NAVI SMART HEALTH – POLICY WORDING

1. PREAMBLE

This Policy has been issued to You by Navi General Insurance Ltd (hereinafter referred to as Company), on the basis of Disclosure to information norm including the information disclosed by You in the Proposal Form together with any statement, report or other document submitted for this Policy or its preceding Policy/Policies of which this is a Renewal and is subject to receipt of the requisite premium. The terms set out in such Proposal Form, this Policy and its Schedule will form the basis of this contract of insurance, and for any claim or benefit under this Policy.

2. DEFINITIONS

2.1 Standard Definitions

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

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

2.1.3 **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.

2.1.4 **Condition Precedent**: means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

2.1.5 **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.

2.1.6 **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-

(a) has qualified nursing staff under its employment.
(b) has qualified Medical Practitioner/s in charge.
(c) has fully equipped operation theatre of its own where Surgical Procedures are carried out;
(d) maintains daily records of patients and will make these accessible to the insurance Company's authorized personnel.

2.1.7 **Day Care Treatment:** means medical treatment, and/or Surgical Procedure which is:

(a) undertaken under General or Local Anaesthesia in a Hospital / Day Care Centre in less than 24 hrs because of technological advancement, and
(b) which would have otherwise required Hospitalization of more than 24 hours.

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

2.1.8 **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 as stated in the policy schedule which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

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

2.1.10 **Disclosure to information norm:** 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.

2.1.11 **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:

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

2.1.12 **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.

2.1.13 **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**.**

2.1.14 **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) Act2010 or under enactments specified under the Schedule of Section 56 (1) of the said act or complies with all minimum criteria as under:

(a) has qualified nursing staff under its employment round the clock.
(b) has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places.
(c) has qualified Medical Practitioner(s) in charge round the clock.
(d) has a fully equipped operation theatre of its own where Surgical Procedures are carried out.
(e) maintains daily records of patients and makes these accessible to the insurance Company's authorized personnel.

2.1.15 **Hospitalization -** 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.

2.1.16 **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

2.1.17 **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.

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

2.1.19 **Intensive Care Unit–** 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.

2.1.20 **ICU 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.

2.1.21 **Maternity Expenses**: means

(a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization)

(b) expenses towards lawful medical termination of pregnancy during the Policy Period.;

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

2.1.23 **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.

2.1.24 **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 and who is not the Insured himself or herself or Insured's close Family member.

2.1.25 **Medically Necessary Treatment:** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

(a) is required for the medical management of the Illness or Injury suffered by the Insured.

(b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.

(c) must have been prescribed by a Medical Practitioner.

(d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.1.26 **Migration**: means, the right accorded to health insurance Policy Holders (including all members under Family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same Insurer.

2.1.27 **Network Provider:** means Hospitals or health care providers enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless Facility.

2.1.28 **Newborn Baby:** means baby born during the Policy Period and is aged up to 90 days.

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

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

2.1.31 **Out-Patient (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. However, the Insured is not admitted for Day Care or In-Patient Treatment**.**

2.1.32 **Portability**: means the right accorded to an individual health insurance Policy Holder (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.

2.1.33 **Pre-existing Disease:** means any condition, ailment, Injury or disease:

(a) that is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by the Insurer or its reinstatement; or

(b) for which Medical Advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy issued by the Insurer or its reinstatement.

2.1.34 **Pre-Hospitalisation Medical Expenses:** means Medical Expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person, provided that:

(a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

(b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.1.35 **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:

(a) Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and

(b) The inpatient Hospitalisation claim for such Hospitalisation is admissible by the insurance Company.

2.1.36 **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.

2.1.37 **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.

2.1.38 **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.

2.1.39 **Room Rent:** means the amount charged by a Hospital towards room and boarding expenses and shall include the Associated Medical Expenses.

2.1.40 **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.

2.1.41 **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.

2.2 Specific Definitions

2.2.1 **Age:** means completed age in years as at the Policy Commencement Date.

2.2.2 **Associated Medical Expenses**: means Medical Expenses such as professional fees, OT charges, procedure charges, etc., which vary based on the room category occupied by the Insured whilst undergoing treatment in a Hospital. Such Associated Medical Expenses do not include cost of pharmacy and consumables, implants medical devices and diagnostics.

