COCO SEASONAL BYTE

POLICY WORDINGS

This is Your **COCO Seasonal Byte Policy**, which has been issued by **Us** relying on the Information disclosed by You in Your Proposal for this **Policy** or its preceding Policy/Policies of which this is a **Renewal.** The insurance cover is provided under this Policy to the **Insured Person**/s up to the **Sum Insured** and shall be subject to (a) the terms, conditions and exclusions to this **Policy** (b) the receipt of premium, and (c) **Disclosure to Information Norm** for Yourself and on behalf of each of the Insured Persons.

1. INTERPRETATIONS & DEFINITIONS

For easy understanding of this **Policy**, the following words or phrases shall have the meanings attributed to them wherever they appear in this Policy. For this purpose and where the context permits the singular shall include the plural, the male gender shall include the female, and references to any statutory enactment shall include subsequent changes to the same.

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

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		are to be carried out; iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorised representative.
6.	**Cashless Facility**	means a facility extended by the Insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the **network provider** by the Insurer to the extent pre-authorization is approved.
7.	**Cancellation (of policy)**	means the terms on which the policy contract can be terminated either by the insurer or the insured by giving sufficient notice to other which is not lower than a period of fifteen days. The terms of cancellation may differ from insurer to insurer.
8.	**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.
9.	**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.
10.	**Commencement Date**	means the start date of this Policy as specified in the Policy Schedule.
11.	**Comorbid condition**	means an **illness** or **injury** happening at the same time but not related to **Specified Illness**.
12.	**Condition precedent**	means a Policy term or condition upon which the insurer's liability under the **Policy** is conditional upon.
13.	**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.
14.	**Diagnosis**	means conclusion drawn by a registered **Medical Practitioner**, supported by acceptable clinical, radiological, histological, histo-pathological, and laboratory evidence wherever applicable.
15.	**Date of Diagnosis**	means the day when the **diagnosis** of **Specified Illness** is established by a **Specialist / Medical Practitioner** through the use of the clinical and/or laboratory findings as supported by the Insured medical records.
16.	**Emergency**	means severe **specified Illness** resulting in symptoms which occur suddenly and unexpectedly and requires immediate care by a **Medical Practitioner** to prevent death or serious long-term impairment of the Insured Person's health.

17.	**Family**	means the persons named in the **Policy Schedule** who are the Insured Person's: i. Spouse – The Insured's legally married spouse as long as she continues to be married to the Primary Insured. ii. Children – The Insured's children as long as they are financially dependent on him/her with no source of independent income and have not established their own independent households. iii. Parents – The Insured's natural parents or parents that have legally adopted him iv. Parents in Law – The Insured's Parents in Law.
18.	**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.
19.	**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.
20.	**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.
21.	**Hospitalisation**	means admission in a **Hospital** for a minimum Period of 24 consecutive "In-patient Care" hours except for specified procedures / treatments, where such admission could be for a Period of less than 24 consecutive hours.
22.	**Illness**	means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

		a) <u>Acute Condition</u> 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) <u>Chronic Condition</u> 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.
23.	**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.**
24.	**Inpatient / Inpatient Care**	means treatment for which the **Insured Person** has to stay in a **Hospital** for more than 24 hours for a covered event.
25.	**Insured Person (Insured)**	means a person whose name specifically appears in the **Policy Schedule** and with respect to whom the premium has been received by **Us.**
26.	**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.
27.	**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.
28.	**IRDAI**	means Insurance Regulatory and Development Authority of India.
29.	**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.
30.	**Medical Advice**	means any consultation or advice from a **Medical Practitioner** including the issuance of any prescription or follow-up prescription.
31.	**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.

