Yourself by adopting healthy lifestyle practices.

Normal level of the parameters pertaining to the chronic disease/s are as below.

Chronic Disease	Parameter	Normal Level
Hypertension	Blood Pressure	SBP - ≤ 119 mmHg DBP - ≤ 79 mmHg
Diabetes Mellitus	HbA1c	≤ 5.6
Hyperlipidaemia	Cholesterol	≤ 200 mg/dl

In case *you* are diagnosed, or you acquire the specified chronic disease during the *Policy Year*, then *you* have to undergo 1st health screening based on the screening test related to the specified chronic disease as provided below at the beginning of the next *Policy Year* in any one of *Our* Empanelled Network Provider only, at *your* own cost. *You* will also have to undergo the 2nd health screening test based on defined set of medical tests in *Our* network diagnostic centres only, at your own cost, 90 days before the expiry of the said *Policy Year*.

If *you* are suffering from the chronic disease as mentioned above and have been covered under the *Policy* after undergoing pre-policy medical tests, then You have to undergo the 2nd health screening based on the screening test related to the specified chronic disease as provided below in *Our* Empanelled Service Provider only, at *your* own cost, 90 days before the expiry of the *Policy Year*.

Chronic Disease	Health Screening Tests
Hypertension	Blood pressure
Diabetes Mellitus	HbA1c (Glycated Haemoglobin)
Hyperlipidaemia	Total Lipids

Healthy Discount:

If *you* manage these chronic disease/s successfully as per laid down parameter, *you* will be entitled to get discount in renewal premium at the end of Policy Period, based on the range of the values obtained from the 2nd health screening tests as per the below grid. In case of management of more than one specified chronic disease in 2nd health screening test, the cumulative discounts shall be offered up to a maximum of 10% at the end of the Policy Period.

HYPERTENSION MANAGEMENT				
Category	**Blood Pressure at 1st test**	**Blood Pressure at 2nd test**	**Discount if Blood Pressure is controlled**	**Discount if <u>all the health screening tests</u> are controlled ***
Pre-Hypertension	*SBP: 120-139 mmHg *DBP: 80-89 mmHg	SBP: ≤ 119 mmHg DBP: ≤ 79 mmHg	2%	3%
Hypertension	SBP: ≥ 140 mmHg DBP: ≥ 90 mmHg	SBP: 120-139 mmHg DBP: 80-89 mmHg	3%	5%
		SBP: ≤ 119 mmHg DBP: ≤ 79 mmHg	5%	8%
SBP- Systolic Blood Pressure; DBP – Diastolic Blood Pressure				

DIABETES MANAGEMENT				
Category	**HbA1C at 1st test**	**HbA1C at 2nd test**	**Discount if Blood Sugar is controlled**	**Discount if <u>all the health screening tests</u> are controlled ***
Pre-Diabetes	5.7-6.4%	≤ 5.6	2%	3%
Diabetes	≥ 6.5	5.7-6.4%	3%	5%
		≤ 5.6	5%	8%

HYPERLIPIDEMIA MANAGEMENT				
Category	**Cholesterol at 1st test**	**Cholesterol at 2nd test**	**Discount if Total Cholesterol is controlled**	**Discount if <u>all the health screening tests</u> are controlled ***
Borderline High	> 200 - 240 mg/dl	≤ 200 mg/dl	2%	3%
High	> 240 mg/dl	200 - 240 mg/dl	3%	5%
		≤ 200	5%	8%

* **<u>"All the Health Screening Tests"</u> means 2nd health screening tests of two or more than two chronic diseases.**

A detailed illustration is available in Annexure II – Illustration 5.

Registered & Corporate Office: Navi General Insurance Limited
402, 403 & 404, A & B Wing, 4th Floor, Fulcrum, Sahar Road, Next to Hyatt Regency, Andheri (E), Mumbai - 400099
Toll-free number: 1800 123 0004 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: insurance.help@navi.com
CIN: U66000MH2016PLC283275 | IRDAI Registration Number: 155

Note –

i. Above discounts shall be applied on the premium of the respective Insured Person based on their individual health score.

ii. Discount percentage shall be applied based on the values obtained from the 2nd health screening test.

iii. If the values obtained in the 2nd health screening test falls within the range as listed in 2nd test Column of the respective Chronic Disease Management Grid then discount corresponding to that range shall be applied.

iv. If the Insured is able to manage more than one specified chronic disease, the cumulative discounts shall be offered up to a maximum of 10% on renewal premium.

III. Stay Fit –

It is a pedometer based simple walking program designed for You to walk your way to a more active and healthier lifestyle. *Insured Persons* 18 years of age and above will only be eligible for this programme.

You may enrol in this programme at any time during the *policy period* by downloading *Our* mobile application. However, to avail maximum discount, *You* must enrol in this programme within 1 month of the *Policy* start date. The average step count walked by the *Insured Person* shall be recorded on the mobile application.

In case you are already using a health gadget (Fitbit, apple health and google fit) to calculate your steps, you may authenticate and synchronise the gadget with our application.

A discount as specified in the grid below can be availed at each *Renewal*, if the *Insured Person* achieves an average step count per day for specified number of days as per the table below.

In a *Non-Floater Policy*, the average step count shall be calculated per individual *Insured Person*. In a *Family Floater Policy*, average step count will be calculated by considering step counts of all adult members (18 years and above) covered.
In *Non-Floater Policies*, the discount percentage (%) would be applied on premium applicable per *Insured Person* and in a *Family Floater Policy*, it would be applied on premium applicable on the *Policy*.

1 Year Policy		
Average No. of Steps per day	Total No. of Days	
	≥ 200	≥ 250
≥ 6000	3%	5%
≥ 8000	5%	7%
≥ 10000	7%	10%

2 Year Policy		
Average No. of Steps per day	Total No. of Days	
	≥ 420	≥ 520
≥ 6000	3%	5%
≥ 8000	5%	7%
≥ 10000	7%	10%

3 Year Policy		
Average No. of Steps per day	Total No. of Days	
	≥ 700	≥ 800
≥ 6000	3%	5%
≥ 8000	5%	7%
≥ 10000	7%	10%

Note: Cumulative discounts under section 2.17.2 - Wellness for I. Health Risk Assessment II. Self Disease management and III. Stay fit shall not exceed 15% every policy year.