2.2.3 **Dependent Child**: means biological or legally adopted son or daughter of the Insured, whose Age is less than or equal to 30 years, is financially dependent on the Insured with no source of income and has not established his/her own independent household.

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

2.2.5 **Emergency Medical Condition -** means medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) of such a nature that the absence of immediate medical attention could reasonably be expected to result in-

(a) placing the health of the Insured in serious jeopardy, including the health of the unborn child where the Insured is a pregnant woman; or
(b) serious impairment of bodily functions; or
(c) serious dysfunction of any organ or part of a body

2.2.6 **Family**: means the persons named in the Policy Schedule who are the Policy Holder's legal spouse, Dependent Children, parents/ parents-in-Law.

2.2.7 **Family Floater:** means a Policy described as such in the Policy Schedule where the Insured and the Insured's Family named in the Policy Schedule are covered under the Policy as at the Policy Commencement Date. The Sum Insured for a Family Floater is the amount specified in the Policy Schedule which represents the Insurer's maximum liability for all claims made by the Insured and/or Insured's Family during each Policy Year.

2.2.8 **Non-Floater:** means a Policy where the Insured and the Insured's Family members named in the Policy Schedule are covered under the Policy as at the Policy Commencement Date. The Sum Insured for Non-Floater is the amount shown in the Policy Schedule against each individual Insured Person which also represents the Insurer's maximum liability for that Insured Person.

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

2.2.10 **Insured Person (Insured)/Policy Holder/You/Your:** means the person(s) named in the Policy Schedule who is covered under this Policy, for whom the insurance is proposed and in respect of whom the applicable premium has been received

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

2.2.12 **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.

2.2.13 **Medical Diagnostic Laboratory:** means a clinical establishment, registered as per applicable law where pathological, bacteriological, genetic, radiological, chemical, biological investigations or other diagnostic or investigative services, are usually carried on with the aid of laboratory or other medical equipment.

2.2.14 **Modern Treatment:** means the following procedures:
(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) Bronchial 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.

2.2.15 **Nominee:** means the person named in the Policy Schedule, Policy certificate and/or endorsement (if any) who is nominated by the Policy Holder/Insured Person, to receive the benefits under this Policy in accordance with the terms of the Policy, if the Insured Person is deceased.

2.2.16 **Organ Donor**: any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs (Amendment) Act , 1994 and relevant rules and amendments thereof. The organ donated is for the use of the Insured Person.

2.2.17 **Organ Donor Expenses:** incurred necessarily towards living donor's Hospitalization for Harvesting the organ donated, where the Insured Person is recipient.

2.2.18 **Policy:** means the 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.

2.2.19 **Policy Period**: means the period commencing from the Policy Commencement Date and time as specified in the Policy Schedule and terminating either at midnight on the Policy End Date as specified in the Policy Schedule or the date of cancellation of the Policy, whichever is earlier.

2.2.20 **Policy Schedule**: means schedule attached to and forming part of this Policy mentioning the details of the Insured Person(s), the Sum Insured, the Policy Period and the limits, and conditions to which the benefits under the Policy are subject to, including any annexures and/or endorsements, as amended from time to time.

2.2.21 **Policy Year**: means a period of twelve consecutive months commencing from the Policy Commencement Date and such twelve consecutive months thereafter but not beyond the Policy Period.

2.2.22 **Proposal Form:** means a form to be filled in by the prospect in written or electronic or any other format as approved by the IRDAI, for furnishing all material information as required by the Insurer, in order to enable the Insurer to take an 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.

2.2.23 **Road Ambulance** – means a motor vehicle operated by a licenced/authorised Service Provider and equipped for taking sick or injured people having Emergency Medical Condition to Hospital.

2.2.24 **Service Provider**: means any person, clinical establishment, organization or institution that has been empanelled with Us to provide service related to Outpatient benefit, wellness benefit, Road Ambulance and Air Ambulance benefit.

2.2.25 **Sum Insured**: means the amount stated in the Policy Schedule for Hospitalization benefit (section 3.1 of the Policy).