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32.	**Medical Practitioner**	means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. Medical Practitioner should not be the **Insured Person** or his/her immediate Family member or anyone who is living in the same household as the **Insured Person**.
33.	**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.
34.	**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.
35.	**Network Provider**	means the **Hospital** enlisted by an Insurer, **TPA** or jointly by an Insurer and **TPA** to provide medical services to an insured by a **cashless facility**.
36.	**Non-Network Provider**	means any **hospital,** day care centre or other provider that is not part of the network.
37.	**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.
38.	**Notification of Claim**	means the process of intimating a claim to the insurer or **TPA** through any of the recognized modes of communication.
39.	**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.
40.	**Policy**	means this Policy document read together with the attached **Policy Schedule**, **Your Proposal Form** including any attachment like endorsement, rider, condition, warranty, declaration etc.
41.	**Policyholder**	means the person named in the **Policy Schedule** as the Policyholder.
42.	**Policy Period**	means the period commencing from Policy start date and time as specified in the **Policy Schedule** and terminating at midnight on the Policy end date as specified in the **Policy Schedule** of this **Policy**.

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43.	**Policy Schedule**	means schedule attached to and forming part of this **Policy** mentioning the details of the **Insured Persons**, the **Sum Insured,** the **Policy Period** and the limits and conditions, to which the benefits under the Policy are subject to, including any annexures and/or endorsements.
44.	**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**.
45.	**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.
46.	**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.
47.	**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.
48.	**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.
49.	**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.
50.	**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.
51.	**Reasonable and Customary charges**	means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the **Illness/Injury** involved.

<table>
<tr><td>52.</td><td>Renewal</td><td>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.</td></tr>
<tr><td>53.</td><td>Road Ambulance</td><td>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.</td></tr>
<tr><td>54.</td><td>Specialist</td><td>means a person who holds a master’s degree in the field of medicine or Surgery and valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.</td></tr>
<tr><td>55.</td><td>Specified Illness</td><td>means Diagnosis of below listed illness(es) confirmed by the Medical Practitioner on the basis of defined laboratory investigations or any other laboratory diagnosis as per the guidelines laid by Ministry of Health & Family Welfare, Govt of India.
<table>
<tr><th></th><th>Illness</th><th>Defined Laboratory Investigation</th></tr>
<tr><td>1</td><td>Dengue Fever</td><td>Non-Structural Protein-1 Antigen Positive/ IgM Antibody Capture ELISA (MAC- ELISA)</td></tr>
<tr><td>2</td><td>Zika Fever</td><td>Viral Nucleic Acid detection/Real Time-Polymerase Chain Reaction</td></tr>
<tr><td>3</td><td>Chikungunya</td><td>IgM Antibody Capture ELISA (MAC-ELISA)/Real Time-Polymerase Chain Reaction</td></tr>
<tr><td>4</td><td>Malaria</td><td>Microscopic laboratory testing or by a rapid diagnostic test</td></tr>
<tr><td>5</td><td>Leptospirosis</td><td>Microscopic agglutination test (MAT) or IgM-ELISA/ Polymerase Chain Reaction</td></tr>
<tr><td>6</td><td>Swine Flu</td><td>Real-time reverse transcriptase-polymerase chain reaction (rRT-PCR)</td></tr>
<tr><td>7</td><td>Vector Borne Encephalitis</td><td>Antibody Detection/Antigen Detection/Isolation/IgM-Enzyme Linked Immuno-Sorbent Assay/RT-PCR</td></tr>
</table></td></tr>
<tr><td>56.</td><td>Sum Insured</td><td>means the specified amount mentioned in the Policy Schedule which represents Our maximum liability for each Insured Person or Family in case of Family Floater for any and all benefits claimed for during the Policy Year.</td></tr>
<tr><td>57.</td><td>Surgery or Surgical Procedure</td><td>means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.</td></tr>
</table>

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58.	**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.
59.	**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.
60.	**Waiting Period**	means the period during which **we** shall not be liable to make payment for any claim within specified number of days from the **commencement date** of the **policy.**
61.	**We/Our/Us/Insurer**	means Navi General Insurance Limited
62.	**You/Your**	means the **Policyholder** or Primary Insured named in the **Policy Schedule.**