2.17.3 Health Helpline

a. *This is an assistance service only and on your own discretion and choice, You* will have access to medical practitioner for any opinion on health related issue or queries from our empanelled service provider through our mobile application /website or telephonic mode for 24 by 7 hours during the *policy period. You* may contact us on our toll-free helpline number for availing this service.

b. The information services provided under this assistance does not substitute for any medical advice and You will be free to consider or not consider the opinion provided and We or our empanelled service provider will not be liable for any damages sustained due to reliance by the insured person on such information provided by medical Practitioner.

c. You may purchase medicines and diagnostic services from our empanelled service provider on your own discretion and choice provided that the cost for the purchase shall be borne by you.

Note:

1. *Empanelled Service Provider means any person, clinic, organisation, institution that has been empanelled with Us to provide the Healthcare & Wellness Services provided under this cover. (List provided on our website: www.naviinsurance.com).*

2.18 Voluntary Co-Payment

a) *You* will bear a percentage share as specified in the *Policy Schedule*, of the admissible claim amount on each claim.
b) Co-*Payment* shall not apply to Out Patient Treatment, Hospital Daily Cash, Medical Second Opinion, Emergency Road Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses, Emergency Air Ambulance, Infertility, Maternity and *New Born Baby* and Health Check-up.
c) Voluntary *Co-Payment* will apply in conjunction with mandatory *Co-Payment* & *Co-Payment* due to treatment taken out of opted zone.
d) Voluntary *Co-Payment* will not be applicable in case of *Accidental Hospitalisation* claims.

2.19 Deductible

a) *You* will bear an amount equal to the *Deductible* as specified in the *Policy Schedule* and *We* shall be liable to make payment under the *Policy* for any claim over and above the *Deductible* amount.
b) The *Deductible* shall be applicable on each claim made by the *Insured Person* during the *Policy Year*.
c) The *Deductible* shall not apply to Out Patient Treatment, Hospital Daily Cash, Medical Second Opinion, Emergency Road Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses, Emergency Air Ambulance, Infertility, Maternity and *New Born Baby* and Health Check-up.
d) In case Mandatory *Co-Payment* is applicable to a Claim, then the same shall apply before the *Deductible* has been applied.

2.20 Waiver of Mandatory Co-Payment

We would not apply the Mandatory *Co-Payment* applicable to the *Insured Persons* whose *Age* at the time of first *Policy* inception is 61 years or above, if this cover is opted.

2.21 Out Patient Treatment

We will cover expenses incurred towards Outpatient consultations, Diagnostic Examinations and pharmacy up to the amount stated in the *Policy Schedule* at any of the Company's Empanelled Service Provider, during the *Policy* Year subject to the below conditions -

a) The Outpatient Consultations/Diagnostic Examinations/Medicines are prescribed by the treating registered *Medical Practitioner*.
b) Spectacles and Hearing Aids – The first claim for the cost of spectacles and hearing aids can be made in the third policy year provided that the policy is continuously in force during this period and prescribed by a Specialist *Medical Practitioner*. Thereafter, the subsequent claims can be made in every alternate year provided the *Policy* is continuously in force and prescribed by a *Specialist Medical Practitioner*.

c) Dental Care – *We* will cover expenses incurred for necessary *Dental Treatment*. However, any *Dental Treatment* for cosmetic purpose will not be covered under this *Policy*.
d) Treating doctor's prescription and bills are submitted to *us*.
e) Any balance amount under this section will not be carried forward to the subsequent *Policy* Year, if the benefit is not utilised.
f) The cover under this benefit is limited as defined in the below grid.
g) Clause 3.2.1 to 3.2.5, 3.2.11 and 3.2.15 (a&b) will not be applicable to the extent of cover provided under this section.
h) The *Sum Insured* available under this benefit will be in addition to the *Sum Insured* under the *Policy*.
i) All waiting periods and exclusions shall not apply to this section.

Policy Sum Insured	₹ 2 Lac - ₹ 100 Lac	₹ 6 Lac - ₹ 100 Lac	₹ 20 Lac - ₹ 100 Lac	
Cover	**OPD Sum Insured Sublimit (in ₹)**			
Consultations	2000	4000	6000	8000
Diagnostic Tests	3000	6000	9000	12000
Medicines				
Dental Care				
Spectacles or contact lenses				
Hearing Aids				
Total Sum Insured	5000	10000	15000	20000

Note: *Empanelled Service Provider means any person, clinic, organisation, institution that has been empanelled with Us to provide the Healthcare & Wellness Services provided under this cover. (List provided on our website: www.naviinsurance.com).*

2.22 Infertility

We will cover *Medical Expenses* for two In-Vitro Fertilisation Cycles in the lifetime of the female *Insured Person* for the treatment of infertility subject to the limit stated in the *Policy Schedule*.

The benefit is subject to the following:

a) The coverage is available for female *Insured* between the ages of 25 and 40 years.
b) The female *Insured Person* along with spouse must have been covered in this *Policy* for a continuous period of 36 months before availing this benefit.
c) If a claim is made under this section in any *Policy Period* and a pregnancy is successfully established, then the benefit under this section shall not be available for any subsequent *Renewal* (even if one In-Vitro Fertilisation cycle is remaining) for the particular *Insured Person(s)* irrespective of the amount claimed in the expiring *Policy*.
d) Clause 3.2.24 shall not apply to the extent of cover provided under this section.
e) The benefit under this section will only be applicable if infertility is diagnosed after the issuance of the first *Policy* with *Us*.
f) *Sum insured* of this cover cannot be enhanced during life time.

Special Condition –

i) This cover is not applicable for couples in which either of the partners had undergone a voluntary sterilization procedure, including tubal ligation or vasectomy, with or without *Surgical* reversal.

ii) This cover will cease once the pregnancy is established and a foetal heartbeat is detected.

2.23 Medical Inflation

We will enhance the Renewal *Policy Sum Insured* by 10% of the Base *Sum Insured*, on cumulative basis for each *Policy* Year irrespective of a claim in the expiring *policy* year.