2.2.26 **TPA:** means any entity who is registered under the IRDAI (Third Party Administrators - Health Services) Regulations, 2016 notified by the IRDAI, and is engaged, for a fee or remuneration by an insurance Company, for the purposes of providing health services.

2.2.27 **Waiting Period:** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

2.2.28 **We/ Our/ Us / Insurer/ Company:** means Navi General Insurance Limited.

3. SCOPE OF COVER

3.1 Hospitalization

We will cover the Insured Persons under this Policy up to the Sum Insured specified in the Policy Schedule for Reasonable & Customary Charges incurred for Medically Necessary Treatment during the Policy Year, subject to the Deductible specified in the Policy Schedule, and also subject to the terms, conditions and exclusions of this Policy, for the following coverage:

We will cover:	Specific Conditions under this Coverage:
1. **Medical and Surgery expense incurred during Hospitalization**, also including: i. Hospitalization due to Covid-19 ii. Hospitalization towards Dental Treatment necessitated due to Illness or Injury iii. Hospitalization towards Plastic Surgery necessitated due to Illness or Injury	1. In any policy year, the **deductible** needs to be exhausted before any claims are payable: a. The deductible is applicable on the admissible claim amount after applying all the policy terms and conditions b. For an Individual policy, the deductible is applicable only once per policy year for all claims combined. c. For a Non-Floater policy, the deductible is applicable only once per policy year for all claims combined, for each insured member separately.

iv. Hospitalization towards MentalIllness treatment v. Day Care Treatment for all eligible procedures vi. Domiciliary Hospitalization 2. **Expenses payable are**: i. Room Rent, boarding & nursing ii. Intensive Care Unit (ICU) iii. Medical Practitioner including Surgeon, Anaesthetist, Specialist, Physiotherapist's fees iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicine and drugs, cost towards diagnostic tests and imaging modalities v. Pre-Hospitalization expenses,for 90 days vi. Post-Hospitalization expenses,for 180 days vii. Organ Donor Expenses viii. Emergency Road Ambulance expenses ix. Expenses towards Modern Treatment procedures x. List I under Annexure I: Toiletries / Cosmetics / Personal Comfort or Convenience Items / Similar Expenses	d. For a Family Floater policy, the deductible is applicable only once per policy year for all claims made by the Insured and/or Insured family members combined. 2. **Proportionate deduction** from the covered Associated Medical Expenses (in addition to difference in the Room Rent) shall be applicable if Your occupancy is in a room category which is higher than a single room occupancy, during Your Hospitalization, and such Hospital adopts differential billing based on room category in relation to, including but not limited to, Medical Practitioner fees including surgeon, anesthetist, specialist, operation theatre charges and nursing expenses. Proportionate deduction will not be applicable on ICU Charges. 3. With regards to **Emergency Road Ambulance** expenses, it covers the expenses incurred for Insured Person's Road transfer between (a) Place of Illness or Accident, and a Hospital; (b) Referral Hospital and a referred Hospital. Only Road Ambulance operated by a registered ambulance Service Provider is covered. 4. For **Domiciliary Hospitalization**, the Medical Practitioner must certify in writing that the Insured Person cannot be transferred to a Hospital due to his/her medical condition, or the Insured Person satisfies Us about non-availability of room in a Hospital. Records of the treatment administered are duly signed by the treating Medical Practitioner and maintained for each day of the Domiciliary Hospitalization

3.2 Unlimited Online Doctor Consultations

We will cover Online doctor consultations with a Medical Practitioner empaneled with Us as Our Service Provider for Diagnosis, treatment and prevention of Illness/ Injury, counseling, health education, medicine prescription. There is no sum insured or deductible specific to this coverage.