2. SCOPE OF COVER

A. INDEMNITY PLAN

We will cover **Reasonable and Customary charges** for **Medically Necessary Treatment** taken by the **Insured Person** for the **Specified Illness**(es) during the Policy Year under any of the benefits specified in the **Policy schedule** subject to the terms, conditions and exclusions of this Policy up to the **Sum Insured** specified in the **Policy Schedule** provided that:

a. The **Insured Person** is diagnosed with the **Specified Illness** specifically listed and defined in this **Policy**; and

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

2A.1 INPATIENT TREATMENT

I. INPATIENT HOSPITALISATION

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

Expenses shall include:

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

II. **PRE - HOSPITALISATION**

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

Note:

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

III. **POST- HOSPITALISATION**

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

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 15 days.

IV. **AYUSH**

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

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

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

c. **AYUSH** Hospitals

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

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

We will cover the expenses up to the sub-limit stated in the **Policy Schedule** incurred towards transportation of an **Insured Person** by a registered healthcare or ambulance service provider in case of an **Emergency**.

Expenses shall include:

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

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

When the **Insured Person** requires to be moved to home after discharge from the **Hospital**. The medical condition of **Insured Person** is such that it requires services of Ambulance and is certified by treating **Medical Practitioner**.

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

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

Coverage shall be applicable only if **We** have accepted claim under In-patient Hospitalisation – 2A.1) I)

2A.2 HOME CARE TREATMENT

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

a. The severity of **Specified Illness** of **Insured Person** is such that it requires continuous care and observation and can be managed at home and the treating **Medical Practitioner** has recommended for such treatment at home; and

b. Such treatment is certified by treating **Medical Practitioner** as non-Emergency.

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

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

Our maximum liability under this section will be limited to the sub-limit specified in the **Policy Schedule**.

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2A.3 OPD TREATMENT

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

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

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

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

Our maximum liability under this section will be limited to the sub-limit specified in the **Policy Schedule**.

B. BENEFIT PLAN

2B.1 FIXED CASH BENEFIT

We will Pay lumpsum amount as specified in the Policy Schedule, if the insured Person is diagnosed with Dengue / Malaria during the Policy Year subject to the terms, conditions and exclusions of this Policy provided that:

a. The **Insured Person** is diagnosed with the Dengue / Malaria as per **Specified Illness** & defined laboratory investigations under this **Policy**; and

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

3. WAITING PERIODS

We will not be liable for any claim for **specified illness** within 15 days from the **commencement date** of the **Policy**.

4. GENERAL EXCLUSIONS

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

EXCLUSIONS SPECIFIC TO THE POLICY WHICH CANNOT BE WAIVED

1. Any **Illness**(es) which is not specified under **Specified Illness**.

2. Any **specified illness** that is not diagnosed by the **Medical Practitioner**.

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

4. Geography
   Diagnosis and treatment outside India.

5. 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**

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

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

8. 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.

9. Congenital anomalies
   Screening, counselling and treatment related to External **congenital anomalies.**

10. Unrecognized Physician
    Certification/**diagnosis**/treatment from persons not registered as **Medical Practitioners**, or from a **Medical Practitioner** who is practicing outside the discipline that he/she is licensed for.

11. Maternity Expenses - Code – Excl18 -
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

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

5. GENERAL TERMS & CONDITIONS

5.1 CONDITION PRECEDENT TO THE CONTRACT

1. AGE

A person shall be eligible to become an **Insured Person** if he is of an **age** group of ninety-one (91) days to seventy-five (75) years.

2. CONDITION PRECEDENT TO ADMISSION OF LIABILITY

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. DISCLOSURE 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* 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. 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.

5. **NO CONSTRUCTIVE NOTICE**

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

5.2 CONDITIONS APPLICABLE DURING CONTRACT

1. **ALTERATIONS TO THE POLICY**

The **proposal form**, declaration, **Policy Schedule** 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**.