The benefit is subject to the following:

a) The accumulated Medical Inflation shall not exceed 50% of the Base Sum Insured in any *Policy* Year.

b) The entire Medical Inflation will be lost if the *Policy* is not renewed on or before the end of the Grace Period.

c) The Medical Inflation shall be applicable on annual basis subject to continuation of the *Policy*.

d) In a Family Floater *Policy*, the Medical Inflation shall be available on Floater basis.

e) The Medical Inflation which is accumulated will be available to all the Insured Persons.

f) This clause does not alter *Our* rights to decline Renewal or cancellation of the *Policy*.

g) If the Base *Sum Insured* under the policy is decreased at renewal, then the applicable Medical Inflation shall also be proportionally reduced to the *Sum Insured*.

h) If the Base *Sum Insured* under the policy is increased at renewal, then the Medical Inflation shall be applicable separately to the preceding Base *Sum Insured* and to the enhanced *Sum Insured*.

i) In case the previous *policy* is non-floater *policy*, then each insured member will have a separate Medical Inflation and when such *policy* is renewed on a floater basis, then the credit of Medical Inflation to the renewed *policy* will be the lowest Medical Inflation of all the individual insured members.

j) In case the previous *policy* is floater *policy* and when such *policy* is renewed by splitting into 2 or more floater or non-floater *policies*, then the credit of Medical Inflation shall be apportioned to each of the renewed *policy* in the proportion of the Base *Sum Insured*.

k) The premium of the Policy shall be fixed for five years i.e. you will not pay more than what you have paid for the first year of the policy during this period subject to the following -

   a. Policy is renewed continuously without any break.

   b. There is no change in plan or coverages at the time of Renewal of the Policy. Discount in premium earned under Wellness Section of the Policy shall be allowed at the time of renewal.

NOTE - A detailed illustration is available in Annexure II – Illustration 3.

2.24 Critical Illness Benefit

We will pay the Sum *Insured* as stated in the *Policy Schedule* if the *Insured Person* is of 18 years or above and is diagnosed to be suffering from a specified Critical Illness and provided the following conditions and other provisions, terms & conditions and limitations of the *Policy* are satisfied.

a) The *Insured Person* is diagnosed with a Critical Illness specifically defined in this *Policy*; and
b) Such Critical Illness occurs itself as a first incidence; and
c) Such Critical Illness commences after a waiting period of 90 days from the inception of the first *Policy* with *Us*; and
d) The *Insured Person* survives such Critical Illness for at least 30 days, from the date of *Diagnosis*/date of undergoing the *Surgical Procedure*.
e) If a claim is settled under this cover, this benefit shall automatically terminate for that insured person and this benefit shall not be available for further renewal.

2.24.1 Cancer of Specified Severity

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This *Diagnosis* must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
II. The following are excluded –
    i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, 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;
    ix. All tumors in the presence of HIV infection.

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Toll-free number: 1800 123 0004 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: insurance.help@navi.com
CIN: U66000MH2016PLC283275 | IRDAI Registration Number: 155

2.24.2 Myocardial Infarction (First Heart Attack of Specified Severity)

I. 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.

II. 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.

2.24.3 Open Chest CABG

I. 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.

II. The following are excluded:
   i. Angioplasty and/or any other intra-arterial procedures

2.24.4 Open Heart Replacement or Repair of Heart Valves

I. The actual undergoing of open-heart valve *Surgery* is 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.

2.24.5 Kidney Failure Requiring Regular Dialysis

I. 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*.

2.24.6 Stroke Resulting in Permanent Symptoms

I. 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.

II. 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.

2.24.7 Major Organ / Bone Marrow Transplant

I. 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 a transplant has to be confirmed by a specialist *Medical Practitioner*.

II. The following are excluded:
    i. Other stem-cell transplants
    ii. Where only islets of langerhans are transplanted

2.24.8 Permanent Paralysis of Limbs

I. 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.

2.24.9 Multiple Sclerosis with Persisting Symptoms

I. 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.

II. Other causes of neurological damage such as SLE and HIV are excluded.

2.24.10 Third Degree Burns

I. 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.

3. EXCLUSIONS

We will not make payment for a claim in respect of any *Insured Person* in any way resulting directly or indirectly from or attributable to any of the following unless specifically covered elsewhere in this *Policy*:

3.1 STANDARD EXCLUSIONS

3.1.1 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.

3.1.2 Chemical & Nuclear Exposure - We will not pay for the treatment costs directly or indirectly caused by or contributed to or arising from nuclear weapons/materials, radioactive material, nuclear waste, nuclear fuel, chemical weapons/materials or biological weapons/materials.

3.1.3 War - We will not pay for the treatment related to any condition resulting from, or as a consequence of War, invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts.

3.2 EXCLUSIONS SPECIFIC TO THE POLICY WHICH CANNOT BE WAIVED

3.2.1 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 number of months (as specified in the Policy Schedule) of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of number of months (as specified in the Policy Schedule) for any pre existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3.2.2 Specified Disease / procedure waiting period – Code – Excl02 -– (Named Ailments)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months (as specified in the Policy Schedule) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy

or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures are mentioned below -

	Organ / Organ Systems	Illness / Surgeries
1.	**Ear Nose Throat**	a. Sinusitis b. Chronic Suppurative Otitis Media (CSOM) c. Tonsillectomy d. Adenoidectomy e. Mastoidectomy f. Tympanoplasty g. Surgery for Deviated Nasal Septum h. Surgery for turbinate/Concha i. Any other benign ear, nose and throat disorder or Surgery
2.	**Eye**	a. Cataract b. Surgical Management of Glaucoma c. Retinopathy
3.	**Gastrointestinal**	a. Calculus Diseases of Gall Bladder including Cholecystectomy b. All types of Surgery of Hernia c. Fissure/Fistula in anus, Hemorrhoids, Pilonidal Sinus d. Ulcer of Stomach & Duodenum e. Gastroesophageal Reflux Disorder(GRD) f. Perianal / Perineal Abscess g. Rectal Prolapse
4.	**Gynaecological**	a. Cysts, polyps b. Any type of Breast lumps (unless malignant) c. Polycystic Ovarian Disease (PCOD) d. Fibroids (Fibromyoma) e. Myomectomy for fibroids f. Prolapse of Uterus unless necessitated by malignancy g. Adenomyosis h. Endometriosis i. Menorrhagia and Dysfunctional Uterine Bleeding (DUB) j. Dilatation & Curettage (D & C) k. Hysterectomy unless due to malignancy

5.	**Orthopaedic**	a. Non-Infectious Arthritis b. Gout and Rheumatism c. Osteoarthritis and Osteoporosis d. Ligament, Tendon & Meniscal Tear (other than caused by *Accident*) e. Spondylitis/Spondylosis/Spondylolisthesis f. *Surgery* for Prolapsed intervertebral disc (other than caused by *Accident*) g. Joint Replacement *Surgeries* (other than caused by *Accident*)
6.	**Urogenital**	a. Calculus of Urinary system (Kidney Stone/Urinary Bladder/Ureteric Stone) b. Any *Surgery* of the genitourinary system unless necessitated by malignancy. c. Benign Hyperplasia of Prostate d. *Surgery* for Hydrocele/Rectocele
7.	**Others**	a. Varicose veins and Varicose ulcers
8.	**General (Applicable to organ systems/organs/disciplines whether or not described above)**	a. Any type of cysts / Nodules / Polyps / Internal tumours / Skin tumours / Lump / growth

3.2.3 30 - day Waiting Period – Code – Excl03 –

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

3.2.4 Waiting Period for coverage of Internal Congenital Anomaly - *We* will not pay in respect of *Internal Congenital Anomaly* within first 24 months from inception of first *Policy* with *Us*.