This coverage is subject to the following terms and conditions:

a. The Medical Practitioner will use his/her professional discretion to gather the type and extent of patient information (history/examination findings/investigation reports/past records etc.) required to be able to exercise proper clinical judgement
b. Online doctor consultation shall be offered in accordance with the applicable Telemedicine Practice Guidelines issued by competent authority of the Government of India.
c. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, quality of service, errors of omission/commission and representations made by the treating Medical Practitioner.
d. We may facilitate the provision of such online consultation, but the Insured Person is free to choose whether or not to obtain such online consultation, and if obtained, it is the Insured Person's sole and absolute discretion to follow such suggestion for any advice related to his/her health.
e. We should receive the request from You for online doctor consultation through Our mobile application

3.3 OPTIONAL COVER: Outpatient Treatment Benefit

We will cover consultation fees incurred by the Insured Person for a consultation, with a Medical Practitioner and the expenses incurred towards a diagnostic test/s as prescribed in writing by the Medical Practitioner up to Rs. 5,000/- per policy year for each Insured Person.

The policy schedule will specify if this benefit is covered under the policy or not.

The sum insured for this benefit is over and above the sum insured for section 3.1. There is no deductible specific to this coverage.

This coverage is subject to the following terms and conditions:

a. Outpatient Treatment Benefit coverage is offered by Us through Our Service Providers (Consultants and Diagnostic service facilities) on cashless basis.
b. We receive the request in advance from the Insured Person through Our mobile application to avail the coverage.
c. If this coverage is extended then Standard exclusion section 4.1 (except 4.1.10, 4.1.11) & Specific exclusion section 4.2 (except 4.2.6, 4.2.10, 4.2.11) shall stand deleted.

4. 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:

4.1 Standard Exclusions

4.1.1 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 12 months 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 12 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Insurer.

4.1.2 Specified Disease / procedure waiting period – Code – Excl02

(a) Expenses related to the treatment of the listed conditions; Surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first Policy with Us. This exclusion shall not be applicable for claims arising due to an Accident.
(b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
(c) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
(d) 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.
(e) List of specific diseases/procedures are mentioned below –

Ear Nose Throat • Sinusitis • Chronic Suppurative Otitis Media (CSOM) • Tonsillectomy • Adenoidectomy • Mastoidectomy • Tympanoplasty • Surgery for Deviated Nasal Septum • Surgery for turbinate/Concha • Any other benign ear, nose and throat disorder or Surgery	**Gastrointestinal** • Calculus Diseases of Gall Bladder including Cholecystectomy. • All types of Surgery of Hernia • Fissure/Fistula in anus, Haemorrhoids, Pilonidal Sinus • Ulcer of Stomach & Duodenum • Gastroesophageal Reflux Disorder (GRD) • Perianal / Perineal Abscess • Rectal Prolapse
Urogenital • Calculus of Urinary system (Kidney Stone/Urinary Bladder/Ureteric Stone) • Any Surgery of the genitourinary system unless necessitated by malignancy. • Benign Hyperplasia of Prostate • Surgery for Hydrocele/Rectocele	**Eye** • Cataract • Surgical Management of Glaucoma • Retinopathy

Gynaecological • Cysts, polyps • Any type of Breast lumps (unless malignant) • Polycystic Ovarian Disease (PCOD) • Fibroids (Fibromyoma) • Myomectomy for fibroids • Prolapse of Uterus unless necessitated by malignancy. • Adenomyosis • Endometriosis • Menorrhagia and Dysfunctional Uterine Bleeding (DUB) • Dilatation & Curettage (D & C) • Hysterectomy unless due to malignancy	**Orthopaedic** • Non-Infectious Arthritis • Gout and Rheumatism • Osteoarthritis and Osteoporosis • Ligament, Tendon & Meniscal Tear (other than caused by Accident) • Spondylitis/Spondylosis/Spondylolisthesis • Surgery for Prolapsed intervertebral disc (other than caused by Accident) • Joint Replacement Surgeries (other than caused by Accident)
Others • Varicose veins and Varicose ulcers	**General** **(Applicable to organ systems/organs/disciplines whether or not described above)** • Any type of cysts / Nodules / Polyps / Internal tumors / Skin tumors / Lump / growth

4.1.3 30 day Waiting Period – Code – Excl03

a. Expenses related to the treatment of any Illness within 30 days from the first Policy commencement date shallbe 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 twelvemonths.

c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of grantinghigher Sum Insured subsequently.

4.1.4 Investigation & Evaluation – Code – Excl04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current Diagnosis and treatment are excluded.