2. **CANCELLATION OF POLICY**

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

Months	1 year	2 years	3 years
< 6	30%	59%	68%
6 -11	0%	37%	54%
12 – 17	0%	15%	39%
18 – 23	0%	0%	25%
24 – 29	0%	0%	10%
30 – 36	0%	0%	0%

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

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

3. **COMMUNICATIONS & NOTICES**

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

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

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

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

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

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

4. FREE LOOK

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;

5. GEOGRAPHY

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

6. 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.

7. PROTECTION OF POLICY HOLDERS INTEREST

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

8. 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

Registered & Corporate Office: Navi General Insurance Limited (Formerly DHFL 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 8200 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: mycare@navi.com
CIN: U66000MH2016PLC283275 | IRDAI Registration Number: 155

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**.

9. 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.

10. 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.

11. TERMINATION OF POLICY

This **Policy** terminates on earliest of the following events:

a. **Cancellation** of Policy as per the cancellation provision.

b. On the Policy expiry date.

c. On death of the **Insured Person.**

12. WITHDRAWAL OF THE 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.

5.3 CONDITIONS FOR RENEWAL OF CONTRACT

1. CONTINUITY

Insured Person would have an option to migrate to **Our** other Health insurance product(s), if available, subject to **Our** underwriting guidelines. Likewise, children when exiting on account of being not dependent on parents will also be given an option to migrate to **Our** Individual health insurance plans subject to **Our** underwriting guidelines. **Insured Person** will be entitled for accrued continuity benefits as per prevailing **Portability** guidelines issued by the regulator.

2. MIGRATION

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance

product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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

3. **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. **PORTABILITY PROCESS**

Insured Persons covered under this **Policy** or any other Retail Health Insurance Policy from a Non-Life Insurance Company/Health Insurance Company registered with the **Authority** shall have the right to migrate from such Policy to a suitable Health insurance Policy offered by **Us** provided that:

a. You should submit application for **portability** with complete documentation at least 45 days prior to expiry of **your** existing health insurance Policy
b. **Portability** benefit will be credited up to the extent of the sum of previous **Sum Insured**
c. All **waiting periods**, if any shall be applicable individually for each **Insured Person.**
d. 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.
e. 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.
f. 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**:
    i. 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.
    ii. 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. **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.

6. 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**.

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.

5.4 CONDITIONS WHEN A CLAIM ARISES

1. ARBITRATION

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

2. DISCLAIMER OF CLAIM

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

3. PHYSICAL EXAMINATION

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

4. 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.

5. 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.

6. CLAIM PROCESS & MANAGEMENT

Completed claim forms and documents for processing 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.

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

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

a. Forthwith intimate the Claim in accordance with claim intimation section # 5.4.5) b) of this Policy.
b. If so, requested by Us, the Insured Person will have to submit himself / herself for a medical examination including any Pathological / Diagnostic examination by Independent Medical Practitioner as often as it is considered reasonable and necessary. The cost of such examination will be borne by Us.
c. Allow the Medical Practitioner or any of Our representatives to inspect the medical and Hospitalization records, investigate the facts.
d. Assist and not hinder or prevent Our representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

b. CLAIM INTIMATION

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

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

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

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

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

c. **CASHLESS FACILITY (Applicable only for Indemnity Plan)**

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

A. For Planned Hospitalization

i. The **Insured Person** should at least 48 hrs prior to admission to the **Hospital** approach the Network Provider for **Hospitalisation** for medical treatment.
ii. The Network Provider will issue the request for authorization letter for **Hospitalisation** in the pre-authorization form prescribed by the **Authority**.
iii. The Network Provider shall electronically send the pre-authorization form along with all the relevant details to the 24 (twenty-four) hour authorization/cashless department of the **TPA** along with contact details of the treating **Medical Practitioner** and the **Insured Person.**
iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider, the eligibility of cover under the **Policy** will be verified.
v. Wherever the information provided in the request is sufficient to ascertain the authorisation, the authorisation letter will be issued to the Network Provider. Wherever additional information or documents are required, the same will be called for from the Network Provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 3 hours from the receipt of last complete documents.
vi. The Authorisation letter will include details of sanctioned amount and any non-payable items if applicable.
vii. The authorisation letter shall be valid only for a period of 15 days from the date of issuance of authorization.