3.2.5 Waiting Period for Named Mental Illness - We will not pay for any treatment / Hospitalisation for the illnesses mentioned below or any complication arising from the same, during first twenty four (24) months from the inception of first Policy with Us.

	Organ / Organ Systems	Illness
1.	**Mental Disorders**	a. Schizophrenia (ICD - F20 ; F21;F25) b. Bipolar Affective Disorders (ICD - F31; F34) c. Depression (ICD - F32; F33) d. Obsessive Compulsive Disorders (ICD - F42 ; F60.5) e. Psychosis (ICD - F 22 ; F23 ; F28 ; F29)

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

3.2.7 **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.

3.2.8 **Circumcision -** We will not pay for Circumcisions unless necessary for the treatment of a disease or necessitated by an *Injury*.

3.2.9 **Rest Cure, Rehabilitation and Respite Care – 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.

3.2.10 **External Congenital Anomaly** - We will not cover for screening, counselling and treatment related to External congenital anomalies.

3.2.11 **Dental Care -** We will not pay for the *Dental Treatment* and *Surgery* of any kind, other than arising out of an *Accident* and subsequently requiring *Hospitalisation*.

3.2.12 **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.

3.2.13 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**

3.2.14 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.

3.2.15 Eyesight, Hearing Aids & External prosthesis –

(a) We will not pay for treatment related to routine eyesight checking or hearing tests including optometric therapy.
(b) We will not pay for any cost of hearing aids / Cochlear Implants, Spectacles or Contact Lenses.
(c) We will not pay for any cost related to providing, maintaining and fitting of external and or durable medical/non-medical equipment (as listed in Annexure I – Non Medical Expenses) used for *Diagnosis* and or treatment, including Continuous Positive Airway Pressure (CPAP), Continuous Ambulatory Peritoneal Dialysis (CAPD) or Infusion Pump, ambulatory devices - walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, artificial limb and also medical equipment which is subsequently used at home (except when used intra-operatively).

3.2.16 Refractive Error – Code- Excl15 - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

3.2.17 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.

3.2.18 Medically Necessary Expenses - We will not pay for 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.

3.2.19 Non-Medical Expenses - We will not pay for any Non-medical expenses defined in Annexure-I.

3.2.20 Non-Allopathic Treatment - We will not pay any expenses related to Non-Allopathic treatment.

3.2.21 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 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 Type2 Diabetes

3.2.22 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.

3.2.23 Preventive Vaccinations - We will not pay for the expenses towards any treatment related to preventive care, vaccination including 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.

3.2.24 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, /CS/
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

3.2.25 Self-inflicted injuries or attempted suicide - We will not pay any expenses for treatment resulting directly or indirectly from self-inflicted *Injury* or suicide, attempted suicide while sane or insane.

3.2.26 Treatment by a Medical Practitioner outside discipline - We will not pay any expenses for treatment rendered by Persons not registered as *Medical Practitioner* or from a *Medical Practitioner* practising outside the discipline that he/she is licensed for.

3.2.27 Time bound Exclusions - We will not pay for any specific time bound exclusion(s) applied by *Us* and mentioned in the Schedule and accepted by the Insured Person.

3.2.28 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.

3.2.29 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.

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

3.2.31 Permanent Exclusions - We will not pay for any disease which is permanently excluded and specified in the policy schedule with your due consent.

4 GENERAL TERMS AND CONDITIONS

4.1 CONDITIONS PRECEDENT

4.1.1 AGE

A person shall be eligible to become an *Insured Person* if he/she is not younger than 91 days. However, there is no maximum entry *Age* limit for *Sum Insured* of Rs. 2 Lac. For all other *Sum Insured's*, the maximum entry *Age* is restricted to 70 years. For a dependent child, the maximum entry *Age* limit is 30 years.

4.1.2 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.

4.1.3 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.

4.1.4 ELECTRONIC TRANSACTIONS

The *Policyholder / Insured Person* agrees to adhere to and comply with all such terms and conditions as may be imposed for electronic transactions that *We* may prescribe from time to time which shall be within the terms and conditions of the contract, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of

electronic, computer, 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 transactions when done in adherence to and in compliance with *Our* terms and conditions for such facilities, as may be prescribed from time to time which shall be within the terms and conditions of the contract. However, the terms of the condition shall not override provisions of any law(s) or statutory regulations including provisions of *IRDAI* regulations for protection of policyholder's interests.

4.1.5 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.

4.1.6 MANDATORY CO PAYMENT

If the entry age of the *Insured Person* at the first inception of *policy* with us is 61 years or above, the *Co-Payment* will be applicable as per the below grid.

Age at Entry	Co-Payment
61-65 years	10%
66-70 years	20%
Above 70 years (Only for ₹ 2 Lac S.I)	30%

4.1.7 ZONE CLASSIFICATION

Zone – I: Delhi, NCR (Municipal limits of Faridabad, Gurgaon, Noida, Ghaziabad), Mumbai (All municipal regions under Mumbai Metropolitan Region), Bangalore (All municipal regions under Bangalore Metropolitan Region)

Zone – II: Hyderabad (All municipal regions under Hyderabad Metropolitan Region), Pune (All municipal regions under Pune metropolitan Region), Chennai (all municipal regions under Chennai Metropolitan Area), Kolkata (all municipal regions under Kolkata Metropolitan Area), Ahmedabad (All municipal regions under Ahmedabad municipal corporation)

Zone – III: All municipal regions of state capitals not included in Zone I and Zone II, Nagpur, Indore, Kochi, Coimbatore, Baroda, Surat, Ludhiana, Jallandhar.