4.1.5 Rest Cure, Rehabilitation and Respite Care – Excl05

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.1.6 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

4.1.7 Change of Gender Treatments – Code – Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those the opposite sex.

4.1.8 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.

4.1.9 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.

4.1.10 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.

4.1.11 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 Policy Holders 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.

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

4.1.13 Treatments received in heath hydro's, 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**

4.1.14 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**

4.1.15 Refractive Error – Code- Excl15

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

4.1.16 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.

4.1.17 Sterility and Infertility – Code – Excl17 –

Expenses related to sterility and infertility. This includes:

4.1.17.1 Any type of contraception, sterilization; (b) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI; (c) Gestational Surrogacy; (d) Reversal ofsterilization

4.1.18 Maternity – Code – Excl18 –

4.1.18.1 Medical treatment expenses traceable to childbirth (including complicated deliveries and caesareansections incurred during Hospitalization) except ectopic pregnancy.

4.1.18.2 Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancyduring the Policy Period.

4.2 SPECIFIC EXCLUSIONS

4.2.1 Biological, Chemical & Nuclear Attack or Weapons - Treatment costs caused by or contributed to or arising from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expenses in relation to the use of nuclear weapons/materials, radioactive material, nuclear waste, nuclear fuel, chemical weapons/ materials or biological weapons/ materials.

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.2.2 **War** - Treatment related to any condition resulting from, or as a consequence of War, invasion, act of foreign enemy, civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and determinant of all kinds.

4.2.3 **External Congenital Anomaly** – Expenses incurred towards screening, counselling and treatment related to External Congenital Anomalies.

4.2.4 **Outpatient (OPD) Treatment** – Expenses incurred for treatment taken on Outpatient care basis unless specifically covered and mentioned in the Policy Schedule by Us.

4.2.5 **Eyesight, Hearing Aids & External prosthesis** –

a. Treatment related to routine eyesight checking or hearing tests including optometric therapy.
b. Cost of hearing aids / Cochlear Implants, Spectacles or Contact Lenses.
c. Cost of ambulatory devices or equipment - walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, blood sugar test strips, artificial limb and medical equipment which is subsequently used at home (except when used intra-operatively).

4.2.6 **Medically Necessary Expenses –** Cost of 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 from Medical Practitioner.

4.2.7 **Preventive Vaccinations** - Expenses incurred 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.

4.2.8 **Self-inflicted injuries or attempted suicide** - Expenses for treatment resulting directly or indirectly from self-inflicted Injury or suicide, attempted suicide while sane or insane.

4.2.9 **Treatment outside geographical limit** – Expenses for treatment taken outside the geographical limits of India.

4.2.10 **Treatment by a Medical Practitioner outside discipline** - 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.

4.2.11 **Un-recognized Medical Diagnostic Laboratory (or Pathological Laboratory)-** Expenses for services provided at diagnostic laboratory that is not registered under The Clinical Establishments (Registration and Regulation) Act,

2010, Clinical Establishments (Central Government) Rules, 2012, Clinical Establishments (Central Government) Amendment Rules, 2018 or any other similar act, statute or regulations and amendments thereof enacted or adopted by the Central and/ or State Government and Union Territories or does not operate or follow the minimum standards as prescribed under the aforementioned legislations

4.2.12 **Time bound Exclusions** – Expenses incurred for any disease/ Illness/ Injury having specific time bound exclusion(s) applied by Us and mentioned in the Policy Schedule and is accepted by the Insured Person.

4.2.13 **Permanent Exclusions** – Expenses incurred for any disease which is permanently excluded and specified in the Policy Schedule and accepted by the Insured Person.

5. GENERAL TERMS & CLAUSES

5.1 Standard General Terms & Clauses

5.1.1 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 Policy Holder.

5.1.2 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.

5.1.3 Complete Discharge

Any payment to the Policy Holder, Insured Person or his/ her Nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5.1.4 Multiple Policies

(a) In case of multiple policies taken by an Insured 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.

(b) 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.

(c) 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.

(d) 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.

5.1.5 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)/Policy Holders(s), who has made the 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 is within the knowledge of the Insurer.