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

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

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

At the time of discharge:

a. The Network Provider may forward a final request for authorization for any residual amount along with the discharge summary and the billing format in accordance with the process.
b. Upon receipt of the final authorisation letter, Insured may be discharged by the Network Provider.
c. Network provider to ensure that the final authorization letter is signed by Insured.
d. Insured must ensure to take photocopies of relevant medical records for future reference.

B. In case of Emergency Hospitalization

i. The **Insured Person** may approach the Network Provider for **Hospitalisation**.
ii. **Insured Person** will need to provide health Card / Health insurance Policy details at **Hospital** admission counter.
iii. The Network Provider shall forward the request for authorization within 24 hours of admission to the **Hospital** or before discharge whichever is earlier.
iv. In the interim, the Network Provider may either consider treating the **Insured Person** by taking a token deposit or treating as per their norms.
v. The Network Provider shall refund the deposit amount to you barring a token amount to take care of non-covered expenses once the authorization is issued.
vi. The Network Provider will send the claim documents to **TPA** within 15 days from the date of discharge from **Hospital**
vii. Any additional documents may be called as required based on the circumstances of the claim.
viii. There can be instances where **Cashless Facility** may be denied for **Hospitalisation** due to insufficient **Sum Insured** or insufficient information to determine admissibility in which case You/**Insured Person** may be required to pay for the treatment and submit the claim for reimbursement to **TPA** which will be considered subject to the **Policy** Terms &Conditions.
ix. **We** in **Our** sole discretion, reserves the right to modify, add or restrict any Network Provider for Cashless services under the **Policy.** Before availing the Cashless service, the **Policyholder** / **Insured Person** is required to check the applicable/latest list of Network Provider on TPA's website or by calling call centre

d. CLAIM REIMBURSEMENT PROCESS

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

e. **CLAIM DOCUMENTS**

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

Completed claim forms and processing documents must be furnished to **Us** within the stipulated timelines for all claims. **We** may consider the delay in extreme cases of hardship where it is proved to **Our** satisfaction that under the circumstances in which the **Insured Person** was placed, it was not possible for him or any other person to give documents.

Section	Necessary Documents
For Section 2A.1 - Inpatient Treatment	a. Claim Form Duly Filled and Signed b. Original signed pre-authorisation request, if applicable c. Copy of authorisation approval letter (s) d. Copy of Photo ID of Patient Verified by the Hospital e. Original Discharge/Death Summary f. Operation Theatre Notes (if any) g. Original Hospital Main Bill along with break up Bill and original receipts h. Original Investigation Reports, X Ray, MRI, CT Films, HPE i. Details of the implants including the sticker indicating the type as well as invoice towards the cost of implant j. Doctors Reference Slips for Investigations/ Pharmacy k. Original Pharmacy Bills l. MLC/FIR Report/Post Mortem Report (if applicable and conducted). m. KYC documents (Photo ID proof, Pan Card, Aadhar Card) n. Cancelled cheque for NEFT payment
For Section 2A.2 - Home Care Treatment / 2A.3 – OPD Treatment	a. Claim Form Duly Filled and Signed b. Copy of Photo ID of Patient c. Original Outpatient Prescriptions or Treatment notes. d. Original Outpatient Invoices e. Original Discharge/Death Summary (if any) f. Original Investigation and Diagnostic Reports g. Doctors Reference Slips for Investigations/ Pharmacy h. Original Pharmacy Bills i. Original Invoices for Medical Services j. KYC documents (Photo ID proof, Pan Card, Aadhar Card) k. Cancelled cheque for NEFT payment Please be informed that all handwritten invoices to be stamped, signed and certified by treating medical practitioner and should include registration number on each invoice.