Zone – IV: Rest of India excluding the cities included in Zone-I, Zone-II and Zone-III.

Policyholder's paying Zone-I premium can avail treatment all over India without any *Co-Payment*.

Policyholder's paying Zone-II premium can avail treatment in Zone-II, Zone-III and Zone-IV without any *Co-Payment* but shall have to bear a *Co-Payment* of 12% of each and every claim if treatment in Zone-I is availed.

Policyholder's paying Zone-III premium can avail treatment in Zone-III and Zone-IV without any *Co-Payment* but shall have to bear a *Co-Payment* of

i) 25% of each and every claim if treatment in Zone-I is availed
ii) 15% of each and every claim if treatment in Zone-II is availed

Policyholder's paying Zone-IV premium can avail treatment in Zone-IV without any *Co-Payment* but shall have to bear a *Co-Payment* of

i) 35% of each and every claim if treatment in Zone-I is availed
ii) 25% of each and every claim if treatment in Zone-II is availed
iii) 10% of each and every claim if treatment in Zone-III is availed

Note:

a) *Policyholder*'s residing in Zone-IV can select to pay premium for Zone-I / Zone-II/ Zone-III and avail treatment in the desired Zone with nil/less *Co-Payment*.
b) *Policyholder*'s residing in Zone-III can select to pay premium for Zone-I / Zone-II and avail treatment in the desired Zone with nil/less *Co-payment*.
c) *Policyholder*'s residing in Zone-II can select to pay premium for Zone-I and avail treatment in Zone-I with no *Co-payment*.
d) The *Co-Payments* for claims occurring outside of the Zone will not apply in case of *Hospitalisation* due to *Accident*.
e) In case of *Family Floater Policy*, a single zone shall be applicable to all the members covered under the *Policy*.
f) In case of *Non-Floater Policy*, there is option of selecting separate Zone for each *Insured Person*.

4.1.8 LOADINGS

We may apply risk loading on premium payable based on the information revealed in the Proposal Form and the current health status of the person.

The maximum risk loading for an individual shall not exceed 100%.

These loadings are applicable from commencement date of policy including subsequent renewal(s) with *Us*.

We will inform *You* about the applicable risk loading through a counter offer letter and We will only issue the *Policy* once We receive your consent and applicable additional premium.

4.2 CONDITIONS APPLICABLE DURING THE CONTRACT

4.2.1 ALTERATIONS TO THE POLICY

The proposal form, declaration and *Policy* constitutes the complete contract of insurance. This *Policy* cannot be changed by any one (including an insurance agent or broker) except *Us*. Any change that *We* make will be communicated to *You* by a written endorsement signed and stamped by *Us*.

4.2.2 CANCELLATION

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

Period on Risk (in Months)	1 Year Policy Term	2 Year Policy Term	3 Year Policy Term
	Premium to be refunded	Premium to be refunded	Premium to be refunded
1	79%	87%	90%
2	71%	83%	88%
3	63%	79%	85%
4	55%	75%	82%
5	47%	71%	80%
6	39%	67%	77%
7	31%	63%	74%
8	23%	59%	72%
9	9%	55%	69%
10	1%	51%	66%
11	0%	47%	64%
12	0%	43%	61%
13		39%	58%
14		35%	56%
15		31%	53%
16		27%	50%
17		23%	48%
18		19%	45%
19		15%	42%
20		11%	40%
21		5%	37%
22		1%	34%
23		0%	32%
24		0%	29%
25			26%

Registered & Corporate Office: Navi General Insurance Limited
402, 403 & 404, A & B Wing, 4th Floor, Fulcrum, Sahar Road, Next to Hyatt Regency, Andheri (E), Mumbai - 400099
Toll-free number: 1800 123 0004 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: insurance.help@navi.com
CIN: U66000MH2016PLC283275 | IRDAI Registration Number: 155

26			24%
27			21%
28			18%
29			16%
30			13%
31			10%
32			8%
33			3%
34			0%
35			0%
36			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.

ii. 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.

4.2.3 COMMUNICATIONS & NOTICES

i) 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.

ii) 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.

iii) 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 after posting.

iv) *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*.

Note: *Please include Your Policy number for any communication with Us.*

4.2.4 FREE LOOK PERIOD

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

i. *a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or*
ii. *where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or*
iii. *Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;*

4.2.5 GEOGRAPHY

This *Policy* covers for events within the territorial limits of India except for cover under Worldwide Emergency Hospitalisation. However, all payments under this *Policy* will only be made in Indian Rupees.

4.2.6 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 instalments from the claim amount due under the policy.

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

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 Sum Insured / age / plan /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.

4.2.7 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.

4.2.8 PROTECTION OF POLICY HOLDERS INTEREST

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

4.2.9 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*.

4.2.10 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.

4.2.11 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.

4.2.12 INCLUSION OF COVER DURING POLICY PERIOD

Based on the plan opted during the proposal stage, You can include following covers in the Policy subject to our underwriting guidelines and payment of pro-rata premium for the unexpired policy period. In such a case, the following conditions will be applicable.

i. All the waiting periods as described in section – 3.2.1, 3.2.2, 3.2.3 ,3.2.4 & 3.2.5 for these cover will be applicable from the date of endorsement.
ii. Coverage will not be applicable for any claim prior to date of endorsement.

Sr. No.	Cover	Sum Insured	Waiting Period
1	Emergency Road Ambulance/Repatriation of Mortal Remains/Funeral Expenses (per hospitalisation)	All Sum Insureds	Below waiting periods shall be applicable from the date of Endorsement – - 30 days - Named Ailments - Pre-Existing Disease - Internal Congenital Anomaly - Mental Illness
2	Organ Donor Expenses		
3	AYUSH		
4	Hospital Daily Cash		
5	Maternity and New Born Baby		
6	Cumulative Bonus		
7	Medical Inflation		
8	Medical Second Opinion		
9	Outpatient Treatment		
10	Infertility	₹ 6 - 100 Lac	
11	Worldwide Emergency Hospitalisation		
12	Emergency Air Ambulance		

4.2.13 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.

4.2.14 WITHDRAWAL OF POLICY

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

4.3 CONDITIONS WHEN A CLAIM ARISES

4.3.1 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.

4.3.2 CLAIMS

Claims Process & Management

Completed claim forms and processing documents must be furnished to *Us / TPA* within the stipulated timelines for reimbursement of all claims. Failure to furnish this documentation within the time required shall not invalidate nor reduce any claim if You can satisfy that it was not reasonably possible for You to submit / give proof within such time.