5.1.6 Cancellation

a) The Policy Holder 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 per the rates detailed below:

Cancellation grid for Upfront Premium option			
Period on Risk	Policy Period is 1 Year	Policy Period is 2 Years	Policy Period is 3 Years
Within 1 month (first time health insurance Policy customers)	Free look period cancellation		
Within 1 month (Renewal Policy)	75%	87.5%	90%
Exceeding 1 months but less than or equal to 3 months	50%	75%	87.5%
Exceeding 3 months but less than or equal to 6 months	25%	62.5%	75%
Exceeding 6 months but less than or equal to 12 months	Nil	50%	60%
Exceeding 12 months but less than or equal to 15 months		25%	50%
Exceeding 15 months but less than or equal to 18 months		12%	25%
Exceeding 18 months but less than or equal to 24 months		Nil	12%
Exceeding 24 months but less than or equal to 36 months			Nil

Note- For monthly premium payment frequency, no refund shall be applicable for cancellation of the Policy except for Free Look period cancellation.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

b) The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of Material Facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of Material Facts or Fraud.

5.1.7 Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the Policy at least 30 days before the Policy Renewal date as per IRDAI guidelines on Migration. 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 accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration.
For Detailed Guidelines on Migration, kindly refer the link www.naviinsurance.com

5.1.8 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 probability. 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 accrued continuity benefits in waiting periods as per IRDAI guidelines on probability.
For Detailed Guidelines on Portability, kindly refer the link www.naviinsurance.com

5.1.9 Refund of Premium in case of Death of Insured

a) No refund shall be made if the policy is taken on Monthly Premium Mode.
b) In the event of death of any insured member during the course of policy period when there is no claim lodged (and in the process to be paid) or paid during the policy period, the proportionate premium for the unexpired policy period for the respective insured member will be paid to the nominee/other existing policyholders.
c) In case claim(s) have been made on a policy, no refund shall be made in the event of death of any insured member during the course of policy period.

5.1.10 Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.
(a) The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

(b) Renewal shall not be denied on the ground that the Insured had made a claim or claims in the preceding Policy Years.
(c) Request for Renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
(d) At the end of the Policy Period, the Policy shall terminate and can be renewed within the Grace Period of 30 Days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.
(e) No loading shall apply on renewals based on individual claims experience

5.1.11 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 affected.

5.1.12 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 shall be allowed free look period of 1 month 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 a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person.

5.1.13 Nomination:

The Policy Holder 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 Policy Holder. 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. For Claim settlement under reimbursement, the Company will pay the Policy Holder. In the event of death of the Policy Holder, 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 Policy Holder whose discharge shall be treated as full and final discharge of its liability under the Policy.

5.1.14 Withdrawal of Policy

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

5.1.15 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.

5.1.16 Claim Settlement (Provision of Penal Interest)

(a) 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.
(b) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policy Holder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
(c) 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.
(d) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policy Holder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(e) "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.

5.1.17 Redressal of Grievance

(a) In case of any grievance the insured person may contact the company through:
Website: www.naviinsurance.com

Toll free: 1800-123-0004
E-mail: insurance.help@navi.com
Fax: 022-4001 8251
Courier: Navi General Insurance Limited
Salarpuria Business Centre, 4th B Cross Road, 5th Block,
Koramangala Industrial Layout, Bengaluru, Karnataka – 560095

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

(b) 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

(c) 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.

(d) 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.

CONTACT DETAILS	JURISDICTION
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@gbic.co.in	Karnataka.

For all other Ombudsman Offices & Addresses: please refer the link – http://ecoi.co.in/ombudsman.html

(e) Grievance may also be lodged at IRDAI Integrated Grievance Management System – http://igms.irda.gov.in

5.2 Specific General Terms & Conditions

5.2.1 Premium Payment in Instalments

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

a) Grace Period of 30 days would be given to pay the instalment premium due for the Policy.
b) 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.
c) The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods" in the event of payment of premium within the stipulated Grace Period.
d) No interest will be charged If the instalment premium is not paid on due date.
e) In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.
f) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
g) The Company has the right to recover and deduct all the pending instalments from the claim amount due under the Policy.

5.2.2 Electronic Transactions

The Policy Holder / 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 Policy Holder's interests.