For Section 2B.1 – Fixed Cash Benefit	a. Claim Form Duly Filled and Signed b. Copy of Photo ID of Patient c. Outpatient / Inpatient Prescriptions or Treatment notes. d. Copy Discharge (if any) e. Copy of Investigation and Diagnostic Reports f. Doctors Reference Slips for Investigations/ Pharmacy g. KYC documents (Photo ID proof, Pan Card, Aadhar Card) h. Cancelled cheque for NEFT payment

f. SCRUTINY OF CLAIM DOCUMENTS

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

a. During claim processing if the claims are found deficient in documents, **TPA** shall intimate the same to the **Policyholder** / **Insured Person** within three (3) working days of receiving claim documents.

b. First reminder for deficient documents will be sent within seven (7) days of first deficiency letter and Second reminder – within ten (10) days of first reminder deficiency letter. Final reminder letter will be sent from ten (10) days from second reminder.

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

g. CLAIM INVESTIGATION

We may investigate claims 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.

h. PRE-& POST HOSPITALISATION CLAIMS

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

i. CLAIM SETTLEMENT (PROVISION FOR 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

v. Multiple Policies

Indemnity Plan:

a) 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.

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.

Benefit Plan:

In case of multiple COCO Seasonal Byte policies from Us by the policyholder, We will accept claim under the respective policies independently.

j. 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.

Registered & Corporate Office: Navi General Insurance Limited (Formerly DHFL 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 8200 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: mycare@navi.com
CIN: U66000MH2016PLC283275 | IRDAI Registration Number: 155

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.

k. TPA Related Information – (Applicable for Indemnity Plan)

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

Region	TPA Address & Contact Details
WEST DADRA & NAGAR HAVELI | DAMAN & DIU | GOA | GUJARAT | MADHYA PRADESH | MAHARASHTRA	PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED Plot No. A-442, Road No. 28, MIDC Industrial Area, Wagle Estate, Ram Nagar, Near Vitthal Rukhmani Mandir, Thane (W), Maharashtra 400604 **Website** - www.paramounttpa.com **IRDAI Reg No:** 006 **Email** - navigi@paramounttpa.com **Toll Free** - 1800 2256 01
SOUTH ANDAMAN & NICOBAR ISLANDS | ANDHRA PRADESH | KARNATAKA | KERALA | LAKSHADWEEP | TAMIL NADU | TELANGANA | PUDUCHERRY	FAMILY HEALTH PLAN INSURANCE TPA LIMITED No:8-2-269/A/2-1 To 6, 2nd Floor, Srinilaya Cyber Spazio, Road No.2, Banjara Hills, Hyderabad, Telangana – 500034 **Website** - www.fhpl.net **IRDAI Reg No:** 013 **Email** - navigi@fhpl.net **Toll Free** - 1800 599 2488

EAST & NORTH ARUNACHAL PRADESH | ASSAM | BIHAR | CHHATTISGARH | JHARKHAND | MANIPUR | MEGHALAYA | MIZORAM | NAGALAND | ODISHA | SIKKIM | TRIPURA | WEST BENGAL | CHANDIGARH | DELHI | HARYANA | HIMACHAL PRADESH | JAMMU & KASHMIR | PUNJAB | RAJASTHAN | UTTAR PRADESH | UTTARAKHAND	**RAKSHA HEALTH INSURANCE TPA PRIVATE LIMITED** C/O Escorts Corporate Centre, 15/5, Mathura Road, Faridabad - 121003 Haryana **Website** - www.rakshatpa.com **IRDAI Reg No:** 015 **Email** - navigi@rakshatpa.com **Toll Free** - 1800 180 1555

6. REDRESSAL OF GRIEVANCE

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

Website: www.naviinsurance.com
Toll free: 1800-123-0004 (From 8 am to 8 pm)
E-mail: mycare@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 1 – 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

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Toll-free number: 1800 123 0004 8200 | Fax: 022-4001 8251 | Website: www.naviinsurance.com | Email: mycare@navi.com
CIN: U66000MH2016PLC283275 | IRDAI Registration Number: 155

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

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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

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