Cashless and Reimbursement Claim processing is through *Our* service partner *TPA*, details of the same will be available on the Health Card issued by *Us* on *Our /TPA* website. For the latest list of *Network Providers*, you can log on to *Our /TPA* website. *TPA* will facilitate health claims processing.

4.3.2.1 Claim Intimation:

If *You* meet with any *Accidental* Bodily *Injury* or suffer an *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.

	Type of Hospitalisation	Notify Us or Our TPA
1)	Planned Hospitalisation	Immediately and in any event at least 48 hours prior to Your admission.
2)	Emergency Hospitalisation	Within 24 hours of Your admission to *Hospital* or before discharge whichever is earlier

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

- Policy Number
- Health Card ID No
- Name of *Policyholder*
- Name of the *Insured Person* in whose relation the Claim is being lodged
- Nature of *Illness / Injury*
- Name and address of the attending *Medical Practitioner* and *Hospital*
- Date of Admission
- Any other information as requested by Us

Failure to intimate a claim within the time required shall not invalidate nor reduce any claim if You can satisfy that it was not reasonably possible for You to intimate the claim within such time.

4.3.2.2 Cashless Facility:

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) For Planned Hospitalisation:

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, any specific limitation on the claim, any *Co-Payments* or *Deductibles* and 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:

i) 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.

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

At the time of discharge:

i) 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.

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

iii) Network provider to ensure that the final authorization letter is signed by *Insured.*

iv) *Insured* must ensure to take photocopies of relevant medical records for future reference.

(b) In case of Emergency Hospitalisation:

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.

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

- Claim Form Duly Filled and Signed
- Original signed pre-authorisation request
- Copy of authorisation approval letter (s)
- Copy of Photo ID of Patient Verified by the *Hospital*
- Original Discharge/Death Summary
- Operation Theatre Notes (if any)
- Original *Hospital* Main Bill along with break up Bill and original receipts
- Original Investigation Reports, X Ray, MRI, CT Films, HPE
- Details of the implants including the sticker indicating the type as well as invoice towards the cost of implant
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted).

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

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.

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.

4.3.2.3 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. The necessary claim documents to be submitted for reimbursement are as following:

- Claim Form Duly Filled and Signed
- Original Discharge/Death Summary
- Operation Theatre Notes (if any)
- Original *Hospital* Main Bill along with break up Bill and original receipts
- Original investigation reports, X Ray, MRI, CT films, HPE
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted).
- Details of the implants including the sticker indicating the type as well as invoice towards the cost of implant
- KYC documents (Photo ID proof, Pan Card, Aadhar Card)
- Cancelled cheque for NEFT payment

We may call for any additional documents/information as required based on the circumstances of the claim.

4.3.2.4 Cashless Claim Process for Health Check Up

i. *You* can call our Network Provider on 022-40004210 / 7777040945 to make a request. Alternatively, *You* may call *Us* for any assistance you need to make such request.

ii. The Network Provider will ask for your location of residence and will give options of Diagnostic Centers nearby your location.

iii. *You* can select your preferential Diagnostic Centers and then the Network Provider will fix the appointment with the Diagnostic Centre.

iv. After fixation of appointment, the Network Provider will generate an OTP (one-time password) and share the same with *You* and the Diagnostic Centre through SMS.

v. On the appointment date You need to visit the Diagnostic Centre and show the OTP for verification.

vi. Once verified, the Diagnostic Centre will conduct the medical test as per the defined set.

vii. Post completion of the medical tests, the Network Provider/ Diagnostic Centre will share the Original Copy medical reports to *You* and also share a soft copy of the medical reports with Us to enable *Us* to make payment to the Diagnostic Centre/Network Provider.

4.3.2.5 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.

During claim processing if the claims are found deficient in documents, *TPA* shall intimate the same to Navi GI customer within 3 working days of receiving claim documents. First reminder for deficient documents will be sent within 7 days of first deficiency letter and Second reminder - within 10 days of first reminder deficiency letter. Final reminder letter will be sent from 10 days from second reminder.

We will send a maximum of three (3) reminders following which, we will send a rejection letter after 15 days of the final reminder letter if the deficient documents are not received.

4.3.2.6 Claim Investigation:

We may investigate claims if reasonably required to determine the validity of claim. Verification carried out, if any, will be done by Individuals or *Medical Practitioners* or entities authorized by *Us* to carry out such verification / investigation(s) and the costs for such verification / investigation shall be borne by *Us*.
You additionally hereby consent to disclose *Us* of documentation and information that may be held with *your* medical professionals and other insurers.

4.3.2.7 Pre-& Post Hospitalisation Claims:

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

4.3.2.8 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

4.3.2.9 Multiple Policies:

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.

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.

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.

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.

4.3.3 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.

4.3.4 TPA Related Information

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

4.3.5 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.

4.3.6 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.

4.3.7 DISCLAIMER OF CLAIM

If Company 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 the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under the *Policy*.

4.3.8 PHYSICAL EXAMINATION

Any *Medical Practitioner* authorized by *Us* shall be allowed to examine the *Insured Person* in case of any alleged disease/*Illness*/*Injury* requiring *Hospitalization*. 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*.

4.4 CONDITIONS FOR RENEWAL OF CONTRACT

4.4.1 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.

4.4.2 CHANGE OF POLICYHOLDER

The *Policyholder* may be changed only at the time of renewal. The new *Policyholder* must be a member of insured person's family (Spouse/ Son/ Daughter/ Parents).

The *Policyholder* may be changed during the *policy period* upon request in case of death of the *Policyholder*, emigration of *Policyholder* from India or in case of divorce of the *Policyholder*.

4.4.3 ADDITION OF INSURED PERSON

Addition of insured person can be made during the *Policy Period* for child between the age of 91 days and 180 days (both days inclusive) and for newly married spouse within 3 months of marriage.

Addition of insured person can also be done at renewal subject to underwriting.

For newly added insured person, all waiting periods will apply afresh.

4.4.4 CHANGE IN SUM INSURED

ENHANCEMENT -

Sum Insured can be enhanced at the time of renewal only. All waiting periods will apply afresh to the enhanced Sum Insured from the effective date of such enhancement.

You can submit a request for the enhancement in Sum Insured by filling the Change Request Form. For such requests, Underwriting will be done as per the Underwriting Guidelines of the Company.