5.2.3 Loadings

a) We may apply a risk loading on the premium payable (based upon the declarations made in the Proposal Form and the health status of the persons proposed for insurance).
b) The maximum risk loading applicable for an individual shall not exceed 100% of premium per diagnosis / medical condition and an overall risk loading of over 150% of premium per person
c) These loadings are applied from Commencement Date of the Policy including subsequent Renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).
d) We will inform You about the applicable risk loading through a counteroffer letter. Please note that We will issue Policy only after getting Your consent

5.2.4 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the Proposal Form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

5.2.5 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policy Holder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

5.2.6 Notice & Communication

(a) Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
(b) Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
(c) The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

5.2.7 Territorial Limit & Nationality

All medical treatment for the purpose of this insurance will have to be taken in India only. Resident Indian or Non-resident Indian paying premium in Indian currency is eligible for coverage under the Policy

5.2.8 Automatic change in Coverage under the Policy

The coverage for the Insured Person(s) shall automatically terminate:

(a) In the case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case, the other Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such person (including his/her relationship with the Insured Person) must be submitted to the Company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy will be effective.
(b) Upon exhaustion of Sum Insured for the Policy Year. However, the Policy is subject to Renewal on the due date as per the applicable terms and conditions.

5.2.9 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

5.2.10 Arbitration

(a) If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
(b) It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided if the Company has disputed or not accepted liability under or in respect of the Policy.

(c) It is hereby expressly stipulated and declared that it shall be a Condition Precedent to any right of action or suit upon the Policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

5.2.11 Endorsements (Changes in Policy)

(a) This Policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except Us. Any change made by the Us shall be evidenced by a written endorsement signed and stamped.

(b) The Policy Holder may be changed only at the time of Renewal. The new Policy Holder must be the legal heir/immediate Family member (Spouse/ Son/ Daughter/ Parents). Such change would be subject to acceptance by the Company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

(c) The Policy Holder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India or in case of divorce of the Policy Holder.

5.2.12 Change of Sum Insured or Deductible

Sum Insured or Deductible can be changed (increased/ decreased) only at the time of Renewal, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhanced portion of the Sum Insured.

5.2.13 Addition of Insured Person

(a) An additional Insured Person can be added to the Policy during the Policy Period if such additional Insured Person is: (i) a child between the age of 91 days and 180 days (both days inclusive); or (ii) a newly married spouse and such addition is requested for within 3 months of the marriage.

(b) An additional Insured Person can be added to the Policy at the time of Renewal of the Policy as well, subject to underwriting by Insurer.

(c) With respect to all newly added Insured Person, waiting periods will apply afresh

5.2.14 Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

5.2.15 Basis of claim payment

(a) If You suffer a relapse of a medical condition within 45 days of the date when You last obtained medical treatment or consulted a Medical Practitioner and for which a claim has been made, then such relapse shall be deemed to be Any One Illness and shall be part of the same claim

(b) We will make the claim payment in Indian Rupees only

(c) You agree that We shall make payment only when You or someone claiming on Your behalf has provided Us with necessary documents and information required for claim assessment and decision.

5.2.16 Claims Process

(a) Completed claim form and other relevant documents including documents must be furnished to Us / TPA within the stipulated timelines for reimbursement of all claims under this Policy. 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.

(b) Cashless Facility and Reimbursement Claim processing shall be carried out through TPAs empanelled by Us or in-house by Us, details of the same will be available on the Policy Schedule. For the latest list of Network Providers, You can log on to Our mobile application/ Our website.

Claim Intimation:

If You meet with any Accident leading to Injury or suffer an Illness that may result in a claim under this Policy, then as a Condition Precedent to Our liability, You must comply with the following claim procedures:

You must notify Your claim to Us through online channel including mobile application that is available or at call centre.

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

The following details may be required by Us at the time of intimation of Claim:

- Policy number/ member number
- Name of the Policy Holder
- 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

Cashless Facility Claim Procedure:

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 Necessary Treatment.

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

iii) The Network Provider may either consider treating the Insured Person by taking a token deposit or treating as per their norms.

iv) The Network Provider shall electronically send the pre-authorization form along with all the relevant details to Us or TPA along with contact details of the treating Medical Practitioner and the Insured Person.