REDUCTION –

Sum Insured can be reduced at the time of renewal only. *You* can submit a request for the reduction in Sum Insured by filling the Change Request Form.

4.4.5 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

4.4.6 PORTABILITY

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link – www.naviinsurance.com

4.4.7 PROCESS OF PORTABILITY

i. *You* can opt to port your existing health insurance *Policy* to this product subject to the following:
   a) *You* should submit application for portability with complete documentation at least 45 days prior to expiry of your existing health insurance *Policy*
   b) *You* were covered under Retail Health Insurance *Policy* from a Non-Life Insurance Company/Health Insurance Company registered with the *Authority*.

c) If the previous *Policy Sum Insured* is lower than the *Sum Insured* opted under this *Policy*, waiting periods will apply to the amount of proposed increase in *Sum Insured* only.

d) If the previous *Policy Sum Insured* is higher than or equal to the *Sum Insured* opted under this *Policy*, then the waiting periods will be reduced by the number of months of continuous coverage under the previous policy.

e) Portability benefit will be credited up to the extent of the sum of previous Sum Insured and cumulative bonus (if any).

f) In case previous policy has permanent exclusions for Maternity, infertility, and Mental Illness then waiting period for these conditions will be afresh.

g) In case previous policy has coverage for Maternity, infertility, and Mental Illness then as per portability guidelines waiting period credit for these covers is permissible.

h) All waiting periods shall be applicable individually for each *Insured Person.*

i) Acceptance of the portability application will be based on the underwriting guidelines of the Company. *We* may at *Our* sole discretion restrict the terms on which *We* may offer the cover.

j) There is no obligation on *Us* to insure all *Insured Persons* on the proposed terms, even if *We* have received all the documentation from *you*.

k) In case *You* opt to port to any other Insurance Company for *Renewal*, under the portability provision and the outcome of such portability request is awaited from the new insurer on the date of *Renewal*:

ii. On *Your* request, *We* may extend this *Policy* for a period of not less than one month at an additional premium to be paid on a prorate basis

iii. If a claim is reported during this extension period, *You* shall be required to first pay the full annual *Policy* premium. *Our* liability for the payment of such claim shall commence only once such premium is received.

5 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 (From 8 am to 8 pm)

E-mail: insurance.help@navi.com

Fax : 022-4001 8251

Courier: Navi General Insurance Limited

402, 403 & 404, A & B Wing, 4th Floor, Fulcrum,
Sahar Road, Next to Hyatt Regency,
Andheri (East),
Mumbai, Maharashtra – 400 099

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 & 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, 1st 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 Email: bimalokpal.hyderabad@ecoi.co.in	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of the Union Territory of Pondicherry
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/

ANNEXURE-I - 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

ANNEXURE – II (ILLUSTRATIONS)

Illustration 1: Cumulative Bonus

If Insured Person has a non-ported policy of Sum Insured 1 Lac. Let's see how cumulative bonus will work in renewals.

	Policy Year	Claim Status	Current Year CB (%)	Current Year CB (₹)	Accumulated CB	Unutilized Policy Sum Insured (Policy Sum Insured-Claim Amt)	Accumulated Sum Insured (Unutilized Policy SI + Accumulated CB)
Scenario 1	1 Year	No Claim	NIL	NIL	NIL	1,00,000	1,00,000
	2 Year	No Claim	10%	10,000	10,000	1,00,000	1,10,000
	3 Year	No Claim	10%	10,000	20,000	1,00,000	1,20,000
	4 Year	No Claim	10%	10,000	30,000	1,00,000	1,30,000
	5 Year	No Claim	10%	10,000	40,000	1,00,000	1,40,000
	6 Year	No Claim	10%	10,000	50,000	1,00,000	1,50,000

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Toll-free number: 1800 123 0004 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: insurance.help@navi.com
CIN: U66000MH2016PLC283275 | IRDAI Registration Number: 155

	7 Year	No Claim	Not Available - Since CB cannot accumulate more than 50% of Sum Insured		50,000	1,00,000	1,50,000
Scenario 2	1 Year	No Claim	NIL	NIL	NIL	1,00,000	1,00,000
	2 Year	No Claim	10%	10,000	10,000	1,00,000	1,10,000
	3 Year	No Claim	10%	10,000	20,000	1,00,000	1,20,000
	4 Year	No Claim	10%	10,000	30,000	1,00,000	1,30,000
	5 Year	Claim ₹ 80,000	10%	10,000	40,000	20,000	60,000
	6 Year	Claim ₹ 40,000	-10% CB reduced by 10% due to claim in previous year.	-10,000	30000	60,000	90,000
	7 Year	Claim ₹ 1,50,000	-10% CB reduced by 10% due to claim in previous year.	-10,000	20,000	0 Sum Insured utilized for paying 1,00,000, unpaid claim amount is 50,000	0 Complete CB (20,000) is utilized for paying unpaid claim amount
	8 Year	No Claim	0%	0	0 As accumulated CB of previous years is completely utilised in last year	1,00,000	1,00,000
	9 Year	No Claim	10%	10,000	10,000	1,00,000	1,10,000
	10 Year	No Claim	10%	10,000	20,000	1,00,000	1,20,000

Illustration 2: Reinstatement of In-patient Hospitalisation Sum Insured

In case an Insured person opts for a Sum Insured of 1 Lac. He also has Cumulative Bonus cover. Let's understand how reinstatement benefit will apply to the Insured person.

	Policy Term	Claim Status	Balance Sum Insured (₹) (Policy SI- Claim Amt)	Current Year CB (%)	Current Year CB (₹)	Accumulated CB	Total Accumulated SI including CB (₹)	Will Reinstatement Trigger
Scenario 1	1 Year	No Claim	1,00,000	NA	NA	NA	1,00,000	No
	2 Year	No Claim	1,00,000	10%	10,000	10,000	1,10,000	No
	3 Year	Claim – ₹ 90,000	10000	10%	10,000	20,000	30,000 (Unutilised SI = ₹ 10,000 + Accumulated CB = ₹ 20,000)	No Sum Insured is still available.