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.

vi) If the procedure above is followed, on Our written authorization, You will not be required to directly pay for the bill amount in the Network Hospital that We are liable under Section 3.1, Hospitalization of the Policy.

vii) You must leave the original bills and evidence of treatment in respect of the Hospitalization with the Network Provider and ensure to take photocopies of relevant medical records for future reference. Pre-authorisation does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.

viii) At the time of discharge, Network Provider may request You to sign the final authorization letter that was issued by Us.

ix) The Network Provider shall refund the deposit amount to You barring an amount to be charged for non-covered expenses, if any.

(b) In case of Emergency Hospitalisation:

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

ii. The Network Provider/ Insured Person shall follow the same process as explained above in septs iii to viii above under section Planned Hospitalization.

It is possible that 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 Us/ 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 Facility under the Policy. Before availing the Cashless Facility, the Policy Holder / Insured Person is required to check the applicable/latest list of Network Providers on Our mobile application/ Our website at www.naviinsurance.com

Reimbursement Claim Procedure:

Wherever You have opted for a reimbursement of expenses, You may submit the documents for reimbursement of the claim electronically including by direct upload on Our mobile application not later than 15 days from the date of discharge from the Hospital. You can obtain a Claim Form from by downloading a copy from Our website at www.naviinsurance.com or from Our mobile application. The necessary copies of claim documents to be submitted for reimbursement may include following: (a) duly filled claim form; (b) discharge/ death Summary (as applicable); (c)

operation theatre notes (if any); (d) hospital main bill along with break up bill and original receipts; (e) investigation reports- Haematology, Histo-pathology and Radiology; (f) doctors referral slips or prescription for investigations/pharmacy; (g) pharmacy bills; (h) MLC/FIR report/post mortem report (if applicable and conducted); (i) details of the implants including the sticker indicating the type as well as invoice towards the cost of implant; (j) KYC documents (Photo ID proof, Pan Card, Aadhar Card); (k) Cancelled cheque for NEFT payment
We may call for any additional documents/information as required based on the circumstances of the claim.

Cashless process to avail Outpatient Treatment benefit:

i) You shall request for an appointment with Service Provider through Our mobile application at least 72 hrs prior to service.
ii) Before scheduling an appointment, You may have to submit certain details about planned service which may include date of service, type and nature of service, details about Illness/ Injury etc.
iii) On receiving the information as above, We shall check Your eligibility to avail the service and process the request further to schedule an appointment or may reject the request.
iv) Insured Person may receive confirmation on appointment booking through SMS, Email or in the form of notification in the mobile application.
v) You will avail the service as per the appointment schedule.
vi) You shall upload the images of all the supporting documents related to service including but not limited to consultation note, prescription, investigation reports within 15 days of the date of service.
vii) Your failure to submit the supporting documents by uploading images through mobile application may lead Us to hold any future service requests for OPD benefit or Complimentary Health Check-up benefit on Our mobile application.

5.2.17 Physical Examination

You may require undergoing medical examination by a Medical Practitioner authorized by Us to examine You to establish Our liability in case of a claim under the Policy. The cost towards performing such medical examination shall be borne by Us.

5.2.18 Claim Related Information

You may submit query related to the claim or intimate the claim or submit claim document to Us through Our mobile application. Alternatively, You may also contact Us through:
Website: www.naviinsurance.com
Toll free: 1800 123 0004
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Annexure I

- Items which are mentioned under List – I are payable under the policy.
- Items which are to be subsumed into room charges are specified in List – II, procedure charges are specified in List III, costs of treatment (including costs of diagnostics) specified in List IV.
- Items which are part of room / surgical procedure / treatment (including diagnostics) as referred in the lists (II-IV) herein may not be eligible for coverage if billed separately by Hospital.

List I - TOILETRIES / COSMETICS / PERSONAL COMFORT OR CONVENIENCE ITEMS / SIMILAR EXPENSES	
No.	**Item**
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 (Toiletries 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

No.	Item
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	
No.	**Item**
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS 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, HARMONICSCALPEL,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	
No.	**Item**
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