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Scenario 2	1 Year	No Claim	1,00,000	NIL	NIL	Nil	1,00,000	No
	2 Year	No Claim	1,00,000	10%	10,000	10,000	1,10,000	No
	3 Year	No Claim	1,00,000	10%	10,000	20,000	1,20,000	No
	4 Year	No Claim	1,00,000	10%	10,000	30,000	1,30,000	No
	5 Year	No Claim	1,00,000	10%	10,000	40,000	1,40,000	No
	6 Year	Claim – ₹ 1,55,000	0	10%	10,000	50,000	0	Yes
							Total Amount paid under the policy is ₹ 1,50,000 (Policy SI = ₹ 1,00,000 + accumulated CB = ₹ 50,000).	Policy SI reinstated for ₹ 1,00,000
								Reinstated amount shall not be available for this Claim which has exhausted the base SI including CB.
	Reinstatement will trigger in 6th year as the insured person has completely exhausted the total sum insured amount eligible for the year i.e Base Sum Insured and cumulative bonus. Reinstated Amount is not inclusive of Cumulative Bonus and Medical Inflation amount, if any.							

Illustration 3: Medical Inflation (MI)						
If Insured Person has a policy of 1 Lac. Let's understand how Medical Inflation benefit will work in renewal						
Policy Term	**Claim Status**	**Balance Sum Insured (₹) (SI-Claim Amt)**	**Medical Inflation (%)**	**Medical Inflation (₹)**	**Total Accumulated MI (₹)**	**Total Accumulated SI including MI (₹)**
1 Year	No Claim	1,00,000	NA	NA	NA	1,00,000
2 Year	No Claim	1,00,000	10%	10,000	10,000	1,10,000
3 Year	No Claim	1,00,000	10%	10,000	20,000	1,20,000
4 Year	Claim ₹ 80,000	20,000	10%	10,000	30,000	50,000
5 Year	Claim ₹ 40,000	60,000	10%	10,000	40,000	1,00,000
			Irrespective of Claim in Previous Policy Year			
6 Year	No Claim	1,00,000	10%	10,000	50,000	1,50,000

7 Year	No Claim	1,00,000	Not Available - Since MI cannot accumulate more than 50% of Sum Insured	50,000	1,50,000

Illustration 4: Reinstatement and Combined Additive effect of Cumulative Bonus & Medical Inflation

If Insured Person has a policy of 1 Lac. Let's understand how Medical Inflation benefit will work in renewal and how medical inflation & cumulative bonus will work at the time of claim.

Policy Term	Policy SI (Base SI + MI)	Claim Status	Balance Base Sum Insured (₹) (Base SI - Claim Amt)	Medical Inflation (%)	Total Accumulated MI (₹)	Current Year CB (%)	Accumulated CB	Balance Policy SI (Policy SI - Claim Amount)	Will Reinstatement Trigger
1 Year	1,00,000	No Claim	1,00,000	NA	NA	NA	NA	1,00,000	No
2 Year	1,10,000	No Claim	1,00,000	10% of Base SI	10,000	10% of Base SI	10,000	1,10,000	No

3 Year	1,20,000	No Claim	1,00,000	10% of Base SI	20,000	10% of Base SI	20,000	1,20,000	No
4 Year	1,30,000	Claim ₹ 80,000	20,000	10% of Base SI	30,000	10% of Base SI	30,000	50,000	No
5 Year	1,40,000	Claim	0	10% of Base SI	40,000	- 10% of Base SI	20,000	0	Yes
		₹ 1,70,000		Irrespective of Claim in Previous Policy Year		Claim in Previous Policy Year		₹ 1,60,000 is paid = 1,40,000 (Policy SI) + ₹ 20,000 (Accumulated CB)	Reinstated Amt 1,00,000 for rest of the policy Year
6 Year	1,00,000	No Claim	1,00,000	10% of Base SI	10,000	- 10% of Base SI	0	1,00,000	No
7 Year	1,10,000	No Claim	1,00,000	10% of Base SI	20,000	10% of Base SI	10,000	1,10,000	No

Illustration 5 - Self Disease Management	
Scenario 1 - An Insured Person opts for a policy with Us and undergoes a Pre-Policy medical check-up due to his Age or his declared medical condition and is found to have Diabetes (HbA1C value 7%). Let's understand how he can avail discount at renewal if he manages his Diabetes well.	
1	He has to manage his health by adopting healthy lifestyle practices to control his Diabetes.
2	Since his 1st health screening is already happened by way of Pre-Policy medical check-up at our empanelled service provider, he has to undergo only 2nd health screening test.
3	Before 90 days of expiry of the Policy year, he has to undergo HbA1C (Glycated Haemoglobin) test as 2nd health screening test at Our Empanelled Service Provider only, at his own cost.
4	If his values are more than 6.4%, he will NOT be eligible for any discount. If his values fall within the range of 5.7-6.4%, he will be eligible for 3% discount. If his values fall within the range of ≤ 5.6%, he will be eligible for 5% discount.

Scenario 2 - An Insured Person opts for a policy with Us and during the policy year found to have acquired Hypertension (Blood Pressure - SBP: >140 mmHg & DBP: >90 mmHg) & Hyperlipidemia (Cholesterol - > 240 mg/dl). Let's understand how he can avail discount at renewal if he manages his Chronic diseases well.	
1	He has to manage his health by adopting healthy lifestyle practices to control his Chronic Diseases.
2	Since he has acquired chronic diseases during the Policy year, he will have to undergo 1st health screening i.e Cholesterol tests & Blood Pressure immediately after the renewal (i.e at the beginning of the next policy year) in our empanelled network provider only , at his own cost.
3	Once 1st health screening test is done at the beginning of the policy year(renewal year), he will have to undergo 2nd health screening i.e Cholesterol tests & Blood Pressure, 90 days before the expiry of the Policy year at Our Empanelled Service Provider only, at his own cost.
4	If he is able to control both the chronic diseases i.e – his Cholesterol values are in range of 200 - 240 mg/dl & Blood pressure range is within 120-139 mmHg (SBP) & 80-89 mmHg (DBP), he will be eligible to get discount of 10% (5% each under respective chronic disease table).
	If he is able to control only one chronic diseases i.e – If Cholesterol values are more than 240 mg/dl & Blood pressure range is within 120-139 mmHg (SBP) & 80-89 mmHg (DBP), he will be eligible to get discount of 3% for managing single disease only.

NOTE –

i. Discount percentage shall be applied based on the values obtained from the 2nd screening test.

ii. If the values obtained in the 2nd screening test falls within the range as listed in 2nd test Column of the respective Chronic Disease Management Grid then discount corresponding to that range shall be applied.

iii. If the Insured is able to manage more than one specified chronic disease, the cumulative discounts shall be offered up to a maximum of 10% on renewal premium.